Commentary on Wu et al.: Sustaining and advancing the global war on tobacco

Despite global health achievements in tobacco control, consistent and sustained adoption of anti-smoking measures must expand in lower and middle-income countries.

Effective tobacco control has decreased smoking prevalence rates in line with the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) [1] and subsequent MPOWER measures [2]. However, smoking still accounts for 7 million deaths annually, and despite public health efforts a sizable minority of the world population continue to smoke [3,4], with the highest mortality rates reported in smokers in China [5]. Wu et al. present further evidence of tobacco control policies introduced in China on hospital admissions. In Beijing, the 2008 Olympic games impetus provided an incentive to reform and enact comprehensive macrolevel tobacco control policies enabling reduced exposure to second-hand smoke (SHS) and reduce cardiovascular hospital admissions. This evidence is consistent with the growing knowledge base supporting broader tobacco control policy developments [6] and promoting a human right to health [7,8].

Adopting a social co-governance approach in initiating comprehensive tobacco control policies produced demonstrable public health benefits and underlines that continued engagement is essential throughout China due to the high smoking rates and risk for stroke [5]. Globally, China, India and Indonesia account for 51.4% of the total number of male smokers [8,9]; more than 80% of the world’s 1.3 billion smokers live in low- and middle-income countries (LMICs) [3].

Higher prevalence rates of smoking exist in those experiencing significant social disadvantage [10]. In a world engulfed in a pandemic, the impact of COVID-19 amplifies the risk of smoking on health outcomes for marginalized populations [11,12]. Bambra et al. suggest that disadvantaged communities encounter a ‘syndemic’—a pandemic interacting and exacerbating their existing health and social conditions—as their reality [13].

Therefore, a health systems approach [14] encompassing broad tobacco control is required to support quit attempts, reduce exposure to SHS and avoid diverting limited smoking cessation resources elsewhere. Adopting a piecemeal approach to implementing tobacco control policies in LMICs is insufficient to advance public health benefits.

The methodological approach adopted by Wu et al. [5] using population-level data and an interrupted time series trend analyses of hospital admission rates is appropriate. It is not feasible to undertake randomized controlled trials, and countries cannot be blind to an intervention of adopting policies as comparable controls. Robust statistical techniques adjust for confounders, and sensitivity analysis of temporal trends increases the confidence in reported health benefits.

However, individual-level reporting of smoking status is absent in analyses. Furthermore, despite the social construction of smoking behaviours [15,16], family members’ smoking status is generally non-existent in hospital admission data capture. Mandatory data capture of smoking status for all hospital attendances, including those of partners, supports a broader perspective of smoking behaviours and social context.

Reporting health outcomes for uninsured and marginalized populations is paramount, focusing upon wider social determinants of health; they have an increased likelihood of smoking, reduced resources to support quitting and generally experience poorer health overall [5,12]. Data assessing the impact of tobacco control policies on seldom-heard groups are inadequate; co-designing and tailoring smoking cessation solutions with smokers are necessary [17,18]—the one-size-fits-all model of intervention does not apply. Marteau et al. [19] suggest a focus upon both behavioural and social causes to improve health outcomes and reduce inequalities, partnering with people at individual, community and policy levels and emphasizing a social determinants of health stance.

When the world watches the impact of social inequities associated with COVID-19, the absence of tobacco control policies in low- and middle-income countries is ever more apparent. A health system lens to developing and implementing tobacco control policies remains critical to promoting health for those most at risk.

Declaration of interests

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Commentary

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