



Tobacco control: all research, no action



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For more on the 1998 Master Settlement Agreement see <https://www.publichealthlawcenter.org/topics/commercial-tobacco-control/commercial-tobacco-control-litigation/master-settlement-agreement>

In a sobering Article in *The Lancet*, the GBD 2019 Tobacco Collaborators¹ refine methods to estimate the increasing toll of tobacco-attributable morbidity and mortality. The authors analysed data on prevalence of smoking tobacco use from 204 countries and territories between 1990 and 2019, based on information from 3625 self-reported nationally representative surveys. Their analysis, the second to focus on tobacco in the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD),² improves on calculations of prevalence of smoking in adults and tobacco-related disease by adding over 800 data sources for prevalence and directly estimating the impact of smoking from Bayesian meta-regression analyses of 36 health outcomes.

The authors found that global age-standardised prevalence of smoking tobacco use decreased by 27.5% (95% uncertainty interval 26.5–28.5) in males and 37.7% (35.4–39.9) in females aged 15 years and older between 1990 and 2019.¹ However, inexorable population growth has increased the number of smokers from 0.99 billion (0.98–1.00) in 1990 to 1.14 billion (1.13–1.16) in 2019, who consumed 7.41 trillion (7.11–7.74) cigarette-equivalents of tobacco in 2019. The authors estimated that 5.96 million (77.5%) of 7.69 million smoking-attributable deaths in 2019 occurred in low-income and middle-income countries and that 66 (93%) of 71 countries that had significant increases in such deaths were low-income and middle-income countries.

A wide variation in prevalence of smoking tobacco use was found in these countries that obscures an understanding of the individual-level factors. For instance, WHO reported that although global tobacco cultivation decreased by 15.7% between 2012 and 2018, it increased by 3.4% in Africa.³ The number of adult users of tobacco in Africa increased from 64 million in 2000 to 73 million in 2018,³ but population growth alone might not fully explain this increase. Affordability of cigarettes and economic reliance on tobacco farming to alleviate poverty could account for increasing consumption.

This Article by the GBD 2019 Tobacco Collaborators comprises descriptive statistics and is not analytical epidemiological research reporting causal inferences. For over 70 years, countless epidemiological studies

have informed us of the tragic toll of cigarette smoking. These latest findings remind us of the ongoing worldwide health crisis resulting from tobacco use. But in their minimal conclusion, the authors do not ask what, precisely, we must do with their data.

How to tackle the global smoking pandemic has become a perpetual dilemma. Tobacco control—a term adopted by 1990s academia to keep radical grassroots antismoking activism at arm’s length—remains mired in descriptive research that generates data to support policies aimed at reducing smoking. However, unlike, for instance, mosquito control, the vector—the tobacco industry—survives and thrives. And, like a mutating virus, it adapts to legislative and regulatory attempts to hinder the sale, promotion, and use of its products.

Taxation or sin taxes are not necessarily the most effective tobacco control policy, but to say so risks derision. Cigarette taxes could be set high enough to crush the tobacco industry, but no governments will go that far. They rely on this revenue for deficit reduction and for things other than curbing smoking.

The vaunted 1998 Master Settlement Agreement between the US state attorneys general and the tobacco industry, ostensibly to recover medical costs for disease caused by smoking, epitomises government addiction to tobacco money. States have spent only 3% of the annual payments to them from the industry to fight smoking, which in some instances is less than before the Master Settlement Agreement. Increases in tobacco taxation might have reduced sales to the poorest consumers, but US cigarette manufacturers are still making huge profits and tobacco stocks remain a healthy investment.⁴

The tobacco industry’s never-ending plea that more research is needed before restricting or banning its products has been heeded for too long. In 1985, US Surgeon General C Everett Koop pointed to the overwhelming scientific base—already more than 50 000 studies—linking smoking to various chronic diseases.⁵ A PubMed search on May 20, 2021, using the terms “smoking”, “cigarettes”, “tobacco”, and “e-cigarettes” yielded 358 858 publications since Jan 1, 1985. Are all these additional papers, and their funding, still insufficient?

Only in the mid-2000s did we begin to flatten the curve for lung cancer mortality for both men and

For more on lung cancer mortality see <https://canceratlas.cancer.org/the-burden/lung-cancer/>

women in the UK and the USA, long after the Royal College of Physicians and the US Surgeon General Luther Terry told us what we needed to do.⁶ By stark contrast with the trillions of dollars allocated by US Congress to address COVID-19, no major funding has ever been approved to fight smoking and its promotion.

The tobacco industry remains the foremost obstacle to tobacco control. State-owned cigarette manufacturers—notably, the China tobacco monopoly in the world's largest cigarette market—pose a daunting challenge to public health. The USA, the UK, Japan, South Korea, Switzerland, and Sweden, among other countries, also host powerful tobacco companies.

Unlike the earnest but static WHO Framework Convention on Tobacco Control, which has not been well implemented,⁷ the tobacco industry is dynamic and resilient. The livelihoods of 100 million people are dependent on the production, distribution, and sale of tobacco products.^{8,9} No jobs in tobacco control will be lost if smoking and the resultant diseases increase. Public health failures engender research funding.

Forget health ministers, legislators, and university trustees. Any hope for ending the tobacco pandemic lies in the commitment of every health professional to make smoking prevention, smoking cessation, and relapse prevention top priorities. Philanthropic foundations can best support this goal by shifting funds from research to hard-hitting, paid, mass media campaigns that indict tobacco companies, shatter myths (eg, that the filter makes smoking safer), and subvert cigarette sales through brand-name satire.¹⁰⁻¹²

We declare no competing interests.

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For the Royal College of Physicians statement on smoking and health from 1962 see <https://www.rcplondon.ac.uk/projects/outputs/smoking-and-health-1962>

Expanding CD38-targeting triplets for relapsed or refractory multiple myeloma



In the rapidly evolving treatment landscape for multiple myeloma, the optimal choice and sequencing of drugs are challenging.¹⁻⁵ At the time of clinical relapse, a number of factors related to the host and the disease ultimately affects treatment selection.¹² However, the depth and duration of response, exposure to previous drugs, and refractoriness to one or more classes of

agents, particularly in the last treatment line, are crucial for the selection of the best sequence.³⁻⁵

In *The Lancet*, Philippe Moreau and colleagues⁶ report the results from an interim analysis of the phase 3 IKEMA study comparing isatuximab, carfilzomib, and dexamethasone (isatuximab group) versus carfilzomib and dexamethasone (control

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“COVAX ‘was a beautiful idea, born out of solidarity. Unfortunately, it didn’t happen...Rich countries behaved worse than anyone’s worst nightmares.”

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