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From teachable moment to national strategy: Acting on readiness to quit smoking

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In this issue of the *Annals*, Fong et al. note that Singapore's daily smoking prevalence has continued its long-term decline, reaching 8.4% among residents in 2024.[1] This progress reflects decades of sustained investment across Singapore's tobacco control ecosystem, spanning legislation, taxation, smoke-free public spaces, and public education.[2] Yet as prevalence falls, the remaining smokers may be harder to reach, and further gains are unlikely to come from conventional measures alone.

What comes next? Singapore has favoured a pragmatic, incremental approach to tobacco control, and it does not anticipate a sudden move towards an explicit tobacco endgame—the time-bound, structural policy approach, adopted in various forms by a growing number of countries, that aims to end the tobacco epidemic rather than simply control it.[3] If Singapore is to reduce smoking rates, it will need to think outside the box and adopt new approaches.

Fong et al. conducted a cross-sectional study of 953 hospitalised smokers referred to an inpatient cessation service between 2021 and 2025, finding that approximately half (49%) were willing to quit.[1] After adjustment, willingness was independently associated with ischaemic heart disease, cerebrovascular accident, higher symptom burden (on the chronic obstructive pulmonary disease assessment test or the modified Medical Research Council dyspnoea scale), a respiratory admission or visit in the past year, and higher educational attainment. Willingness rose progressively as these clinical features accumulated, although this composite was derived post hoc and awaits validation. Importantly, the study measured willingness, not quitting; these associations should not be read as predicting cessation.

That sicker patients are more willing to quit is intuitive, but it should prompt action. Illness, heightened perceived risks, and a smoke-free ward may together open a window of enhanced openness to change. The proportion willing to quit in this cohort exceeds the 31.3% of current smokers reporting quit intention in a national survey conducted in 2020 to 2022, although definitions and populations differ.[4] An earlier Singapore study of 7194 patients recruited into inpatient cessation programmes at 2 institutions reported 24.7% abstinence at 6 months, with the highest quit rates among those admitted with cardiovascular disease, in keeping with Fong et al.'s findings.[5]

Admission offers multiple touch points. Admission nurses already identify smokers routinely in most Singapore institutions, and the inpatient team can then deliver counselling and start nicotine replacement therapy (NRT), which also eases withdrawal once access to cigarettes is cut off. Such efforts work best when built into routine care rather than left to individual clinicians. Tobacco dependence is a treatable chronic disease, not a lifestyle choice for which patients must request help. In a randomised trial among hospitalised smokers in the US, an opt-out model, in which treatment is offered by default and patients decline if they wish, roughly doubled treatment use and increased quit attempts, regardless of stated readiness to quit.[6] Empowering nurses and other non-physician staff to initiate NRT would build on existing workflows. Because motivation during illness may be transient, the opportunity should not end at discharge—hospital and community cessation services are best viewed as parts of a single, longitudinal treatment pathway.

NRT is a well-established first-line pharmacotherapy for smoking cessation, available as patches, gum, and lozenges. Systematic review evidence shows that NRT increases quit rates by 50% to 60% regardless of setting, with no clear evidence of increased risk of myocardial infarction, and it does not need to be prescribed by a doctor.[7] Cost, however, may still deter some smokers from starting treatment.

Singapore takes a multipronged approach to tobacco control and subsidises cessation aids. The Medication Assistance Fund (MAF) subsidises clinically proven, cost-effective but high-cost drugs for eligible patients at public hospitals and polyclinics, and NRT patches,

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gum, and lozenges have been on the MAF list since 2023 for patients who are willing to quit and are enrolled in a counselling programme.[8] This has been anecdotally associated with increased NRT use. However, the subsidy is currently limited to public healthcare institutions, and eligibility criteria based on stated willingness to quit may exclude smokers who are undecided but could be engaged, as suggested by evidence on opt-out approaches. Extending subsidised NRT to general practitioner (GP) clinics and community pharmacies, coupled with pharmacist-delivered behavioural counselling at the point of sale, could reach more smokers and further increase quit rates.

Regulatory reform could widen access further. NRT is currently a Pharmacy-Only Medicine in Singapore,[9] restricting supply to hours when a pharmacist is on duty—a meaningful barrier since cravings do not keep to office hours. Reclassifying NRT as a General Sale List medicine would give smokers round-the-clock access to a safe, effective aid, potentially forestalling the single cigarette that so often precipitates relapse. Any such move should be accompanied by appropriate safeguards, including standardised product labelling and patient education on correct dosing, duration of use, and combination therapy, delivered through channels such as pharmacist helplines or printed guidance rather than only face-to-face counselling, as well as ongoing monitoring.

Fong et al.'s findings also expose a limitation in how smokers are currently reached—referral depended on patient agreement and clinical judgement, likely favouring those already inclined to quit. Since admission nurses already screen patient's smoking status, active case finding could become the default, with every smoker identified in hospital offered at least brief engagement whatever their initial stance. This first step would address the selection issue directly, at negligible extra cost, and extend the reach of cessation services to the larger group of hospitalised smokers who are undecided or not yet ready. Whether more intensive or repeated engagement for this group justifies the additional resource warrants further study in Singapore. A recent Cochrane review found only low-certainty evidence that motivational interviewing improves quit rates beyond brief advice, while the staff time and resource implications of such follow-up have yet to be formally evaluated in Singapore. Universal brief engagement at the point of admission may therefore serve as a low-cost first step for smoking cessation, with more intensive follow-up warranting pilot testing and further economic evaluation.

However, hospitals should not be the sole entry point for cessation support. Routine cessation counselling in primary and community care, at GP visits, polyclinic consultations, and pharmacy encounters, would give smokers repeated opportunities to engage, and would pair naturally with the more accessible cessation aids described above.

Education deserves particular attention. In Fong et al., educational attainment showed the strongest association with willingness to quit, although the estimates were imprecise, with wide confidence intervals and a small reference group. The national survey similarly found lower intention to quit among smokers with secondary or pre-tertiary education.[4] Generic posters and campaign messages may fail to resonate with smokers with low education attainment or health literacy, highlighting the need to tailor message content, rather than simply expand its reach. Tailored approaches built on personal engagement and relationship-based care are likely to resonate more, and Koh et al. likewise call for simpler messaging for lower-literacy groups.[4]

Finally, willingness is dynamic rather than fixed. In the Stages of Change model, smokers move through precontemplation, contemplation, action, and maintenance, often relapsing and cycling back before quitting for good.[10] Fong et al. grouped undecided smokers with those unwilling to quit, yet ambivalence provides an opportunity for engagement. Hospital admissions should therefore be viewed not merely as a means of identifying smokers ready to quit, but as an opportunity to help all smokers, regardless of readiness, progress towards cessation.

Behind every statistic in Fong et al.'s cohort is a person, embedded in a family and a community, with their own reasons for smoking and for wanting to quit smoking. Readiness to quit is not static—it can be assessed, nurtured, and advanced through timely support, one stage at a time. Longitudinal studies should now test whether the clinical features identified here relate to quit attempts and sustained abstinence, and trials should evaluate active case finding and NRT-on-discharge pathways. Meanwhile, every opportunity should be seized—whether during a hospital admission, a clinic visit, or a conversation at the pharmacy counter—to meet smokers where they are and strengthen the systems and support that make quitting easier to initiate and sustain. Do this well, and Singapore's smoking rate can fall further and faster.

Ethics statement

Not applicable, as no study participants were recruited.

Declaration

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