

# **The State of Youth Tobacco Prevention and Control Spending in Alabama: Struggles, Consequences, and Solutions**

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## Executive Summary

A wealth of evidence indicates an association between the level of funding allocated by a state for tobacco prevention and control programs and the uptake and continued use of tobacco products by its youth population (Campaign for Tobacco Free Kids, 2012; Indiana Tobacco Prevention and Cessation, 2008; Niederdeppe, et al., 2008; Pizacani et al. 2009; Sly et al., 2005; Tobacco Free Florida, 2013). In Alabama (as in other states across the nation), increased funding for tobacco prevention programs following the Master Settlement Agreement (MSA) of 1999 led to a substantial decline in youth tobacco prevalence rates throughout the first decade of the 21<sup>st</sup> century (CDC, 2014a). Subsequently, reallocation of state funding and, thus, the loss of the Youth Tobacco Prevention Program (YTPP) mini-grant awards, has resulted in stagnation and in some cases reversal of this trend. Without state financial support, community led efforts to prevent Alabama adolescents from initiating and continuing tobacco use have become untenable and the positive outcomes of these efforts are being lost as well.

Alabama's YTPP mini-grant program was designed to support youth-serving, community organizations within the state in their efforts to locally implement the components of a comprehensive state tobacco prevention and control program as recommended by the Centers for Disease Control and Prevention (CDC; CDC, 2007). Grant recipients worked to 1) educate community leaders concerning the effectiveness of price increases for reducing youth tobacco use, 2) develop and implement media campaigns concerning the dangers of youth tobacco use, and 3) provide evidence-based prevention programs to students in local schools, who, in turn, became advocates for policy change concerning youth access to tobacco products. As in other states such as California, Massachusetts, and Florida, which have successfully implemented similar programs, the mini-grant program's efforts proved effective in reducing youth tobacco use in Alabama. However, as in other states, with the disappearance of funding for youth tobacco prevention programs, the decline seen in youth tobacco use has also disappeared (CDC, 2014a).

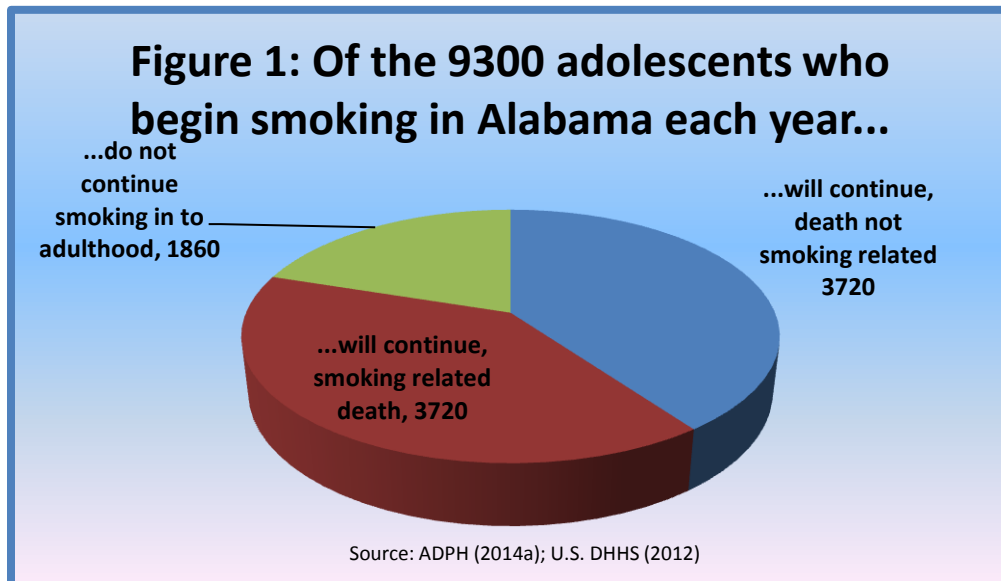
Encouragingly, evidence also suggests Alabama's ability to recoup this loss. In Florida, the return of lost tobacco prevention and control funding led to the lowest adolescent smoking rate ever reported by any state (Tobacco Free Florida, 2013). And research conducted by public health officials, as well as economists, indicates that restoring and maintaining funding to Alabama's tobacco prevention and control efforts at the minimum level recommended by the CDC could save the state as much as \$1.1 billion a year in health care costs (Chattopadhyay & Pieper, 2012), while also preventing youth initiation of tobacco use and, in turn, the illnesses and deaths caused by its long-term use (Fosson & McCallum, 2011; U.S. DHHS, 2010).

# The State of Tobacco Prevention and Control Spending in Alabama: Struggles, Consequences, and Solutions

## Tobacco Use and Alabama Youth

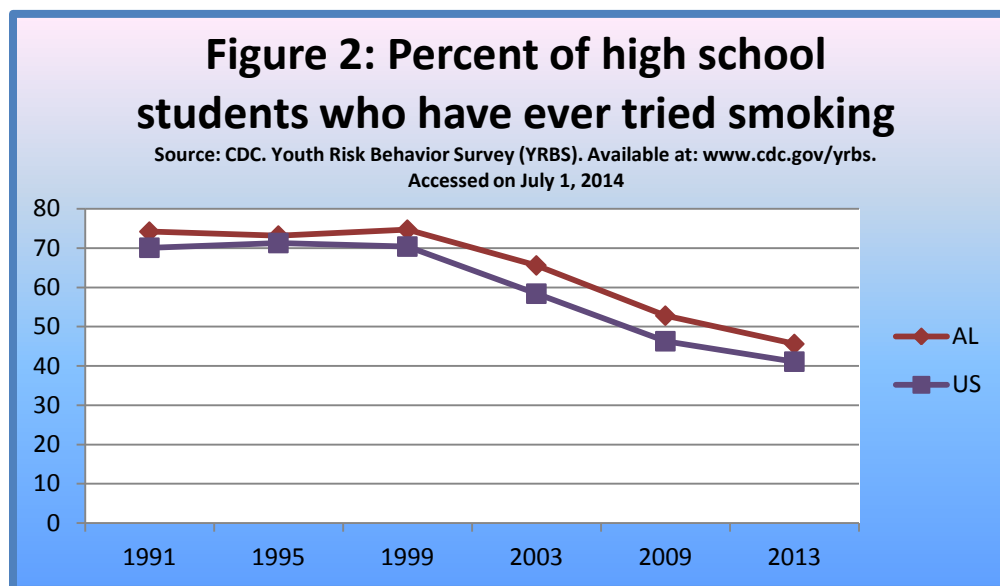
### Prevalence and consequences of youth smoking

In the state of Alabama, 25% of high school seniors (18% of all high school students, grades 9-12) smoke cigarettes regularly (CDC, 2014a). Of the approximately 9300 adolescents under the age of 18 who began smoking in the state of Alabama last year (Fosson & McCallum, 2011), 7440 (80%) will continue to do so in adulthood (U.S. DHHS, 2012). It follows that approximately 3720 of these children will be among the estimated 50% of smokers who eventually die of smoking related causes (Figure 1, U.S. DHHS, 2010). During their life time, their smoking related health care costs will average \$2,051 per person per year, totaling \$15.3 million each year, adding to the current estimate of \$1.66 billion already expended per year for current smokers (Fosson & McCallum, 2011). These numbers represent health costs only and do not consider the indirect costs of lost work and productivity, not to mention the value of lives lost or the cost of suffering.



In contrast, the costs of implementing and maintaining tobacco use prevention and control programs are relatively low. Based on population size and evidence-based estimated minimum statewide and community intervention costs, as well as six state-specific factors (CDC, 2007), the Centers for Disease Control and Prevention (CDC) recommend a minimum of \$55.9 million per year for tobacco prevention and control spending in the state of Alabama (CDC, 2014b). This would equal just 3% of the estimated annual smoking related health care

costs. Although the state has expended less than \$1 million per year on programs and initiatives to prevent the onset of youth tobacco use in recent years (CDC, 2014c), the percent of youth who reported ever trying cigarettes declined 20 percentage points in the ten-year period between 2001 and 2011, from 70.6% to 50.4% (Figure 2; CDC, 2014a). Considering such comparisons, these programs and initiatives seem well worth the cost.



### Youth tobacco prevention methods

To prevent the onset and continuation of youth tobacco use, the (CDC) recommends that each state develop a comprehensive state tobacco control program which includes three measures specifically aimed at preventing use among youth (CDC, 2014b).

1) Increase the unit price of tobacco products

Numerous studies have documented the effect of the cost of cigarettes on adolescent smoking behavior (see Institute of Medicine, 2007, and U.S. DHHS, 2012 for a list of reviews). By and large, the research shows that price increases reduce the level of cigarette use by all groups. Youth in particular are affected by these cost increases as they appear to decrease the incidence of initial experimentation with tobacco products, as well as their continued use by established adolescent smokers (Emery et al., 2001, Thomson et al., 2004). Specifically, research indicates that adolescents living in states with the highest levels of cigarette excise tax rates are less likely to experiment with smoking.

2) Conduct mass-media education campaigns in combination with other community interventions

The most recent Surgeon General's report on preventing tobacco use among youth (U.S. DHHS, 2012) reviewed the evidence resulting from studies concerning strategies for reducing

initiation and prevalence, as well as intensity, of smoking among young people. This report concluded there is sufficient evidence indicating that mass media campaigns, particularly in conjunction with community and statewide prevention efforts, can effectively alter social norms and prevent smoking among targeted adolescents. In addition, these same efforts have been shown to reduce smoking and related health problems among the general population, resulting in the reduction of tobacco related health-care spending state wide (Lightwood, et al., 2008; Lightwood & Glantz, 2011; Niederdeppe, et al., 2004; Sly et al., 2001).

3) Mobilize the community to restrict minors' access to tobacco products in combination with additional interventions (stronger local laws directed at retailers, active enforcement of retailer sales laws, and retailer education with reinforcement)

A number of legislative and regulatory policies have been enacted in recent years with the goals of strengthening and enforcing laws that restrict youth access to cigarettes and other tobacco products (i.e., the Family Smoking Prevention and Tobacco Control Act of 2009 and the ADAMHA Reorganization Act of 1992). These acts have resulted in outputs such as stronger laws concerning sales to minors; enforcement of retailer education and compliance; and prohibition of possession, use, and purchase of tobacco products by those who are underage. In Alabama, electronic cigarettes were included in this prohibition effective August 2013. Reviews have concluded that these measures have been shown to improve retailer compliance, which in turn can reduce the prevalence of smoking among young people (Stead and Lancaster, 2005; Task Force on Community Preventive Services, 2005).

It is upon these bodies of research that the CDC recommendations for youth tobacco prevention and control programs are based (CDC, 2014b). A further review of community-based tobacco control programs with a more limited range also indicated positive, but somewhat more limited support for such programs, due to inconsistent results (Sowden and Stead, 2003). It is clearly the overall conclusion of the CDC, as well as the Surgeon General, that comprehensive tobacco prevention programs including all three recommended components are the most effective means of reducing tobacco use. Following an examination of the results of such programs instituted in California and Massachusetts, the Institute of Medicine (2007) agreed. "To effectively reduce tobacco use, states must maintain, over time, a comprehensive and integrated tobacco control strategy" (page 172).

### **Youth-targeted tobacco prevention funding in the state of Alabama**

Between 2002 and 2012, the state of Alabama provided funds to its Community Tobacco Prevention Branch, enabling the administration of a community and public health area grant program. The program was designed to provide funds to agencies and areas for the purpose of instituting localized youth tobacco prevention efforts. As of 2012, this funding was no longer available, causing a further dearth of support for programs that, according to the CDC, were already severely underfunded (CDC, 2014b).

Since that time, data from the CDC's Youth Risk Behavior Survey (YRBS) show some evidence that the decline seen in the youth smoking rate in Alabama during the funded period has stagnated and in some cases reversed, resulting in an increase in some teen smoking rate indicators by 2013 (CDC, 2014a). This is in contrast to the national data, which continue to indicate a decline in teen smoking nation-wide. As such, an examination of the previously funded program in Alabama, including its activities and outcomes, as well as trends following the de-funding, seems warranted.

### **Alabama's Youth Tobacco Prevention Program**

#### **Funding for prevention of youth tobacco use in Alabama**

The Alabama Department of Public Health (ADPH) houses a Tobacco Prevention and Control Branch (TPCB) within its Division of Behavioral Health (ADPH, 2014a). The goals of the TPCB include:

- Eliminating environmental tobacco use exposure.
- Promoting quitting among adults and youth.
- Preventing youth initiation.
- Identifying and eliminating disparities among populations.

Beginning in 2001, the CDC allocated additional funds to the TPCB, in part due to the 24.4% adult smoking rate in the state of Alabama (Alabama's Health, March 2001). At that time, the adolescent smoking rate according to the YRBS was nearly identical to that of adults, as 23.7% of middle and high school students reported smoking within the past 30 days (CDC, 2014a). This additional CDC funding enabled the TPCB to promote the development of 19 local area tobacco control coalitions by supporting full-time coordinators in each of the state's public health areas (PHAs), as well as to provide limited support to the statewide Coalition for Tobacco Free Alabama.

Utilizing the financial support of the CDC, in combination with funding from the state, and federal dollars allocated in the later years through the American Recovery and Reinvestment Act of 2009 (ARRA), the TPCB began issuing annual funding opportunity announcements, inviting community-based organizations to apply for mini-grants through its Youth Tobacco Prevention Program (YTPP). Mini-grant funding was designated for allocation to organizations with previous success organizing and conducting county-wide activities with goals overlapping those of the TPCB.

From 2002 to 2012, Alabama's YTPP awarded between 9 and 26 mini-grants per year to eligible applicants on a competitive basis, with award amounts ranging from approximately \$20,000 to \$30,000 per grantee. According to ADPH annual reports, annual total award amounts ranged from a high of \$771,000 in 2009 (26 recipients) to a low of \$276,000 in 2012 (9



recipients) as the program drew to a close (ADPH, 2014b). Awards were provided to qualified applicants who submitted proposals outlining plans to conduct evidence-based programs and activities designed to promote policy and social norms changes at the local and state levels.

### **YTPP mini-grant activities**

During the period between 2002 and 2012, requests for applications were made available annually to qualified community-based organizations. Not-for-profit organizations with pre-existing youth-oriented programs were invited to submit requests to enter in to a grant agreement with the ADPH for the opportunity to assist in implementing a statewide youth tobacco prevention initiative. According to the funding opportunity announcement for the program, the stated goal for the program was to “reduce the youth tobacco prevalence rates in local schools and communities.” Listed objectives included engaging the general public and youth through 1) community presentations; 2) policy advocacy activities; 3) youth prevention and cessation education; and 4) media messages to raise awareness of the dangers of tobacco use and exposure to second-hand smoke.

Funding levels and number of awardees varied from year to year. However, all grantee projects were designed to achieve program objectives with reference to the best practices established by the CDC (CDC, 2007). Mini-grantees thus worked closely with area tobacco prevention and control coordinators whose activities support the CDC National Tobacco Control Program. For example, campaigns were conducted to educate community leaders, decision-makers, and the public concerning the effectiveness of tobacco price increases on youth tobacco use. Mini-grantees also utilized earned and paid media campaigns in conjunction with national tobacco awareness days that were designed to raise local community awareness regarding youth and tobacco. Grantees sponsored tobacco prevention events and presented educational information annually during Red Ribbon Week, Great American Smokeout Day, Through with Chew Week, and Kick Butts Day.

In addition to awareness and advocacy efforts, mini-grantees implemented prevention strategies in their local middle and high schools, as recommended by the Institute of Medicine (2007). Research has shown such programs to be instrumental for reducing the onset of tobacco use. *Lifeskills Training*, a research-validated substance use prevention program that targets the social and psychological factors that promote the initiation of risky behaviors such as tobacco use, was provided to local 6<sup>th</sup> grade students by grantees in their area ([lifeskillstraining.com](http://lifeskillstraining.com)). The Youth Empowerment Program (YEP!) encourages high school students to become anti-tobacco advocates ([www.youthempowerment.com](http://www.youthempowerment.com)), while Not On Tobacco (N-O-T) provides assistance to teen smokers who wish to quit ([www.cdc.gov/prc/pdf/not-on-tobacco-smoking-cessation.pdf](http://www.cdc.gov/prc/pdf/not-on-tobacco-smoking-cessation.pdf)). All three programs were offered by mini-grantees throughout the state.

Subsequently, YEP! students and their sponsors worked to raise awareness in their community concerning the dangers of youth access to tobacco products. Activities of YEP!

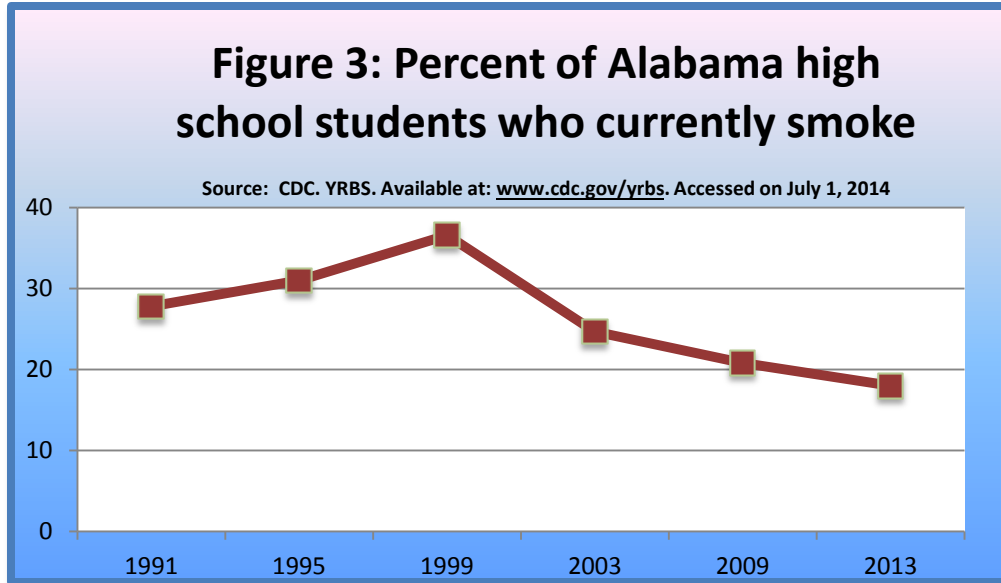
advocates included presentations to city council members, as well as within their schools, concerning policy gaps that allow youth tobacco use and exposure to persist. Advocates also conducted on-campus tobacco use surveillance at local schools and reported findings to school boards regarding infractions, with the goal of strengthening policy enforcement. Thus, the combined activities of mini-grantees addressed not only the goals of TPCB, but also the “best practice” recommendations of the CDC (CDC, 2014b).

### **Smoking prevalence before and after mini-grant program implementation**

Throughout the 1990’s, youth smoking was on the rise in the state of Alabama, as well as across the U.S. Smoking prevalence among Alabama high school students increased from 27.8% in 1991 to 36.6% in 1999 according to the YRBS, reflecting the national trend (CDC, 2014a). The percent of students experimenting with tobacco for the first time was also high throughout this period, with no sign of decline. For instance, between 1991 and 1999, more than 70% of Alabama high school students, as well as those across the country, had experimented with cigarettes. During this same period, adult smoking data collected through the Behavioral Risk Factor Surveillance System (BRFSS) by the CDC indicated little change in the prevalence of adult smoking, with rates ranging from approximately 23%-25% (CDC, 2014d).

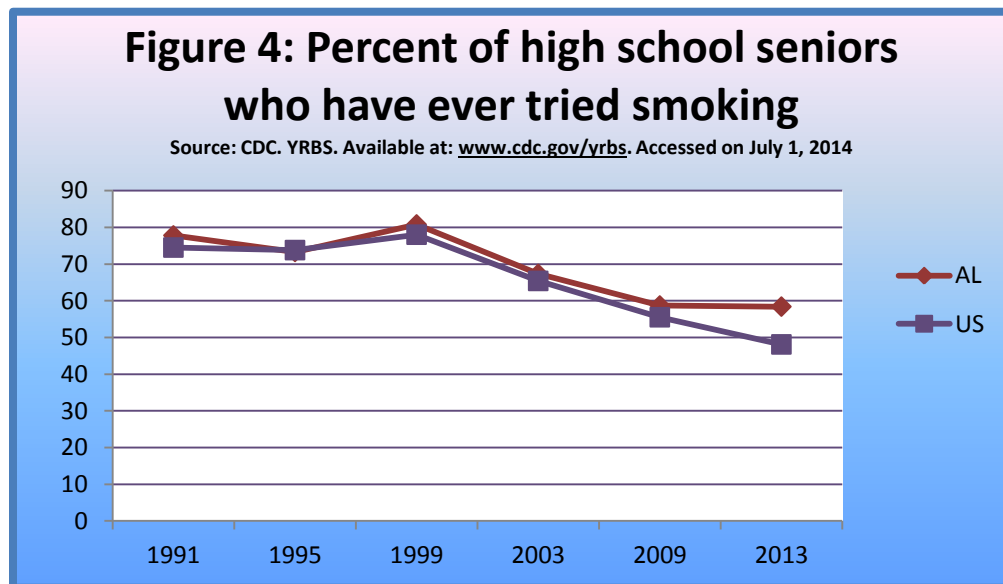
In November of 1998, the nation’s four largest tobacco companies entered in to the Master Settlement Agreement (MSA) with forty-six U.S. states’ attorneys general, including that of the state of Alabama. One of the ostensible, primary purposes of MSA funds was youth tobacco use prevention and cessation efforts (Congressional Research Service, 1999). Making use of the push provided by the MSA, many states across the nation began increasing funding to programs directed at curtailing the rise in tobacco use by young people, as well as helping current smokers to quit. When the CDC began awarding additional funds to Alabama’s TPCB in 2001, the state of Alabama joined other states in markedly increasing funding for tobacco control and prevention. Funds appropriated for such programs were increased from approximately \$1,700,000 in 2000 to approximately \$7,328,000 in 2001 (CDC, 2014c).

As part of this effort, the youth tobacco prevention mini-grant program, described in the previous section, was instituted to conduct prevention and empowerment programs with youth in local communities across the state. The program continued, with varying degrees of funding, for the next ten years. YRBS data (CDC, 2014a) collected during this period demonstrate a marked reversal in the patterns of youth tobacco use. For instance, while the percent of surveyed Alabama high school students who smoked *increased* from 27.8% in 1991 to 36.6% in 1999, this percentage *decreased* to 22.9% in 2011. (Figure 3) In addition, while the rate of initial experimentation with smoking remained stable throughout the 1990s, in the decade following increased funding for programs, this statistic dropped by 20 percentage points from 70.6% in 2001 to 50.4% in 2011. (Figure 2)

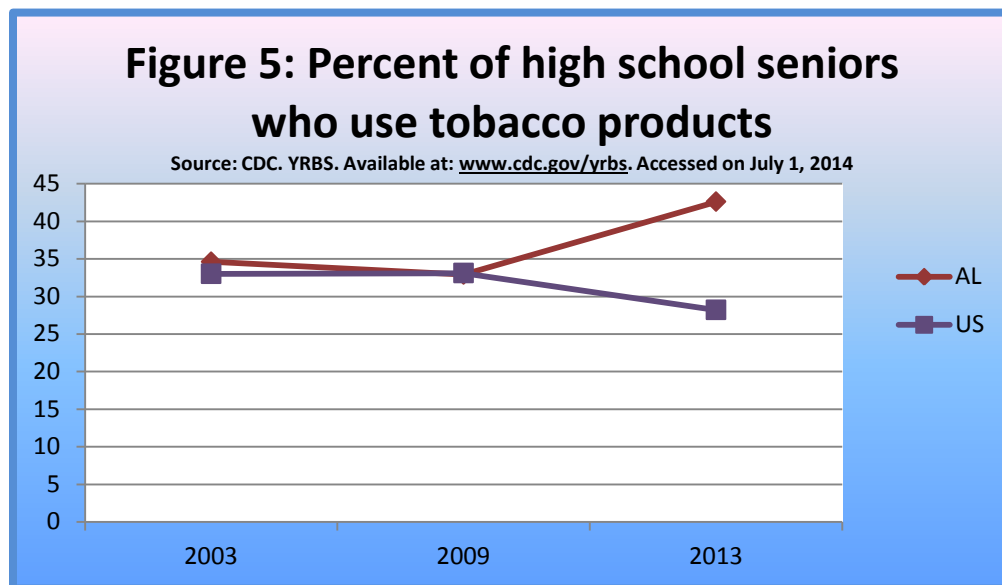


#### Loss of funding leads to loss of progress

As of 2012, funds that made the youth prevention mini-grant program possible were re-allocated and the program ended (ADPH, 2014b). As the program had not reached the point of self-sustainability, no further mini-grants have been awarded since that time. Unfortunately, the loss of the program is reflected in the recent smoking prevalence indices of Alabama youth (CDC, 2014a). For example, the percent of Alabama 12<sup>th</sup> grade students who have ever tried cigarettes, which had been declining since 1999, has remained unchanged over the past two years (holding steady at approximately 58%), while this same statistic saw a decrease of more than 6 percentage points (from 54.5% to 48.1%) nationwide (Figure 4).



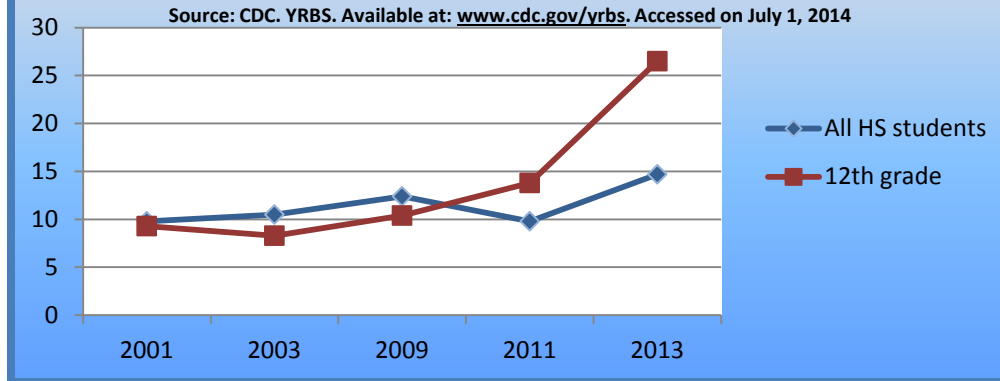
Additionally, as overall tobacco use (i.e., all tobacco products) by young people continues to decline across the U.S., a reversal of the trend can be seen in youth tobacco consumption in Alabama. Specifically, between 2011 and 2013, nationwide tobacco product use by high school seniors dropped from 31% to 28%, furthering the decline seen throughout the previous decade. Conversely, the percent of Alabama 12<sup>th</sup> grade students who use these same products increased from 39.1% to 42.6% over the same two-year period (Figure 5).



This rise in prevalence may be due in large part to the idiosyncratic rise in the use of smokeless tobacco products (chewing tobacco, snuff, dip) reported by this population, as the years between 2011 and 2013 saw a sharp increase in their prevalence. Although no increase in the use of smokeless tobacco by Alabama youth was apparent between 2001 and 2011, use by Alabama high school students increased from 9.8% in 2011 to 14.7% in 2013. This surge was particularly pronounced with older youth, as smokeless tobacco use among 12<sup>th</sup> grade students nearly doubled from 13.8% to 26.5% between 2011 and 2013 (Figure 6).

Based on recent surveys of high school students, it is clear that the prevalence of tobacco use in Alabama is still well above the national average (CDC, 2014a). Alabama high school students continue to use all forms of tobacco products at greater rates than do students across the country. National tobacco prevalence among high school students was 22.4% in 2013; in Alabama the rate was 27.8%. Users of tobacco products also tend to do so more heavily in Alabama. For example, while only 8.6% of nationwide youth smoke more than ten cigarettes a day, 16.2% of Alabama youth do so. Lack of funding for prevention and cessation programs is only serving to widen these gaps. Although progress was made over the past decade with respect to youth tobacco use Alabama, it appears that progress has slowed or reversed in the past few years.

**Figure 6: Percent of Alabama high school students who use smokeless tobacco**

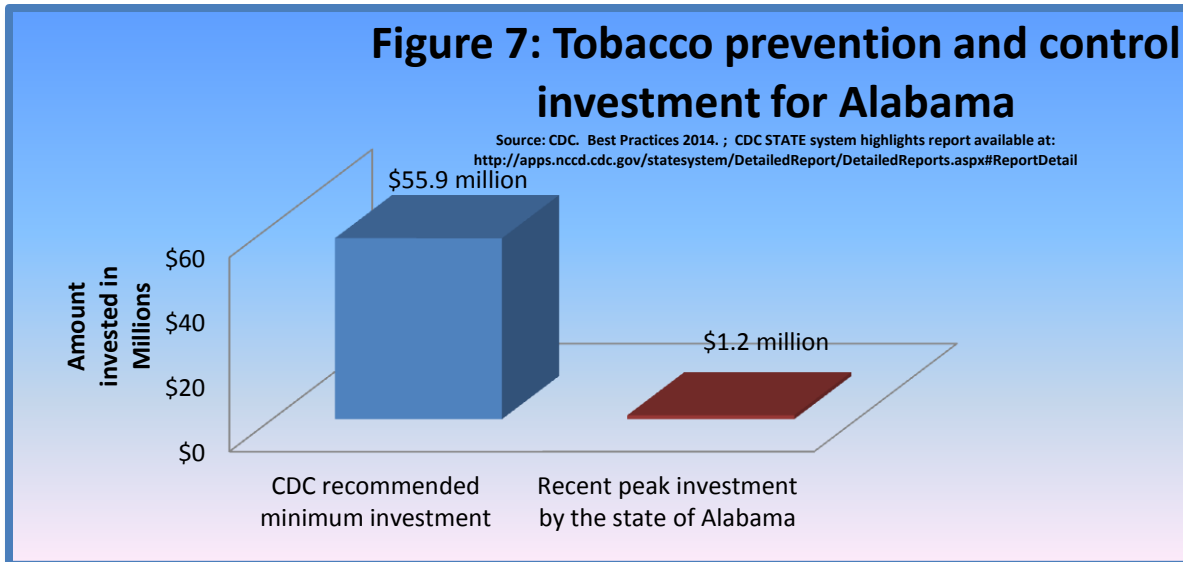


### Considering the Potential Returns on Investing in Youth Tobacco Prevention

#### Cost-benefit analysis of tobacco control

The human and economic costs of tobacco use are enormous. In 2010 alone, \$1.66 billion of excess medical expenditures in the state of Alabama were attributable to smoking. This is in addition to the \$3.78 billion worth of lost productivity due to premature death and smoking attributable illness (Fosson & McCallum, 2011). More importantly, nearly 8,000 people die in Alabama each year from tobacco-related illnesses, that is, 18% of all deaths per year are related to tobacco use. Another 157,000 are living with smoking attributable illnesses at a given time, including many types of cancer, cardiovascular disease, and respiratory disease.

The vast majority of these preventable deaths and expenses began as adolescent experimentation with tobacco. According to the U.S. Surgeon General (U.S. DHHS, 2012), 88% of adult smokers began the habit before the age of 18. For this reason, reducing the onset of tobacco use is a primary goal of tobacco control efforts. And yet, over the past decade, Alabama has expended less than 2% of the CDC recommended amount of \$55.9 million on tobacco prevention and control annually (CDC, 2014c). At its peak, the total amount budgeted by the state within the last decade was \$1.2 million in 2009 (Figure 7). In 2014, that amount dropped to only \$275,000.



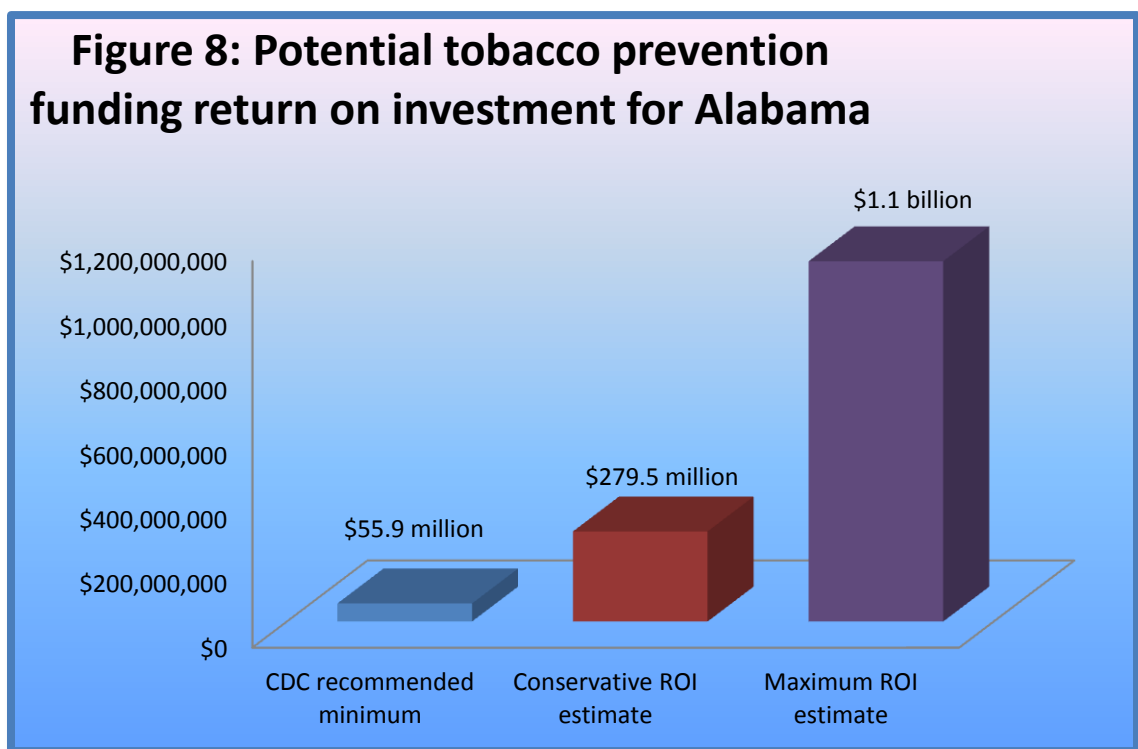
To weigh the costs and benefits of funding youth tobacco control, we first look specifically at youth-oriented programs. During the time that youth programs were funded, smoking rates fell from 36.6% in 1999 to 22.9% in 2011, or a little more than 1% per year, on average. Due to the gains during that time in reduced levels of initiation or experimentation, the overall rate continued to decline to 18% in 2013. At the same time, however, there have been disturbing increases in some indicators of smoking experimentation and tobacco use since the halt in funding for the youth-targeted programs. If these increases lead to a rise in overall smoking prevalence, long-term healthcare costs will rise accordingly.

There were approximately 219,000 students in high schools in Alabama last year (Alabama State Department of Education, 2014). With a smoking rate of 18% in 2013, there were approximately 39,000 smokers in high school. As noted previously, smokers account for an average of \$2,051 in smoking-attributable annual medical costs across their lifetime. Therefore, a 1% increase in smoking prevalence, that is an increase of 2,091 smokers in a year, would result in increased annual smoking-related medical costs of \$3.4 million across the lifetime of the 80% of these smokers who are likely to continue to smoke in adulthood. On the flip side, if the smoking rate decreased by 1% in a year, that would represent a future annual savings of \$3.4 million. This is far more than the highest cost of one year of funding for the youth programs or the total spent on tobacco control and prevention by the state.

As advocated by the Institute of Medicine, states must maintain a *comprehensive* tobacco control strategy. Any efforts targeting youth are part of a comprehensive program, and youth are affected by all aspects of the program (e.g., media, quitline promotion, community smoke-free policies), not just the activities targeting them. Therefore, it is difficult to separate the impact of specifically-youth oriented interventions from other interventions. However, the increase in some indicators following the decrease in funding for youth interventions indicates that, modest

though they were, these youth programs may have been making an impact. In their absence, the progress being made has stalled or reversed – just as has been seen in other states.

It is important, however, to view the larger cost-benefit picture as well, beyond the youth tobacco program itself. Based on recent conservative estimates, for every \$1 spent on comprehensive state funded tobacco control programs, at least \$5 are saved in tobacco related medical expenditures over a relatively short time span of 10 years (Dilley et al., 2012). Another recent study that calculated the potential future benefits of a sustained state-level tobacco prevention and control program estimated that the return on investment of supporting comprehensive, ongoing programs was in the range of 14-20 times the cost of implementing the program (Chattopadhyay & Pieper, 2012). These benefits were calculated based on savings that would accrue throughout the year following a given year in which funding was sustained. Applying these estimates (reported by both public health officials as well as economists) to the state of Alabama would predict that **the state could experience savings between \$279 million and \$1.1 billion annually by allocating sustained financial support to tobacco prevention and control programs at the minimum level recommended by the CDC (Figure 8).**



### Effects of defunding (and reinstating funds) for tobacco prevention and control: State experiences

States that have pioneered comprehensive tobacco control programs have become models for other states wishing to do the same. In particular, California and Massachusetts have been spotlighted due to the success of their programs and, thus, the experiences of these states are

often used to inform the development and progress of tobacco control and prevention activities across the country. As funding for tobacco prevention in these states, as well as in Florida, Indiana, and Oregon, has generally been relatively high, while also fluctuating quite a bit over time, their experiences are useful not only as examples of what works and what does not work in terms of tobacco control programming, but also in terms of how funding levels affect the ability of a state to sustain progress made through such programs.

The California Tobacco Control Program (CTCP) was launched in early 1990 following the passage of legislation which significantly increased the state's tobacco tax and allocated a portion of the resulting revenue to the creation of a comprehensive state-wide tobacco control program. The CTCP included components aimed at reducing youth access to tobacco products, as well as school-based education interventions (Institute of Medicine, 2007). As a result, the rate of youth tobacco uptake and use in California was significantly reduced by 2003. However, the program has also seen fluctuating levels of funding since that time which, in turn, have led to stalls and even reversals in youth smoking indicators within the state. For example, following reductions in program funding in 2003, smoking among high school students increased between 2004 (13.2%) and 2006 (15.4%). During this period, the percentage of youth who perceived benefits to smoking increased as well (Campaign for Tobacco Free Kids, 2012).

The same pattern has been observed when other states have experienced cuts to tobacco prevention and control funding. In Massachusetts, the peak funding amount for the Massachusetts Tobacco Control Program (MTCP) was similar to the amount recommended by the CDC for the state of Alabama (\$54 million per year). When MTCP funding was reduced in 2003 to only \$2.5 million (still nearly twice that of Alabama at its peak), cigarette sales to minors increased by between 74% in communities with partial funding loss and 98% in communities that lost all funding (Campaign for Tobacco Free Kids, 2012; Sly et al, 2005). Similarly, a 2009 study found that, while funding for school-based prevention programs in the state of Oregon resulted in reduced youth smoking initiation, youth smoking returned to pre-program levels following loss of program funding (Pizacani et al., 2009). Data from Florida (Niederdeppe et al., 2008) and Indiana (Indiana Tobacco Prevention and Cessation, 2008) tell the same story.

Encouragingly, evidence does exist that re-instating state tobacco prevention funding can result in the recouping of such losses in progress. Although the Florida Truth campaign significantly reduced the high school smoking rate in the state between 1998 and 2003, funding for the program was subsequently diverted due to state budget short-falls, virtually eliminating the program by 2003. However, in 2006, Florida voters passed a constitutional amendment requiring that a portion of the state's tobacco settlement funds be allocated to a new Tobacco Free Florida (TFF) program. The TFF is a statewide, comprehensive program based on the CDC's recommended best practices (CDC, 2007), which includes youth-led efforts to mobilize their communities against tobacco use, in addition to hard-hitting media campaigns, as well as cessation support for smokers who wish to quit. Since 2008, funding for the program has been maintained at approximately \$60 million per year, resulting in an 8.6% smoking rate among



Florida high school students in 2013. This represents more than a 40% decrease since 2007, as well as the lowest youth smoking rate ever reported by any state (Tobacco Free Florida, 2013).

### **Conclusions**

Ground has been lost in the state of Alabama in the battle to prevent youth tobacco use. Although progress was made through the efforts of Alabama Department of Public Health's Youth Tobacco Prevention and Control Program and its community grant recipients, loss of funding for the program has led to loss of progress. However, a solution to this problem can be found in the story told by the association between funding for tobacco prevention and control and prevalence rates of use in Alabama, as well as in the stories of other states that have experienced the same challenges. It is clear that by providing funding for tobacco and control and prevention, the state can indeed exercise influence over the rate at which youth initiate tobacco use and continue to use tobacco products. In turn, influence can also be asserted over the amount of state funds which must be spent to cover the costs resulting from tobacco related disease and death.

Before funding for tobacco prevention and control was significantly increased in 1999, tobacco use by adolescents and young adults in Alabama was high and on the rise. Following the availability of additional funding for state programs, which resulted in the development of the Youth Tobacco Prevention Program, many indices of youth tobacco prevalence fell sharply and reached an all-time low. Subsequently, some of these indicators have begun to reverse themselves as funding that provided communities with a means to combat youth tobacco use became unavailable. More young people in Alabama now report initiation of cigarette use and continued smoking than would be predicted based on previous state prevalence patterns, as well as national trends. And more high school students than ever are reporting regular use of smokeless tobacco.

Alabama is not unique in these respects. Other states have experienced sharp increases, followed by decreases, in funding for state tobacco prevention and control programs, resulting in similar patterns of smoking behaviors within their youth populations. The good news is that this association appears to work in reverse as well. By re-instating funding for tobacco control and prevention at the level recommended by the CDC, Florida has recovered and surpassed its previous successes in reducing youth tobacco use. This evidence indicates that, were Alabama to again allocate substantial portions of its Master Settlement Agreement funds to tobacco prevention (as was originally intended), the state would again see progress in the battle to combat the uptake of tobacco use by its young people and, in turn, improvements in the rates of illness, healthcare costs, and death resulting from the long-term use of tobacco products.

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