

Prevention Status Report | 2013

Tobacco Use

Alabama

The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce important health problems. This report focuses on tobacco use and briefly describes why it is a public health problem, both for Alabama and the United States as a whole. It also provides an overview of solutions (i.e., evidence-based or expert-recommended policy and practice options) for preventing or reducing tobacco use and reports the status of these solutions in Alabama.

PSR Framework

The PSRs follow a simple framework:

- Describe the public health **problem** using public health data
- Identify potential **solutions** to the problem drawn from research and expert recommendations
- Report the **status** of those solutions for each state and the District of Columbia

Criteria for Selection of Policies and Practices

The policies and practices included in the PSRs were selected because they

- Can be monitored using state-level data that are readily available for most states and the District of Columbia
- Meet one or more of the following criteria:
 - Supported by systematic review(s) of scientific evidence of effectiveness (e.g., *The Guide to Community Preventive Services*)
 - Explicitly cited in a national strategy or national action plan (e.g., *Healthy People 2020*)
 - Recommended by a recognized expert body, panel, organization, study, or report with an evidence-based focus (e.g., Institute of Medicine)

Ratings

The PSRs use a simple, three-level rating scale to provide a practical assessment of the status of policies and practices in each state and the District of Columbia. It is important to note that the ratings reflect the *status of policies and practices* and do not reflect the *status of efforts* by state health departments, other state agencies, or other organizations to establish or strengthen those policies and practices. Strategies for improving public health vary by individual state needs, resources, and public health priorities.

More Information

For more information about public health activities in Alabama, visit the Alabama Department of Public Health website (<http://www.adph.org/>). For additional resources and to view reports for other health topics, visit the CDC website (<http://www.cdc.gov/stltpublichealth/psr/>).

Suggested Citation

Centers for Disease Control and Prevention. *Prevention Status Reports 2013: Tobacco Use—Alabama*. Atlanta, GA: US Department of Health and Human Services; 2014.

PSR | 2013

www.cdc.gov/stltpublichealth/psr






Prevention Status Report | 2013

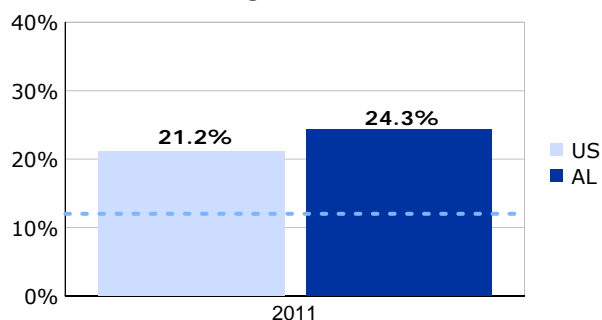
Tobacco Use

Alabama

Public Health Problem

-  Tobacco use is the leading cause of preventable death in Alabama and the United States overall. Smoking harms nearly every organ in the body and causes cancer, heart disease, stroke, respiratory illness, and many other health problems (1).
-  During 2007–08, in the United States, 37% of adult nonsmokers and 54% of children aged 3–11 years were exposed to secondhand smoke (2).
-  Smoking and exposure to secondhand smoke result in \$96 billion in medical expenditures and \$97 billion in lost productivity annually in the United States. In Alabama, smoking causes \$1.44 billion in personal healthcare expenditures and \$2.24 billion in lost productivity annually (3).

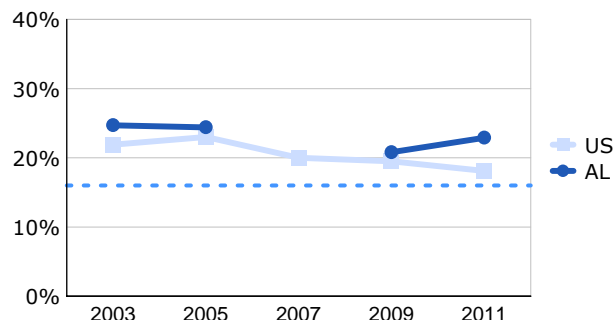
Proportion of adults who smoke cigarettes



Sources: Behavioral Risk Factor Surveillance System (4), National Health Interview Survey (5)

Healthy People 2020 target: 12.0% (dotted blue line) (6)

Proportion of high school students who smoke cigarettes



Source: Youth Risk Behavior Surveillance System (7)

Healthy People 2020 target: 16.0% (dotted blue line) (6)

Note: Alabama data were not available for one or more years from the source used for this graph. Similar data may be available from another national or state source.

Policy and Practice Solutions

This report focuses on policies and practices recommended by the Institute of Medicine, World Health Organization, Community Preventive Services Task Force, US Surgeon General, and Centers for Disease Control and Prevention on the basis of scientific studies supporting the policies' effectiveness in preventing or reducing tobacco use (8–11,13,14). These policies and practices include 1) increasing state cigarette excise taxes, 2) establishing statewide smoke-free policies, and 3) sustaining tobacco control program funding. Other strategies also supported by scientific evidence include hard-hitting media campaigns and systemic changes to increase access to and use of cessation services. For information about why certain tobacco-related indicators were selected, and for links to additional data and resources, visit the CDC website (<http://www.cdc.gov/stltpublichealth/psr/tobacco/>).

Prevention Status Report | 2013

Tobacco Use

Alabama

Status of Policy and Practice Solutions in Alabama

State cigarette excise tax

As of June 30, 2013, Alabama's cigarette excise tax was \$0.425 per pack, compared with the highest state tax of \$4.35 (range = \$0.17–\$4.35) (15).

Healthy People 2020 target: An increased excise tax in all states and the District of Columbia by \$1.50 per pack by the year 2020 (6). This increase would generate millions of dollars in revenue annually, prevent more children from starting to smoke, help smokers quit, save lives, and save millions in long-term healthcare costs (16,17).



Rating	State excise tax was
Green	\$2.00 per pack or above
Yellow	\$1.00–\$1.99 per pack
Red	Less than \$1.00 per pack

Comprehensive state smoke-free policy

As of June 30, 2013, Alabama had no statewide smoke-free policy covering workplaces, restaurants, or bars (15).

Healthy People 2020 target: A statewide ban on smoking in public places and worksites in all states and the District of Columbia (6). Studies have shown that smoke-free policies reduce secondhand smoke exposure, help smokers quit, and reduce heart attack and asthma hospitalizations (10,11,17–21).



Rating	State smoke-free policy covered
Green	Workplaces, restaurants, and bars
Yellow	Two of the three locations
Red	One or none of the locations

Funding for tobacco control

As of fiscal year 2010, Alabama allocated 3.9% of the CDC-recommended funding for tobacco control (\$2.2 million of \$56.7 million) (22).

CDC recommendation: Tobacco control funding at 100% of CDC's recommended annual investment in all states and the District of Columbia (14). States that have made larger investments in comprehensive tobacco control programs have seen cigarette sales drop more than twice as much as sales in the United States as a whole, and smoking prevalence among adults and youth has declined faster as spending for tobacco control programs has increased (14,23,24).



Rating	Funding level was at
Green	100% or more of CDC recommendation
Yellow	50.0%–99.9% of CDC recommendation
Red	Less than 50% of CDC recommendation

Simplified Rating System

A more detailed explanation of the rating system for tobacco use is available at <http://www.cdc.gov/stltpublichealth/psr/tobacco/>.

Green

The policy or practice is established in accordance with supporting evidence and/or expert recommendations.

Yellow

The policy or practice is established in partial accordance with supporting evidence and/or expert recommendations.

Red

The policy or practice is either absent or not established in accordance with supporting evidence and/or expert recommendations.

Prevention Status Report | 2013

Tobacco Use

Alabama

Indicator Definitions

State cigarette excise tax: The amount of state excise tax, in dollars, on a pack of 20 cigarettes.

Comprehensive state smoke-free policy: A state law that prohibits smoking in all indoor areas of private workplaces, restaurants, and bars, with no exceptions (25).

Funding for tobacco control: The amount of funding allocated for state tobacco control activities, including state and federal dollars. Note: Data provided for fiscal year 2010 funding do not include nongovernmental funding sources or federal funds from the American Recovery and Reinvestment Act Prevention Wellness Initiative announced in March 2010. Additionally, the amount allocated per fiscal year does not always match the amount spent during the year.

References

1. US Surgeon General. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services; 2010.
2. CDC. Vital signs: nonsmokers' exposure to secondhand smoke—United States, 1999–2008. *MMWR* 2010;59(35).
3. Smoking—Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) [database]. Accessed Dec 10, 2012.
4. CDC. Behavioral Risk Factor Surveillance System [database]. Accessed Jun 13, 2013.
5. Schiller JS, Lucas JW, Peregoy JA. Summary health statistics for U.S. adults: National Health Interview Survey, 2011. *Vital Health Statistics* 2012;10(256).
6. US Department of Health and Human Services. Tobacco use across the life stages. In: *Healthy People 2020*. Rockville, MD: US Department of Health and Human Services; Updated Nov 20, 2012.
7. CDC. Youth Risk Behavior Surveillance System [database]. Accessed Jun 13, 2013.
8. Institute of Medicine. *Ending the Tobacco Problem: A Blueprint for the Nation*. Washington, DC: National Academies Press; 2007.
9. World Health Organization. *WHO Report on the Global Tobacco Epidemic, 2008—The MPOWER Package*. Geneva, Switzerland: World Health Organization; 2008.
10. The Task Force on Community Preventive Services. *The Guide to Community Preventive Services: What Works to Promote Health?* New York, NY: Oxford University Press; 2005.
11. CDC. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services; 2006.
12. CDC. *Preventing Tobacco Use among Youth and Young Adults: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services; 2012.
13. CDC. *Reducing Tobacco Use: A Report of the Surgeon General*. Atlanta, GA: US Department of Health and Human Services; 2000.
14. CDC. *Best Practices for Comprehensive Tobacco Control Programs—2007*. Atlanta, GA: US Department of Health and Human Services; 2007.
15. CDC. State Tobacco Activities Tracking & Evaluation (STATE) System [database]. Accessed Dec 10, 2012.
16. Congressional Budget Office. *Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget*. Washington, DC: Congressional Budget Office; 2012.
17. Hopkins DP, Razi S, Leeks KD, et al. Smoke-free policies to reduce tobacco use: a systematic review. *American Journal of Preventive Medicine* 2010;38(2S):275–89.
18. Hahn EJ. Smokefree legislation: a review of health and economic outcomes research. *American Journal of Preventive Medicine* 2010;39(6 Suppl 1):S66–S76.
19. Institute of Medicine. *Secondhand Smoke Exposure and Cardiovascular Effects: Making Sense of the Evidence*. Washington, DC: National Academies Press; 2010.
20. Millett C, Lee JT, Lavery AA, et al. Hospital admissions for childhood asthma after smoke-free legislation in England. *Pediatrics* 2013;131(2):e495–e501.
21. Herman PM, Walsh ME. Hospital admissions for acute myocardial infarction, angina, stroke, and asthma after implementation of Arizona's comprehensive statewide smoking ban. *American Journal of Public Health* 2011;101:491–6.
22. CDC. State tobacco revenues compared with tobacco control appropriations—United States, 1998–2010. *MMWR* 2012;61:370–4.
23. Farrelly MC, Pechacek TP, Chaloupka FJ. The impact of tobacco control program expenditures on aggregate cigarette sales: 1981–2000. *Journal of Health Economics* 2003;22(5):843–59.
24. Tauras JA, Chaloupka FJ, Farrelly MC, et al. State tobacco control spending and youth smoking. *American Journal of Public Health* 2005;95:4:338–44.
25. CDC. State smoke-free laws for worksites, restaurants, and bars—United States, 2000–2010. *MMWR* 2011;60:472–5.