
# Overview

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# Introduction

## History of the Healthy People Initiative

In setting forth a vision for realizing improved health for all Americans, Healthy People 2010, initiated in November 2000, identified a set of 10-year health goals and objectives to be achieved during the first decade of the 21st century. Its two overarching goals—to increase quality and years of healthy life and to eliminate health disparities—were supported by specific objectives in 28 Focus Areas. In this way, Healthy People 2010 built on initiatives that had been pursued over the previous few decades, beginning with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979 [1]. That report led to the initiation of this decade-long, management-by-objective process with the publication of *Promoting Health/Preventing Disease: Objectives for the Nation* [2]. This 1980 initiative was followed by the publication of *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* in 1991 [3]. Now, Healthy People 2020 will continue these efforts through the second decade of the 21st century. Appendix E provides a summary of the evolution of Healthy People over the past four decades.

## Healthy People 2010

Through Healthy People 2010, the Department of Health and Human Services (DHHS) set out objectives that called for improvements in health status, risk reduction, public and professional awareness of prevention, delivery of health services, protective measures, surveillance, and evaluation, all expressed in specific metrics that allowed the measurement of progress over time toward targets that were to be achieved by the year 2010. Like its predecessors, Healthy People 2010 was developed through a broad collaborative process that drew on the best scientific knowledge available.

Full achievement of the goals and objectives of Healthy People 2010 was predicated on a health system accessible to all Americans that would integrate personal health care and population-based public health activities. The concept of healthy people in healthy communities, which is the foundation of the initiative, necessitates monitoring and tracking of data on broad-based prevention efforts beyond services provided within physicians' offices, clinics, and hospitals. The concept expands the traditional disease-centered medical care system to recognize the impact of health promotion and disease prevention efforts based in schools, neighborhoods, workplaces, and families in which people live their daily lives. These are the environments in which a large proportion of preventive action takes place.

The 28 Focus Areas of Healthy People 2010 were developed by Federal agencies that had the most relevant scientific expertise in each subject area. The development process drew on the collective expertise of the Healthy People Consortium—an alliance which, at the time, encompassed more than 350 national membership organizations and 250 State health, mental health, substance abuse, and environmental agencies. In addition, through a series of regional and national meetings, more than 11,000 public comments on the draft objectives were collected and considered. The Secretary's Council on National Health Promotion and Disease Prevention Objectives for 2010 also provided leadership and advice in the development and implementation of these national health objectives. More information is available from http://www.healthypeople.gov/2010/data/midcourse/.

## Healthy People 2010 Midcourse Review

Midway through the decade, staff of DHHS and other Federal agencies together with experts from across the nation assessed the status of the national objectives as they had developed over the first half of the decade. This midcourse review process involved an examination of trends in data that had become available by January 1, 2005, and it took into account any pertinent new science. The review resulted in changes to some objectives that

were made to ensure that Healthy People 2010 remained current and accurate and kept abreast of emerging public health priorities. DHHS solicited and considered public comments on these midcourse changes to the Healthy People 2010 objectives. The results of this midcourse assessment were published in the *Healthy People 2010 Midcourse Review* [4].

## Changes to Healthy People 2010 Objectives at the Midcourse Review

Midcourse changes to Healthy People 2010 objectives encompassed the following: rewordings of objectives; deletion of 66 objectives; additions of new objectives; revisions to baselines and targets; and establishment of baselines and targets for objectives that moved from "developmental" to "measurable," as explained in the next paragraph. Changes were made to reflect the most current science, to reflect the data more accurately, or to provide a more logical or understandable presentation.

To be included in Healthy People 2010, an objective was required to have a national data source that provided a baseline and at least one additional data point for tracking progress. Some objectives lacked baseline data at the time of their development but had a potential data source and were considered of sufficient national importance to be included in Healthy People. These were called developmental objectives; they provided a vision for a desired outcome or health status. Developmental objectives with no prospect of having a national (baseline) data source were deleted as part of the Midcourse Review. (At the Final Review, 53 developmental objectives that were retained at the Midcourse Review still did not have baseline data.)

## Measuring Healthy People 2010 Progress Throughout the Decade

### Progress Reviews

In addition to the Midcourse Review, progress reviews on the individual Focus Areas were conducted, one each month, until the full cycle of 28 had been completed. Two cycles of these reviews were held during the decade. The progress reviews were formal meetings, chaired by the Assistant Secretary for Health, at which the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), DHHS, provided data updates for the Focus Area under review, and Federal lead agencies for the Focus Area reported on progress toward achieving Focus Area objectives and initiatives to help in accomplishing that purpose. More information is available from http://www.healthypeople.gov/2010/data/PROGRVW/.

## DATA2010

A critical part of Healthy People 2010 was measuring progress toward the targets for the year 2010. The compilation and management of current health data sources were central to assessing and implementing Healthy People 2010 goals and objectives. The data that provided the basis for the *Midcourse Review* and the *Healthy People 2010 Final Review* are available on DATA2010, developed by the Health Promotion Statistics Branch at NCHS. This is an interactive database system that compiled the monitoring data for tracking all the measurable objectives. These are primarily national data; selected state-based data are provided when available. Additional information is available from http://wonder.cdc.gov/data2010.

## Healthy People 2010 Final Review

The *Healthy People 2010 Final Review* presents a quantitative summary assessment of progress in achieving the Healthy People 2010 objectives over the course of the decade. The *Healthy People 2010 Final Review*, which incorporates the 2005 Midcourse Review modifications to the objectives, provides the final tracking data for the objectives in each of the 28 Focus Areas. A Progress Chart included in each chapter provides a summary display of the progress of each objective for which there were at least two data points available during the decade. Also, a Health Disparities Table provides a summary of health disparities by race and ethnicity, sex, education level, income, geographic location, and disability status whenever data were available for each objective. Finally, the report includes a summary of progress for the Healthy People 2010 Leading Health Indicators as well as a summary of progress toward achieving the Healthy People 2010 goals of: 1) increasing quality and years of healthy life, and 2) eliminating health disparities.

# Initiatives Related to Healthy People

## Other Departmental Priorities and Healthy People

As the latest iteration of a long-running initiative, Healthy People 2020 follows the lead of Healthy People 2010 in supporting a wide range of DHHS initiatives. Healthy People 2020 aligns with and plays a foundational and mutually supportive role with several other major DHHS undertakings, including the following:

- The **National Prevention and Health Promotion Strategy** (NPS), which was mandated by the March 23, 2010, Patient Protection and Affordable Care Act. NPS aims to identify and prioritize national actions to reduce the incidence and burden of the leading causes of death and disability. NPS aims to move the nation toward a system of health care that features prevention as the cornerstone of care, by concentrating on the underlying drivers of chronic disease. NPS will promote actions aimed at prevention and healthy development and behavior throughout the stages of life, all of which will be directed toward its primary goal of achieving significant gains in Americans' life expectancy at birth and age 65. The NPS targets reflect those of Healthy People 2020.

- **First Lady Michelle Obama's *Let's Move!* Campaign**, which began in 2010 and focuses on one ambitious goal: to halt and reverse the epidemic of childhood obesity within one generation, so that children today reach adulthood at a healthy weight. Over the past 3 decades, childhood obesity rates in America have tripled, and today, nearly one in three children in America are overweight or obese. The *Let's Move!* initiative focuses on the reform of behavioral factors and environmental factors by promoting active lifestyles and healthy eating through community involvement by way of schools, parents, health care providers, and other agents of change. Implementation strategies are now in development for Healthy People 2020 objectives that relate to this initiative and support the *Let's Move!* goal.

- The **National HIV/AIDS Strategy**, which the White House released in July 2010 and is the nation's first-ever comprehensive, coordinated HIV/AIDS roadmap with clear and measurable targets to be achieved by 2015. Since 1980, more than 575,000 Americans have lost their lives to AIDS and, currently, more than 1.1 million Americans are living with HIV. Among the 2015 goals of the National Strategy are to: lower the annual number of new infections by 25% and to increase from 79% to 90% the proportion of people living with HIV who know their serostatus. The objectives encompassed by the Healthy People 2020 HIV Topic Area are consonant with and supportive of these and other goals of the National HIV/AIDS Strategy.

- The **National Drug Control Strategy,** which was inaugurated in 2010, updated yearly, and has set policy priorities of reducing prescription drug abuse and drugged driving and of promoting activities to prevent such abuse from occurring. Implementation of the National Strategy is centered in the White House Office of National Drug Control Policy and engages the energies of several other Federal agencies, as well, including the DHHS Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is the lead agency for the Healthy People 2020 Topic Area on Substance Abuse, which embraces a number of objectives that are directly supportive of the National Strategy. Although the Strategy is primarily a blueprint for the federal government, it is also proving useful in guiding State and local decisions.

- The **President's Food Safety Working Group,** which was created in 2009 to advise the President on how to upgrade the U.S. food safety system. Chaired jointly by the DHHS Secretary and Secretary of Agriculture, the Working Group recommended a public health-focused approach to food safety based on three core principles: prioritizing prevention, strengthening surveillance and enforcement, and improving response and recovery. Taken together, the objectives of the Food Safety Topic Area of Healthy People 2020 all serve to advance these principles.

- The **DHHS Action Plan to Reduce Racial and Ethnic Health Disparities,** which outlines goals and actions DHHS will take to reduce health disparities among racial and ethnic minorities. With the DHHS Disparities Action Plan, the Department commits to continuously assessing the impact of all policies and programs on racial and ethnic health disparities. It will promote integrated approaches, evidence-based programs and best practices to reduce these disparities. The DHHS Action Plan builds on the strong foundation of the Affordable Care Act and is aligned with programs and initiatives such as the First Lady Obama's *Let's Move!* initiative, the President's National HIV/AIDS Strategy, and Healthy People 2020.

- The new DHHS **Tobacco Control Strategic Action Plan**, which was presented in November 2010 and seeks to help smokers quit and stop others from starting to use tobacco. One high profile piece of the plan will result in bolder health warnings that must cover the upper half of the front and back of cigarette

packages and at least 20% of tobacco product advertisements beginning in 2012. In June 2009, the Family Smoking Prevention and Tobacco Control Act had granted the Food and Drug Administration (FDA) the authority to regulate tobacco products. Under the law, the FDA now has sweeping new authorities related to the manufacture, marketing, and sale of tobacco products—authorities covered by a more expansive public health standard than had traditionally been granted to the agency. The objectives of the Healthy People 2020 Topic Area on Tobacco Use provide the data that underpin the Plan and give it direction toward the outcomes we hope to achieve by the end of the decade.

- The new **Global Health Initiative** (GHI), which the U.S. announced in February 2010 and which invests $63 billion over 6 years to help partner countries improve health outcomes through strengthened health systems and integrated services, with a particular focus on improving the health of women, newborns, and children. Other topics of particular concern in developing countries include HIV/AIDS, malaria, tuberculosis, family planning and reproductive health, nutrition, safety of water supplies, and neglected tropical diseases. The GHI has set a number of targets for accomplishment in assisted countries, for example: reduction of maternal mortality by 30%, reduction of under-five mortality rates by 35%, reduction of child under-nutrition by 30%, and prevention of 54 million unintended pregnancies. Healthy People 2020 includes a Topic Area on Global Health, new in this decade.

## Guide to Clinical Preventive Services

The *Guide to Clinical Preventive Services* includes U.S. Preventive Services Task Force (USPSTF) recommendations on screening, counseling, and preventive medication topics, as well as clinical considerations for each topic. Sponsored since 1998 by the Agency for Healthcare Research and Quality (AHRQ), the USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. The task force rigorously evaluates clinical research to assess the merits of preventive measures. In the 2010–11 edition of the Guide, the recommended preventive services for adults are in the clinical categories of: cancer; heart, vascular, and respiratory diseases; infectious diseases; injury and violence; mental health conditions and substance abuse; metabolic, nutritional, and endocrine conditions; musculoskeletal conditions; obstetrics and gynecologic conditions; and vision disorders. Recommendations for children and adolescents are given in a separate section. More information is available from http://www.ahrq.gov/clinic/cps3dix.htm.

## Guide to Community Preventive Services

The *Guide to Community Preventive Services* serves as a filter for scientific literature on specific health problems that can have a large-scale impact on groups of people who share a common community setting. This guide summarizes what is known about the effectiveness, economic efficiency, and feasibility of interventions to promote community health and prevent disease. The Task Force on Community Preventive Services, an independent decision-making body convened by DHHS, makes recommendations for the use of various interventions based on the evidence gathered in rigorous and systematic scientific reviews of published studies conducted by review teams for the guide. The findings from the reviews are published in peer-reviewed journals and also are made available online. Over the last decade or so, the task force has published hundreds of findings across the following topic areas: adolescent health; alcohol; asthma; birth defects; cancer; diabetes; health communication; HIV/AIDS, other STIs and pregnancy; mental health; motor vehicle occupant injury; nutrition; obesity; oral health; physical activity; social environment; tobacco use; vaccines; violence; and worksites. Additional information is available from http://www.thecommunityguide.org.

# Summary of Progress

## Healthy People Objectives

For the end-of-decade assessment of the Healthy People 2010 objectives, the status of 969 specific objectives in 28 Focus Areas was assessed. Progress was measured for objectives using the final tracking data available—that is, baseline data and at least one additional data point. For some objectives, although more recent data may have been available, the final Healthy People 2010 data year was selected to be consistent with the baseline year used for the new Healthy People 2020 objectives [5].

The status of the 969 objectives is shown on the left-hand side of Figure O-1. Based on an evaluation of each objective and comments received from the public as part of the Midcourse Review, 66 objectives were deleted because data were unavailable or because of a change in the science [6]. Tracking data were unavailable to assess progress for 170 objectives (17.5% of the total), 53 of which lacked baseline data and, therefore, remained developmental.

Progress is assessed for 733 objectives with tracking data available, as seen in the right-hand side panel of Figure O-1.

- 172 objectives (23%) met or exceeded the Healthy People 2010 targets.
- 349 objectives (48%) moved toward the Healthy People 2010 targets.
- 39 objectives (5%) demonstrated no change from the baseline.
- 173 objectives (24%) moved away from the Healthy People 2010 targets.

Figure O-1. Healthy People 2010 Objectives: Status at the Final Review and Summary of Progress Toward Target Attainment

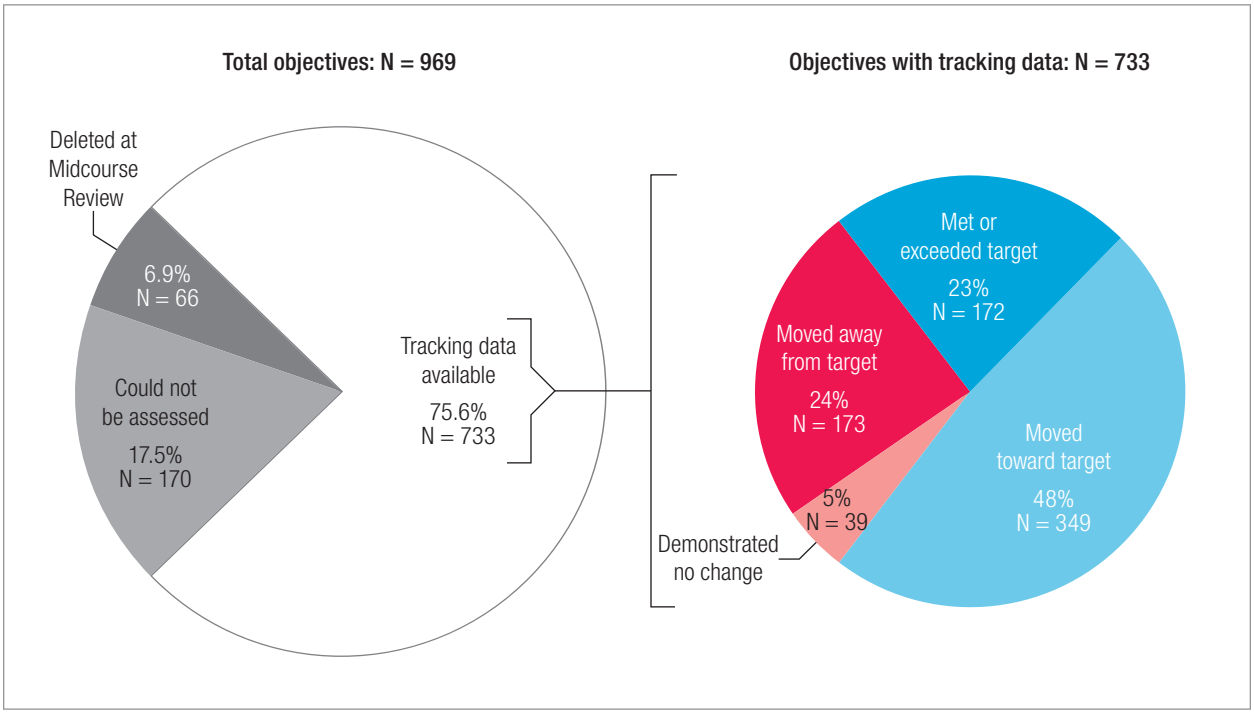


Figure O-2 and Table O-1 show similar assessments for each of the 28 Focus Areas. In each Focus Area, some objectives moved toward, met, or exceeded their 2010 targets. For 8 Focus Areas, Educational and Community-Based Programs (Focus Area 7), Environmental Health (Focus Area 8), Health Communication (Focus Area 11), Heart Disease and Stroke (Focus Area 12), Immunization and Infectious Diseases (Focus Area 14), Mental Health and Mental Disorders (Focus Area 18), Occupational Safety and Health (Focus Area 20), and Tobacco Use (Focus Area 27) more than 75% of the objectives with tracking data available moved toward or achieved their targets. The proportion of objectives that were deleted at Midcourse Review or could not be assessed was more than 30% for Access to Quality Health Services (Focus Area 1), Disability and Secondary Conditions (Focus Area 6), Educational and Community-based Programs (Focus Area 7), Environmental Health (Focus Area 8), and Mental Health and Mental Disorders (Focus Area 18). Two Focus Areas, Arthritis, Osteoporosis, and Chronic Back Conditions (Focus Area 2) and Nutrition and Overweight (Focus Area 19), moved toward or achieved less than 25% of their targets.

Figure O-2. Healthy People 2010 Objectives: Status at the Final Review by Focus Area

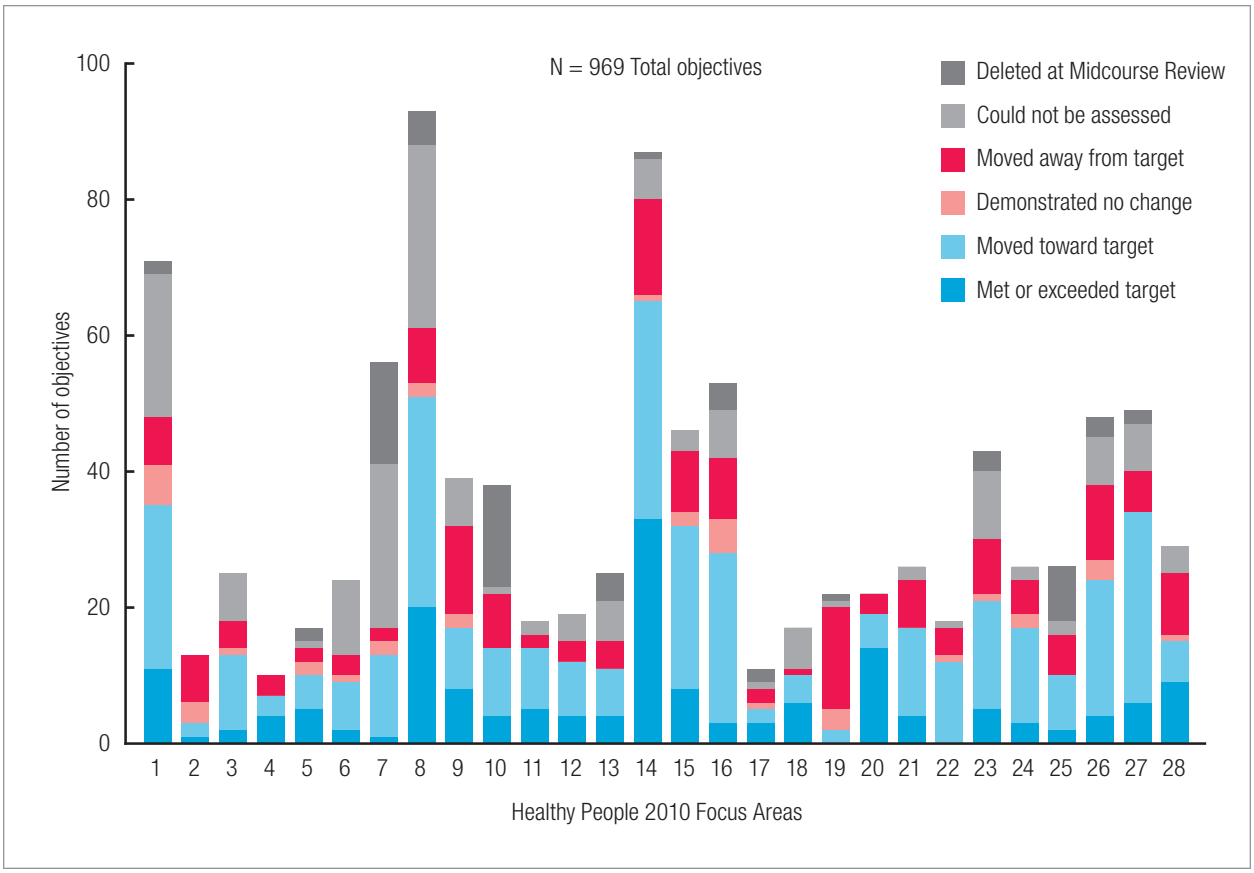


Table O-1. Healthy People 2010 Objectives: Summary of Progress by Focus Area

| | Focus Area | Tracking data available | | | | Could not be assessed | | Deleted at Midcourse Review | Total |
|---|---|---|---|---|---|---|---|---|---|
| | | Met or exceeded target | Moved toward target | Demonstrated no change | Moved away from target | Developmental† | No tracking data beyond baseline | | |
| 1. | Access to Quality Health Services | 11 | 24 | 6 | 7 | 1 | 20 | 2 | **71** |
| 2. | Arthritis, Osteoporosis, and Chronic Back Conditions | 1 | 2 | 3 | 7 | 0 | 0 | 0 | **13** |
| 3. | Cancer | 2 | 11 | 1 | 4 | 0 | 7 | 0 | **25** |
| 4. | Chronic Kidney Disease | 3 | 3 | 0 | 3 | 0 | 0 | 0 | **9** |
| 5. | Diabetes | 5 | 5 | 2 | 2 | 0 | 1 | 2 | **17** |
| 6. | Disability and Secondary Conditions | 2 | 7 | 1 | 3 | 4 | 7 | 0 | **24** |
| 7. | Educational and Community-Based Programs | 1 | 12 | 2 | 2 | 2 | 22 | 15 | **56** |
| 8. | Environmental Health | 21 | 30 | 2 | 8 | 8 | 19* | 5 | **93** |
| 9. | Family Planning | 8 | 9 | 2 | 13 | 6 | 1 | 0 | **39** |
| 10. | Food Safety | 5 | 11 | 0 | 6 | 1 | 0 | 15 | **38** |
| 11. | Health Communication | 5 | 9 | 0 | 2 | 0 | 2 | 0 | **18** |
| 12. | Heart Disease and Stroke | 4 | 8 | 0 | 3 | 2 | 2 | 0 | **19** |
| 13. | HIV | 4 | 7 | 0 | 4 | 6 | 0 | 4 | **25** |
| 14. | Immunization and Infectious Diseases | 33 | 32 | 1 | 14 | 2 | 4 | 1 | **87** |
| 15. | Injury and Violence Prevention | 8 | 24 | 2 | 9 | 0 | 3 | 0 | **46** |
| 16. | Maternal, Child, and Infant Health | 3 | 25 | 5 | 9 | 3 | 4 | 4 | **53** |
| 17. | Medical Product Safety | 3 | 2 | 1 | 2 | 0 | 1 | 2 | **11** |
| 18. | Mental Health and Mental Disorders | 6 | 4 | 0 | 1 | 0 | 6 | 0 | **17** |
| 19. | Nutrition and Overweight | 0 | 2 | 3 | 15 | 0 | 1 | 1 | **22** |
| 20. | Occupational Safety and Health | 14 | 5 | 0 | 3 | 0 | 0 | 0 | **22** |
| 21. | Oral Health | 4 | 13 | 0 | 7 | 0 | 2 | 0 | **26** |
| 22. | Physical Activity and Fitness | 0 | 12 | 1 | 4 | 0 | 1 | 0 | **18** |
| 23. | Public Health Infrastructure | 5 | 16 | 1 | 8 | 6 | 4 | 3 | **43** |
| 24. | Respiratory Diseases | 3 | 14 | 2 | 5 | 1 | 1 | 0 | **26** |
| 25. | Sexually Transmitted Diseases | 2 | 8 | 0 | 6 | 1 | 1 | 7 | **25** |
| 26. | Substance Abuse | 4 | 20 | 3 | 11 | 5 | 2 | 3 | **48** |
| 27. | Tobacco Use | 6 | 28 | 0 | 6 | 4 | 3 | 2 | **49** |
| 28. | Vision and Hearing | 9 | 6 | 1 | 9 | 0 | 4 | 0 | **29** |
| | **Total** | **172** | **349** | **39** | **173** | **53** | **117** | **66** | **969** |

† Objectives that lacked baseline data remained developmental.

* One objective (8-11) did have tracking data beyond the baseline, but the final data point was statistically unreliable.

## Population Groups

In Figure O-3, progress is assessed for specific population groups. This assessment is limited to population-based objectives with tracking data for these groups. It does not include objectives that are not population-based, such as those based on states, worksites, or those monitored by the number of events. The number of objectives with tracking data varied according to the characteristic and, therefore, the bar's length in Figure O-3 varies for each population group. For Healthy People 2010, most population-based objectives were monitored by race and ethnicity, but the availability of data for specific racial and ethnic populations varied. Comparisons by sex were not applicable to all population-based objectives because some applied only to females or only to males. Geographic location and disability status were optional characteristics included for monitoring selected objectives.

When possible, population-based objectives were also monitored either by education level or by income, as a measure of socioeconomic status. Most data systems used in Healthy People 2010 define income as a family's income before taxes. To facilitate comparisons among groups and over time, while adjusting for family size and for inflation, Healthy People 2010 categorizes income using the poverty thresholds developed by the Census Bureau. Thus, the three categories of family income that are primarily used are:

- Poor—below the Federal poverty level
- Near poor—100% to 199% of the Federal poverty level
- Middle/high income—200% or more of the Federal poverty level.

These categories may be overridden by considerations specific to the data system, in which case they are modified as appropriate.

In general, data on educational attainment are presented for persons aged 25 and over, consistent with guidance given by the Census Bureau. However, because of the requirements of the different data systems, the age groups used to calculate educational attainment for any specific objective may differ from the age groups used to report the data for other Healthy People 2010 objectives, as well as from select populations within the same objective. The three categories of education level that are primarily used are:

- Less than high school
- High school graduate
- At least some college education.

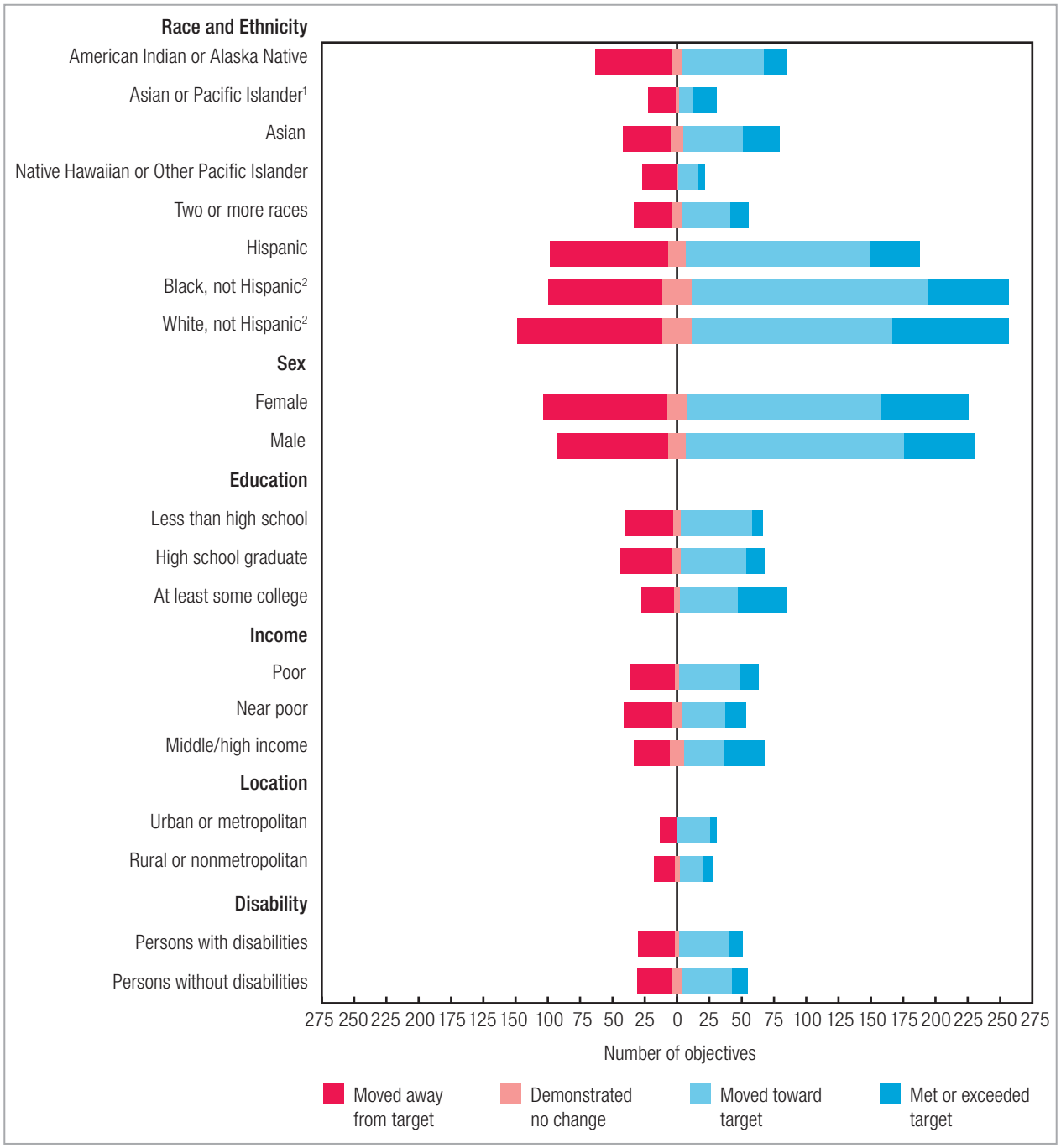
Further information regarding population groups can be found in *Healthy People 2010: General Data Issues*, available from: http://www.cdc.gov/nchs/healthy_people.htm.

For each select population group, the number of objectives is shown for each of the following: moved away from the target, demonstrated no change, moved toward the target, and met or exceeded the target. Because a single target was set for all population groups, there were some instances where certain population groups had met the Healthy People 2010 target at baseline while other groups had not met the target.

In general, for each select population group, the number of objectives that moved toward, met, or exceeded the target surpassed the number that moved away from the target. For the American Indian or Alaska Native population, for example, 81 objectives moved toward, met, or exceeded their respective targets whereas 59 moved away and 9 showed no change between the baseline and the final time points (Table O-2). For the Native Hawaiian and Other Pacific Islander population, more objectives moved away from the target (26 objectives) than moved toward, met, or exceeded the target (21 objectives).

The progress for each objective with data beyond the baseline is shown in the Progress Chart in Focus Area chapters of this report. Health disparities between population groups and changes in disparities between the baseline and the most recent time point are examined in the section of this Overview that discusses Goal 2: Eliminate Health Disparities. When data are available, disparities are summarized in the Health Disparities Table in Focus Area chapters.

Figure O-3. Summary of Progress for Objectives with Tracking Data for Each Population Group




[1]For some objectives, data are unavailable for the categories 'Asian' and 'Native Hawaiian or Other Pacific Islander'; these data are available for the combined 'Asian or Pacific Islander' population instead. See *Healthy People 2010: General Data Issues*, referenced above.

[2]For some objectives, data include persons of Hispanic origin.

## Table O-2. Healthy People 2010 Objectives: Summary of Progress for Population Groups

| Characteristics and Groups | Met or exceeded target | Moved toward target | Demonstrated no change | Moved away from target | **Total** |
|---|---|---|---|---|---|
| Race and Ethnicity | | | | | |
| American Indian or Alaska Native | 18 | 63 | 9 | 59 | **149** |
| Asian or Pacific Islander[1] | 18 | 11 | 3 | 21 | **53** |
| Asian | 28 | 46 | 10 | 37 | **121** |
| Native Hawaiian or Other Pacific Islander | 5 | 16 | 2 | 26 | **49** |
| Two or more races | 14 | 37 | 9 | 29 | **89** |
| Hispanic | 38 | 143 | 14 | 91 | **286** |
| Black, not Hispanic[2] | 62 | 183 | 23 | 88 | **356** |
| White, not Hispanic[2] | 90 | 155 | 23 | 112 | **380** |
| Sex | | | | | |
| Female | 67 | 151 | 15 | 96 | **329** |
| Male | 55 | 169 | 14 | 86 | **324** |
| Education | | | | | |
| Less than high school | 8 | 55 | 6 | 37 | **106** |
| High school graduate | 14 | 50 | 7 | 40 | **111** |
| At least some college | 38 | 45 | 5 | 25 | **113** |
| Income | | | | | |
| Poor | 14 | 47 | 4 | 34 | **99** |
| Near poor | 16 | 33 | 9 | 37 | **95** |
| Middle/high income | 31 | 31 | 11 | 28 | **101** |
| Location | | | | | |
| Urban or metropolitan | 5 | 25 | 1 | 13 | **44** |
| Rural or nonmetropolitan | 8 | 18 | 4 | 16 | **46** |
| Disability | | | | | |
| Persons with disabilities | 11 | 38 | 4 | 28 | **81** |
| Persons without disabilities | 12 | 39 | 8 | 27 | **86** |

[1]For some objectives, data are unavailable for the categories 'Asian' and 'Native Hawaiian or Other Pacific Islander'; these data are available for the combined 'Asian or Pacific Islander' population instead. See *Healthy People 2010: General Data Issues*, referenced above.

[2]For some objectives, data include persons of Hispanic origin.

# GOAL 1:
# Increase Quality and Years of Healthy Life

*Healthy People 2010: Understanding and Improving Health* highlighted the importance of maximizing and increasing both years of life and quality of life in the first overarching goal [6]. Progress toward achieving this goal is currently assessed by measuring life expectancy and three measures of healthy life expectancy: 1) Expected years in good or better health; 2) Expected years free of activity limitations; and 3) Expected years free of selected chronic diseases. These assessments result in the following conclusions:

- Life expectancy improved for the populations that could be assessed throughout the decade.
- Women had a longer life expectancy than men, and the white population had a longer life expectancy than the black population.
- Expected years in good or better health (at birth) and expected years free of activity limitations (at birth) increased; and expected years free of selected chronic conditions (at birth) decreased.
- Differences by race and sex were observed in all three healthy life expectancy measures (at birth)—expected years in good or better health, expected years free of activity limitations, and expected years free of selected chronic diseases.

## Life Expectancy

Life expectancy is the average number of years a hypothetical cohort of people born in a given year could be expected to live based on the age-specific death rates in that year. Since the launch of Healthy People 2010, life expectancy at birth and at age 65 have increased for all populations (Table O-3 and Figure O-4). In 2006–07, life expectancy for the total population was 77.8 years, an increase from 76.8 years in 2000–01. Improvements in overall life expectancy reflect improvements in disease-specific death rate objectives within the Healthy People 2010 Focus Areas. Death rates declined for many Healthy People 2010 cause-specific mortality objectives including: female breast cancer (objective 3-3), colorectal cancer (objective 3-5), prostate cancer (objective 3-7), coronary heart disease (objective 12-1), stroke (objective 12-7), cardiovascular disease and diabetes-related deaths among persons with diabetes (objectives 5-6 and 5-7) and HIV (objective 13-14). Even with these improvements, in 2007 the U.S. male life expectancy ranked 26th and female life expectancy ranked 25th out of 33 selected countries [7].

From 2000–01 to 2006–07, the percent increase in life expectancy was greater at age 65 (5.1%) than at birth (1.3%). In 2006–07, men (75.3 years) had a lower life expectancy at birth than women (80.3 years), and the black population (73.4 years) had a lower life expectancy at birth than the white population (78.3 years). However, from 2000–01 to 2006–07, the black population (2.1%) had a greater relative increase in life expectancy at birth than the white population (1.2%). Men (1.5%) also had a greater relative increase in life expectancy at birth than women (1.1%).

Table O-3. Life Expectancy at Birth and at Age 65 (in Years)

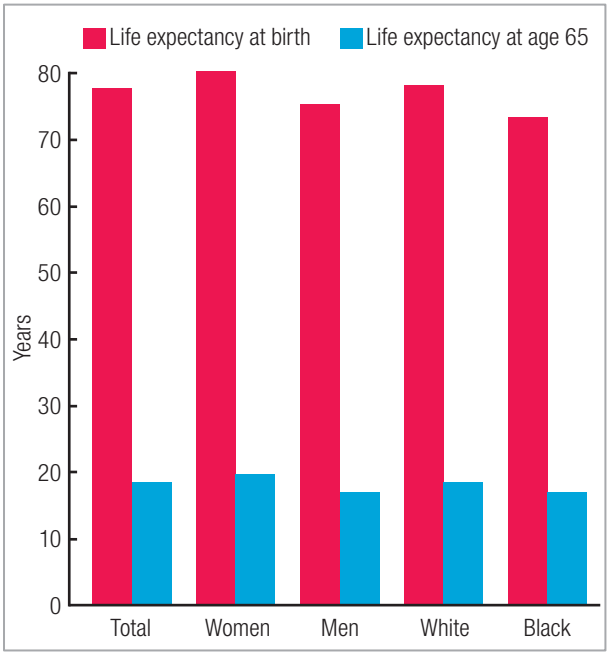
| | | Total | Black | White | Women | Men |
|---|---|---|---|---|---|---|
| Life expectancy at birth | 2000–01 | 76.8 | 71.9 | 77.4 | 79.4 | 74.2 |
| | 2002–03 | 77.0 | 72.2 | 77.5 | 79.5 | 74.4 |
| | 2004–05 | 77.4 | 72.8 | 77.9 | 79.9 | 74.9 |
| | 2006–07 | 77.8 | 73.4 | 78.3 | 80.3 | 75.3 |
| Life expectancy at age 65 | 2000–01 | 17.7 | 16.1 | 17.8 | 19.0 | 16.1 |
| | 2002–03 | 17.9 | 16.4 | 18.0 | 19.1 | 16.4 |
| | 2004–05 | 18.3 | 16.8 | 18.3 | 19.5 | 16.8 |
| | 2006–07 | 18.6 | 17.1 | 18.6 | 19.8 | 17.1 |

Source: National Vital Statistics System (NVSS), CDC, NCHS.

In this report, life expectancy for the periods 2000–01 to 2006–07 is not presented for racial and ethnic

groups other than the white population and the black population. Data quality problems have prevented the production of reliable U.S. life tables for all minority populations during this time period with the exception of data for the Hispanic population, which became available beginning in 2006. Two issues previously affected the quality of life expectancy data available for the Hispanic population: misclassification in reporting of race and ethnic origins on U.S. death certificates in comparison with the Census, surveys, and birth certificates; and misstatement of age at the oldest ages in both Census and vital statistics data. Recent research has shown that the classification of race and Hispanic origin on death certificates has improved and that a relatively minor adjustment is required to correct for the effects of the misclassification. In addition, the issue of age misstatement at the oldest ages can be addressed by recent research on Hispanic mortality patterns. Due to the improvement in data quality for the Hispanic population, complete period life tables for the total Hispanic population in 2006 became available in October 2010. However, additional data years for the Hispanic population were not available until September 2011 and therefore life expectancy for the Hispanic population is not addressed in this report [8].
Much of the recent gain in life expectancy is concentrated in the older population, which is the age group that has the highest prevalence of functional limitations. As a result, measuring longevity is no longer sufficient to describe the health of a population. Preventing disabling conditions, improving function, relieving physical pain and emotional distress, and maximizing health across the lifespan have become important public health goals along with increasing life expectancy [9].

Figure O-4. Life Expectancy at Birth and at Age 65, by Sex and Race, 2006–07




Source: National Vital Statistics System (NVSS), NCHS, CDC.

## Measuring Quality and Years of Healthy Life

Given the multidimensional nature of health, assessing quality and healthy life is a much more complex process than measuring life expectancy, and the field is evolving. Various measures are used nationally and internationally to measure healthy life. These measures fall into three general categories:

- Self-assessments of overall health status by individuals or their proxies [10].
- Composite measures that include multiple dimensions of health. Scores on the various dimensions are combined into a single measure using a predetermined algorithm (for example, SF-36, Healthy Days) [11,12].
- Measures that combine death rates and health (where the health indicator can be either of the types described above or an indicator of a single dimension of health). These measures use years as the metric to quantify healthy life (for example, healthy life expectancy, Years of Healthy Life) [13].

*Healthy People 2010: Understanding and Improving Health* mentioned several possible measures of population health: respondent-assessed health status; healthy days; and the measure used in Healthy People 2000, Years of Healthy Life (YHL) [6,13]. In response to the need to measure Goal 1 of Healthy People 2010, at the beginning of the decade, NCHS convened a workshop to select measures that best capture the complexity of assessing years of healthy life within the context of Healthy People 2010 [14]. As a result of the workshop, three measures of healthy life expectancy that combine death rates with different measures of health were selected to track progress toward Goal 1 of Healthy People 2010. These healthy life expectancy measures represent the breadth of recommendations from the workshop. The three new measures are:

1. Expected years in good or better health
2. Expected years free of activity limitations
3. Expected years free of selected chronic diseases.

Two of the three new healthy life expectancy measures, years in good or better health and years free of activity limitation, evolved from the YHL measure used to track

the years and quality of life in Healthy People 2000. YHL combined information about death rates, self-rated health, and activity limitations into a single measure. The current set of healthy life expectancy measures separate the self-rated health component from the limitation of activities component to better track and understand change over time. For more detail on these measures, see the Technical Appendix.

Data for these three measures of healthy life expectancy were analyzed for the period 2000–01 through 2006–07 for expected years in good or better health and expected years free of activity limitations and for the period 2002–03 through 2006–07 for expected years free of selected chronic diseases. Prevalence data on physician- or health professional-diagnosed arthritis were unavailable for the years 2000 and 2001; therefore, the expected years free of selected chronic diseases was not analyzed for those years as arthritis is one of the chronic conditions included in the measure. Results of the analysis are mixed, with years in good or better health and years free of activity limitations showing an increase whereas years free of chronic conditions decreased during the decade.

## Measures of Healthy Life Expectancy for Healthy People 2010

The measures of healthy life expectancy are calculated using a life-table technique. This technique combines information about average health states and death rates to produce age-specific estimates of expected years of healthy life (see Technical Appendix for details on the methodology).

***Expected years in good or better health*** is defined as the average number of years a person can expect to live in good or better health. This measure assesses healthy life using a single global assessment question which asks a person to rate his or her health as "excellent," "very good," "good," "fair," or "poor."

***Expected years free of activity limitations*** is defined as the average number of years a person can expect to live free from limitation in activities, the need for assistance in personal or routine care needs, or the need to use special equipment because of health problems.

***Expected years free of selected chronic diseases*** is defined as the average number of years a person can expect to live without being diagnosed by a physician or health professional as having one or more of the following selected conditions for which nationally representative data are available annually: arthritis, asthma, cancer, diabetes, heart disease, high blood pressure, kidney disease, or stroke.

## Healthy Life Expectancy at Birth

Table O-4 and Figure O-5 present healthy life expectancy at birth for each of the three measures. Life expectancy is included in Figure O–5 for comparison purposes. Based on data from the years 2006–07, individuals in the U.S. could expect to live 69.0 years in good or better health, 66.2 years free of activity limitations, and 43.1 years free of selected chronic diseases. Expected years in good or better health increased 0.5 years and expected years free of activity limitations increased 0.7 years between 2000–01 and 2006–07. Expected years free of selected chronic conditions declined 0.6 years between 2002–03 and 2006–07.

### Table O-4. Measures of Healthy Life Expectancy at Birth (in Years)

| | | Total | Black | White | Women | Men |
|---|---|---|---|---|---|---|
| Expected years in good or better health | 2000–01 | 68.5 | 59.8 | 69.7 | 70.2 | 66.6 |
| | 2006–07 | 69.0 | 61.3 | 70.0 | 70.7 | 67.3 |
| Expected years free of activity limitations | 2000–01 | 65.5 | 59.3 | 66.1 | 67.2 | 63.8 |
| | 2006–07 | 66.2 | 60.2 | 66.8 | 67.8 | 64.7 |
| Expected years free of selected chronic diseases | 2002–03 | 43.7 | 38.9 | 43.9 | 43.6 | 43.8 |
| | 2006–07 | 43.1 | 38.6 | 43.4 | 43.5 | 42.7 |

Sources: National Health Interview Survey (NHIS), CDC, NCHS; National Vital Statistics System (NVSS), CDC, NCHS.

Women can expect to spend a slightly greater proportion of their lives in fair or poor health, with activity limitations, and with selected chronic conditions than their male counterparts. Based on data from years 2006–07, women could expect to live 80.3 years (see Table O–3), of which 70.7 years would be in good or better health, 67.8 would be free of activity limitations and 43.5 would be free of selected chronic diseases. Women could, therefore, expect to spend approximately 12% of their lives in fair or poor health:

$$\frac{80.3 - 70.7}{80.3} \times 100 = \frac{9.6}{80.3} \times 100 = 12\%.$$

Similarly, women could expect to spend 16% of their lives with activity limitations and 46% of their lives with one or more selected chronic conditions. In the years

2006–07, men could expect to spend 11% of their lives in fair or poor health, 14% with activity limitations, and 43% with one or more selected chronic conditions.

Compared with the white population, the black population could expect to spend a greater proportion of life in an unhealthy state. Based on data from years 2006–07, the black population, at birth, could expect to spend 16% of life in fair or poor health, 18% of life with activity limitations, and 47% of life with one or more selected chronic conditions.

## Healthy Life Expectancy at Age 65

Table O-5 and Figure O-6 present the three measures of healthy life expectancy at age 65. Life expectancy is included in Figure O–6 for comparison purposes. Based on 2006–07 data, individuals at age 65 could expect to live an additional 13.7 years in good or better health, 11.8 years free of activity limitations, and 2.7 years free of selected chronic diseases. Between the years 2000–01 and 2006–07, for those at age 65, expected years in good or better health and expected years free of activity limitations increased. From 2002–03 to 2006–07, expected years free of selected chronic diseases declined.

Table O-5. Measures of Healthy Life Expectancy at Age 65 (in Years)

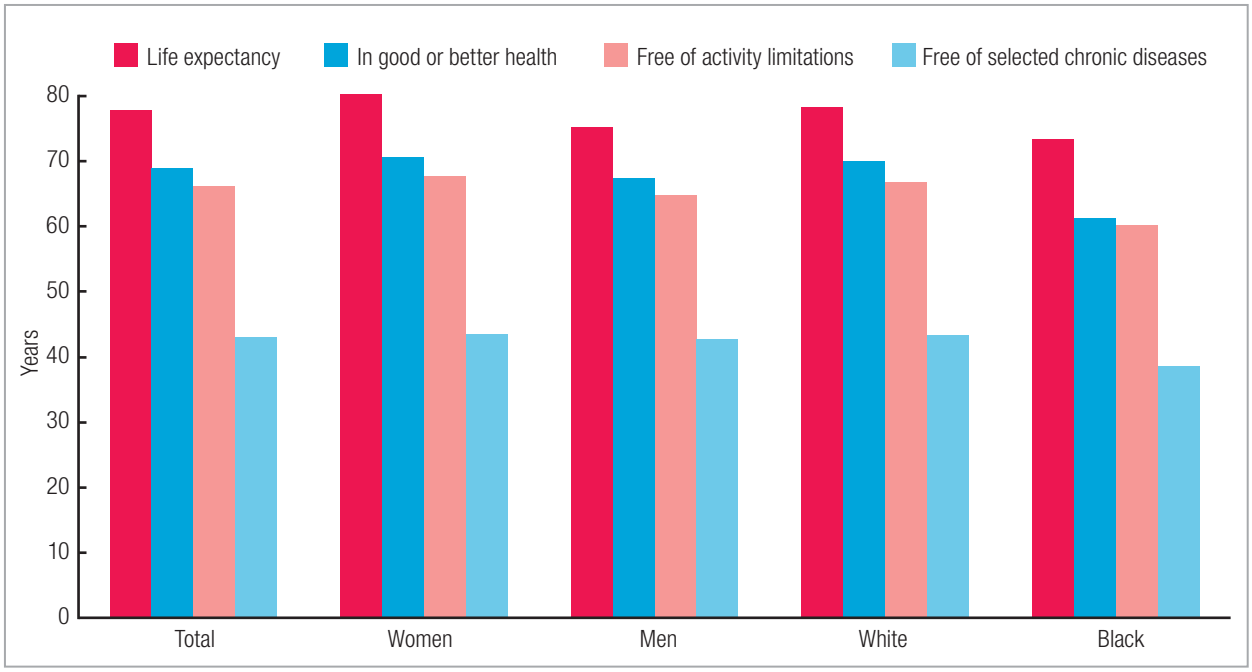
| | | Total | Black | White | Women | Men |
|---|---|---|---|---|---|---|
| Expected years in good or better health | 2000–01 | 12.9 | 9.2 | 13.3 | 13.9 | 11.7 |
| | 2006–07 | 13.7 | 10.5 | 13.9 | 14.5 | 12.6 |
| Expected years free of activity limitations | 2000–01 | 11.1 | 8.6 | 11.3 | 11.5 | 10.6 |
| | 2006–07 | 11.8 | 9.3 | 12.0 | 12.1 | 11.5 |
| Expected years free of selected chronic diseases | 2002–03 | 2.8 | 2.0 | 2.9 | 2.9 | 2.7 |
| | 2006–07 | 2.7 | 1.6 | 2.6 | 2.8 | 2.4 |

Sources: National Health Interview Survey (NHIS), CDC, NCHS; National Vital Statistics System (NVSS), CDC, NCHS.

Similar to the patterns at birth, women at age 65 could expect to live a greater number of years in a healthy life state, but they would spend a greater proportion of their lives with activity limitations or in fair or poor health. Based on data from years 2006–07, older women could expect to spend 39% of their remaining lives with activity limitations, whereas men could expect to spend 33% of their remaining lives with activity limitations. It was expected that both older men and older women would spend a large proportion of their remaining lives with one or more selected chronic conditions (86% for men; 86% for women). Older men and older women were expected to spend similar proportions of their remaining lives in fair or poor health (26% for men; 27% for women).

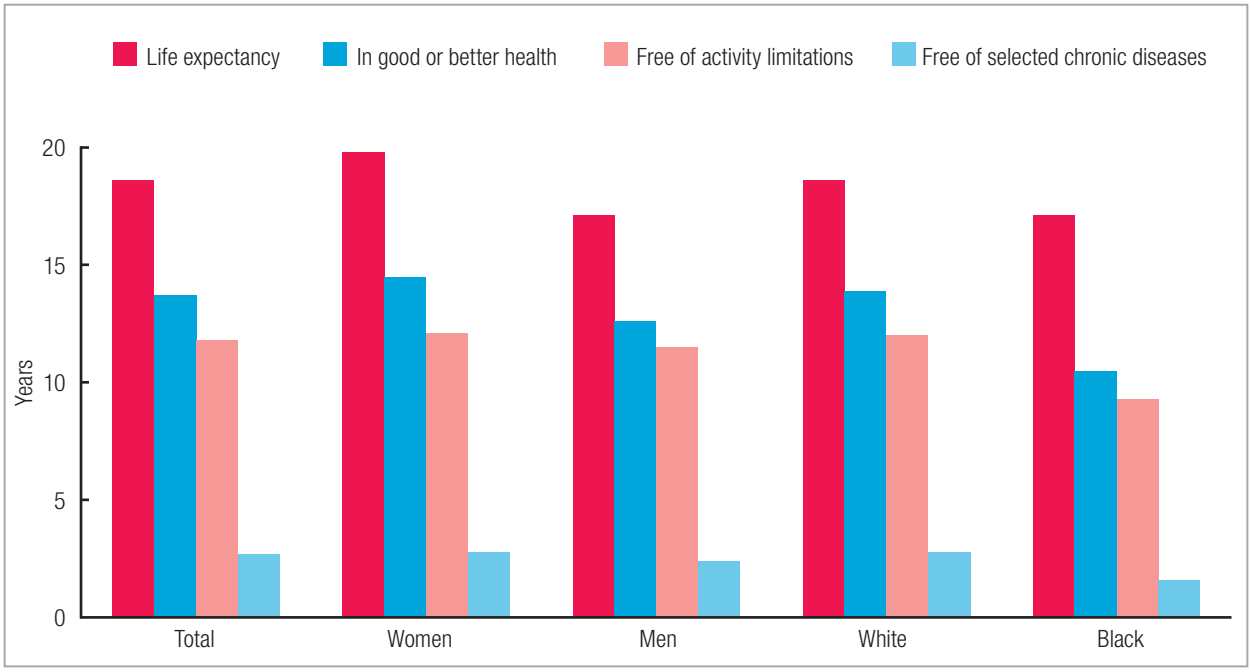
Similar to the patterns at birth, the older black population could expect to spend a greater proportion of remaining life in an unhealthy state than the older white population. Based on data from the years 2006–07, the black population aged 65 could expect to live 39% of remaining life in fair or poor health, 46% with activity limitations, and 91% with one or more selected chronic conditions. From 2000–01 to 2006–07, the older black population experienced a greater increase in expected years in good or better health than the older white population. There was no statistically significant difference in the expected years free of activity limitations or the expected years free of selected chronic diseases between the older black and white populations.

Figure O-5. Life Expectancy and Measures of Healthy Life Expectancy at Birth, 2006–07




Sources: National Health Interview Survey (NHIS), NCHS, CDC; National Vital Statistics System (NVSS), NCHS, CDC.

Figure O-6. Life Expectancy and Measures of Healthy Life Expectancy at Age 65, 2006–07




Sources: National Health Interview Survey (NHIS), NCHS, CDC; National Vital Statistics System (NVSS), NCHS, CDC.

# GOAL 2:
# Eliminate Health Disparities

The second goal of Healthy People 2010 was to eliminate health disparities that occur by race and ethnicity, sex, education, income, geographic location, disability status, or sexual orientation. Findings for specific objectives and populations are presented in 27 of the 28 Focus Area chapters. None of the objectives in Public Health Infrastructure (Focus Area 23) were tracked with population-based data. The findings concerning health disparities are summarized below.

Substantial health disparities were observed for many Healthy People 2010 objectives. Both increases and decreases in health disparities also were observed for specific objectives; however, most of the population-based objectives with data to measure disparities had no change in health disparities on average.

For specific population characteristics:

- Among 169 objectives with data for racial and ethnic groups, health disparities, on average, decreased for 27 objectives and increased for 25.
- Among 216 objectives with data for males and females, health disparities decreased for 26 objectives and increased for 23. Females more often had better group rates than males.
- Among 132 objectives with data for education groups, health disparities, on average, decreased for 7 objectives and increased for 20.
- Health disparities among income groups, as well as by geographic location and disability status did not change, with the exception of a few objectives.

In total, there were 469 population-based objectives for which health disparities could be measured. Presented as the second figure in each Focus Area chapter (except for chapter 23), the Health Disparities Table provides detailed information about health disparities for the objectives in that Focus Area. The Health Disparities Table provides information about the availability of data for each population, the size of health disparities relative to the group with the best rate for each characteristic, and the magnitude of changes in these disparities between the Healthy People 2010 baseline and the most recent time point for each objective. Data were not available for all populations for each objective, and tracking data were not always available to assess changes in disparity from the baseline.

Data by sexual orientation were unavailable for all Healthy People 2010 objectives.

In this Final Review, health disparities are measured using the "best" or most favorable (or least adverse) group rate as the reference point. "Best" is used to identify the population group with the most favorable (or least adverse) rate among the groups associated with a particular characteristic. "Best" does not imply that no further improvement is called for. Health disparities by race and ethnicity, for example, are measured using the rate for the racial and ethnic population with the best rate as the reference point. Health disparities are measured in relative terms as the percent difference between the rate for each population group and the best group rate for each characteristic. In the measurement of health disparities, objectives are generally expressed in terms of adverse events or conditions, such as death rates, to facilitate comparisons among them. Changes in disparities are measured by subtracting the percent difference from the best group rate at the baseline from the percent difference from the best group rate at the most recent time point. As a result, changes in disparities are expressed in percentage points. In addition, when more than two groups are associated with a characteristic (race and ethnicity, education, or income), a summary index is used to describe the average percent difference from the best group in the population overall. The summary index provides a basis for conclusions about changes in the average size of the disparities associated with these characteristics. A detailed description of the methods used to measure and evaluate disparities is provided in the Technical Appendix.

# Findings Concerning Disparities

## Race and Ethnicity

Information about health disparities among racial and ethnic populations at the most recent time point based on the Health Disparities Table for each Focus Area is summarized in Figure O-7. The measurement of health disparities depends on the availability of data for each population. The number of objectives with data needed to measure health disparities varied from 38 for the Native Hawaiian or Other Pacific Islander population to 354 for the non-Hispanic white population.

### American Indian or Alaska Native Population

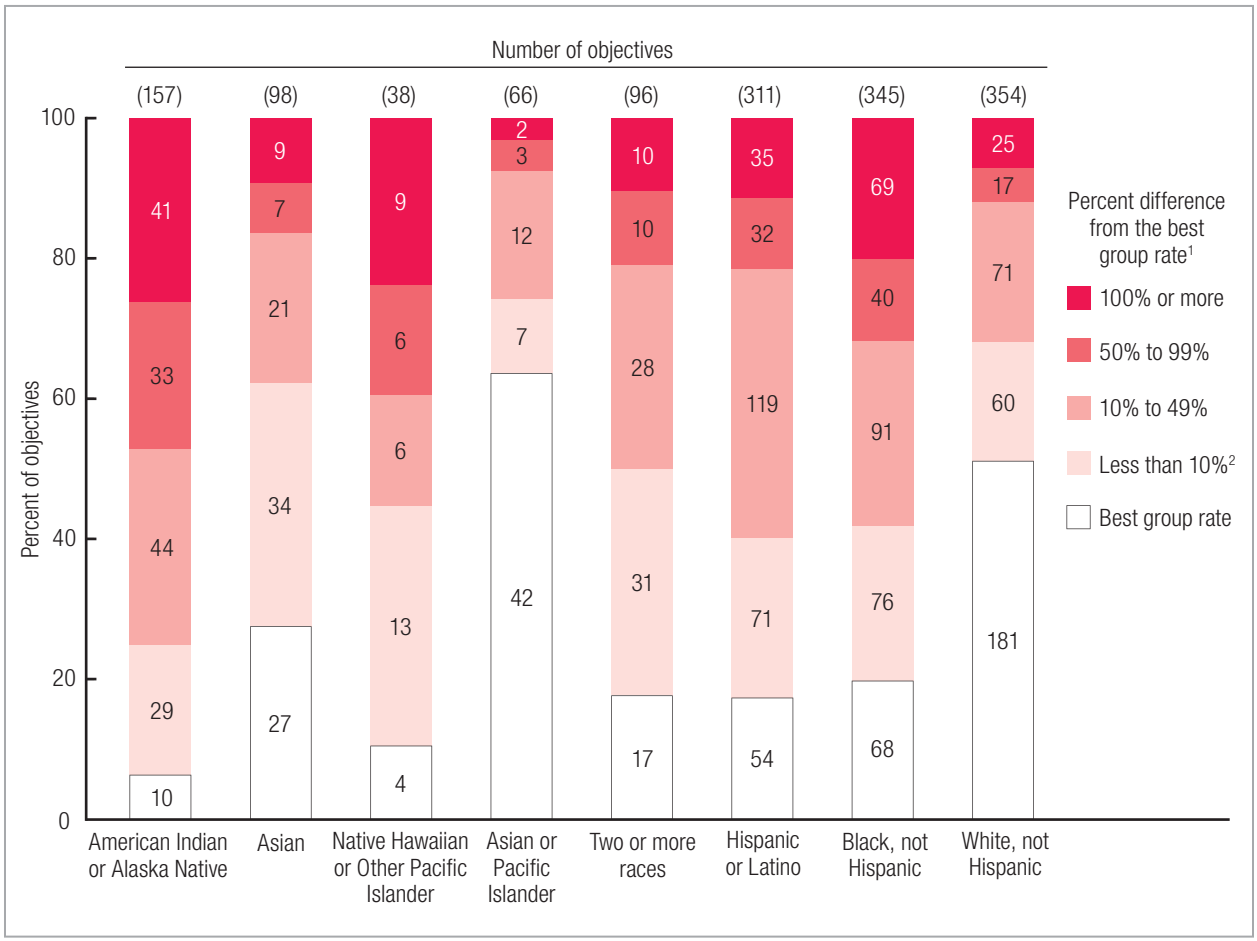
Data needed to assess health disparities for the American Indian or Alaska Native population were available for 157 objectives (Figure O-7). This population had the best group rate (i.e., least adverse) for 6% of these objectives. The American Indian or Alaska Native population had rates at least twice as high as the least adverse group rate (i.e.,100% or more range) for 26% of the 157 objectives, which is a larger proportion of health disparities in the 100% or more range than any of the other racial and ethnic populations.

### Asian Population and Native Hawaiian or Other Pacific Islander Population

Data needed to assess health disparities for the Asian population (excluding the Native Hawaiian or Other Pacific Islander population) were available for 98 objectives; see Figure O-7. The Asian population had the best group rate (i.e., least adverse) for 28% of these objectives. This population had rates at least twice as high as the least adverse group rate (100% or more range) for 9% of the 98 objectives.

Data for the Native Hawaiian or Other Pacific Islander population were available for 38 objectives (Figure O-7).

Figure O-7. Health Disparities at the Most Recent Time Point, by Race and Ethnicity




[1]Best group rate refers to least adverse group rate among racial and ethnic groups.
[2]"Less than 10%" includes percent differences that were not statistically significant (when estimates of variability were available).

This population had a smaller percentage of best group rates (11%) and a larger percentage of health disparities of 100% or more (24%) than the Asian population.

Data were available for the combined Asian or Pacific Islander population for 66 objectives (Figure O-7). This combined population had the best group rate for 64% of these objectives. The Asian or Pacific Islander population had rates at least twice as high as the least adverse group rate (100% or more range) for two objectives: cases of hepatitis B in adults aged 19–24 (objective 14-3a) and cases of hepatitis A (objective 14-6).

### Two or More Races

Data for individuals who identified with more than one race were available for 96 objectives (Figure O-7). The population of persons of two or more races had the best group rate for 18% of these objectives. This population had rates at least twice as high as the least adverse group rate (100% or more range) for 10% of the 96 objectives.

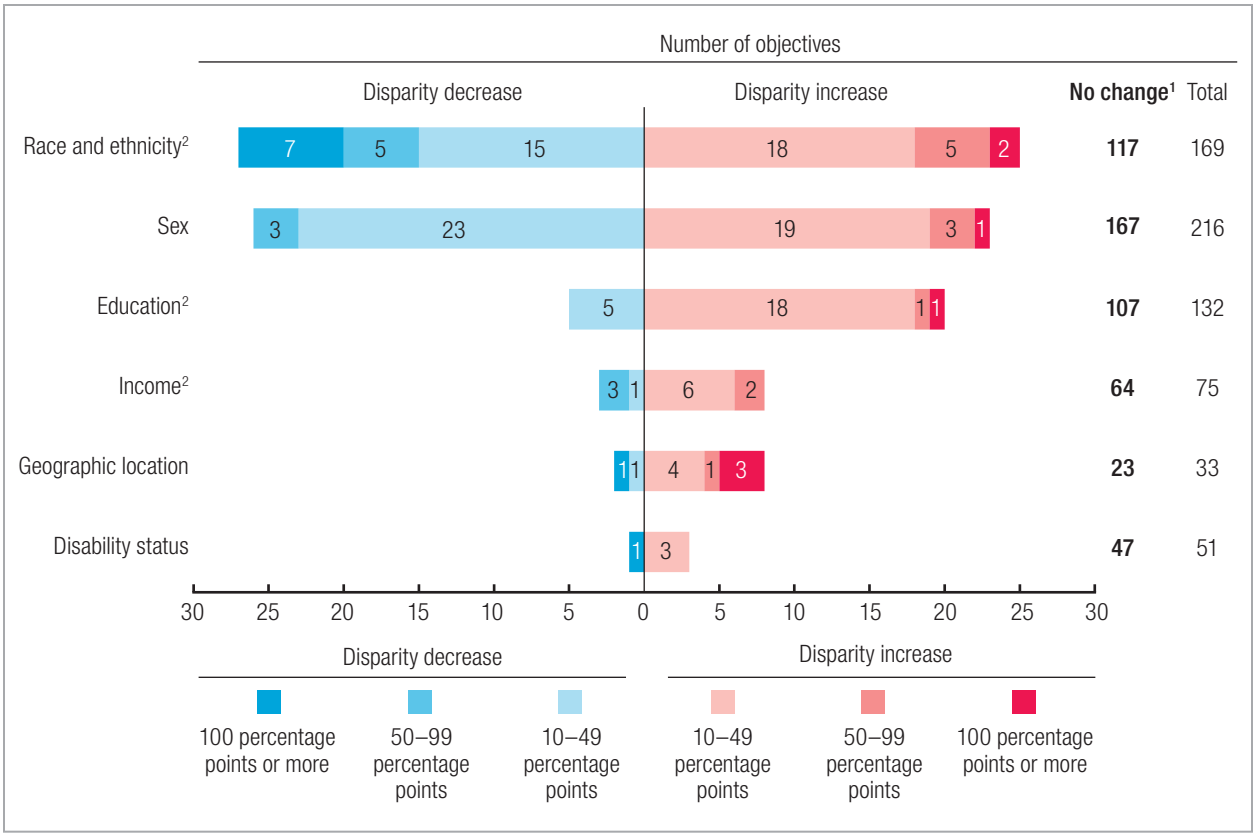
### Hispanic Population

Data needed to assess health disparities for the Hispanic population were available for 311 objectives (Figure O-7). The Hispanic population had the best group rate for 17% of these objectives. This population had rates at least twice as high as the least adverse group rate (100% or more range) for 11% of the 311 objectives.

### Non-Hispanic Black Population

Data needed to assess health disparities for the non-Hispanic black population (or, in some cases, the black population, including persons of Hispanic origin) were available for 345 objectives (Figure O-7). This population had the best group rate for 20% of these objectives. This population had rates at least twice as high as the least adverse group rate (100% or more range) for 20% of the 345 objectives, including most leading causes of death.

Figure O-8. Changes in Health Disparities from the Baseline to the Most Recent Time Points, by Population Characteristic




[1]"No change" includes: changes of less than 10 percentage points, regardless of statistical significance; and all changes that were not statistically significant, when estimates of variability were available. See Technical Appendix.
[2]Number of objectives with changes in the summary index as the measure of disparity. Health disparities by income were not included for Focus Area 19 due to data limitations.

NOTES: Changes in disparity from the baseline to the most recent time points are only shown when they could be assessed. Changes could not be assessed for 54, 82, 4, 3, 10, and 17 objectives by race and ethnicity, sex, education, income, geographic location, and disability status, respectively.

### Non-Hispanic White Population

Data needed to assess health disparities for the non-Hispanic white population (or, in some cases, the white population, including persons of Hispanic origin) were available for 354 objectives (Figure O-7). This population had the best group rate for 51% of these objectives. This population had rates at least twice as high as the least adverse group rate (100% or more range) for 7% of the 354 objectives.

### Changes in Health Disparities Among Racial and Ethnic Groups

In addition to the findings for specific racial and ethnic groups, a summary index allows the evaluation of changes in overall health disparities by race and ethnicity over time. There was no change in health disparities among racial and ethnic populations for 111 (69%) of the 169 objectives with data to calculate the summary index and assess its change over time. ("No change" includes changes of less than 10 percentage points, regardless of statistical significance, and all changes that were not statistically significant, when estimates of variability were available; see Technical Appendix.) The average percent difference from the best group rate decreased for 27 objectives and increased for 25 objectives (Figure O-8).

## Sex

Data by sex were available for 318 objectives (Figure O-9). As noted below, trends in disparity could only be measured for 216 objectives. Health disparities by sex were not relevant to objectives that applied only to females or only to males, including those in Family Planning (Focus Area 9), and a number of objectives in other Focus Areas. Findings concerning health disparities by sex are summarized in Figure O-9.

Females had the better group rate (i.e., less adverse) for 68% of the 318 objectives, compared with 42% for males. (Those two percentages, 68% and 42%, add to over 100% because there were a number of cases in which the two groups had the same rate; therefore, both were counted as having achieved the best group rate.) Females had a smaller percentage of objectives with adverse rates that were at least twice as high as those for males (100% or more range).

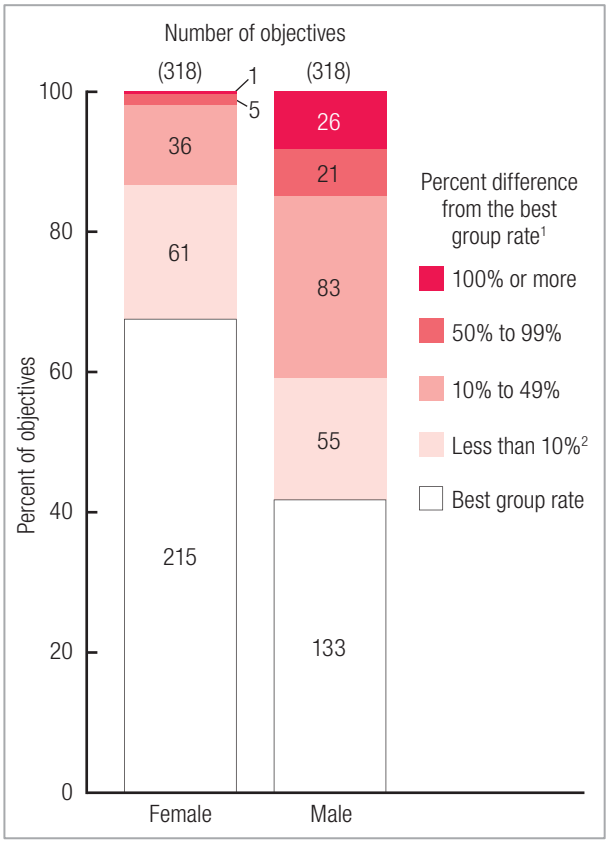
### Changes in Disparities by Sex

Data needed to evaluate changes over time in health disparities by sex were available for 216 objectives. There was no change in disparity for 167 objectives, or 77% of the total with data. ("No change" includes changes of less than 10 percentage points, regardless of statistical significance, and all changes that were not statistically significant, when estimates of variability were available; see Technical Appendix.) Disparities decreased for 26 objectives and increased for 23 (Figure O-8). In addition, there were 33 objectives for which changes in disparities could not be assessed because the group with the best rate changed (e.g., from males to females).

## Education Level

Data needed to assess health disparities among populations by education level were available for 160 to 161 objectives (Figure O-10). Education was not included as a characteristic in all Focus Areas. The population with at least some college education had the best rate (i.e., least adverse) for 88% of the objectives with data by education. The population with less than a high school education and high school graduates had the best group rate for 8% and 10% of the objectives with data by education, respectively. There were no objectives for which the disparity between the population with at least some college education and the group with the least adverse rate was 100% or more. High school graduates had rates at least twice as high as the least adverse group rate (100% or more range) for 18% of the

Figure O-9. Health Disparities at the Most Recent Time Point, by Sex




[1]Best group rate refers to less adverse group rate.
[2]"Less than 10%" includes percent differences that were not statistically significant (when estimates of variability were available).

160 objectives, and the population with less than a high school education had rates at least twice as high as the least adverse group rate (100% or more range) for 24% of the 160 objectives.

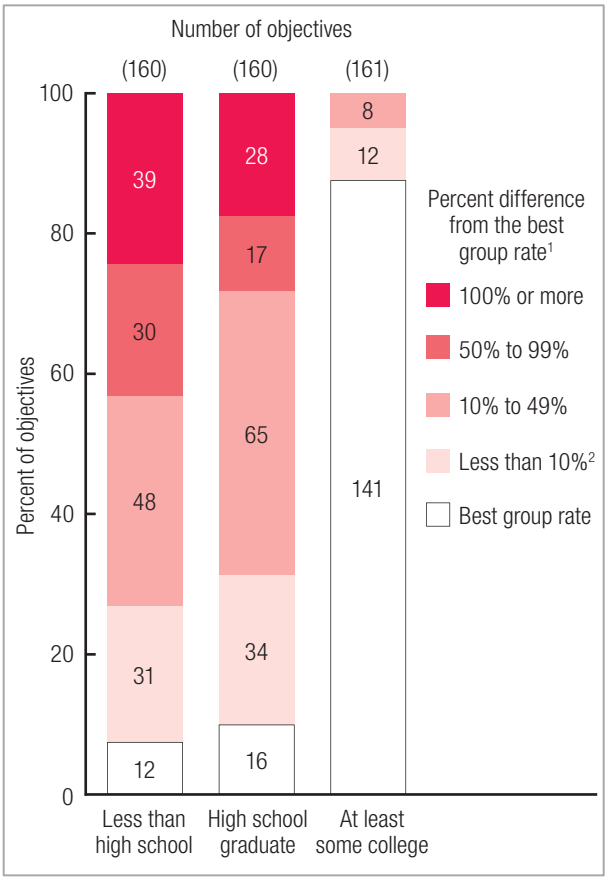
### Changes in Health Disparities by Education Level

In addition to the findings for individual populations, the summary index permits the evaluation of changes in overall health disparities over time by level of education. There was no change in health disparity among populations by education level for 107 objectives, or 81% of the 132 objectives with data to calculate the index and assess change over time. ("No change" includes changes of less than 10 percentage points, regardless of statistical significance, and all changes that were not statistically significant when estimates of variability were available; see Technical Appendix.) On average, disparities decreased for five objectives and increased for 20 (Figure O-8). There was 1 increase and 0 decreases of 100 percentage points or more.

## Income

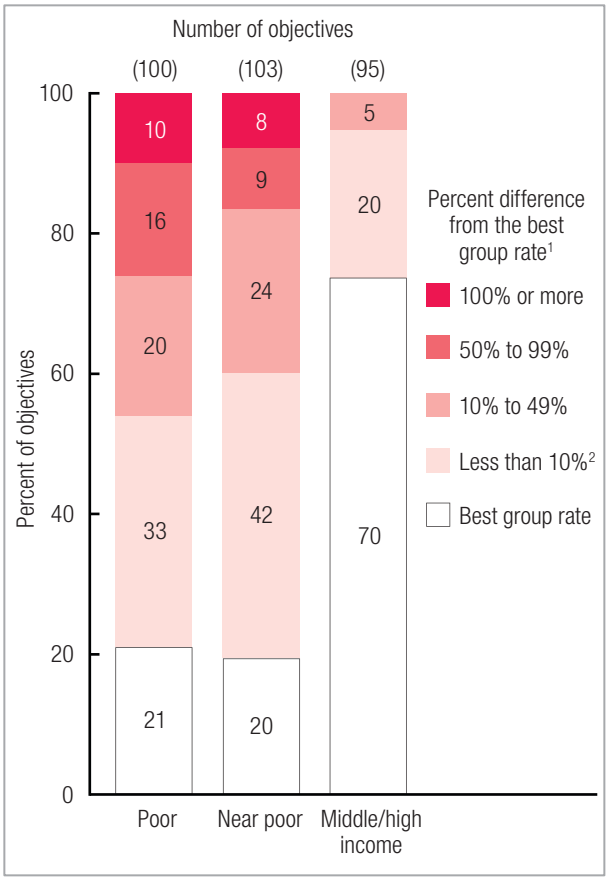
Income was not included as a characteristic in all Focus Areas. All of the objectives in Nutrition and Overweight (Focus Area 19) and six objectives in Immunization and Infectious Diseases (Focus Area 14) were excluded from the summary in Figure O-11 because data by income were available for only two population subgroups (persons with income at or below 130% of the Federal poverty level, and persons with income above 130% of the Federal poverty level). This summary is based on 95 to 103 objectives with data by income (Figure O-11). The population with middle/high income (at or above 200% of the Federal poverty level) had the best rate for 74% of the objectives with data by income. The poor (below the Federal poverty level) and near-poor (100–199% of the Federal poverty level) populations each had the best rate (i.e., least adverse) for 21% and 19% of their objectives, respectively.

Figure O-10. Health Disparities at the Most Recent Time Point, by Education Level




[1]Best group rate refers to least adverse group rate by education level.
[2]"Less than 10%" includes percent differences that were not statistically significant (when estimates of variability were available).

Figure O-11. Health Disparities at the Most Recent Time Point, by Income




[1]Best group rate refers to least adverse group rate by education level.
[2]"Less than 10%" includes percent differences that were not statistically significant (when estimates of variability were available).

There were no objectives for which the health disparities between persons with middle/high incomes and the group with the least adverse rate were 100% or more. The near-poor population had rates at least twice as high as the least adverse group rate (100% or more range) for 8% of the objectives with data. The poor or lowest income population had rates at least twice as high as the least adverse group rate (100% or more range) for 10% of the objectives with data.

### Changes in Health Disparities by Income

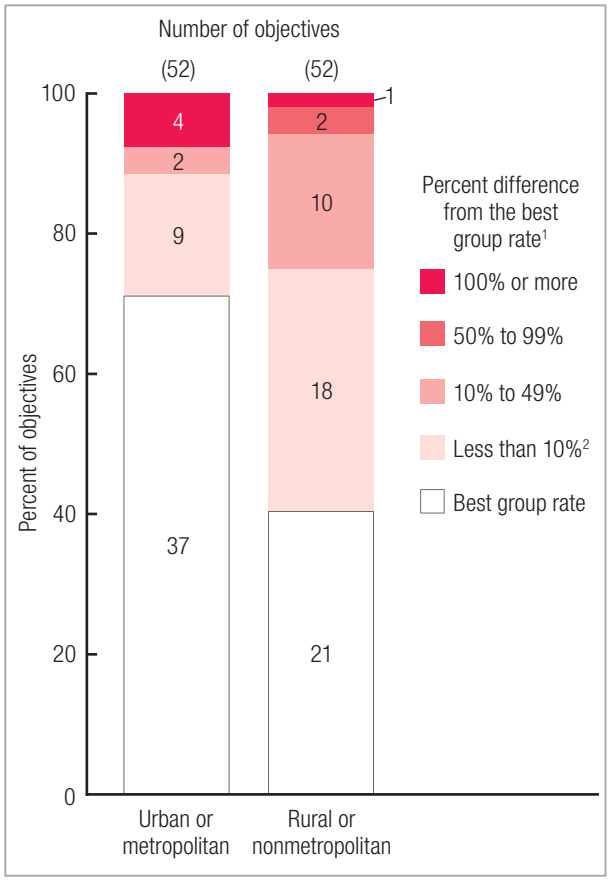
The summary index enables the evaluation of changes in disparity over time by income. Data needed to evaluate changes in disparity were available for 75 objectives (Figure O-8). There was little evidence of any change in disparity among populations by income. On average, disparities decreased for 3 objectives and increased for 8 (Figure O-8).

## Geographic Location

Geographic location was defined in different ways in Healthy People 2010. For some objectives, the distinction was between urban and rural areas, whereas for others, the distinction was between metropolitan and nonmetropolitan areas. Findings for health disparities by geographic location for 52 objectives are summarized in Figure O-12.

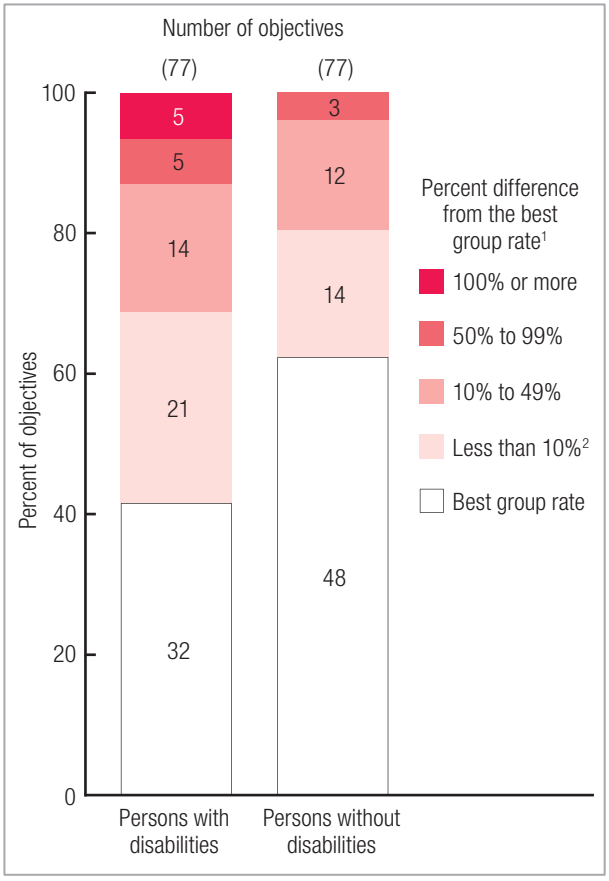
Urban or metropolitan areas had the better rate (i.e., less adverse) for 71% of the 52 objectives. Urban or metropolitan areas also had more objectives (4 objectives) with health disparities of 100% or more than rural or nonmetropolitan areas (1 objective). Rural or nonmetropolitan areas had the better rate for 40% of the 52 objectives. (Those two percentages, 71% and 40%, add to over 100% because there were a number of cases in which the two groups had the same rate; therefore, both were counted as having achieved the best group rate.)

Figure O-12. Health Disparities at the Most Recent Time Point, by Geographic Location




[1]Best group rate refers to less adverse group rate.
[2]"Less than 10%" includes percent differences that were not statistically significant (when estimates of variability were available).

Figure O-13. Health Disparities at the Most Recent Time Point, by Disability Status




[1]Best group rate refers to less adverse group rate.
[2]"Less than 10%" includes percent differences that were not statistically significant (when estimates of variability were available).

### Changes in Health Disparities by Geographic Location

Data needed to evaluate changes in health disparities between geographic areas were available for 33 objectives. Health disparities from the better group rate declined for 2 objectives, and increased for 8 (Figure O-8).

## Disability Status

Data for persons with disabilities and persons without disabilities were available for 77 objectives and are summarized in Figure O-13. Persons with disabilities had the better group rate (i.e., less adverse) for 42% of these objectives, and persons without disabilities had the better group rate for 62%. (Those two percentages, 42% and 62%, add to over 100% because there were a number of cases in which the two groups had the same rate; therefore, both were counted as having achieved the best group rate.) Persons with disabilities had adverse rates at least twice as high as for persons without disabilities (100% or more range) for 6% of the 77 objectives.

### Changes in Health Disparities by Disability Status

Data needed to evaluate changes in health disparities between disability groups were available for 51 objectives (Figure O-8). There were few changes in disparities by disability status. Health disparities between these populations declined for 1 objective and increased for 3 objectives.

## Data Limitations

Several factors limited the number of objectives for which health disparities and changes in disparities could be assessed:

- This assessment is based only on data at the baseline and at the most recent time points; intervening data values were not considered.
- Some populations, such as the American Indian or Alaska Native, Asian, Hispanic, and Native Hawaiian or Other Pacific Islander populations, lacked data to assess disparities or changes in disparities.
- Some data systems lacked reliable or valid information about the persons on whom this assessment is based. For example, reporting of race and income was sometimes problematic.
- Assessments of the likelihood that health disparities or changes in disparities were due to random fluctuations in the data were limited by the lack of estimates of variability for some data. See the Technical Appendix for more information.

# Transitioning to Healthy People 2020: The Decade Ahead

In December 2010, DHHS launched Healthy People 2020, the successor health promotion initiative for the second decade of the 21st century which builds on the strengths of Healthy People 2010 while breaking new ground in the scope, outreach, and scientific underpinning of the initiative. In contrast with the two goals of Healthy People 2010, Healthy People 2020 is grounded in four overarching goals to:

1. Attain high quality, longer lives free of preventable disease, disability, injury, and premature death.
2. Achieve health equity and eliminate disparities.
3. Create social and physical environments that promote good health for all.
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

The framework of Healthy People 2020 is organized into 42 Topic Areas (formerly Focus Areas), with 13 new areas added:

- Adolescent Health
- Blood Disorders and Blood Safety
- Dementias, Including Alzheimer's Disease
- Early and Middle Childhood
- Genomics
- Global Health
- Healthcare-Associated Infections
- Health-Related Quality of Life and Well-Being
- Lesbian, Gay, Bisexual, and Transgender Health
- Older Adults
- Preparedness
- Sleep Health
- Social Determinants of Health.

In addition, the 2010 Vision and Hearing Focus Area was split into two separate Topic Areas for 2020: Vision, and Hearing and Other Sensory or Communication Disorders.

The Healthy People 2020 Topic Areas encompass approximately 1,200 objectives as compared with 969 objectives in Healthy People 2010. As of the Healthy People 2010 launch, 366 objectives have been carried over without change into Healthy People 2020; 358 appear in modified form; 242 have been archived, that is, preserved on inactive but retrievable status on the strength of having at least one data point; and 84 have been discontinued because they had no prospect of acquiring a data source, an improved data source had been identified, or the science had changed. Appendix D, "A Crosswalk Between Objectives From Healthy People 2010 to Healthy People 2020," summarizes the changes between the two decades of objectives.

## Innovations of Healthy People 2020

Healthy People 2020 places a renewed focus on identifying, measuring, tracking, and reducing health disparities using a determinants of health approach. Health status and health behaviors are determined by influences at multiple levels, including personal (i.e., biological, psychological), organizational and institutional, environmental (i.e., both social and physical), and policy levels. Because significant and dynamic inter-relationships exist among these different levels of health determinants, interventions are most likely to be effective when they address determinants at all levels. Historically, many initiatives have focused on individual-level health determinants and interventions. Healthy People 2020 therefore expanded its focus from previous iterations to emphasize tracking and monitoring of health-enhancing social and physical environments. Integrating prevention into the continuum of education—from the earliest ages on—is

an integral part of this ecological and determinants approach. Another important innovation in Healthy People 2020 is the expanded population template which will allow a more in-depth analysis of health disparities in comparison with Healthy People 2010.

As with Healthy People 2010, each Healthy People 2020 objective has a:

- Reliable data source
- Baseline measure
- Target for specific improvements to be achieved by the year 2020.

Draft objectives have been prepared by experts from multiple lead federal agencies. The proposed objectives have then been reviewed through a public comment process and by the Healthy People Federal Interagency Workgroup, which used specific selection criteria to choose the final objectives.

Many objectives focus on interventions that are designed to reduce or eliminate illness, disability, and premature death among individuals and communities. Others focus on broader issues such as:

- Eliminating health disparities
- Addressing social determinants of health
- Improving access to quality health care
- Strengthening public health services
- Improving the availability and dissemination of health-related information.

Over the course of the decade, Foundation Health Measures will be used to monitor progress toward promoting health, preventing disease and disability, eliminating disparities, and improving quality of life. These broad, crosscutting measures include:

- General Health Status, as measured by such factors as life expectancy, healthy life expectancy, years of potential life lost, limitation of activity, chronic disease prevalence, self-assessed health status, and the CDC "Healthy Days Measures."
- Health-Related Quality of Life and Well-Being, as measured in terms such as: physical, mental, and social health-related quality of life; well-being/satisfaction; and participation in common activities.
- Determinants of Health, that is, a range of personal, economic, and environmental factors that influence health status, including factors such as biology, genetics, individual behavior, access to health services, and the particular environment(s) in which people may find themselves in the course of their lives or their daily round.
- Disparities and inequities in health status observed across race/ethnicity, sex, physical and mental ability, and geographical location.

Concurrent with the release of Healthy People 2020, a redesigned website (http://www.healthypeople.gov) was launched. Replacing the traditional print publication with an interactive website as the main vehicle for dissemination will expand the reach and accessibility of Healthy People and allow users to tailor information to their particular needs and explore evidence-based resources for implementation. Among the new features of the site are the following:

- An index to the Topic Areas and their objectives, with information about each objective's baseline, target, and data source.
- A "Determinants of Health" section with an animated graphic to illustrate the range of personal, social, economic, and environmental factors that influence health status and often account for health-related disparities among population groups.
- A "Stay Connected" section with information about signing up for the listserv and links to social networking sites.

Plans for the future include adding capabilities for the website to disseminate research-based implementation strategies for Topic Areas and objectives and to receive public comments on the objectives during periods set aside for this purpose on an annual basis.

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