

GOAL 1
Increase Quality and Years of Healthy Life

Number	Objective
1	Total mortality
2	Adolescent and young adult deaths
3	Adult deaths
4	Life expectancy
5	Years of potential life lost
6	People with good, very good, or excellent health
7	Healthy days
8	Able to do usual activities
9	Years of healthy life
10	Years of healthy life, older adults

1
2 **Goal #1: Increase Quality and Years of Healthy Life**
3

4 The first goal of Healthy People 2010 is to increase the quality as well as the years of healthy life. Here
5 the emphasis is on the health status and nature of life, not just longevity.
6

7 The life expectancy of Americans has steadily increased. In 1979, when the first *Healthy People: The*
8 *Surgeon General's Report on Health Promotion and Disease Prevention*¹ was published, average life
9 expectancy was 73.7 years. Based on current mortality experience, babies born in 1995 are expected to
10 live 75.8 years. However, people have become increasingly interested in other health goals such as
11 preventing disability, improving functioning, and relieving pain and the distress caused by physical and
12 emotional symptoms. For the purposes of understanding broad trends in the public's health and
13 comparing the value of health promotion strategies, it is helpful to have some overall measures of health
14 and well-being in addition to information on specific aspects or dimensions of health that are the focus of
15 the objectives in the specific focus areas of Healthy People 2010.
16

17 From an individual perspective, healthy life means a full range of functional capacity at each life stage,
18 from infancy through old age, allowing one the ability to enter into satisfying relationships with others, to
19 work, and to play. From a national perspective, healthy life means a vital, creative, and productive
20 citizenry contributing to thriving communities and a thriving Nation. The proportion of the population
21 who assess their current health status positively has not changed substantially during the past decade. In
22 1987, 90.5 percent of the population assessed their health status as good, very good or excellent.² In
23 1994, the percentage was 90.4 percent. During the same period, the percentage of the population
24 reporting that they were limited in major activity due to chronic conditions actually increased from 18.9
25 percent in 1988 to 21.4 percent in 1995.
26

27 As the limitations of separately measuring mortality and morbidity have been recognized, many
28 individuals and organizations have begun developing new measures that reflect both life duration *and*
29 morbidity or health-related life quality.³ The goal of increasing quality and years of healthy life will be
30 tracked with a set of measures of population health that capture some of the aspects of this goal. Some
31 measures focus on mortality, others focus on morbidity, and some measures incorporate aspects of both
32 mortality and morbidity. The attributes of health (sometimes called domains or dimensions) that are
33 captured by the different measures vary. Hence, a range of measures will be used to evaluate progress
34 toward accomplishing this goal.
35

36 ***Measures of Mortality and Life Expectancy***
37

38 Historically, measures of mortality have been important tools for assessing the health status of a
39 population. Because information on every death occurring in the United States is available, mortality
40 measures are especially important for population health surveillance at the State and local levels. Most
41 prominent among measures of mortality are death rates, life expectancy, and years of potential life lost
42 before age 75 (YPLL-75). These measures can be calculated for the total population and can also be
43 broken out by demographic subgroups and cause-of-death.

1 **Total Mortality**
2

- 3 **1. Decrease the total death rate to no more than 454 per 100,000 by 2010.** (Baseline: 503.9
4 age-adjusted death rate per 100,000 in 1995)
5

Select Populations	1995
African American	765.7
American Indian/Alaska Native males	468.5
Asian/Pacific Islander males	298.9
Hispanic	386.8
White, non-Hispanic	475.2
Male	646.3
Female	385.2

6
7 **Target Setting Method:** 10 percent improvement.
8

9 **Data Source:** National Vital Statistics System (NVSS), CDC, NCHS.
10

- 11 **2. Reduce the death rate for adolescents and young adults (15-24 years) to no more than 81**
12 **per 100,000 by 2010.** (Baseline: 95.3 per 100,000 in 1995)
13

Select Populations	1995
African American	159.8
American Indian/Alaska Native	134.6
Asian/Pacific Islander	57.4
Hispanic	107.1
White	84.3
Male	140.5
Female	48.1

14
15 **Target Setting Method:** 10 percent improvement.
16

17 **Data Source:** National Vital Statistics System (NVSS), CDC, NCHS.
18

- 19 **3. Reduce the death rate for adults (25-64 years) to no more than 358 per 100,000 by 2010.**
20 (Baseline: 397.3 per 100,000 in 1995)
21

Select Populations	1995
African American	691.1
American Indian/Alaska Native	416.8
Asian/Pacific Islander	175.8
Hispanic	288.4
White	365.4
Male	517.3
Female	280.9

22 **Note:** Within the Maternal, Infant, and Child Health focus area, objectives tracking infant
23 mortality and child mortality are included.

24 **Target Setting Method:** 10 percent improvement.

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

1 **Life Expectancy**

2
3 **4. Increase life expectancy to 77.3 years by 2010.** (Baseline: 75.8 years in 1995)

4

Select Populations	1995
African American	69.6
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	Not available
White	76.5
Male	72.5
Female	78.9

5
6 **Target Setting Method:** Assumes a 10-year increase of 1.5 years.

7
8 **Data Source:** National Vital Statistics System (NVSS), CDC, NCHS.

9
10 **Years of Potential Life Lost**

11
12 **5. Decrease years of potential life lost before age 75 to no more than 7,315 per 100,000 by 2010.**
13 (Baseline: 8,128.2 age-adjusted years of potential life lost before age 75 per 100,000 in 1995)

14

Select Populations	1995
Male	
African American	20,272.8
American Indian/Alaska Native	12,349.1
Asian/Pacific Islander	5,310.0
Hispanic	9,989.4
White, non-Hispanic	9,226.3

15

Select Populations	1995
Female	
African American	10,179.7
American Indian/Alaska Native	6,788.9
Asian/Pacific Islander	Not available
Hispanic	4,378.8
White, non-Hispanic	4,968.7

16
17 **Target Setting Method:** 10 percent improvement.

18
19 **Data Source:** National Vital Statistics System (NVSS), CDC, NCHS.

1 **Measures of Health-Related Quality of Life**

2
3 **Overview**

4
5 **What Is Quality of Life?**

6
7 *Quality of life (QOL)* is a popular expression that, in general, connotes an overall sense of well-being
8 when applied to an *individual* and a pleasant and supportive environment when applied to a *community*.
9 QOL is a global outcome that is highly valued by all populations. In addition to the many common
10 popular uses of the term, professionals in many disciplines identify *quality of life* as an important
11 measurement construct:

12
13 “It is counterproductive to evaluate development programs without considering their impact on the **quality**
14 **of life** in the community. We can no longer maintain strict, artificial divisions between physical and mental
15 well-being.” (**World Mental Health, 1995**)

16
17 “Underpinning all of the worries about Social Security, the economy, work, housing, and other issues is the
18 **quality of life** that we seek for ourselves and as a nation as we age in America.”
19 (**Aging Today, May/June 1995**)

20
21 “Increasing emphasis on disease prevention and health promotion attests to growing recognition of the
22 importance of **quality of life** as a standard for measuring the performance of the nation's health care system
23 and its supporting research enterprise.... Fully embracing **quality of life** as a national health standard can
24 bridge artificial boundaries between disciplines and between social and medical services.”
25 (**Disability in America, 1991**)

26
27 **Why Is QOL an Important Public Health Issue?**

28
29 One result of our success in extending the normal span of human life is that attention is now shifting to
30 apply scientific methods to improve the *quality* of our longer lives. As public health agencies evolve,
31 their traditional roles are changing to reflect current community needs and issues, such as the *quality of*
32 *life*, an issue with broad implications. The concept of health-related quality of life (HRQOL) provides the
33 health community with a popularly supported and justifiable approach for expanding the recent morbidity
34 and mortality-related definition of “health” to include aspects of *functional status*, *well-being*, and
35 *participation*. This has led to a growing QOL literature in the 1990s, e.g.,

36
37 “We hope that government agencies, employers, and private providers will begin to collect
38 health-related **quality of life** data on the constituents and populations they serve. Even if these
39 data are imperfect or primitive, the effects of improving accessibility and quality of health care
40 can only be assessed adequately in terms of the health-related **quality of life** of the nation.”
41 (**Patrick and Bergner, Annual Review of Public Health, 1990**)

42
43 **HRQOL Definition and Measurement**

44
45 *Health-Related Quality of Life (HRQOL)* is a broad concept of health that includes aspects of both
46 physical and mental health and their determinants. Whereas general or *global QOL* includes all aspects of
47 life—including beauty, culture, rights, values, beliefs, and aspirations—HRQOL is limited to those
48 aspects that can be clearly shown to affect the physical or mental health of individuals or communities. It
49 is based on technically sound measures that track the functional status and well-being of individuals,
50 largely through surveys of health perceptions. On the community level, accumulated population HRQOL

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1 data help to assess health needs and guide efforts to provide services and environments conducive to
2 better individual-level HRQOL.

3
4 On the *individual level*, HRQOL has a strong relationship to a person’s health perceptions and ability to
5 function. It integrates mental and physical health concepts and provides a reasonable way to expand the
6 definition of “health” beyond simply being the opposite of the negative concepts of death and disease. On
7 the *community level*, HRQOL includes all aspects of community life that have a direct and *quantifiable*
8 influence on the physical or mental health of its members. The chart below shows key distinguishing
9 aspects of “health,” HRQOL, and QOL on both individual and community levels.

“HEALTH”	vs. HRQOL	vs. QOL
INDIVIDUAL LEVEL		
<i>death</i>	<i>functional status</i>	<i>happiness</i>
<i>disease</i>	<i>well being</i>	<i>life satisfaction</i>
COMMUNITY LEVEL		
<i>life expectancy</i>	<i>environment</i>	<i>participation</i>
	<i>livability</i>	<i>sustainability</i>

11
12 ***HRQOL Measures***

13
14 Several HRQOL survey measures and their associated summary scales and indexes have also been used
15 with success during the 1990s to directly assess the HRQOL of large segments of the population. Among
16 these are the Medical Outcomes Study Short Form 36 (SF-36) and its shorter versions and the "healthy
17 days" measures. Short Form measures are being used by the Health Care Finance Administration and are
18 included in the National Committee for Quality Assurance’s Health Plan Employer Data and Information
19 Set (HEDIS 3.0) recommended data set. Similarly, the Centers for Disease Control and Prevention
20 (CDC) "healthy days" measures, developed by CDC, are being widely used by State and local health
21 agencies and are recommended as community health profile indicators by the Institute of Medicine.
22 Although no one HRQOL measurement approach presently meets all health policy needs, each measure
23 and index included below is believed to be sufficiently valid and informative to warrant its use in
24 monitoring the Nation’s HRQOL.

25
26 ***Healthy Days Measures***

27
28 The “healthy days” measures are an integrated set of questions and a summary index designed to assess
29 the physical and mental health perceptions of the population over time. Healthy days items on self-rated
30 health, and recent physical health, mental health and activity limitations have been the first 4 questions
31 asked by the State-based Behavior Risk Factor Survey since January, 1993, providing a continuous source
32 of adult HRQOL surveillance data, that includes key behavioral risk factor and demographic data.⁴⁻⁷
33 These measures have been used to derive three key indicators of population health: (1) ***self-rated health***
34 that tracks the percentage of adults with good or better health, (2) a summary ***healthy days*** index that
35 estimates the recent person-days when both physical and mental health were felt to be at least good, and
36 (3) an ***activity days*** indicator that estimates the recent reported capacity of persons to perform their usual
37 activities due to good health. Other conceptually related measures including questions on recent pain,
38 depression, anxiety, sleeplessness, and vitality, and on current activity limitation, disability, and broader
39 quality-of-life concepts are also now in use by many BRFSS States.

1 **Self-Rated Health**

2
3 **6. Increase the percentage of persons reporting good, very good, or excellent general health***
4 **to at least 90 percent by 2010.** (Baseline: 86.2 percent of adults in 1993-96)
5

Select Populations	1993-96					
	≤17 years		18-64 years		≥65 years	
	Men	Women	Men	Women	Men	Women
African American	**	**	86.7	82.0	60.7	55.7
American Indian/Alaskan Native	**	**	85.3	80.1	64.9	55.1
Asian/Pacific Islander	**	**	92.7	91.6	74.4	81.6
Hispanic	**	**	84.8	80.5	67.0	60.2
White	**	**	91.5	91.0	73.1	72.1
Reported activity limitation	**	**	**	**	**	**
No reported limitation	**	**	**	**	**	**
Less than high school	***	***	74.9	69.7	58.3	56.1
High school graduate	***	***	90.5	89.7	74.3	74.1
College graduate	***	***	95.9	95.6	83.9	83.7
Less than \$25,000	**	**	82.2	81.1	63.9	65.6
\$25,000-\$49,999	**	**	92.5	92.4	80.9	81.0
\$50,000 or more	**	**	96.1	95.7	85.5	87.1
Employed	***	***	93.2	92.9	85.1	86.5
Unemployed/unable to work	***	***	63.8	62.5	34.3	33.0
Homemaker, student, other	***	***	86.5	87.5	71.1	69.9
Married	***	***	90.5	90.5	73.7	74.0
Widowed, divorced, separated	***	***	85.1	81.6	66.0	67.1
Never married	***	***	92.7	90.8	67.9	71.6
Insured	**	**	91.3	90.3	72.1	70.3
Uninsured	**	**	85.8	81.5	68.0	66.7

6
7 * Self-rated health is based on responses to a question in the BRFSS core questionnaire.

8 ** Not available.

9 *** Not applicable.

10
11 **Target Setting Method:** A target of 90 percent was selected based on an assumption that the
12 1993-96 level of 86.2 percent in the BRFSS could be raised to the nearest higher decile by 2010.

13
14 **Data Source:** Behavior Risk Factor Survey (BRFS). Based on overall 50-State data weighted to
15 reflect the State age/race/sex population distribution. Not adjusted for institutionalized and other
16 adults missed by survey methods.

17
18 *Self-rated health (SRH)* has potential policy value for community mobilization around health issues due
19 to its simplicity and intuitive appeal. SRH is an independent predictor of important health outcomes,
20 including mortality, functional status, and health services utilization. SRH has been found to be a good
21 proxy index for chronic physical health conditions in populations; some studies have shown improvement
22 in self-rated health following an intervention.⁸

23
24 SRH has been collected for many years on national NCHS surveys and since 1993 on the State-based
25 BRFSS. SRH is also included in the Medical Outcomes Study Short Form (SF-36, SF-12), and Years of

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1 Healthy Life (YHL) index. The percentage of adults reporting good to excellent health is recommended
 2 by the Institute of Medicine as one of 25 Community Health Profile Indicators.⁹

3
 4 **Healthy Days**

5
 6 **7. Increase healthy days* to at least 26 days during the past 30 days by 2010.** (Baseline: 24.7
 7 days in 1993-96)
 8

Select Populations	1993-96					
	≤17 years		18-64 years		≥65 years	
	Men	Women	Men	Women	Men	Women
African American	**	**	25.7	23.6	23.6	22.0
American Indian/Alaskan Native	**	**	23.8	21.3	24.2	24.5
Asian/Pacific Islander	**	**	26.8	25.4	25.4	25.2
Hispanic	**	**	25.3	23.5	22.8	21.9
White	**	**	25.8	24.0	24.7	23.5
Reported activity limitation	**	**	**	**	**	**
No reported limitation	**	**	**	**	**	**
Less than high school	***	***	23.7	21.4	22.7	21.4
High school graduate	***	***	25.6	23.8	24.9	23.8
College graduate	***	***	26.7	25.2	26.1	25.1
Less than \$25,000	**	**	24.0	22.4	23.3	22.6
\$25,000-\$49,999	**	**	26.2	24.5	26.0	25.1
\$50,000 or more	**	**	26.9	25.3	26.4	25.8
Employed	***	***	26.5	24.7	***	***
Unemployed/unable to work	***	***	17.8	17.1	***	***
Homemaker, student, other	***	***	25.2	24.0	***	***
Married	***	***	26.2	24.6	24.9	24.0
Widowed, divorced, separated	***	***	23.9	21.9	23.2	22.7
Never married	***	***	25.5	23.6	24.3	24.2
Insured	**	**	26.0	24.2	24.6	23.4
Uninsured	**	**	24.5	22.5	23.0	21.1

9
 10 * Healthy days are recent days when both physical and mental health are believed to be at least
 11 “good” and are based on responses to Q2 and Q3 in the BRFSS core questionnaire.¹⁰⁻¹³

12 ** Not available.

13 *** Not applicable.

14
 15 **Target Setting Method:** A target of 26.0 mean healthy days was selected based on an
 16 assumption that the BRFSS overall population level of 24.7 days in 1993-96 could be raised by 5
 17 percent by 2010.

18
 19 **Data Source:** Behavioral Risk Factor Surveillance System (BRFSS),^{14,15} CDC, NCCDPHP. Based
 20 on overall 50-State data weighted to reflect the State age/race/sex population distribution. Not
 21 adjusted for institutionalized and other adults missed by survey methods.
 22

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1 The *healthy days index* provides a performance-based approach for tracking population health-related
2 quality of life (HRQOL). With relative simplicity and good face validity, it is based on a broad definition
3 of health that includes mental as well as physical health. Extensive population baseline data on adult
4 healthy days, collected in the core BRFSS since January 1993, are available by State and many counties.
5 The healthy days metric has also been found to have good construct validity¹⁶⁻¹⁹ and has been acceptably
6 cross-validated in a general population adult sample with the SF-36.²⁰

7
8 An equivalent form of the healthy days index was recommended in 1997 by the Institute of Medicine as
9 one of 25 Community Health Profile Indicators.²¹ Related questions on recent days of pain, depression,
10 anxiety, sleeplessness, and vitality are part of an expanded set of healthy days questions and provide more
11 specific measures of HRQOL burden and needs.²² In 1998 17 States are using the expanded set of
12 HRQOL questions in their BRFSS, with most of these States also using several other activity limitation
13 and quality-of-life questions developed by the CDC Office on Disability and Health.

14

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Ability Days

8. Increase recent days able to do usual activities due to good physical or mental health* to at least 28.7 days during the past 30 days by 2010. (Baseline: 28.3 days in 1993-96)

Select Populations	1993-96					
	≤17 years		18-64 years		≥65 years	
	Men	Women	Men	Women	Men	Women
African American	**	**	28.3	27.9	26.3	26.4
American Indian/Alaskan Native	**	**	27.7	27.1	27.8	27.9
Asian/Pacific Islander	**	**	29.1	29.0	27.6	28.9
Hispanic	**	**	28.5	28.2	27.0	26.5
White	**	**	28.7	28.4	27.7	27.5
Reported activity limitation	**	**	**	**	**	**
No reported limitation	**	**	**	**	**	**
Less than high school	***	***	27.2	26.9	26.2	26.3
High school graduate	***	***	28.7	28.3	27.9	27.7
College graduate	***	***	29.2	28.9	28.4	28.3
Less than \$25,000	**	**	27.6	27.6	26.9	27.0
\$25,000-\$49,999	**	**	29.0	28.7	28.4	28.3
\$50,000 or more	**	**	29.3	28.9	28.6	28.5
Employed	***	***	29.2	28.9	***	***
Unemployed/unable to work	***	***	22.6	23.0	***	***
Homemaker, student, other	***	***	28.3	28.5	***	***
Married	***	***	28.8	28.6	27.7	27.8
Widowed, divorced, separated	***	***	27.8	27.3	27.0	27.0
Never married	***	***	28.8	28.4	27.5	27.4
Insured	**	**	28.7	28.4	27.6	27.4
Uninsured	**	**	28.3	27.9	25.6	25.9

* Recent ability days are the complement of activity limitation days (30 days minus the number of recent days when usual activities are not performed due to poor physical or mental health.) This measure is based on responses to Q2-Q4 in the BRFSS core questionnaire.²³⁻²⁵

** Not available.

*** Not applicable.

Target Setting Method: A target of 28.7 mean days without activity limitation was selected based on an assumption that the 1993-96 BRFSS level of 28.3 days could be raised by 0.4 days (about a 24% reduction in recent activity limitation days).

Data Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP. Based on overall 50-State data weighted to reflect the State age/race/sex population distribution. Not adjusted for institutionalized and other adults missed by survey methods.

Extensive population baseline data on adult “ability days,” collected in the core BRFSS since January 1993, are also available by State and many counties. More than 500,000 adults have reported their recent ability days as of the end of 1997. This measure is one of the few examples of a global disability question in use in a surveillance system.²⁶ It is being used to help provide State and local intercensal estimates of work disability and other forms of disability. The metric has also been found to have good construct validity in relation to other health constructs measured in the BRFSS²⁷⁻²⁹ and has been acceptably cross-

1 validated in a general population adult sample with the Medical Outcomes Study Short-Form 36 (SF-36)
2 widely used clinical HRQOL measure.³⁰ A measure of recent days of ability due to good health also
3 offers promise for tracking population HRQOL good enough to provide persons with the capacity to
4 perform their usual activities, such as work, self-care, and recreation. This measure is derived from a
5 question on days of recent activity limitation due to poor physical or mental health asked of all
6 respondents in the BRFSS.

7 ***Medical Outcomes Study Short Form Scales***

8
9
10 The SF-36 and its subset, SF-12, are a widely used and clinically-validated set of HRQOL measures,
11 subscales and summary scales designed to measure key aspects of physical and mental health. Both of
12 the commonly used short forms include validated questions from each of eight HRQOL domains (i.e.,
13 physical functioning, social functioning, role limitation (physical), role limitation (emotional), mental
14 health, energy/vitality, bodily pain, and general health perception), and both can be scored to produce
15 summary scales for physical health and mental health.

16
17 The main strengths of the Short Form measures are that they are broadly accepted in many areas of health
18 services and medical research (www.SF36.com) and are now being used to monitor the health of large
19 populations — particularly patient populations (HEDIS 3.0) and groups with a high prevalence of chronic
20 health conditions, such as older adults. In particular, the SF-36 has proven psychometric and empirical
21 strength,^{31,32} standardized data collection and scoring procedures, and documented population norms. For
22 cross-cultural comparisons, there is also a vibrant and extensive body of research on the use of these
23 measures in both developed and developing countries.

24 ***Summary Measures That Combine Mortality and Morbidity***

25 ***Overview***

26
27
28
29 As defined by the Institute of Medicine (IOM),³³ *measures of population health* involve mortality data or
30 morbidity data. However, *summary measures of population health* combine both mortality and morbidity
31 data to represent overall population health in a single number.

32 **Definition and Measurement**

33
34
35 Summary measures of population health are constructed by evaluating a measure of the health-related
36 quality of life (HRQOL) and then linking this measure to life expectancy to produce a single measure of
37 population health. For some measures, population health is evaluated as a decrement from full, healthy
38 potential life. That is, the summary measure is the decrement from a hypothetical population in which all
39 the people live healthy lives until a specified age. Therefore, as the longevity and quality of healthy years
40 increases, these measures decrease in value. In other cases, the summary measure is an accumulation of
41 years, in which each year is weighted by a HRQOL. That is, the summary measure increases as the
42 longevity and quality of healthy years increases. A variety of methodologies have been developed during
43 the previous decade to measure the HRQOL. The measures are used as numerical weights that adjust life
44 expectancy. *Health-adjusted life expectancy* utilizes a numerical weight representing average health
45 status at that age. *Quality-adjusted life expectancy* represents people's preferences for different health
46 States. *Disability-adjusted life years* uses expert-derived weights for the value of additional years of life
47 at each age and weights for more than 100 categories of health deficits resulting from different diseases or
48 injuries.

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1 The Years of Healthy Life measure was developed for the purpose of monitoring progress for Healthy
2 People 2000. This measure will be continued for Healthy People 2010. Additional summary measures
3 will be considered for inclusion in the set of measures used to monitor the goal of increasing years and
4 quality of health life.

5
6 *Years of Healthy Life (All Ages)*

7
8 **9. Increase years of healthy life* to at least 66 years.** (Baseline: 63.9 years in 1995)
9

Select Populations	1995
African American	56.0
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	64.2 (1994)
White	65.0

10
11 * Years of healthy life was used to track the first goal of Healthy People 2000. The measure was
12 calculated by combining self-rated data on limitation of activity and self-perceived health status
13 from the National Health Interview Survey with life-expectancy data from life tables from the
14 National Vital Statistics System.³⁴ The methodology has been adopted by 18 States using data
15 from the Behavioral Risk Factor Surveillance System (Years of Healthy Life module) and State
16 vital statistics.

17
18 **Target Setting Method:** Target is an increase of 2 years over the national average.

19
20 **Data Sources:** National Health Interview Survey (NHIS), CDC, NCHS; National Vital Statistics
21 System (NVSS), CDC, NCHS.

22
23 Years of healthy life is a summary measure that combines mortality and health-related quality of life data
24 into a single population measure. Its main strengths are its use of national population data dating back
25 many years and its comprehensiveness in that it produces an estimate for the entire population —
26 including young and old, whether residing in the community or an institution, and regardless of ability to
27 respond to survey questions. Years of healthy life was developed for Healthy People 2000 in response to
28 the need for a summary measure that could be assessed annually with existing data systems. Because it
29 was a key guiding objective for Healthy People 2000, its continued use provides continuity with that
30 effort—particularly as an overall national summary measure.

1 **Years of Healthy Life (Older Adults)**
2

3 **10. Increase years of healthy life* for persons 65 and older to 14 years.** (Baseline: 12.0 years in
4 1995)
5

Select Populations	1995
African American	9.7
American Indian/Alaska Native	Not available
Asian/Pacific Islander	Not available
Hispanic	13.8 (1994)
White	12.3

6
7 * Years of healthy life was used to track the first goal of Healthy People 2000. The measure was
8 calculated by combining data on limitation of activity and self-perceived health status from the
9 National Health Interview Survey with life-expectancy data from life tables from the National
10 Vital Statistics System.³⁵ The methodology has been adopted by 18 States using data from the
11 Behavioral Risk Factor Surveillance System and State vital statistics.
12

13 **Target Setting Method:** Target assumes an increase of 2 years from the national baseline.
14

15 **Data Sources:** National Health Interview Survey (NHIS), CDC, NCHS; National Vital Statistics
16 System (NVSS), CDC, NCHS.
17

18 The proportion of the population that suffers from chronic disease and disability and requires assistance
19 with activities of daily living increases with age. In 1994, the proportion of the population with limitation
20 of activity was 10.1 percent among 15- to 44-year-olds, but increased to 38.2 percent among those 65
21 years and over, and to 44.1 percent for 75 years and older.³⁶ Therefore, the elderly segment of the
22 population has a substantial influence on the overall Years of Healthy Life for the total population.
23 Improving the longevity and quality of healthy life among these older adults will have an important
24 impact on the overall health of the Nation.
25

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GOAL 2
Eliminate Health Disparities

1 **Goal #2: Eliminate Health Disparities**

2
3 In the first round of public comments on the proposed framework for Healthy People 2010, “Eliminate
4 Health Disparities” met with resounding support from a wide range of constituent groups. Many advocacy
5 groups felt that accepting lower standards for racial and ethnic groups as compared to the total population
6 was unjust. During the 1997 Healthy People progress reviews for Hispanics and Asian American and
7 Pacific Islanders, a consensus emerged to do away with differential targets for racial and ethnic minority
8 groups in Healthy People 2010. Subsequently, this recommendation was extended to people with low
9 income, people with disabilities, women, and people in different age groups.

10
11 Eliminating disparities is a bold step forward from the goal of Healthy People 2000, which was to reduce
12 disparities in health status, health risks and use of preventive interventions among population groups.
13 Healthy People 2000 special population targets were established for racial and ethnic minority groups,
14 women, people with low incomes, people with disabilities, and specific age groups (i.e., children,
15 adolescents, and the elderly). Targets were set, challenging and calling for greater improvements for each
16 of these groups than for the total population. However, with the exception of service interventions, these
17 targets rarely aimed at achieving equity by 2000. Healthy People 2010, on the other hand, is setting the
18 goal of eliminating these disparities during the next decade.

19
20 Eliminating disparities by the year 2010 will require new knowledge about the determinants of disease
21 and effective interventions for prevention and treatment. It will also require improved access for all to the
22 resources that influence health. Reaching this goal will necessitate improved collection and use of
23 standardized data to correctly identify all high-risk populations and monitor the effectiveness of health
24 interventions targeting these groups. Research dedicated to a better understanding of the relationships
25 between health status and income, education, race and ethnicity, cultural influences, environment, and
26 access to quality medical services will help us acquire new insights into eliminating the disparities and
27 developing new ways to apply our existing knowledge toward this goal. Improving access to quality
28 health care and the delivery of preventive and treatment services will require working more closely with
29 communities to identify culturally sensitive implementation strategies.

30
31 In February 1998, President Clinton committed the Nation to eliminate health disparities between racial
32 and ethnic minority groups by the year 2010 in six health issue areas. These areas are infant mortality,
33 cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and childhood and adult
34 immunizations. This commitment is the foundation for the Department of Health and Human Services’
35 Initiative to Eliminate Disparities in Health and reinforces the principle of equity that undergirds the
36 change in Healthy People 2010 from a goal of reducing to one of eliminating disparities. While a separate
37 initiative from Healthy People 2010, the HHS initiative to eliminate racial and ethnic disparities in health
38 utilizes Healthy People objectives as outcome measures in each of the six health areas.

39
40 Compelling evidence that race and ethnicity correlate with persistent, and often increasing, health
41 disparities among U.S. populations demands national attention. Indeed, despite notable progress in the
42 overall health of the Nation, there are continuing disparities in the burden of illness and death experienced
43 by African Americans, Hispanics, American Indians and Alaska Natives, and Pacific Islanders, compared
44 to the U.S. population as a whole. These disparities are even greater if comparisons are made between
45 each racial and ethnic group and the white population. Infant mortality rates are 2½ times higher for
46 African Americans and 1½ times higher for Native Americans. African-American men under 65 suffer
47 from prostate cancer at nearly twice the rate of whites. Vietnamese women suffer from cervical cancer at
48 nearly five times the rate of whites. African-American men suffer from heart disease at nearly twice the
49 rate of whites. Native Americans suffer from diabetes at nearly three times the average rate, while African
50 Americans suffer 70 percent higher rates than whites and prevalence of diabetes in Hispanics is nearly

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1 double that of whites. Racial and ethnic minorities constitute approximately 25 percent of the total U.S.
2 population, yet they account for nearly 54 percent of all AIDS cases. These disparities are not acceptable.
3 We must do more than work toward reduction; we must work toward elimination.

4
5 The demographic changes that are anticipated over the next decade magnify the importance of addressing
6 disparities in health status. Groups currently experiencing poorer health status are expected to grow as a
7 proportion of the total U.S. population; therefore, the future health of America as a whole will be
8 influenced substantially by our success in improving the health of racial and ethnic minorities.

9 While disparities among racial and ethnic groups—especially between whites and African Americans—
10 have received considerable attention over the last decade, differential access to social and health care
11 resources most often reflect occupational, educational, and income and wealth differences among
12 Americans. Differences in the life circumstances of those with less income and those with more income in
13 the United States are substantial. Furthermore, education is a major determinant of earnings potential.
14 These differences in access to economic and social resources appear to drive many of the health
15 disparities found across Americans.

16
17 Growing inequalities in income and wealth over the last two decades should refocus attention on
18 socioeconomic position as a key determinant of growing disparities in health in the coming decade.
19 Evidence suggests that socioeconomic inequalities in health are increasing. Widening disparities in
20 mortality by educational level and by income level have been observed despite the overall decline in
21 mortality rates. The population-attributable death rate due to poverty increased between the early 1970s
22 and early 1990s. Mortality rates for both children and adults are directly related to poverty as well as the
23 degree of income inequality.

24
25 Socioeconomic disparities in health have been identified across time and place. Yet identifying and
26 understanding the causes for these differences remain a challenge. Socioeconomic disparities in the
27 United States are apparent in smoking, overweight, elevated blood lead, sedentary lifestyle, oral diseases,
28 health insurance coverage, physician and dentist visits, ambulatory care sensitive hospitalizations, low
29 birthweight, heart disease mortality, personal health perceptions, diabetes mortality, and activity
30 limitations.

31
32 Income- and education-related differences in knowledge and time to pursue healthy behaviors, adequate
33 housing, nutritious foods, safe communities to live in, and healthy environments to work in may influence
34 the health and well-being of Americans in different socioeconomic positions. Certainly the stresses and
35 strains of individuals with lower incomes imposes an emotional and psychological cost that is reflected in
36 poorer health. Alternatively, individuals with higher education may have greater exposure to health
37 related information that assists them in adopting health promoting behaviors.

38
39 Income is perhaps the most relevant indicator of socioeconomic position with regard to health policy
40 formulation and social program implementation. Yet, income is not a simple variable to collect. Income
41 tends to be poorly reported and nonresponse to questions about income is often high. Despite these
42 limitations, income provides an assessment of the resources available to individuals or families to acquire
43 the resources, such as food, housing, clothing, and health care, needed to maintain or improve their well-
44 being. Income, however, may not adequately reflect the longer term accumulation of assets among the
45 elder population who can use these resources to acquire needed services or other material goods.

46
47 As more HHS surveys incorporate additional measures of income, we can rely on various indicators of
48 income, such as family income adjusted for family size (poverty index), or family income and education,
49 as measures of socioeconomic position that reflect resource based assessments. Occupation or type of job
50 can also serve as an indicator of socioeconomic position that reflects income and education as well as

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1 social prestige. Alternatively, linking census-based socioeconomic measures and health data may aid
2 efforts to monitor health disparities.

3
4 Furthermore, examinations of the relationship of socioeconomic position or socioeconomic status and
5 health have focused largely on the lowest end of income distribution. Comparisons often focus only on
6 people below the Federal poverty line compared with people above that threshold. These comparisons
7 imply a great homogeneity among people above the thresholds of poverty. This approach contributes to
8 the stigma associated with the poor while obscuring the social gradient that puts lower and middle income
9 people at increased risk of ill health. Evidence from many countries, including the United States,
10 indicates that the relationship between socioeconomic status and health takes the form of a gradient. In
11 general, poor people have worse health status than people of middle income who in turn have worse
12 health status than people of higher income. Each increase in social position, measured by income or
13 education, improves the chances of being in good health.

14
15 No single factor accounts for the relationship between socioeconomic position and health. Investigators
16 have identified multiple interconnected pathways through which a person's health can be helped or
17 harmed by his/her standard of living, working conditions, social interactions with others and the
18 environment. Our society's commitment to ensuring healthy living and working conditions, as well as
19 opportunities for individuals and communities to secure their well-being, serve as mediating factors along
20 these pathways.

21
22 Progress toward the Healthy People 2000 objectives for the population as a whole appears primarily to
23 reflect the achievement among the higher socioeconomic groups; lower socioeconomic groups continue to
24 lag behind. For example, substantial progress has occurred in mortality from heart disease, lung cancer,
25 infant mortality, low birthweight, dental caries prevalence, cigarette smoking, receipt of early prenatal
26 care, and having regular mammograms. Further gains in these areas require further improvements among
27 people in lower socioeconomic positions.

28
29 To illustrate the magnitude of the challenge before us, Table 1 lists Healthy People 2000 objectives where
30 the disparity is 25 percent or greater between the general population and at least one select population.
31 This list is categorized by race and ethnicity, socioeconomic status, disability, gender, age, and
32 geographical location. The 25 percent or greater disparity is based on the most recent published data
33 available at this writing. Table 1 gives a revealing and compelling picture of the disparities that we know
34 exist based on the most recent data.

35
36 Although health statistics on race, ethnicity, socioeconomic status and disabilities are sparse, the data we
37 do have demonstrate the volume of work needed to eliminate health disparities. The greatest opportunities
38 for improvement and the greatest threats to the future health status of the Nation reside in the population
39 groups that have historically been disadvantaged economically, educationally and politically. We must do
40 a better job in identifying the disparities that exist, work toward elimination, and strive to create better
41 health for all.

Table 1: Health Disparities of \geq 25 percent in Healthy People 2000*

Race/Ethnicity

coronary heart disease deaths (1.1)
 sedentary lifestyle (1.5)
 cancer deaths (2.2)
 overweight (2.3)
 growth retardation among low-income children (2.4)
 colorectal cancer deaths (2.23)
 prevalence of diabetes (2.25)
 cigarette smoking (3.4)
 smokeless tobacco use (3.9)
 stroke deaths (3.18)
 alcohol-related motor vehicle deaths (4.1)
 cirrhosis deaths (4.2)
 drug-related deaths (4.3)
 teen pregnancies (5.1)
 planned pregnancies (5.2)
 infertility (5.3)
 suicides (6.1)
 homicide (7.1)
 firearm-related deaths (7.3)
 high school completion rates (8.2)
 unintentional injury deaths (9.1)
 motor-vehicle crash deaths (9.3)
 drowning deaths (9.5)
 residential fire deaths (9.6)
 asthma hospitalizations (11.1)
 dental caries (13.1)
 diagnosis/treatment of dental caries (13.2)
 gingivitis (13.5)
 oral cancer deaths (13.7)
 regular dental visits (13.14)
 infant deaths (14.1)
 fetal deaths (14.2)
 maternal mortality (14.3)
 fetal alcohol syndrome (14.4)
 severe complications of pregnancy (14.7)
 low birth weight incidence (14.5)
 breast-feeding in the first 6 months (14.9)
 prenatal care in the first trimester (14.11)
 end-stage renal disease (15.3)
 female breast cancer deaths (16.3)
 cervical cancer deaths (16.4)
 diabetes deaths (17.9)
 HIV infection incidence (18.1)
 adolescent sexual intercourse (18.3)
 gonorrhea infection incidence (19.1)
 primary and secondary syphilis (19.3)
 congenital syphilis (19.4)
 hospitalizations for pelvic inflammatory ds. (19.6)
 viral hepatitis cases (20.3)
 tuberculosis cases (20.4)
 influenza vaccine in last 12 months > 65 yrs (21.2)
 pneumococcal vaccine in lifetime > 65 yrs (21.2)
 tetanus booster in last 10 yrs (21.2)
 preventive services receipt (21.4)

Socioeconomic Status

(income, education and employment related)
 vigorous physical activity (1.4)
 sedentary lifestyle (1.5)
 cigarette smoking (3.4)
 smoking initiation by children and adolescents (3.5)
 smoking cessation during pregnancy (3.7)
 work-related injury deaths (10.1)
 nonfatal work-related injuries (10.2)
 cumulative trauma disorders (10.4)
 diagnosis/treatment of dental caries (13.2)
 complete tooth loss for 65 yrs or older (13.4)
 breast cancer screening (16.11)
 limitation in major activity (17.2)

Disability

sedentary lifestyle (1.5)
 overweight (2.3)

Gender

smokeless tobacco use (3.9)
 suicides (6.1)
 diagnosis/treatment of depression (6.15)
 homicide (7.1)
 unintentional injury deaths (9.1)
 drowning deaths (9.5)
 hip fractures among adults 65 yrs and older (9.7)
 non-fatal spinal cord injuries (9.10)
 oral cancer deaths (13.7)

Age

sedentary lifestyle (1.5)
 alcohol-related motor vehicle deaths (4.1)
 homicide (7.1)
 motor-vehicle crash deaths (9.3)
 fall-related deaths (9.4)
 drowning deaths (9.5)
 residential fire deaths (9.6)
 hip fractures among adults 65 yrs and older (9.7)
 nonfatal poisoning (9.8)
 asthma hospitalizations (11.1)
 cervical cancer screening (16.12)
 gonorrhea infection incidence (19.1)
 hospitalizations for pelvic inflammatory ds. (19.6)
 tetanus booster in last 10 yrs (21.2)

Geographic Location

regular dental visits (13.14)
 preventive services receipt (21.4)

* 25 percent or greater disparity as reported in *Healthy People 2000 Review, 1997*.

() Numbers in parentheses indicate the number for this objective in *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*.

1
2
3
4

**Figure:
Healthy People 2010
Healthy People in Healthy Communities**

