

Edward Sondik, PhD

Healthy People 2000: Meshing National and Local Health Objectives

Healthy People 2000 is an action plan to improve the health of Americans through lifestyle and environmental changes.¹ Its framework of 319 unique objectives and an equal number of sub-objectives for specific population groups provides the mechanism to monitor progress, identify problems, and, where necessary, modify public health strategies and programs. The latest progress review of *Healthy People 2000* has just been released by the National Center for Health Statistics (NCHS), which is responsible for tracking the objectives at the national level. *Healthy People 2000 Review, 1995-96* shows that at mid-decade 8%

of the objectives had been met and significant progress had been made in an additional 40%, while 18% of the objectives showed movement from the target and for 8% there had been no change.² (A summary of the findings is presented in the table.) This accounting, however, leaves 26% of the objectives with no result to report at this time.

Some of these objectives lack baseline data; for others, there are no data beyond the baseline measure.

More than 200 data systems and sets are used to monitor the objectives and sub-objectives outlined in *Healthy People 2000*. These data come from an amazing range of sources and point to notable success in identifying and bringing together both traditional and non-traditional data for this collaborative effort. *Healthy People 2000* is the latest national effort to prevent disease by setting and promulgating goals to unite and guide the many public health programs and services. Unlike the pioneering efforts in this field, *Healthy People 2000* incorporates a thoughtful approach to how objectives should be measured. Yet with this effort we still lack the data to assess progress for over a quarter of the objectives. We should consider whether objectives too important to leave out of *Healthy People 2000* are also too important not to measure, and we should redouble our

efforts to identify, create, or build the data resources needed to check their progress.

Healthy People 2000, a national initiative, is not just a Federal campaign; it has become a state and local effort to improve the health of the citizens in each state and community. It was recognized early on that most localities would not have access to the types of data needed to monitor the full set of Year 2000 objectives. Working with representatives from national and state organizations, in 1991 CDC developed a set of 18 Health Status Indicators (HSIs) for which data were generally available at the state and local levels.³ These indicators cover a range of health and health-related topics and are at the core of the efforts to produce data comparable on a state-by-state as well as on a national basis. "Year 2000 Health Status Indicators: A Profile of California" by Sutocky and others, in this issue, demonstrates the importance of setting goals and implementing a surveillance system to measure progress toward those goals.⁴ California is an excellent example of how a state can utilize information from a wide variety of sources to produce a useful and informative profile of the health of its citizens. This process has been duplicated in other states and at the local level; the May 1996 issue of *Healthy People 2000 Statistics and Surveillance*⁵ details what some states and local jurisdictions have accomplished using the HSIs.

The *Healthy People 2000* initiative has contributed greatly to the improvement of data systems and the dissemination of public health information, but there is much that could be done to relate national measures to local situations. Perhaps it is time to promote the concept of a hierarchical health statistics system—national, state, and local—in light of new means of communication and information collection, a growing reliance on corporations to manage care for various populations, and improvements in communication, with even the smallest public/private health office potentially able to access the latest health information and perform statistical analyses.

National surveys usually provide results at the national level, or possibly for large regions or a few selected areas of significant population size. It is still not generally economically feasible to operate national surveys with sufficient sample size to produce state and local data. Survey data are often available by many demographic and socioeconomic variables and are used extensively at the national level but at the state level may give only a general understanding or indication without

local specificity or awareness of unique local circumstances. Because it is expensive to develop direct local area estimates, methods of using national data for local purposes have been explored. Past efforts focused on synthetic estimates, in which population characteristics were used as the basis for applying data to the local population, producing estimates for state or local areas.

It may be time for a new or renewed research initiative to create the state and local area data needed by

public and private entities to foster improvements in public health. We have not fully explored the methods by which national data could be coupled with readily available local measures to give reasonable estimates of a local picture. For example, to create cancer incidence data, local mortality figures can be coupled with national estimates relating incidence and survival to mortality to give estimates of incidence for a particular locality. In another direction, NCHS is beginning to explore with

Progress toward Healthy People 2000 priority area targets, by percentages of objectives within each priority area

Priority areas (number of objectives ^a)	Target met	Movement toward objectives	Movement away from objectives	No change ^b	No tracking data
Physical activity and fitness (13)	8	31	31	15	15
Nutrition (27)	15	37	15	7	26
Tobacco (26)	0	58	12	23	8
Substance abuse: alcohol and other drugs (20).	5	35	10	20	30
Family planning (12)	0	17	17	17	50
Mental health and mental disorders (15)	7	33	27	7	27
Violent and abusive behavior (19)	21	16	26	5	32
Educational and community based programs (14)	14	21	14	0	50
Unintentional injuries (26)	19	50	4	4	23
Occupational safety and health (20)	15	35	35	5	10
Environmental health (17)	6	71	12	6	6
Food and drug safety (8)	25	38	0	13	25
Oral health (17)	0	59	12	6	24
Maternal and infant health (17)	6	47	24	6	18
Heart disease and stroke (17)	12	76	12	0	0
Cancer (17)	6	76	0	0	13
Diabetes and chronic disabling conditions (23).	4	9	48	17	22
HIV infection (17)	6	35	12	6	41
Sexually transmitted diseases (17)	6	35	6	12	41
Immunization and infectious diseases (19)	5	21	32	16	26
Clinical preventive services (8).	0	25	25	13	28
Surveillance and data systems (7).	0	71	14	0	14
TOTAL (319).	8	40	18	8	26

NOTE: The table compares data trends from baseline year—in most cases 1987—to latest year for which data are available. Numbers across rows total 100% (with rounding errors) and represent percentages of objectives for each priority area.

^aSome objectives are duplicated in several priority areas. There are 319 unique objectives. If all the duplications are counted, the total is 376.

^bIncludes mixed progress.

Copies of Healthy People 2000 Review, 1995–96 are available from Data Dissemination Branch, NCHS, Room 1064, 6525 Belcrest Road, Hyattsville MD 20782; tel. 301-436-8500; URL <<http://www.cdc.gov/nchswww/nchshome.htm>>.

state and local officials how we might broaden the existing statewide immunization survey to obtain data on other important health indicators. The widespread use of the Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System have been important steps forward, and their concept and methodology point to other applications.

Clearly, for the future we need a hierarchical system that gives information on the aggregate pulse of the country and gives local officials and decision makers a reading of their own communities. The means of communicating this information and of creating value-added information in the process are now available, and the cost is dropping. Approaches to building state and local capacity through CDC's Information for Public Health Officials project and the CDC-wide Assessment Initiative, which is working to build data capacity within states, are just two of the important endeavors in this regard.

Of course, it is essential that we all work together to create the national-state-local network of data resources. Partnerships have taken on new meaning, with an expansion in the number and types of partners, over just the past few years. Managed care creates a population of its own, defined not so much by geographic boundaries as by enrollment, participation, and selection. These managed care communities have much to offer in terms of data collection and analysis capabilities and have much to benefit from the use of population-based data as well. Data streams of the future will not be one- or even two-directional, but will flow as the need and technology exist, as soon or as long as the quality and confidentiality of the information is assured.

Because of socioeconomic factors, differences in access to or availability of care, and personal or group mores, customs, or values, some population groups do not or cannot take advantage of all that can be done to prevent disease and promote health. It is essential to

It may be time for a new or renewed research initiative to create the state and local area data needed to direct and manage public health and health resources by both public and private entities.

gain a better picture of the health status of these special populations and a better understanding of the factors that influence and may improve their health.

Healthy People 2000 has been enormously successful in setting a national public health agenda and stimulating the development of information systems to track and evaluate prevention efforts. With continued developments in the Healthy People process, with success in

forging a new public health focus, and with new and expanding technology, we can more effectively assess the status of not solely the single broad concept of national public health, but the multiple publics' health. The overall public health integrates the health of many different groups, each with different issues and problems. To do it all, cooperative ventures will be essential; measured, prudent inference a tool; consistent energy and interest a necessity; and creativity and innovation a jump start to the future.

Dr. Sondik is the Director of the National Center for Health Statistics.

Address correspondence to Dr. Sondik, National Center for Health Statistics, 6525 Belcrest Road, Hyattsville MD 20782; tel. 301-436-7016; fax 301-436-5202; e-mail <efs2@nch11a.em.cdc.gov>.

References

1. National Center for Health Statistics [US]. *Healthy people 2000 midcourse review and 1995 revisions*. Washington DC: NCHS; 1995.
2. National Center for Health Statistics [US]. *Healthy People 2000 review, 1995-96*. Hyattsville (MD): NCHS; 1996.
3. Freedman MA, in collaboration with the CDC Health Status Indicators Consensus Work Group. *Health status indicators for the year 2000*. *Healthy People 2000 Statistical Notes Vol.1, No. 1*. Hyattsville (MD); National Center for Health Statistics; 1992.
4. National Center for Health Statistics [US]. *Healthy People 2000 Statistics and Surveillance No.8*. Hyattsville (MD): NCHS; 1996.