

# **CHAPTER 1**

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## **The Health of the Nation**

**Highlights of the  
HEALTHY PEOPLE 2000 GOALS**

**1995 Report on Progress**

### HEALTHY PEOPLE 2000

HEALTHY PEOPLE 2000 provides a vision for achieving improved health for all Americans. Through a national process, people from across the country helped define and are pursuing a prevention agenda for the Nation. Leadership for this process has come from every level of government—national, State, and local—from professional groups, and from people in multiple sectors of American communities working through a HEALTHY PEOPLE 2000 Consortium of more than 300 organizations. Most States have developed HEALTHY PEOPLE 2000 objectives tailored and targeted to their own populations. This midcourse review of HEALTHY PEOPLE 2000 offers an opportunity to renew and reemphasize the importance of prevention and to make midcourse corrections to this decade-long plan for reducing preventable deaths, disabilities, and diseases.

The year 2000 objectives were built upon the 1990 objectives effort, which was initiated in 1979 with the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* and established in 1980 with the publication of *Promoting Health/Preventing Disease: Objectives for the Nation*. Adopting a management-by-objectives planning process familiar in the world of business, the Public Health Service (PHS) set out objectives addressing improvements in health status, risk reduction, public and professional awareness of prevention, health services and protective measures, and surveillance and evaluation, expressed in terms of measurable targets to be accomplished by 1990. These objectives were organized in 15 priority areas under the general headings of preventive services, health protection, and health promotion.

The year 2000 priority areas expanded upon those of the 1990 objectives, with the addition of areas focused on topics such as HIV infection and cancer. In addition, the year 2000 objectives were characterized by an increased emphasis on prevention of disability and morbidity; greater attention to improvements in the health status of definable population groups at highest risk of premature death, disease, and disability; and inclusion of more screening interventions to detect asymptomatic diseases and conditions early enough to prevent early death or chronic illness.

Full achievement of the goals and objectives of HEALTHY PEOPLE 2000 is dependent on a health system reaching all Americans and integrating personal health care and population-based public health. The vision of healthy people in healthy communities moves beyond what happens in physicians' offices, clinics, and hospitals—beyond the traditional medical care system—to the neighborhoods, schools, workplaces, and families in which people live their daily lives. These are the environments in which a large portion of prevention occurs.

This midcourse review reports progress toward the national health promotion and disease prevention objectives. Much has been accomplished; more than two-thirds of the objectives for which data are now available are moving toward the targets. However, in order for the Nation to achieve its prevention agenda and to make a

profound difference in the health of all Americans by the year 2000, renewed efforts will be required. The purpose of this report is to assess the challenges that remain and to demonstrate that the opportunities for achieving a healthier America are at hand.

## **Prevention As the Foundation for Health**

Foundations for achieving and maintaining good health are multidimensional, including mental, emotional, and social elements that are as critical to health outcomes as biomedical ones. A century of biomedical research has improved our ability to predict, diagnose, and intervene against disease. Basic scientific studies have revealed a great deal about the factors that predispose individuals to various health threats and about actions that individuals can take to control risks for disease and disability. Attention has increasingly been focused on health protection and promotion, risk prevention, and equality in the health status of populations.

In 1789 the Reverend Edward Wigglesworth assessed the health of Americans and produced the first American mortality tables. In 1900, the main causes of death in the United States were influenza, pneumonia, tuberculosis, and gastrointestinal infections; the average life expectancy at birth was 47 years. By 1950, there was a phenomenal rise in life expectancy at birth to 68 years, primarily due to improvements in diet, sanitation, the development of antibiotics, and the availability of vaccines. In the 1990s, life expectancy is more than 75 years and the chief causes of death are heart disease and cancer. Chronic diseases have emerged as the leading health problems.

During the 1960s and 1970s epidemiological studies and clinical trials began to characterize the predisposing conditions that lead to chronic diseases. Cigarette smoking, high blood pressure, and high blood cholesterol were determined to be prominent contributors to the occurrence of chronic diseases. Population-based preventive programs were developed to combat these risk factors and the diseases they produced. Many chronic diseases once thought to be the inevitable result of aging were reclassified as avoidable. The realization that disease prevention and health promotion could improve the quality and length of life prompted national interest and resulted in new prevention programs. The Surgeon General initiated a campaign against tobacco use in 1964, and in 1972 the National High Blood Pressure Education Program was established. Private and public organizations were created, often dedicated to a single disease, for research, treatment, eradication of disease, and education of the public about risk factors.

As our knowledge about health and the potential to prevent unnecessary disease and disability has increased, the national perspective on health and disease has changed dramatically. A 1994 assessment by the Centers for Disease Control and Prevention (CDC) estimated that nearly 47 percent of premature deaths among Americans could have been avoided by changes in individual behaviors and another 17 percent by reducing environmental risks. In contrast an estimated 11 percent of premature deaths among Americans are deemed preventable through improvements in access to medical treatment.<sup>1</sup>

## Healthy People 2000 Midcourse Review and 1995 Revisions

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Of the 2.1 million deaths in the United States in 1992, one-third were attributable to heart disease and one-fourth to cancers. HIV infection became the tenth leading cause of death in this country in 1990, and in 1992 was the eighth leading cause. But when one looks beyond the vital statistics records and examines the causes underlying premature deaths, the real benefits of behavioral changes, risk-reduction strategies, and clinical preventive services become evident.

- The elimination of tobacco use alone, either through the prevention of its initial use or through cessation of its current use, could prevent over 400,000 deaths annually from cancer, heart and lung diseases, and stroke.
- Better dietary and exercise patterns can contribute significantly to reducing conditions like heart disease, stroke, diabetes, and cancer, and could prevent 300,000 deaths.
- The prevention of underage drinking and excess alcohol consumption could prevent nearly 100,000 deaths, particularly in reducing deaths from motor vehicle crashes, falls, drownings, and other alcohol-related injury deaths.
- Most injuries, which account for the largest number of deaths among young Americans, can be prevented through safety measures at worksites, at home, in recreational settings, in communities, and on roadways. Improved worker training and safety programs could reduce occupational injuries and diseases, improve productivity, and lower medical care costs.
- Immunizations could prevent many infectious childhood diseases and prevent serious, sometimes fatal diseases among adults. It is estimated that about 63,000 of 90,000 deaths attributable to microbial agents each year could be prevented through immunizations.
- Violent acts with firearms—murder, suicide, and accidental discharge—have emerged as a leading threat to Americans. Firearms now account for about 35,000 deaths each year. Ensuring that weapons are kept out of the hands of children and adolescents could reduce the tragedies of accidental discharge and suicides. Addressing the use of guns by adolescents and young adults in homicides is an imperative of the public health agenda.
- Unprotected sexual intercourse leads to unintended pregnancies, sexually transmitted diseases (STDs), and HIV infection, accounting together for 30,000 preventable deaths each year. Another tragedy of STDs is the number of children born with congenital syphilis or HIV infection.

- Screening for breast and cervical cancer could save lives and reduce extensive treatment.
- Recognition and control of high blood pressure and elevated blood cholesterol levels can protect against heart attacks and strokes.<sup>2</sup>

The scope of preventable loss of life, nearly 1 million Americans each year, is not news to the public health community. Public health professionals from around the country have been working—with remarkable success under constrained conditions—to shift the national emphasis to prevention. Since the 1970s, stroke death rates have declined by 58 percent, and coronary heart disease death rates have dropped by 49 percent. Tobacco use among adults declined from 34 percent to 25 percent between 1974 and 1993. Increased use of automobile safety restraints contributed to a 32 percent decline in the death rate from car crashes. The number of people living in counties meeting the clean air quality standards of the U.S. Environmental Protection Agency (EPA) increased by 23 percent between 1988 and 1993.<sup>3</sup> At the same time, however, AIDS, tuberculosis, asthma, and birth defects have increased, especially in poor and underserved populations. The need for renewed commitment to meet prevention challenges has never been more compelling.

Despite the fact that knowledge exists to help avoid premature death, serious illness, and chronic disability, they continue to occur—and they are costly. For example, physical injuries, both unintentional (“accidental”) and violent, cost more than \$150 billion annually. The financial burden of heart disease and stroke amounts to about \$135 billion a year. The annual health care and related costs attributable to alcohol abuse are \$98.6 billion and to illicit drug use, \$66.9 billion. The yearly costs of tobacco use amount to about \$65 billion.<sup>4</sup>

This report calls for renewed commitment to improving the Nation’s health. HEALTHY PEOPLE 2000 cannot be accomplished by the Federal Government alone. Leadership must come from institutions and individuals throughout the Nation. Each person makes decisions about how fast to drive, whether to wear a safety belt, what to eat, and how much alcohol to drink. In families, parents have the opportunity to promote health and encourage healthy habits for their children. Community organizations—schools, religious institutions, and voluntary organizations—can become more actively engaged in promoting health. Employers can make worksites healthy. This midcourse review offers not only a report to the Nation on progress to date, or a blueprint for what is possible by the year 2000, but it outlines opportunities to renew the Nation’s commitment to making a difference in the health of its citizens as the 21st century approaches.

## HIGHLIGHTS OF THE HEALTHY PEOPLE 2000 GOALS

### Goal 1—Increase the span of healthy life

The first HEALTHY PEOPLE 2000 goal is to increase the span of healthy life for all Americans—here the emphasis is on healthy years, not just longevity. The good news is that people are living longer. Life expectancy at the time that the first *Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention* was published in 1979 was 73.7 years.<sup>5</sup> When HEALTHY PEOPLE 2000 was released in 1990 life expectancy was 75 years. On average babies born in 1992 will live an additional three quarters of a year, with life expectancy at nearly 76 years.<sup>6</sup>

Using self-reported health status and activity limitation data in the National Health Interview Survey, coupled with standard life tables produced by the CDC, National Center for Health Statistics (NCHS), 64 years of life (or 85 percent of life years) are estimated to be healthy. Some 11.4 years of life (or 15 percent of life years) are estimated to be unhealthy, with limitations of major life activities such as self-care (bathing, grooming, and cooking), recreation, school, and work. Because activity limitations increase with age, the challenge in this goal is to minimize disability and to increase independence and health of older adults.

Among racial and ethnic minorities the percentage of life years considered healthy varies. The number of years of healthy life for Hispanics (64.8 years) was slightly less than that of whites in 1990. Blacks, however, had substantially fewer years of healthy life (56.0 years).

New 1992 estimates of years of healthy life years show a decline in health-related quality of life despite increases in life expectancy. The Nation appears to be losing ground on this important goal. This measure will be used to track this goal throughout the decade, while research continues on refining the measurement tool for years of healthy life. In the meantime, this measure enables the Nation to move from merely tracking mortality to examining also the quality of life.

### Goal 2—Reduce health disparities among Americans

The second goal is to close the gaps in health status and health outcomes between racial and ethnic minorities and the total population. Across many health measures—mortality, morbidity, and health services utilization—the differences between whites and minorities continue to be substantiated.

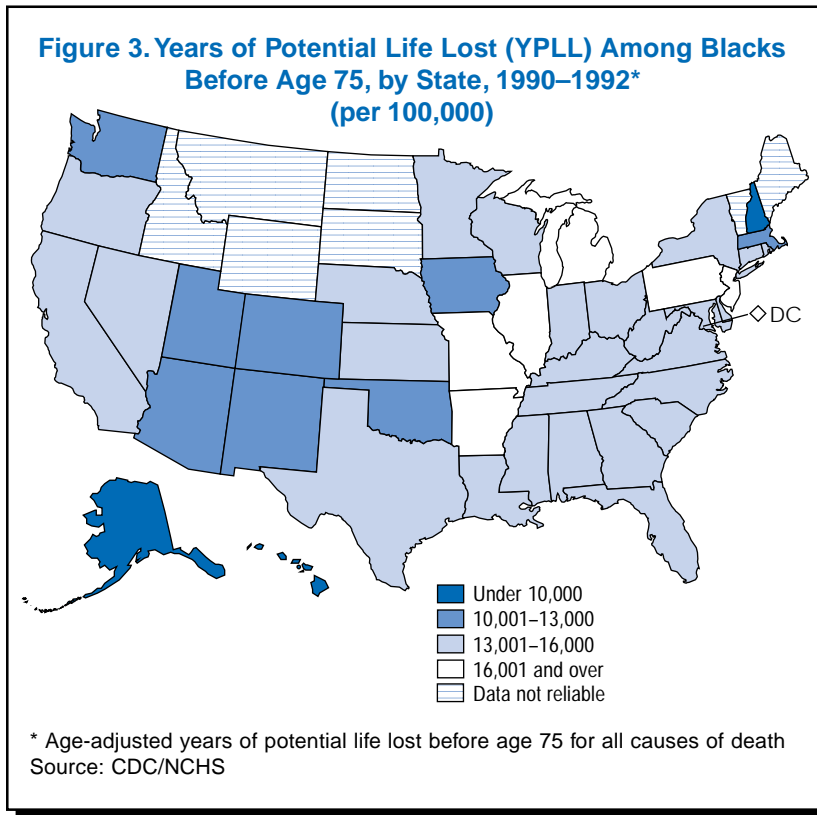
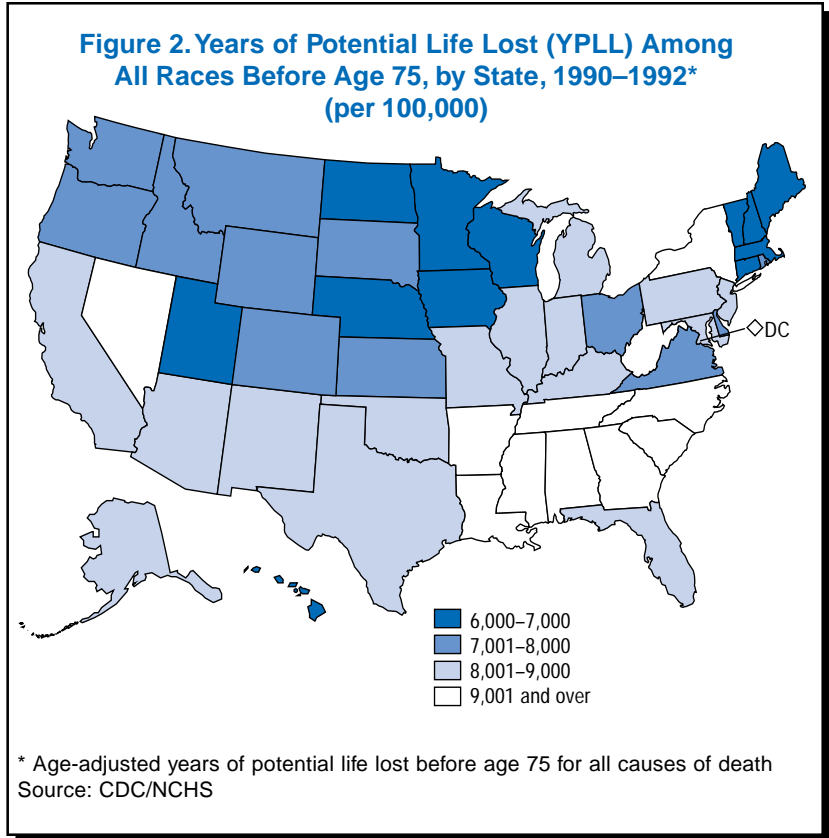
**Figure 1. Years of Healthy Life and Life Expectancy, by Race and Hispanic Origin, 1990**

	All Races	White	Black	Hispanic
<b>Healthy Years</b>	64.0	65.0	56.0	64.8*
<b>Life Expectancy</b>	75.4	76.1	69.1	N/A

\* Estimated from preliminary data.  
Source: Centers for Disease Control and Prevention (CDC)/National Center for Health Statistics (NCHS)

Years of potential life lost (YPLL) is a measure of premature death. Figures 2 through 5 show the years of potential life lost before age 75 (YPLL-75) per 100,000

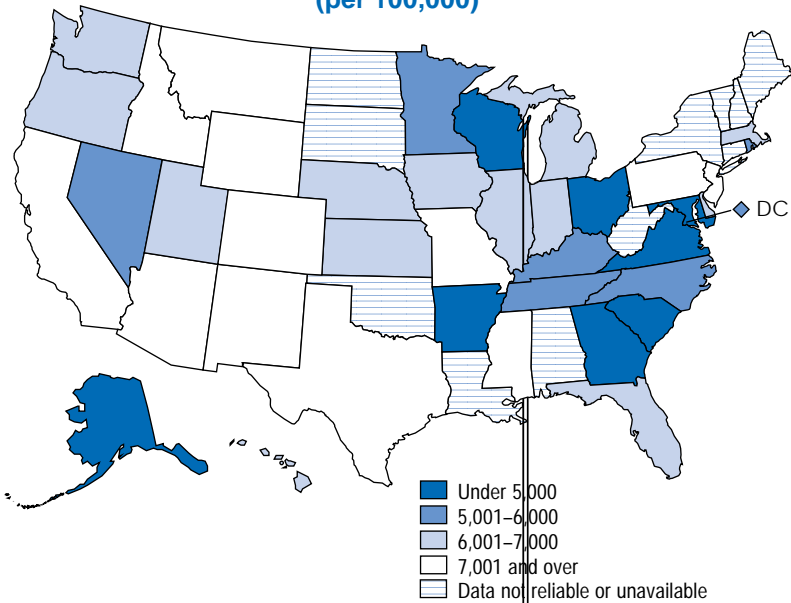
State population for selected racial and ethnic populations for the 3-year period 1990–92. In the calculation of YPLL-75, infants who die before their first birthday have lost 74.5 years of life; a person dying at 50 years has lost 25 years of life. Therefore, the younger the decedent, the more years of potential life lost. To facilitate comparisons among States and racial/ethnic groups with different age compositions, the data have been age-adjusted to the 1940 U.S. standard population. Data are not shown for States for which the number of



deaths was too small to compute a reliable rate. Figure 4 data are also not shown for the five States (Connecticut, Louisiana, New Hampshire, New York, and Oklahoma) for which Hispanic origin data for 1990–92 were not available from the National Vital Statistics System.

For the United States as a whole, the 1990–92 age-adjusted YPLL-75 for all races was 8,384 per 100,000. For blacks and American Indians/Alaska Natives in

**Figure 4. Years of Potential Life Lost (YPLL) Among Hispanics Before Age 75, by State, 1990–1992\* (per 100,000)**



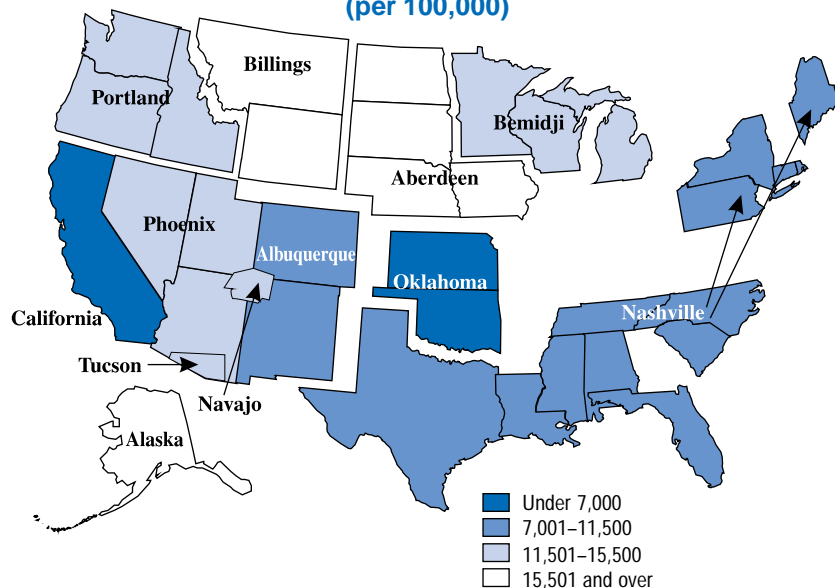
\* Age-adjusted years of potential life lost before age 75 for all causes of death  
 Source: CDC/NCHS, 1990-92 combined

Indian Health Service (IHS) areas the rates are considerably higher, 15,468 and 11,875, respectively. This disparity reflects the higher mortality for blacks for a number of major causes of death that primarily affect younger people such as infant mortality, homicide, and HIV infection. Contributing to the disparity for American Indians/Alaska Natives are higher rates for infant mortality, unintentional injury death, homicide, and suicide. Because there are known problems with the underreporting of

Indian race on death certificates, these YPLL rates are considered to be conservative. For Hispanics, YPLL-75 is 7,114 per 100,000 reflecting lower death rates for most major causes of death.

Assessment of health disparities among Americans requires data systems that collect information on race, ethnicity, socioeconomic status, and disabilities. Such systems are addressed by

**Figure 5. Years of Potential Life Lost (YPLL) Among American Indians/Alaska Natives Before Age 75, by Indian Health Service Areas, 1990–92\* (per 100,000)**



Note: Total IHS=11,874.9

\* Age-adjusted to the standard 1940 U.S. population under age 75

Source: IHS

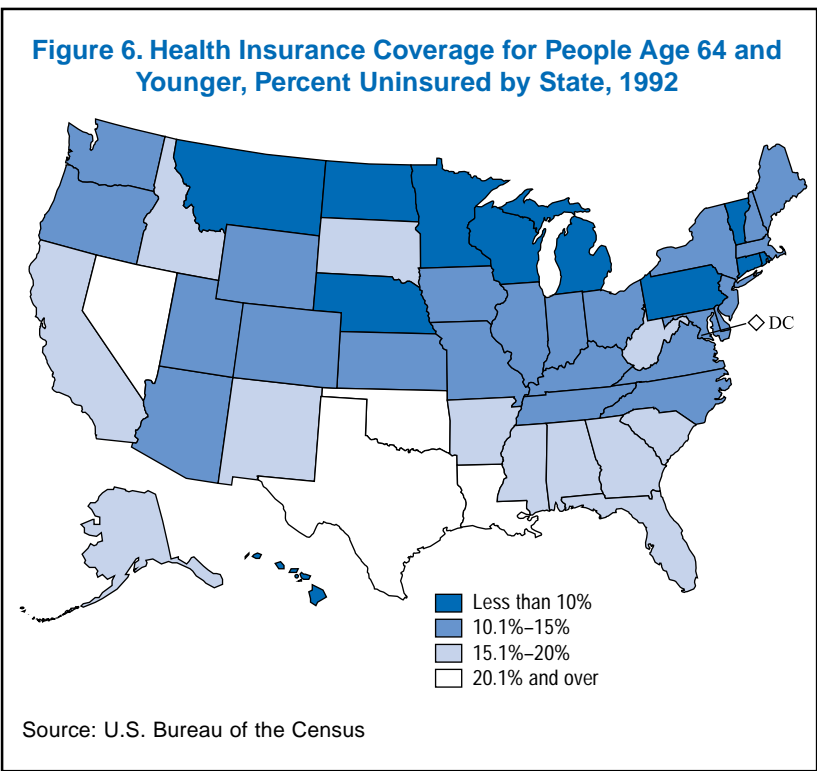


HEALTHY PEOPLE 2000 objective 22.4, which calls for development of a national process to identify gaps in the Nation's disease prevention and health promotion data for racial and ethnic minorities, people with low income, and people with disabilities, and to establish mechanisms to meet these data needs.

A note of caution should be expressed about the ability to identify health disparities. The lack of data about subgroups of the population and small geographic areas hampers the ability to quantify health problems. In recent years, oversampling of blacks and Mexican Americans in national surveys has taken place, providing data that show disparities. These data have been used to establish new HEALTHY PEOPLE 2000 population targets in this 1995 revision. But as the United States becomes more diverse, the challenge of identifying disparities as they emerge and addressing differences in health status and health outcomes will increase. To meet the ambitious year 2000 targets set forth in HEALTHY PEOPLE 2000 will require improvements in the information available on health status, behaviors, and clinical preventive services utilization of population groups at greater risk for health problems including racial and ethnic minorities, as well as people with disabilities and people with low income.

### Goal 3—Achieve access to preventive services for all Americans

The third goal is to achieve access to preventive services for all Americans. Setting this goal put the Nation on record in 1990 as being committed to universal access to preventive health services as a part of primary care. As a result of the work of the U.S. Preventive Services Task Force, substantial consensus has emerged about what services should be made available to various groups at regular intervals. On the other hand, the percentage of Americans with health insurance coverage has declined, creating a barrier to delivery of these services. Although 77 percent of people under age 65 had private insurance in 1986, only 71.9 percent had it in 1992. While some of these people were covered by Medicaid, which increased coverage from 6 percent of Americans in 1986 to 9.2 percent in 1992, the



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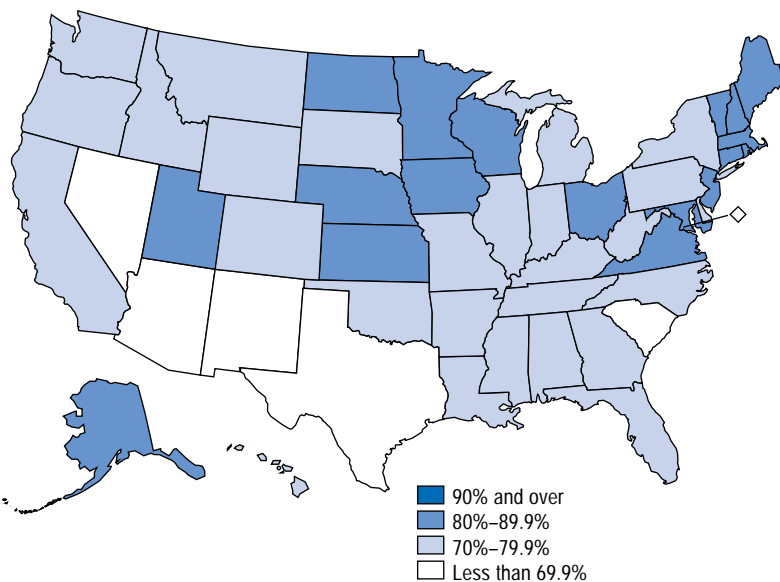
number of people who were uninsured rose from 15 to 17.2 percent over this same period. Among blacks and Hispanics (data on other races are unavailable), the percentage of uninsured is even greater. Using data from the 1993 Current Population Survey, which encompassed all people regardless of age, the Census Bureau estimated that 39.7 million Americans, or 15.3 percent, were without health insurance. Among blacks, 20.5 percent were uninsured, as were 31.6 percent of Hispanics.

First trimester prenatal care is one measure of the extent to which women have access to primary care. Data from the 1991 National Vital Statistics System indicate that no State had achieved the HEALTHY PEOPLE 2000 target of 90 percent of pregnant women receiving first trimester prenatal care. However, 18 States had first trimester prenatal care rates exceeding 80 percent. The New England States, several midwestern States, Maryland, and Virginia were among them. Connecticut, Iowa, Maine, and Rhode Island all had rates of first trimester prenatal care exceeding 85 percent. The receipt of prenatal care also differs by race. In 1991, American Indians/Alaska Natives had the lowest rate of first trimester prenatal care—59.9 percent—compared with 61.9 percent for blacks, 61.0 percent for Hispanics, and 79.5 percent for whites.

### Life-Stage Objectives

With the publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* in 1979, broad national goals were established for 1990 for mortality rate reductions in four age groups from birth to age 65 years. These life-stage targets continue to be tracked as objectives for the year 2000.

**Figure 7. Prenatal Care in the First Trimester, by State of Residence of the Mother, 1992**



Source: CDC/NCHS, Vital Health Statistics, Natality Division, 1992

Infant mortality is one of the sentinel events in health and a broad measure of a Nation's health. Although infant mortality declined by 35 percent between 1977 and 1990, the grim fact remains that 33,000 babies still die each year before their first birthday. The United States ranked 22nd among industrialized countries in its infant mortality rate in 1991.<sup>9</sup> The newest data show continued improvements in the infant mortality rate—as of

Figure 8. Progress on Life-Stage Objectives, 1995

Age Group	Year 1990 Targets*			Year 2000 Targets*		
	1977 Baseline	1990 Target	1990 Final	1987 Baseline	2000 Target	1992 Status
<b>Infants</b> (aged <1)	1412	900	908	1008	700	852
<b>Children</b> (aged 1–14)	42.3	34	30.1	33.7	28	28.8
<b>Young People</b> (aged 15–24)	114.8	93	104.1	97.8	85	95.6
<b>Adults</b> (aged 25–64)	532.9	400	400.4	426.9	340	394.7

\* Deaths per 100,000 population  
Source: CDC/NCHS National Vital Statistics System

1992, the infant mortality rate was 850 per 100,000 people under the age of 1 year. On the other hand, the rate per 100,000 live births for blacks was more than double the rate for whites. This disparity is one of the most important reasons for the HEALTHY PEOPLE 2000 target. Reducing infant mortality by 30 percent during the 1990s will require special emphasis on reducing the prevalence of low birthweight babies and on preventing birth defects.

For the year 2000, a 15 percent mortality reduction was set as the target for children aged 1–14. This level was nearly reached in 1992 as the child death rate reached 28.8 per 100,000. Significant declines in injury deaths, particularly from motor vehicle crashes, have contributed to this success story. By 1985, child safety seat use had become mandatory in all 50 States and the District of Columbia.

For adolescents and youths aged 15–24, the reduction in mortality has fallen short of the target. In fact, this was the only life-stage goal not met in 1990. For the year 2000, a 15 percent mortality reduction was established as the goal. In 1992, with 95.6 deaths per 100,000 population, this life-stage goal is proving elusive. Real progress is needed in curbing both interpersonal and self-inflicted violence in order to achieve the year 2000 target. Reducing motor vehicle crash deaths, particularly those involving alcohol, is another challenge for this age group.

A 20 percent reduction in the adult aged 25–64 death rate is the goal for the year 2000. Real progress has occurred in reducing heart disease and stroke death rates for adults. Successful efforts to increase high blood pressure detection and control, to raise awareness of blood cholesterol and dietary fats, and to warn of the hazards of tobacco use have contributed to the progress in this area. Cancer now is the leading

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cause of death for this age group. Slowing the rise in cancer deaths and in HIV infection remains a real obstacle to the achievement of the year 2000 target for adults.

The 1990 goal of reducing the days of disability for persons over 65 years of age was not met, although considerable progress was made. On an age-adjusted basis, restricted activity days declined on average from 36.5 days in 1977 to 31.4 days in 1990, compared with the goal of 30 days. For the year 2000, the life-stage goal set for older adults is to reduce the proportion of people who have difficulty in performing two or more personal care activities, thereby preserving independence. Personal care activities include bathing, dressing, grooming, and eating. According to data from the National Health Interview Survey, about 33 percent of people aged 65 and over were limited in one or more personal care activities.

### 1995 REPORT ON PROGRESS

At the midpoint of the decade, the Nation and the public health community are examining the health status of all Americans. While all of the data are not in hand, many 5-year trends have been established. Overall progress has been made on the Nation's year 2000 targets, with 50 percent proceeding in the right direction, 18 percent moving away from the targets, and 3 percent showing no change from the baseline. Tracking data are not yet available for 29 percent. The priority area midcourse reviews of the 22 HEALTHY PEOPLE 2000 priority areas that follow in the next chapter provide a more detailed picture of the changes.

For racial and ethnic population groups there is a similar picture of progress, with roughly the same percentage of objectives moving in the right direction for minorities as for the total population. However, for blacks there are proportionately more objectives moving away from the targets. For Asian Americans there is a considerable problem in getting the data needed to track progress.

**Figure 9. Progress on Racial and Ethnic Minority Objectives, 1995**

	<b>Right Direction</b>	<b>Wrong Direction</b>	<b>No Change</b>	<b>No Tracking Data*</b>
Total Population (300 targets)	50%	18%	3%	29%
Special Populations (116)	53%	27%	3%	17%
Black (48)	50%	35%	2%	13%
Hispanic (28)	54%	14%	4%	29%
Asians/Pacific Islanders (9)	56%	11%	0%	33%
American Indians/Alaska Natives (31)	56%	31%	3%	10%

\* Includes objectives with no baseline (8%) and objectives with no update beyond baseline (22%)  
Source: CDC/NCHS

Another summary of progress is shown in Figure 10 on the status of the 47 sentinel objectives in the 22 HEALTHY PEOPLE 2000 priority areas. The picture is also one of progress—33 objectives are proceeding in the right direction, 9 are moving away from the targets, 2 show no change from the baseline, and 3 lack data to track progress.

## **Prevention Opportunities**

Families, schools, worksites, and community programs all provide important opportunities for prevention. Midcourse assessments of HEALTHY PEOPLE 2000 objectives point to the continuing need to deal effectively with problems experienced by families and even whole communities—problems such as poverty, insufficient education, single parenthood, and violence, that can only be addressed through those settings.

### ***Families***

Beginning a family should be one of the joys of life. Through family planning, parents can ensure that they are ready to assume responsibility to care for and provide for their children. Once the choice has been made to begin a new life, the mother has the responsibility of seeking prenatal care in the first trimester of pregnancy to ensure a healthy birth. Breastfeeding can also help give a child a healthy start. A nutritious diet that supports physical growth and development coupled with physical activity can ensure that a child begins life with healthy habits. It is within families that behaviors are first observed and learned. Diet and activity patterns, oral hygiene, and coping skills are established at an early age and are supported by the examples set by family members. Patterns of alcohol consumption and tobacco use are similarly established within families. For adolescents and young adults, learning about physical development can foster positive awareness of their sexuality. Promoting self-esteem and reinforcing positive behaviors also builds the mental health of children. Primary care providers can support families by ensuring that they are provided scientifically sound clinical preventive services, including immunizations, screening to detect asymptomatic disease in its early stages, and appropriate counseling to foster healthy behaviors.

### ***Schools***

For the nearly 48 million children in this country, schools play an important supporting role in maintaining and promoting good health. Schools can provide health education to prepare children and teenagers to care for themselves. Children can learn about their bodies and the health effects of different behaviors and can adopt patterns for healthy life for themselves. In and through schools, children can be linked to necessary preventive services, including nutritious meals, regular physical activity, age-appropriate immunizations, screening for early diagnosis of diseases, referrals for treatment, and appropriate counseling about the many challenges to healthy maturation. Recognizing the role of schools in ensuring health for young citizens, the need for enhancing school health education and for developing school-based and school-linked health services is clearly called for.

Figure 10. Progress on 47 Sentinel Objectives

Objective	% Change		Year 2000 Targets	Right Direction	Wrong Direction	No Change	No Data
	Targeted	Baseline <sup>a</sup>					
<b>HEALTH PROMOTION</b>							
<b>1. Physical activity</b>							
• more people exercising regularly	+36%	22% <sup>c</sup>	30%	X			
• fewer people never exercising	-38%	24% <sup>c</sup>	15%			X	
<b>2. Nutrition</b>							
• fewer people overweight	-23%	26% <sup>b</sup>	20%		X		
• lower fat diets	-17%	36% <sup>b</sup>	30%	X			
<b>3. Tobacco</b>							
• fewer people smoking cigarettes	-48%	29%	15%	X			
• fewer youth beginning to smoke	-50%	30%	15%	X			
<b>4. Alcohol and other drugs</b>							
• fewer alcohol-related automobile deaths (per 100,000)	-13%	9.8	8.5	X			
• less alcohol use among youth aged 12–17 years	-50%	25.2% <sup>e</sup>	12.6%	X			
• less marijuana use among youth aged 12–17 years	-50%	6.4% <sup>e</sup>	3.2%	X			
<b>5. Family planning</b>							
• fewer teen pregnancies (per 1,000)	-30%	71.1% <sup>c,r</sup>	50.0 <sup>r</sup>		X		
• fewer unintended pregnancies	-46%	56% <sup>e</sup>	30%				X
<b>6. Mental health and mental disorders</b>							
• fewer suicides (per 100,000)	-10%	11.7	10.5	X			
• fewer people reporting stress-related problems	-21%	44.2% <sup>c</sup>	35%	X			
<b>7. Violent and abusive behavior</b>							
• fewer homicides (per 100,000)	-15%	8.5	7.2		X		
• fewer assault injuries (per 100,000)	-10%	9.7 <sup>d</sup>	8.7		X		
<b>8. Educational and community-based programs</b>							
• more schools with comprehensive school health education	NA	NA	75%				X
• more workplaces with health promotion programs	+31%	65% <sup>c</sup>	85%	X			

Objective	% Change Targeted	Baseline <sup>a</sup>	Update <sup>s</sup>	Year 2000		Wrong Direction	No Change	No Data
				Targets	Direction			
<b>HEALTH PROTECTION</b>								
<b>9. Unintentional injuries</b>								
· fewer unintentional injury deaths (per 100,000)	-16%	34.7	29.6	29.3	X			
· more people using automobile safety restraints	+102%	42% <sup>e</sup>	67% <sup>i</sup>	85%	X			
<b>10. Occupational safety and health</b>								
· fewer work-related deaths (per 100,000)	-33%	6 <sup>m</sup>	5	4	X			
· fewer work-related injuries (per 100,000)	-22%	7.7 <sup>m</sup>	7.9	6.0	X			X
<b>11. Environmental health</b>								
· no children with blood lead 25 µg/dl	-100%	234,000 <sup>n</sup>	93,000 <sup>h</sup>	0	X			
· more people with clear air in their communities	+71%	49.7% <sup>e</sup>	76.5%	85%	X			
· more people in radon-tested houses	+700%	5% <sup>i</sup>	11.4%	40%	X			
<b>12. Food and drug safety</b>								
· fewer <i>salmonella</i> outbreaks	-68%	77 <sup>i</sup>	63	25	X			
<b>13. Oral health</b>								
· fewer children with dental caries	-34%	54%	52%	35%	X			
· fewer older people without teeth	-44%	36% <sup>d</sup>	30%	20%	X			
<b>PREVENTIVE SERVICES</b>								
<b>14. Maternal and infant health</b>								
· fewer newborns with low weight	-28%	6.9%	7.1% <sup>k</sup>	5%	X			
· more mothers with first trimester care	+18%	76.0%	77.7% <sup>k</sup>	90%	X			
<b>15. Heart disease and stroke</b>								
· fewer coronary heart disease deaths (per 100,000)	-26%	135	114 <sup>k</sup>	100	X			
· fewer stroke deaths (per 100,000)	-34%	30.4	26.4	20.0	X			
· better control of high blood pressure	+355%	11% <sup>b</sup>	21% <sup>h</sup>	50%	X			
· lower cholesterol levels	-6%	213 mg/dl <sup>b</sup>	205 mg/dl <sup>h</sup>	200 mg%	X			
<b>16. Cancer</b>								
· decrease cancer deaths (per 100,000)	-3%	134	133	130	X			
· increase screening for breast cancer (age>50)	+140%	25%	55%	60%	X			
· increase screening for cervical cancer (age>18)	+8%	88%	95%	95%	X			
· increase fecal occult blood testing (age>50)	+85%	27%	30% <sup>k</sup>	50%	X			

<sup>a</sup> 1987 unless otherwise noted  
<sup>b</sup> 1976-80  
<sup>c</sup> 1985  
<sup>d</sup> 1986  
<sup>e</sup> 1988  
<sup>f</sup> 1989  
<sup>g</sup> 1993 unless otherwise noted  
<sup>h</sup> 1988-91  
<sup>i</sup> 1990  
<sup>j</sup> 1991  
<sup>k</sup> 1992  
<sup>l</sup> 1994  
<sup>m</sup> 1983-1987  
<sup>n</sup> 1984  
<sup>o</sup> 1979-80 through 1986-87 influenza seasons  
<sup>p</sup> 1987-88 through 1989-90 influenza seasons  
<sup>q</sup> Data are expressed as measles cases  
<sup>r</sup> rate per 1,000

**Figure 10. Progress on 47 Sentinel Objectives (continued)**

Objective	% Change		Year 2000 Targets	Right Direction	Wrong Direction	No Change	No Data
	Targeted	Baseline <sup>a</sup> Update <sup>g</sup>					
<b>17. Diabetes and chronic disabling conditions</b>							
· fewer people disabled by chronic conditions	-15%	9.4%	8%		X		
· fewer diabetes-related deaths (per 100,000)	-11%	38 <sup>d</sup>	34			X	
<b>18. HIV infection</b>							
· slower increase in HIV infection (per 100,000)	0%	400 <sup>f</sup>	400				X
<b>19. Sexually transmitted diseases</b>							
· fewer gonorrhea infections (per 100,000)	-25%	300 <sup>f</sup>	225	X			
· fewer syphilis infections (per 100,000)	-45%	18.1 <sup>f</sup>	10.4	X			
<b>20. Immunization and infectious diseases</b>							
· no measles cases	-100%	3058 <sup>g,i</sup>	312 <sup>g</sup>	X			
· fewer pneumonia and influenza deaths (per 100,000)	-63%	19.9 <sup>g</sup>	7.3		X		
· higher immunization levels (ages 19–35 months)	+53%	54-64%	67%	X			
<b>21. Clinical preventive services</b>							
· no financial barrier to recommended preventive services	-100%	16% <sup>t</sup>	17%			X	
<b>SURVEILLANCE AND DATA SYSTEMS</b>							
<b>22. Surveillance and data systems</b>							
· common and comparable health status indicators in use across States		0 States	48 States	40 States	X		
<b>Total</b>					<b>33</b>	<b>9</b>	<b>2 3</b>

<sup>a</sup> 1987 unless otherwise noted  
<sup>b</sup> 1976-80  
<sup>c</sup> 1985  
<sup>d</sup> 1986  
<sup>e</sup> 1988  
<sup>f</sup> 1989  
<sup>g</sup> 1993 unless otherwise noted  
<sup>h</sup> 1988-91  
<sup>i</sup> 1990  
<sup>j</sup> 1991  
<sup>k</sup> 1992  
<sup>l</sup> 1994  
<sup>m</sup> 1983-1987  
<sup>n</sup> 1984  
<sup>o</sup> 1979-80 through 1986-87 influenza seasons  
<sup>p</sup> 1987-88 through 1989-90 influenza seasons  
<sup>q</sup> Data are expressed as measles cases  
<sup>r</sup> rate per 1,000



Low educational achievement is a consistent indicator of increased risk for preventable disease and premature death. With the passage of the GOALS 2000 Educate America Act, the potential exists to initiate a broad range of actions that, together with HEALTHY PEOPLE 2000, will result in a healthier, better educated Nation. GOALS 2000 challenges the Nation to ensure that all children arrive at school ready to learn; to increase the high school completion rate; to attain student competencies in core subjects; to make U.S. students first in the world in math and science achievement; to improve teacher education and professional development; to achieve universal adult literacy and lifelong learning; to ensure safe, disciplined, and alcohol- and drug-free schools; and to promote parental participation. Achieving these goals can produce a generation of educated adults for whom disease prevention and health promotion is understood, practiced, and valued.

### ***Workplaces***

Nearly 110 million people go to work each day. A prevention-based orientation to health can be enhanced by employers who promote good health for their employees through supportive policies (e.g., smoking restrictions), exercise facilities, health promotion education, health insurance, and targeted preventive services. In addition, workplace programs protect employee health through standard setting and enforcement, worker training, and safety education. By encouraging safe practices and healthy behaviors, worksite programs help sustain the national effort to reduce preventable death, disease, and disability.

### ***Communities***

Each day, millions of Americans come together to pursue neighborhood improvement projects, engage in recreation, continue their education, and maintain social support and friendship. From athletics to volunteer social service, community-based activities support better health—for participants and recipients alike. For families and neighborhoods that are least able to provide healthy, safe environments, community programs can be a bridge to a better life.

Religious institutions offer spiritual support that can promote emotional and mental health. The religious community has become increasingly engaged in the lives of its members through sponsorship of child care centers, afterschool programs, homeless programs, and programs for older adults. Through all of these activities, churches, temples, and other places of worship promote health.

An increasing number of community-based projects that join the skills, devotion, and energy of the community with the expertise of local public health departments and health care providers promotes better health in America's communities and neighborhoods. These healthy communities projects work to build communities that support good health decisions and promote improvements in the quality of life.

HEALTHY PEOPLE 2000 provides a framework for State and local action, helping communities tailor strategies to meet the unique needs of their residents. As of June 1995, 42 States, Guam, and the District of Columbia had used HEALTHY PEOPLE 2000 to

create their own State-level prevention agendas. Equally impressive is the degree to which private and voluntary organizations have taken on the HEALTHY PEOPLE 2000 challenge. Acceptance of a common prevention agenda has built bridges between public and private agencies at national, State, and local levels. To emphasize the importance of action at the State level, this report is arranged with maps illustrating how statistics from various jurisdictions compare on certain indicators of health.

### Prevention Challenges—Special Population Priorities

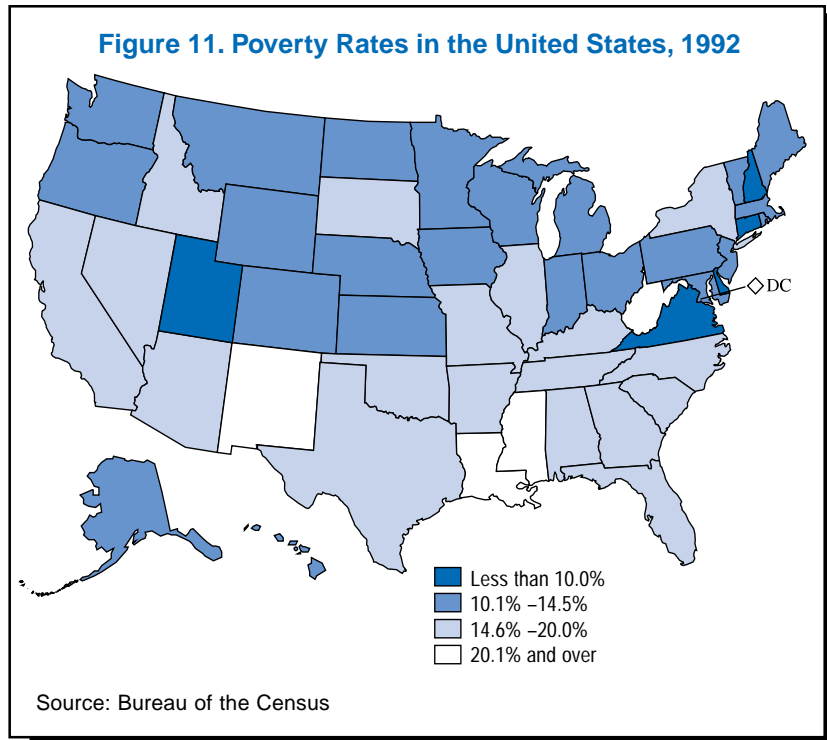
Some problems are so compelling that particular attention is required to change the behaviors of individuals and community norms. These problems occur disproportionately among the most vulnerable in the society, and solutions to these problems require the mobilization of multiple social institutions.

The population of the United States continues to grow and to diversify. At the time of the 1990 census, there were nearly 250 million Americans, with a combined minority population at 24 percent. In 1990, the racial composition of the population was 75.7 percent white non-Hispanic, 11.8 percent black non-Hispanic, 2.4 percent Asians/Pacific Islanders, and 0.7 percent American Indians/Alaska Natives. Based on official Census Bureau projections, the resident population will be 276 million by the year 2000, with a combined minority population of 28.4 percent. This growth of 17.5 million minorities reflects both migration and the natural increase of the population as births exceed deaths. Some 9 percent of the population were of Hispanic origin. By 2000 the population is expected to be 71.6 percent white non-Hispanic, 12.2 percent black non-Hispanic, 4.1 percent Asians/Pacific Islanders and 0.7 percent American Indians/Alaska Natives. Some 11.3 percent of the population are expected to be people of Hispanic origin.<sup>10</sup> As America's diversity increases, so does the need to ensure that broad public health messages are culturally and linguistically appropriate.

By the year 2000, there will also be 4 million more Americans over the age of 65 than there were in 1990. The average age of the population is rising, and the number of people living beyond age 85 is at record levels. The aging of America will challenge the mental health system to minimize the effects of social isolation and depression that arise from illness and from the losses of loved ones and friends. Primary care providers will be faced with identifying risks to independence and health, counseling patients to remain physically active, providing immunizations for pneumonia and influenza, and performing periodic screenings to detect cancers, heart disease, and other life-threatening conditions.

Another special population focus in *Healthy People 2000* is people with disabilities. According to the Census Bureau there were 48.9 million Americans with a disability in 1992. Almost half of these people were considered to be severely disabled, while the disability for the others was considered not severe. Among the severely disabled are the frail elderly, mentally retarded/developmentally disabled people, and adults and children with disabling physical and mental illnesses. These people may be limited in their activities of daily living such as going to work or school or in per-

forming personal grooming, cooking or housework. Although there are no official projections of the disabled population for the year 2000, the trend data indicate that the numbers of disabled may be increasing. In part this trend reflects the aging of the population. The 1994/95 Disability Supplement to the National Health Interview Survey will provide important information on the severity, onset, and duration of disabling conditions.



For nearly every measure of health, the poor suffer more than the population as a whole. The number of people living in poverty has increased since *Healthy People 2000* was published. Between 1987 and 1992, there was an increase of 4.7 million people in poverty—which brought the total population living with incomes below the official poverty level to 36.9 million Americans. Of these, 13.9 million were children under the age of 18. There are no official projections for poverty by the year 2000. As shown in Figure 11, poverty rates differ by State, with Mississippi having nearly three times the rate of poverty of Delaware in 1992.

These demographic trends indicate enormous challenges. To prevent premature death and disability and to thwart morbidity in a more diverse and older population in which poverty has been on the rise requires that health promotion and disease prevention messages and interventions be broadened. Resource constraints require that services be targeted to those with the greatest needs.

## Conclusion

*Healthy People 2000* offers goals for what can be achieved for the Nation's health by the end of this decade as well as an agenda to realize that vision. Each of the 22 priority areas is important and has substantial impact on the ability to reach the targets comprising other priority areas. Achieving the heart disease and cancer objectives also requires progress in the diet, physical activity, and tobacco use objectives. Reaching targets related to violence and unintentional injury also requires progress on the substance abuse, mental health, and educational and community-based program objectives.

## Healthy People 2000 Midcourse Review and 1995 Revisions

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This decade will witness profound changes in the Nation's public and personal health care system. This midcourse review reaffirms a commitment to better health in its broadest sense. *Healthy People 2000* offers an important tool. Its use can ensure that efforts are focused on activities that can reduce the burden of illness and move the Nation steadily toward a higher level of health as a new century dawns.

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