APPENDIX B

History of the Objectives Development and the Midcourse Revisions Process

Healthy People 2000 Midcourse Review and 1995 Revisions

The year 2000 objectives build upon an effort, 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 to the world of business, the U.S. 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. In 1985, an interim assessment resulted in the publication of *The 1990 Health Objectives for the Nation: A Midcourse Review*. The following year, a steering committee was formed within PHS to oversee the process of revising the objectives to target the year 2000.

The approach taken in developing year 2000 objectives paralleled the 1990 objectives in the comprehensiveness of the issues addressed. To broaden participation in the year 2000 objectives development effort, the Assistant Secretary for Health invited 157 national membership organizations and all the State and Territorial health departments to join PHS in a national consortium. In addition, PHS established a partnership with the Institute of Medicine, National Academy of Sciences to convene a series of regional hearings across the country. Using the input and expert review of over 7,000 individuals and groups, the PHS Steering Committee defined 22 priority areas to serve as the initial framework for drafting year 2000 objectives.

The year 2000 priority areas expand 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 are 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 premature death or chronic illness.

Within PHS, there are lead agencies for each priority area. The 1995 revisions were developed by the lead PHS agencies. New objectives for the year 2000, new special population targets, modifications to the year 2000 targets, and revisions to language in selected objectives were coordinated and edited by the Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health, which has been designated by the Assistant Secretary as the coordinating office for this process.

In developing the year 2000 objectives and the 1995 midcourse revisions, lead agencies were guided by eight criteria. They are:

- *Credibility*—Objectives should be realistic and should address the issues of greatest priority.

- *Public comprehension*—Objectives should be understandable and relevant to a broad audience, including those who plan, manage, deliver, use, and pay for health services.
- *Balance*—Objectives should be a mixture of outcome and process measures, recommending methods for achieving changes and setting standards for evaluating progress.
- *Measurability*—Objectives should be quantified.
- *Continuity*—Year 2000 objectives should be linked to the 1990 objectives where possible but reflect the lessons learned in implementing them.
- *Compatibility*—Objectives should be compatible where possible with goals already adopted by Federal agencies and health organizations.
- *Freedom from data constraints*—The availability or form of data should not be the principal determinant of the nature of the objectives. Alternate and proxy data should be used where necessary.
- *Responsibility*—The objectives should reflect the concerns and engage the participation of professionals, advocates, and consumers as well as State and local health departments.

The year 2000 objectives are organized broadly into three major sections that identify the principal type of preventive intervention they involve: Health Promotion, Health Protection, and Clinical Preventive Services. The 22 priority areas have been retained. *The numbers do not indicate a rank ordering of priorities*. In each priority area (with the exception of Surveillance and Data Systems), objectives are organized by three types:

- *Health Status* - targets to reduce death, disease, and disability and to enhance functional status, including physical, mental, and social functioning and well-being as well as general perception of health and satisfaction.
- *Risk Reduction* - targets to reduce the prevalence or incidence of risks to health or to increase behaviors known to reduce such risks.
- *Services and Protection* - targets to increase comprehensiveness, accessibility, and/or quality of preventive services and protective interventions.

On October 3, 1994, proposed midcourse revisions were published in the *Federal Register* for public review and comment. There were no changes proposed to the three goals of HEALTHY PEOPLE 2000 or to the organization of the 22 priority areas. Proposed were:

- new objectives that reflect scientific developments and new information that has become available;
- revisions to published objectives to encompass current issues and data reporting systems;
- new special population targets to focus on groups that are of highest risk of premature death, disease, or disability; and
- revisions to year 2000 targets where the baseline has changed.

A recurring theme in the development and review process conducted to date has been the focus on the needs of those population groups that are at highest risk for premature death, disease, or disability. Consequently, the year 2000 revisions proposal contained more than 100 proposed special population targets. In each case, targets were only offered if the population in question—whether an age group, a minority group, people with disabilities, or people with low incomes—had demonstrated higher risk or was more vulnerable to the subject disease or condition than the population as a whole. It should be noted that data were not available on all possible population groups that may have been at higher risk than the general population.

These special population targets have been set using three criteria: 1) They should be *realistic* and thus may not be the same as targets set for the population as a whole, which starts at a better baseline. 2) They should be *challenging* and thus should call for greater proportional improvements than the general population targets. 3) The targets for special population groups must seek to *close the gap* between the special population and the total population.

More than 550 public comments were received on the proposed midcourse revisions. Those public comments were used by the lead PHS agencies to finalize the Summary List of Objectives published in Appendix A of this document.