

## Chapter 2

# Promoting Health for a Nation: Healthy People 2010

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## OBJECTIVES

After studying this chapter, the student should be able to

1. Explain the historical development process of Healthy People 2010.
2. Describe the goals, objectives, and function of Healthy People 2010.
3. Identify the 10 leading health indicators used to monitor progress toward Healthy People 2010 objectives.
4. Describe the processes used to evaluate the impact of Healthy People 2010 objectives.

## INTRODUCTION

*Healthy citizens are the greatest asset any country can have.*

Winston Churchill (1874–1965)

Modern medical miracles offer the hope of long and healthy lives to many Americans. Along with the increase in life expectancy, a host of allied health professionals have expanded the scope and practice of health care in the United States. We have seen an increase in professional specialization, as healthcare providers strive to achieve a diverse, culturally competent health workforce that provides the highest quality health care for all, especially the underserved populations. The prevention, diagnosis, and treatment of disease and injury and the rehabilitation and maintenance of individuals challenged by acute and chronic health conditions support a trillion-dollar industry. In fact, US

health expenditures grew to \$1.7 trillion in 2003, accounting for 15.3% of the Gross Domestic Product, and outpacing growth in the overall economy by 3 percentage points (CMS, 2003). Rising medical costs are frequently topics of debate, around dinner tables, political circles, and within the healthcare industry itself.

While over a trillion dollars seems like a huge sum, especially when compared to poorer countries, higher spending on health care does not necessarily prolong lives. In 2000, the United States spent more on health care than any other country in the world: an average of \$4,500 per person. Switzerland was second highest, at \$3,300 or 71%. Nevertheless, average US life expectancy ranks 27th in the world, at 77 years. Many countries achieve higher life expectancy rates with significantly lower spending. With a life expectancy of 76.9 years, Cuba ranks 28th in the world. However, Cuba's spending per person on health care is one of the lowest in the world, at \$186, about one twenty-fifth of the spending of the United States (UC Atlas, 2005). Comparing Cuba with the United States, vastly increased spending does not necessarily enable significantly longer life expectancies.

In addition to spending more per capita, over 45 million Americans lack basic health insurance, and are therefore less likely to receive preventive care. In contrast, Cuba has universal health care and one of the highest doctor-to-patient ratios in the world. While health care in the United States is among the best in the world, the technologies and treatments available are not accessible to all. People of color and other vulnerable populations are more likely to experience healthcare barriers and to suffer from high rates of disease and early death.

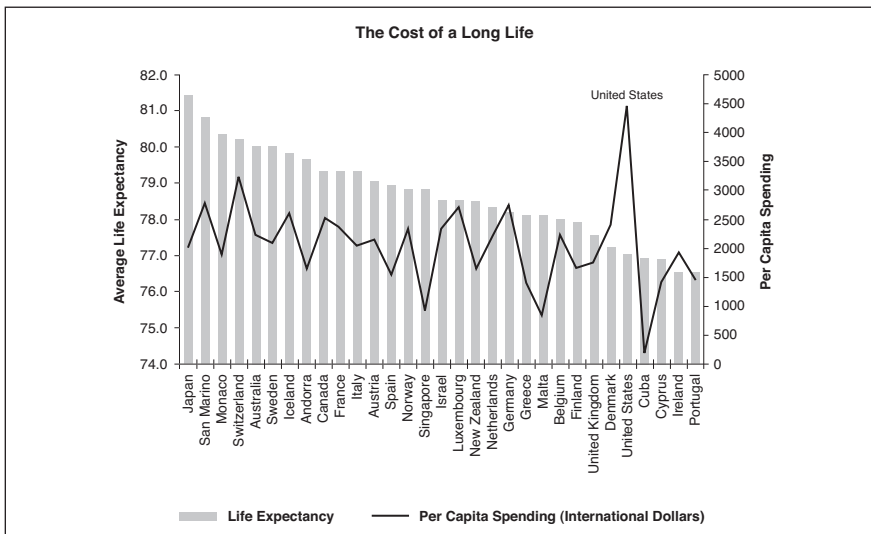


Figure 2.1 *The Cost of a Long Life*

Source: UC Atlas of Global Inequality (<http://ucatlas.ucsc.edu/spend.php>)

## Healthy People 2010

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Even as the size, complexity, and technological sophistication of health care have expanded in recent years, more and more Americans are experiencing limited access to services, inconsistent quality of services, and uncontrolled expenses. Reducing the disparities to improve the quality and quantity of life for *all* Americans is the goal of Healthy People 2010, a framework for prevention for the nation. Healthy People 2010 is a statement of national health objectives. The Office of Disease Prevention and Health Promotion, within the US Department of Health and Human Services, manages these objectives to strengthen the disease prevention and health promotion priorities.

Designed to identify the most significant preventable threats to health, and establish national goals to reduce these threats, Healthy People 2010 objectives build on initiatives pursued over the past two decades. The 1979 Surgeon General's Report, *Healthy People*, laid the foundation for a national prevention agenda. The 1980 *Promoting Health/Preventing Disease: Objectives for the Nation*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, established national health objectives and served as the basis for the development of state and community plans.

*The new century brings new challenges and opportunities to improve the health of everyone in the United States. People not only want to live a long life, but they also want to enjoy a healthy life. As the baby boom becomes the senior boom, quality of life will become a central issue for our health system. With Healthy People 2010, we want to add years to your life and health to your years.*

—HHS Secretary Donna E. Shalala, January 2000

States, communities, professional organizations, and others use these objectives to help develop programs to improve health. Developed through a broad consultation process, Healthy People 2010 built on the best scientific knowledge, designed to measure programs over time. The first of two overarching goals of Healthy People 2010 is to *help individuals of all ages increase life expectancy and improve their quality of life*. Life expectancy is the average number of years people born in a given year can expect to live based on a set of age-specific death rates. Life expectancy for persons at every age group has increased during the past century. Based on today's age-specific death rates, an individual who was 75 in 2002 could expect to live another 11.5 years. Living longer with chronic or debilitating illness may decrease the quality of the individual's life. Quality of life reflects the value assigned to duration of life as modified by the impairments, functional status, and social opportunities, influenced by disease, injury, and treatment or social

and political policy. It highlights a general sense of happiness and satisfaction with our lives and environment. Quality of life may encompass all aspects of life, including health, recreation, culture, rights, values, beliefs, and aspirations. Health-related quality of life is an overall sense of well-being with a strong relation to a person's health perceptions and ability to function. On a larger scale, quality of life can be viewed as including all aspects of community life that have a direct and quantifiable influence on the physical and mental health of its members.

Globally, the constitution of the World Health Organization states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, or economic or social condition. Yet even in North America, where technological advances in the healthcare field have made significant improvements in the quantity and quality of lives, there remain disparities between groups based on these very distinctions. There are large differences in health status by race and ethnic origin. Several factors may account for this, including socioeconomic status, health practices, psychosocial issues, limited resources (that is, housing, food, etc.), environmental exposures, discrimination, and access to health care. Socioeconomic and cultural differences among racial and ethnic groups in the United States will likely continue to influence patterns of disease, disability, and health care use in the future.

However, the second overarching goal of Healthy People 2010 is to *eliminate health disparities among different segments of the population*. Differences in health, life expectancy, and quality of life can occur by gender, race, or ethnicity, education or income, disability, geographic location, or even sexual orientation.

Documented repeatedly across a broad range of medical conditions, racial and ethnic disparities in health status continue to exist. This is true despite major health improvements for the nation as a whole. In response, government agencies and organizations are sponsoring research, collecting data, and developing resources to close the gaps in the health of, and the health services provided to, the minority and majority populations. Understanding the trends in disparities between different segments of the population enables healthcare programs to address the prevention needs of those groups. It is possible to split the US population along many different lines—racial and ethnic, gender, age, socioeconomic, and geographic. When determining whom a particular type of illness or injury affects, it is important to consider all of these characteristics. They shape a person's beliefs, values, preferences, and life experiences. Those factors, in turn, strongly affect how a person responds to prevention efforts. Research by the Agency for Healthcare Research and Quality (AHRQ) focuses on identifying and understanding how

inequities in health care contribute to disparities, and how to eliminate those disparities. For example

- Cancer mortality rates are 35% higher in blacks than whites, however much can be done to reduce or eliminate this disparity by administering population- and community-based prevention programs and improving the effective delivery of both preventive and treatment services in the clinical setting.
- Cervical cancer, a disease that can be greatly reduced by effective health care, is 5 times higher in Vietnamese women in the United States than white women.
- Infant mortality is nearly 2.5 times higher in African-Americans than in whites.
- Before age 75, women are more likely to die in the hospital after a heart attack, yet studies suggest that women typically receive fewer high-technology cardiac procedures than men do.
- African-American diabetics are 7 times more likely to have amputations and develop kidney failure than white diabetics.

Within Healthy People 2010, leading federal agencies with the most relevant scientific experience developed 28 different focus areas. The Healthy People Consortium—an alliance of more than 350 national membership organizations and 250 state health, mental health, substance abuse, and environmental agencies—also informed the development process for these objectives. In addition, a series of regional and national meetings and an interactive Web site, received more than 11,000 public comments on the draft objectives. Within those 28 focus areas, Healthy People 2010 features 467 science-based objectives and 10 Leading Health Indicators, which are a smaller set of objectives chosen to track progress toward meeting Healthy People 2010 goals. The Leading Health Indicators represent the important determinants of health for the full range of issues in the 28 focus areas of Healthy People 2010.

Both public and private organizations have made great strides in identifying causes of disease and disability, discovering treatments and cures, and working with practitioners to educate the public to reduce the incidence and prevalence of major diseases as well as the functional limitations and discomfort or premature death they may cause. Healthy People 2010 and the Leading Health Indicators provide a means to assess where we are in health care today, and what steps we can improve for the future. The Healthy People 2010 objectives seek to increase life expectancy and quality of life for all Americans by helping individuals gain the knowledge, motivation, and opportunities needed to make informed decisions about their health.

Table 2.1 *Healthy People 2010 Focus Areas*

1. Access to Quality Health Services	15. Injury and Violence Prevention
2. Arthritis, Osteoporosis, and Chronic Back Conditions	16. Maternal, Infant, and Child Health
3. Cancer	17. Medical Product Safety
4. Chronic Kidney Disease	18. Mental Health and Mental Disorders
5. Diabetes	19. Nutrition and Overweight
6. Disability and Secondary Conditions	20. Occupational Safety and Health
7. Educational and Community-Based Programs	21. Oral Health
8. Environmental Health	22. Physical Activity and Fitness
9. Family Planning	23. Public Health Infrastructure
10. Food Safety	24. Respiratory Diseases
11. Health Communication	25. Sexually Transmitted Diseases
12. Heart Disease and Stroke	26. Substance Abuse
13. HIV	27. Tobacco Use
14. Immunization and Infectious Diseases	28. Vision and Hearing

The Leading Health Indicators (LHIs) are measures of the health of the nation over the next 10 years. The process of selecting the Leading Health Indicators mirrored the collaborative and extensive efforts undertaken to develop Healthy People 2010. The process, led by an interagency work group within the US Department of Health and Human Services, allowed individuals and organizations to provide comments at national and regional meetings or via mail and the Internet. A report by the Institute of Medicine, National Academy of Sciences, provided several scientific models on which to support a set of indicators. Research using focus groups ensured the indicators are meaningful and motivating to the public.

Each of the 10 Leading Health Indicators has one or more objectives from Healthy People 2010 associated with it. As a group, the Leading Health Indicators reflect the major health concerns in the United States at the beginning of the 21st century. The Leading Health Indicators, selected based on the availability of data to measure progress, and their importance as public health issues, are listed below.

- |                                |                           |
|--------------------------------|---------------------------|
| 1. Physical Activity           | 6. Mental Health          |
| 2. Overweight and Obesity      | 7. Injury and Violence    |
| 3. Tobacco Use                 | 8. Environmental Quality  |
| 4. Substance Abuse             | 9. Immunization           |
| 5. Responsible Sexual Behavior | 10. Access to Health Care |

Each LHI represents an important health issue by itself. Together, the set of indicators helps us understand that many factors influence the health of individuals, communities, and the nation. Each of the indicators depends to some extent on

- The information people have about their health status as well as information on how to make improvements in their health.
- Choices people make (behavioral factors).
- Where and how people live (environmental, economic, and social conditions).
- The type, amount, and quality of health care people receive (access to health care and characteristics of the healthcare system).

The Leading Health Indicators motivate citizens and communities to take actions to improve the health of individuals, families, communities, and the nation. The indicators can help us determine *what each one of us can do and where we can best focus our energies*—at home, and in our communities, worksites, businesses, or states—to live better and longer. Some possible actions are

- Adopt the 10 LHIs as personal and professional guides for choices about how to make health improvements.
- Encourage public health professionals and public officials to adopt the LHIs as the basis for public health priority-setting and decision-making.
- Urge our public and community health systems and our community leadership to use the LHIs as measures of local success for investments in health improvements.

Realizing improvements for the 10 Leading Health Indicators will require effective public and private sector programs that address multiple factors. Significant reductions in infant mortality, fewer teen pregnancies, and childhood vaccination rates at record highs are recent positive healthy trends. However, obesity is now epidemic in the United States. Diabetes rates among people ages 30 to 39 rose by 70% in the past decade. About 46.5 million adults in the United States smoke cigarettes, even though this single behavior will result in disability and premature death for half of them. More than 60% of American adults do not get enough physical activity, and more than 25% are not active at all (HealthierUS.gov, 2005). There is much work to be done!

The indicators can provide the foundation for new partnerships across health issues and new thinking about how to address the many health concerns we face as a nation. An example of this type of innovative thinking is collaboration among those who want to increase the amount of physical activity individuals do and promote weight loss to reach a healthy weight. In short, the Leading Health Indicators serve as a tool to develop comprehensive health activities that work simultaneously to improve many aspects of health. The following table identifies which indicators most closely relate to each of the 28 focus areas and suggests opportunities for collaboration across focus areas.

Table 2.2 *Leading Health Indicators*

<i>Focus Area</i>	<i>Leading Health Indicators</i>									
	<i>Physical activity</i>	<i>Overweight and obesity</i>	<i>Tobacco Use</i>	<i>Substance Abuse</i>	<i>Responsible Sexual Behavior</i>	<i>Mental Health</i>	<i>Injury and Violence</i>	<i>Environmental Quality</i>	<i>Immunization</i>	<i>Access to Health Care</i>
Access to Quality Health Services	•	•	•	•	•	•	•		•	•
Arthritis, Osteoporosis, and Chronic Back Conditions	•	•					•			
Cancer	•	•	•	•	•				•	•
Chronic Kidney Disease	•	•	•					•		
Diabetes	•	•	•						•	•
Disability and Secondary Conditions	•	•	•	•		•			•	•
Educational and Community-Based Programs	•	•	•	•	•	•	•	•	•	•
Environmental Health								•		
Family Planning				•	•					•
Food Safety								•		•
Health Communication	•	•	•	•	•	•	•	•	•	•
Heart Disease and Stroke	•	•	•					•		
HIV				•	•	•				•
Immunization and Infectious Diseases									•	•
Injury and Violence Prevention			•	•		•	•			
Maternal, Infant, and Child Health	•	•	•	•	•	•	•		•	•
Medical Product Safety					•					
Mental Health and Mental Disorders			•	•	•	•				•
Nutrition and Overweight	•	•	•			•				
Occupational Safety and Health				•			•	•		
Oral Health		•	•	•				•		•
Physical Activity and Fitness	•	•	•		•	•		•		
Public Health Infrastructure	•	•	•	•	•	•	•	•	•	•
Respiratory Diseases	•		•					•		
Sexually Transmitted Diseases				•	•					
Substance Abuse			•	•	•		•			•
Tobacco Use			•					•		•
Vision and Hearing										•

*Source:* Leading Health Indicators Touch Everyone, [http://www.healthypeople.gov/LHI/Touch\\_fact.htm](http://www.healthypeople.gov/LHI/Touch_fact.htm)

## Leading Health Indicators and Healthy People 2010 Objectives

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The following descriptions provide a basic illustration of the concepts addressed by each of the Leading Health Indicators. Examples of some Healthy People 2010 objectives demonstrate the goals and identify benchmarks for measuring improvement. The complete set of 467 science-based objectives is available at [www.healthypeople.gov](http://www.healthypeople.gov). In most objectives, baseline data provide understanding of the current known measurements; the targets indicate the expected or desired improvement by 2010. For objectives that address health services and protection (for example, access to prenatal care, health insurance coverage, etc.) the targets have been set so that there is an improvement for all racial/ethnic segments of the population (that is, the targets are set to “better than the best” for the racial/ethnic subgroup shown for the objective). For objectives that can be influenced in the short term by policy decisions, lifestyle choices, and behaviors (for example, physical activity, diet, smoking, suicide, alcohol-related motor vehicle deaths, etc.), the target setting method is also “better than the best” group. For objectives that are unlikely to achieve an equal health outcome in the next decade, regardless of the level of investment (for example, occupational exposure and resultant lung cancer), the target represents an improvement for a substantial proportion of the population and is regarded as a minimum acceptable level. Implicit in setting targets for these objectives is the recognition that population groups with baseline rates already better than the identified target should continue to improve.

Most objectives are tracked by a single measure to assess progress made over the decade. For these objectives, progress is assessed by the change from the baseline measure toward the target. Some objectives seek to increase positive behaviors or outcomes while others are defined in terms of decreasing negative behaviors or outcomes. A number of objectives contain multiple measures. Progress will be assessed separately for each measure. For these objectives, therefore, the progress may be mixed if some measures are progressing toward the target and others are regressing. For some objectives, precise measures that match the objective are not available. In these cases, similar proxy measures may be used to track progress. The tracking data and methods for assessing progress will be reviewed during the midcourse review in 2005, and a determination will be made at that time whether any changes will be made.

Developmental objectives are those that currently do not have national baseline data established, therefore, they currently have no operational definitions. Some objectives that contain several measures may have parts that are developmental. Developmental objectives indicate areas that need to be placed on the national agenda for data collection. They address subjects of

sufficient national importance that investments should be made over the next decade to measure their change.

Healthy People 2010 uses population estimates from the US Census Bureau to calculate morbidity and mortality rates for many of the objectives. Every 10 years, the Census Bureau conducts a full census of the resident population of the United States, Puerto Rico, and US territories and collects data on gender, race, age, and marital status; the estimates produced represent the US population as of April 1 of the census year. More detailed data on education, housing, occupation, income, and other information are also collected from a representative sample of the population (about 17% of the total population).

Midway through the decade, a Midcourse Review assesses the status of the national objectives determined by Healthy People 2010. The Midcourse Review process identifies significant trends and gaps in preventive health issues and assesses whether objectives are moving away or toward their target. The final Midcourse Review, released in 2006, is available at the Healthy People 2010 Web site at [www.healthypeople.gov](http://www.healthypeople.gov).

## Physical Activity

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*I have never taken any exercise except sleeping and resting.*

Mark Twain (1835–1910)

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Millions of Americans suffer from illnesses prevented or improved through regular physical activity. Regular physical activity reduces people's risk for heart attack, colon cancer, diabetes, and high blood pressure and may reduce their risk for stroke. It also helps to control weight; contributes to healthy bones, muscles, and joints; reduces falls among older adults; helps to relieve the pain of arthritis; reduces symptoms of anxiety and depression; and is associated with fewer hospitalizations, physician visits, and medications. Moreover, physical activity need not be strenuous to be beneficial; people of all ages benefit from moderate-intensity physical activity, such as 30 minutes of brisk walking 5 or more times a week.

Despite the proven benefits of physical activity, more than 50% of US adults do not get enough physical activity to provide health benefits; 26% are not active at all in their leisure time. Activity decreases with age, and sufficient activity is less common among women than men and among those with lower incomes and less education. Insufficient physical activity is not limited to adults. More than a third of young people in grades 9 through 12 do not regularly engage in vigorous physical activity. Daily participation in high school physical education classes dropped from 42% in 1991 to 28% in 2003 (CDC, 2004).

The US Surgeon General estimates 13.5 million people have coronary heart disease and 1.5 million people suffer from a heart attack in a given year. Approximately 8 million people have adult-onset (non-insulin-dependent) diabetes and 250,000 people suffer from hip fractures each year. Over 60 million people (a third of the population) are overweight and 50 million people have high blood pressure. Millions of Americans suffer from illnesses that can be prevented or improved through regular physical activity (CDC, 2005).

## Sample Healthy People 2010 Objectives for Physical Activity

**22-2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.**

**Target:** 30 percent.

**Baseline:** 15 percent of adults aged 18 years and older engaged in moderate physical activity for at least 30 minutes 5 or more days per week in 1997 (age adjusted to the year 2000 standard population).

**22-7. Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.**

**Target:** 85 percent.

**Baseline:** 65 percent of students in grades 9 through 12 engaged in vigorous physical activity 3 or more days per week for 20 or more minutes per occasion in 1999.

## Overweight and Obesity:

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*Getting my lifelong weight struggle under control has come from a process of treating myself as well as I treat others in every way.*

Oprah Winfrey (1954–), *O Magazine*, August 2004

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During the past 20 years, obesity among adults has risen significantly in the United States. Results of the National Health and Nutrition Examination Survey for 1999–2002 indicate that an estimated 30 percent of US adults aged 20 years and older—over 60 million people—are obese, defined as having a body mass index (BMI) of 30 or higher. Approximately 65% of US adults aged 20 years and older are either overweight or obese, defined as having a

BMI of 25 or higher. This increase is not limited to adults. The percentage of young people who are overweight has more than tripled since 1980. Among children and teens aged 6–19 years, 16 percent, over 9 million young people, are overweight (CDC, 2005b).

These increasing rates raise concern because of their implications for Americans' health. Although one of the national health objectives for the year 2010 is to reduce the prevalence of obesity among adults to less than 15%, current data indicate that the situation is worsening rather than improving (see Figure 2.2). Obese individuals are at increased risk for heart disease, high blood pressure, diabetes, arthritis-related disabilities, and some cancers. The estimated annual cost of obesity in the United States in 2000 was about \$117 billion. Promoting regular physical activity and healthy eating and creating an environment that supports these behaviors are essential to reducing this epidemic of obesity (CDC, 2005b).

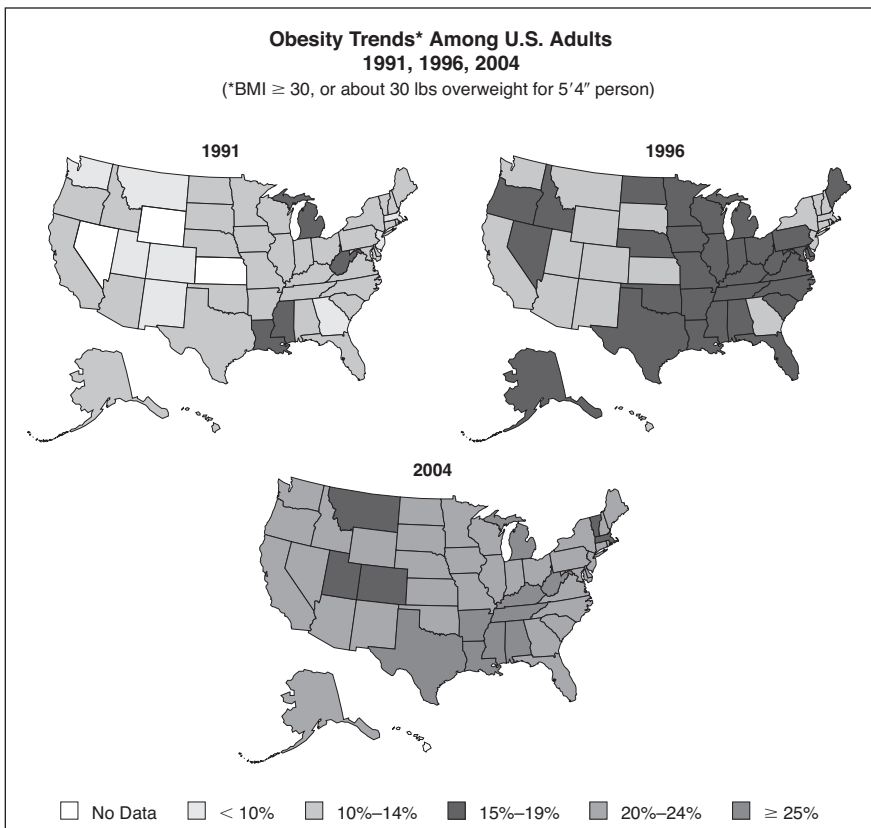


Figure 2.2 *Obesity Trends\* Among U.S. Adults 1991, 1996, 2004*

Note: (\*BMI  $\geq$ 30, or about 30 lbs overweight for 5'4" person)

Source: Behavioral Risk Factor Surveillance System, CDC.

*As a society, we can no longer afford to make poor health choices such as being physically inactive and eating an unhealthy diet; these choices have led to a tremendous obesity epidemic. As policy makers and health professionals, we must embrace small steps toward coordinated policy and environmental changes that will help Americans live longer, better, healthier lives.*

—Vice Admiral Richard H. Carmona,  
MD, MPH, FACS, US Surgeon General

## Sample Healthy People 2010 Objectives for Overweight and Obesity

### 19-2. Reduce the proportion of adults who are obese.

**Target:** 15 percent.

**Baseline:** 23 percent of adults aged 20 years and older were identified as obese (defined as a BMI of 30 or more) in 1988–94 (age adjusted to the year 2000 standard population).

### 19-3. Reduce the proportion of children and adolescents who are overweight or obese.

**Target and baseline:**

Objective	Reduction in Overweight or Obese Children and Adolescents*	1988–94	2010
		Baseline	Target
		Percent	
19-3a.	Children aged 6 to 11 years	11	5
19-3b.	Adolescents aged 12 to 19 years	11	5
19-3c.	Children and adolescents aged 6 to 19 years	11	5

\*Defined as at or above the gender- and age-specific 95th percentile of BMI based on the revised CDC Growth Charts for the United States.

## Tobacco Use

*For thy sake, tobacco, I would do anything but die.*

Charles Lamb, English Critic, Poet and Essayist (1775–1834)

Tobacco is the second major cause of death in the world. It is currently responsible for the death of one in ten adults worldwide, about 5 million deaths each year. If current smoking patterns continue, it will cause some 10

million deaths each year by 2020. Half the people that smoke today—that is about 650 million people—will eventually be killed by tobacco (WHO, 2005b). In spite of decades of Surgeon General warnings on every package of cigarettes, tobacco use remains the leading preventable cause of death in the United States, causing more than 400,000 deaths every year in this country. Each year, smoking kills more people than AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires—combined! Approximately 80% of adult smokers started smoking before the age of 18. Every day, nearly 3,000 young people under the age of 18 become regular smokers. More than 5 million children living today will die prematurely because of a decision they will make as adolescents—the decision to smoke cigarettes. Though 30% of Americans over age 12 still smoke, the trend with tobacco use continues to be good; rates keep coming down. The rate of lifetime cigarette use among youth ages 12 to 17 declined from 37% in 2001 to 33% in 2002. Since 1980, when girls' smoking caught up with boys', the two sexes have smoked at nearly the same rates. The rate of teen youth who smoke daily is going down, from 11% in 2001 to 8% in 2002 (SAMHSA, 2003). Cigarette smoke contains roughly 4,000 chemicals, including 200 known poisons of which 43 are carcinogenic (cancer causing). Smoking remains the leading cause of preventable death and has negative health impacts on people at all stages of life. It harms unborn babies, infants, children, adolescents, adults, and seniors.

Coronary heart disease and stroke—the primary types of cardiovascular disease caused by smoking—are the first and third leading causes of death in the United States. Smoking causes coronary heart disease, the leading cause of death in the United States. In 2003, an estimated 1.1 million Americans had a new or recurrent coronary attack. Cigarette smoking has been associated with sudden cardiac death of all types in both men and women (Surgeon General, 2004a).

Lung cancer is the leading cause of cancer death, and cigarette smoking causes most cases. Compared to nonsmokers, men who smoke are about 23 times more likely to develop lung cancer and women who smoke are about 13 times more likely. Smoking causes about 90% of lung cancer deaths in men and almost 80% in women. In 2003, an estimated 171,900 new cases of lung cancer occurred and approximately 157,200 people died from lung cancer. The 2004 Surgeon General's report adds more evidence to previous conclusions that smoking causes cancers of the oral cavity, pharynx, larynx, esophagus, lung, and bladder (Surgeon General, 2004a). Even environmental tobacco smoke (ETS) or secondhand smoke, has been designated a class-A carcinogen (a substance or agent producing cancer) by the US Environmental Protection Agency, comparable to asbestos (EPA, 1993).

In 2001, chronic obstructive pulmonary disease (COPD) was the fourth leading cause of death in the United States, resulting in more than 118,000 deaths. More than 90% of these deaths were attributed to smoking. Accord-

ing to the American Cancer Society's second Cancer Prevention Study, female smokers were nearly 13 times as likely to die from COPD as women who had never smoked. Male smokers were nearly 12 times as likely to die from COPD as men who had never smoked. Roughly, 10 million people in the United States have been diagnosed with COPD, which includes chronic bronchitis and emphysema. COPD is consistently among the top 10 most common chronic health conditions in women (Surgeon General, 2004a).

While regulations on smoking limit some exposure to Environmental Tobacco Smoke (ETS) in the United States, the problem continues around the globe. Smoking rates are still high in most European countries, exposing more than 50% of all children to ETS in some areas. Young children's exposure to ETS occurs mainly in the home, but also in other indoor environments (for example, vehicles, schools, and other public places). Rising smoking rates among children and teenagers in many countries and a decrease in the age of onset are additional reasons for concern. The World Health Organization issued a summary of the proven health effects of exposure to ETS, including respiratory problems; irritation of eyes, nose, and throat; and lung cancer. A person in a smoke-filled room for 8 hours a day smokes the equivalent of one cigarette each hour. The nonsmoking spouse of a smoker has a 30% greater risk of lung cancer compared to spouses of non-smokers. Exposure to ETS is a serious health threat to children. Compared to children of nonsmokers, children exposed to high levels of ETS have a much higher risk of upper respiratory infection, pneumonia, bronchitis, asthma, reduced hearing (middle-ear effusion), ear infections, and long-term lung damage. Children and adolescents who smoke are less physically fit and have more respiratory illnesses than their nonsmoking peers. In general, smokers' lung function declines faster than that of nonsmokers (WHO, 2005b).

## Sample Healthy People 2010 Objectives for Tobacco:

### 27-1. Reduce tobacco use by adults.

#### Target and baseline:

Objective	Reduction in Tobacco Use by Adults Aged 18 Years and Older	1988	2010
		Baseline	Target
		<i>Percent</i>	
<b>27-1a.</b>	Cigarette smoking	24	12
<b>27-1b.</b>	Spit tobacco	2.6	0.4
<b>27-1c.</b>	Cigars	2.5	1.2
<b>27-1d.</b>	Other products	Developmental	

\*Age adjusted to the year 2000 standard population.

## Substance Abuse

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*If we burn ourselves out with drugs or alcohol,  
we won't have long to go in this business.*

John Belushi (1949–1982), *Playboy* Interview, May 1977

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John Belushi, one of the original comedians on *Saturday Night Live*, died from a lethal combination of drugs and alcohol. His death is one of many tragic losses due to substance abuse. Substance abuse problems, both those of individuals and communities at large, impose a staggering burden on the people and resources in our nation. Drug and alcohol abuse and dependence affect individuals of all ages, from all geographic areas, and all ethnicities, education, and employment levels. Alcohol or drug abuse occurs when individuals repeatedly drink or use drugs even though it causes significant problems in their lives. If the substance abuse continues, it can lead to dependence—a physical and emotional addiction to alcohol or drugs. In 2002, an estimated 22 million Americans suffered from substance dependence or abuse, according to the newest results of the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2002 National Survey on Drug Use and Health, or NSDUH (formerly called the National Household Survey on Drug Abuse). The primary source of statistics on substance abuse in the United States, NSDUH is based on 68,126 interviews nationwide. Other new NSDUH findings include the following:

- Abuse of pain relievers and stimulants otherwise used legitimately as medicine continues to be one of the few classes of drug abuse that is rising. Four times as many people have begun to abuse pain relievers in 2001 (2.4 million) as did in 1990 (628,000).
- African-Americans and whites abuse substances at about the same rate (9.5 and 9.3%, respectively). Fourteen percent of Native Americans (the highest rate), 4 percent of Asian Americans (the lowest), and 10 percent of Hispanic Americans abuse substances.
- Of those youth whose parents “strongly” disapprove of marijuana use, only 5.5 percent had used it in the past month; of those whose parents disapproved somewhat or were indifferent, 30 percent were past month marijuana smokers.

Marijuana continues to be the most widely used illicit drug, though youth 12 to 17 who had *ever* tried it declined slightly (from 22% in 2001 to 21% in 2002). Unfortunately, in the college-to-young adult bracket (18 to 25) the rate of those who have *ever* tried marijuana has been increasing for almost a decade.

In 2002, the rate (53.8%) reached its highest level since 1982 (54.4%). At the same time, only 6% of the population over 12 years of age were “current” marijuana smokers (used in the past month). A marked increase in use of hallucinogens from 1992 to 2002 (14% to 24%) among youth 18–25 appears driven by the popularity of ecstasy (MDMA). At the same time, new use of LSD, which like ecstasy is an extremely toxic hallucinogen, has dropped precipitously (33%) in only one year (2000 to 2001). Lifetime use of pain relievers non-medically by youth ages 12 to 17 increased from 9.6% in 2001, to 11.2% in 2002, a 10-fold increase in a little over a decade (from 1.2% in 1989).

An estimated 120 million Americans reported being current drinkers (drank in the past month). About 23% of Americans report binge-drink (5 or more drinks at a sitting) at least once in the 30 days prior to completing the NSDUH survey. Seven percent of Americans are classified as heavy drinkers (binge drinking on 5 different days in the past month). In the 12 to 20 age bracket, 29% are current drinkers and 19 percent binge drinkers. Current drinking rates increase exponentially as students get older: 20% at age 15, 29% at 16, and 36% at 17.

In 2002, nearly 8% of Americans 12 and over needed treatment for a serious alcohol problem, and 3% needed treatment for a diagnosable drug problem. Yet less than half with a drug problem got treatment, and less than one fifth with a drinking problem sought treatment (SAMHSA, 2003). Science has proven that the abuse of alcohol and alcohol dependency can adversely affect physical and mental health, both in the individual who drinks, and those around them.

- **Accidents**—Alcohol-related motor vehicle crashes kill someone every 30 minutes and injure someone every 2 minutes. Forty-one percent of all traffic-related deaths are alcohol related. In 2002, the National Highway Traffic Safety Administration reported arrests of about 1.5 million drivers for driving under the influence of alcohol or narcotics (NHTSA, 2004). That’s slightly more than one percent of the 120 million self-reported episodes of alcohol-impaired driving among U.S. adults each year (Dellinger, et al., 1999) with 17,419 of those episodes resulting in death in 2002. Though there is significant progress to reduce drunk driving since the 1980s, the number of alcohol-related fatalities is again trending upward.
- **Violence**—Perpetrators of family violence are often using alcohol or drugs when they lash out at their victims.
- **Increase in birth defects**—Alcohol can have a number of harmful effects on a baby, including mental retardation, and learning and behavioral problems.
- **Drinking-related medical conditions**—Those who are alcohol dependent run a higher risk of liver disease, and various forms of cancer, including breast cancer. They are also more likely to be injured by falling.

## Sample Healthy People 2010 Objectives for Substance Abuse

### **26-10. Reduce past-month use of illicit substances.**

**26-10a.** Increase the proportion of adolescents not using alcohol or any illicit drugs during the past 30 days.

**Target:** 89 percent.

**Baseline:** 79 percent of adolescents aged 12 to 17 years reported no alcohol or illicit drug use in the past 30 days in 1998.

**26-10b.** Reduce the proportion of adolescents reporting use of marijuana during the past 30 days.

**Target:** 0.7 percent.

**Baseline:** 8.3 percent of adolescents aged 12 to 17 years reported marijuana use in the past 30 days in 1998.

**26-10c.** Reduce the proportion of adults using any illicit drug during the past 30 days.

**Target:** 2.0 percent.

**Baseline:** 5.8 percent of adults aged 18 years and older used any illicit drug during the past 30 days in 1998.

## Responsible Sexual Behavior

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*In America sex is an obsession; in other parts of the world it is a fact.*

Marlene Dietrich, Actor (1901–1992)

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Sexual intercourse is the most powerful of human behaviors. In the same instant, intercourse can start a new life (pregnancy) and begin a deadly disease (HIV/AIDS). Five of the ten most commonly reported infectious diseases in the United States are sexually transmitted diseases. Nearly one-half of all pregnancies in the United States are unintended. Unintended pregnancy is not only medically costly, it is also socially costly in terms of out-of-wedlock births, reduced educational attainment and employment opportunity, increased welfare dependency, and later child abuse and neglect (Surgeon General, 2004b).

Teen pregnancy and birth rates have declined steadily in the United States in recent years. Despite these declines, the United States continues to have the highest teen birth rate among all industrialized nations and a higher teen birth rate than over 50 developing nations. Experts attribute the declining rates to a substantial increase in contraceptive use by sexually active teens and to a decrease in sexual activity among adolescents. Yet, millions of American youth

are still engaging in behaviors that put them at risk for unintended pregnancy and sexually transmitted infections (STIs), including HIV. Each year in the United States, about 900,000 adolescent females become pregnant, 20,000 young people are newly infected with HIV, and nearly four million new STI infections occur among 15- to 19-year-olds (Advocates for Youth, 2005).

## Sample Healthy People 2010 Objectives for Responsible Sexual Behavior

### 13-6. Increase the proportion of sexually active persons who use condoms.

#### Target and baseline:

Objective	Increase in Sexually Active Persons Using Condoms	1995	2010
		Baseline	Target
13-6a.	Females aged 18 to 44 years	23	50
13-6b.	Males aged 18 to 49 years	Developmental	

**Target-setting method:** Better than the best.

**Data source:** National Survey of Family Growth (NSFG), CDC, NCHS.

### 25-11. Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.

**Target:** 95 percent.

**Baseline:** 85 percent of adolescents in grades 9 through 12 abstained from sexual intercourse or used condoms in 1999 (50 percent had never had intercourse; 14 percent had intercourse but not in the past 3 months; and 21 percent currently were sexually active and used a condom at last intercourse).

## Mental Health

*A crust eaten in peace is better than a banquet partaken in anxiety.*

Aesop (620 BC–560 BC), *The Town Mouse and the Country Mouse*

Mental health influences the ways individuals look at themselves, their lives, and others in their lives. Like physical health, mental health is important at every stage of life. According to the World Health Organization, 450

million people worldwide are affected by mental, neurological, or behavioral problems at any time. About 873,000 people die by suicide every year. Mental illnesses are common to all countries and cause immense suffering. People with these disorders may be subject to social isolation, poor quality of life, and increased mortality. These disorders are the cause of staggering economic and social costs. Mental illnesses affect and are affected by chronic conditions such as cancer, heart and cardiovascular diseases, diabetes, and HIV/AIDS. Untreated, they bring about unhealthy behavior, non-compliance with prescribed medical regimens, diminished immune functioning, and poor prognosis. Cost-effective treatments exist for most disorders and, if correctly applied, could enable most of those affected to become functioning members of society. Barriers to effective treatment of mental illness include lack of recognition of the seriousness of mental illness and lack of understanding about the benefits of services. In addition, the stigma attached to mental illness, and to the people who have it, is a major obstacle to better care and to the improvement of the quality of their lives. Policy makers, insurance companies, health and labor policies, and the public at large all discriminate between physical and mental problems (WHO, 2005a).

The National Institute of Mental Health (NIMH) states “the burden of psychiatric conditions has been heavily underestimated.” Mental illness, including suicide, accounts for over 15% of the burden of disease in established market economies, such as the United States. This is more than the disease burden caused by all cancers. This measure is called Disability Adjusted Life Years (DALYs). DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of this measure is weighted for severity of the disability. For example, disability caused by major depression was found to be equivalent to blindness or paraplegia, whereas active psychosis seen in schizophrenia produces disability equal to quadriplegia. Using the DALYs measure, major depression ranked second only to ischemic heart disease in magnitude of disease burden in established market economies. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contributed significantly to the total burden of illness attributable to mental disorders (NIMH, 2005). Mental illness clearly has a negative impact on quality of life.

## Sample Healthy People 2010 Objective for Mental Health

### 18-9. Increase the proportion of adults with mental disorders who receive treatment.

#### Target and baseline:

Objective	Increase in Adults with Mental Disorders Receiving Treatment	1997	2010
		Baseline (unless noted) Percent	Target
18-9a.	Adults aged 18 to 54 years with serious mental illness	47 (1991)	55
18-9b.	Adults aged 18 years and older with recognized depression	23	50
18-9c.	Adults aged 18 years and older with schizophrenia	60 (1984)	75
18-9d.	Adults aged 18 years and older with generalized anxiety disorder	38	50

## Injury and Violence

*We live in a time when the words impossible and unsolvable are no longer part of the scientific community's vocabulary. Each day we move closer to trials that will not just minimize the symptoms of disease and injury but eliminate them.*

Christopher Reeve, Actor (1952–2004),  
1999 Testimony to US House of Representatives

Christopher Reeve, the actor perhaps best known for portraying Superman on the big screen, suffered permanent disability after a horseback riding injury. Injuries and violence can affect everyone, even “Superman.” Some injuries, however, disproportionately affect different groups of individuals. The following is a look at how injuries affect different groups of Americans and what the CDC is doing to address them (NCIPC, 2002).

Males are at higher risk for motor vehicle crashes, falls, drowning, and homicide. Several factors may account for these differences. For instance, males are more likely than females to engage in behaviors that put them at

risk, such as driving or boating after drinking alcohol, failing to wear seat belts, participating in potentially dangerous sports and leisure activities, and perpetrating violent acts.

The injury rate for African-Americans is higher than that for nearly all other racial and ethnic groups. This disparity may be due in part to the fact that a greater percentage of African-Americans have lower education levels and higher poverty levels. Such characteristics may increase risk for injury. They are clearly associated with higher pedestrian fatality rates and higher fatality rates from residential fires. These factors are also linked to an increase in violence-related injuries and deaths.

Overall, the injury rate for Hispanic Americans is lower than for non-Hispanics. However, for some injury problems, Hispanics are at a higher risk than other racial or ethnic groups. Among this group, pedestrian fatalities are nearly twice as high as for whites. One possible explanation is that Hispanics make 55% more walking trips than do non-Hispanics. This difference may be attributable to a lower vehicle ownership rate among Hispanics. Hispanic youth are at higher risk than whites for injuries resulting from violence. This disparity may be due in part to the fact that a greater percentage of Hispanic Americans have lower education levels and higher poverty levels. Such characteristics, along with family disruption and weak intergenerational ties in families and communities, may increase risk for violent behavior.

Native Americans and Alaska Natives are at higher risk for several types of injuries, both unintentional and violence-related. This group has a higher rate than many racial and ethnic groups for injuries resulting from fires in their homes. This disparity may be attributable to a higher percentage of Native Americans and Alaska Natives living in rural areas and in manufactured housing, a known risk for fire-related injuries and deaths. Teens and young adults among this racial group are at increased risk for suicide. This higher risk may be due to several factors, including limited availability of employment and educational opportunities, alcohol use among this population, and loss of traditional spiritual practices and indigenous languages.

Infants and young children are also at greater risk for many injuries. This increased risk may be attributable to many factors. Children are curious and like to explore their environment. This characteristic may lead children to sample the pills in the medicine cabinet, play with matches, or venture into the family pool. Young children have limited physical coordination and cognitive abilities, leading to a greater risk for falls from bicycles and playground equipment and may make it difficult for them to escape from a fire. Their small size and developing bones and muscles may make them more susceptible to injury in car crashes if they are not properly restrained.

## Sample Healthy People 2010 Objective for Injury and Violence

### 15-15. Reduce deaths caused by motor vehicle crashes.

#### Target and baseline:

Objective	Reduction in Deaths Caused by Motor Vehicle Crashes	1998 Baseline Percent	2010 Target
15-15a.	Deaths per 100,000 population	15.6*	9.2
15-15b.	Deaths per 100 million vehicle miles traveled	1.6	0.8

\*Age adjusted to the year 2000 standard population.

## Environmental Quality

*The environment is everything that isn't me.*

Albert Einstein

Einstein is right; the environment is everything that is not you. Your environment can contribute to health problems. The water you drink, the air you breathe, even the bugs in your home, can influence your health. For example, the quality of our air, whether indoors or outdoors, affects everyone. The National Center for Environmental Health at the Centers for Disease Control and Prevention strives to promote health and quality of life by preventing or controlling those diseases or deaths that result from interactions between people and their environment. The Air Pollution and Respiratory Health Program of the National Center for Environmental Health leads CDC's fight against environmental-related respiratory illnesses, including asthma, and studies indoor and outdoor air pollution. Research-based intervention conducted in partnership with international, national, and local partners is applied to CDC's work in preventing carbon monoxide poisoning, studying the health effects of exposure to forest fire smoke, battling chronic obstructive pulmonary disease, and investigating human health effects of mold exposure. One health-related outcome related to air quality is chronic obstructive pulmonary disease, or COPD, which refers to a group of diseases that cause airflow blockage and breathing-related problems. It includes emphysema, chronic bronchitis, and in some cases asthma. COPD is a leading cause of death, illness, and disability in the United States. In 2000, COPD was responsible for 119,000 deaths, 726,000 hospitalizations, and 1.5 million hospital emergency department visits.

An additional 8 million cases of hospital outpatient treatment or treatment by personal physicians were linked to COPD in 2000. In the United States, tobacco use is a key factor in the development and progression of COPD, but asthma, exposure to air pollutants in the home and workplace, genetic factors, and respiratory infections play a role. In the developing world, indoor air quality is thought to play a larger role in the development and progression of COPD than it does in the United States.

## Sample Healthy People Objectives for Environmental Air Quality

**8-1. Reduce the proportion of persons exposed to air that does not meet the US Environmental Protection Agency's health-based standards for harmful air pollutants.**

**Target and baseline:**

Objective	Reduction in Air Pollutants	1997	2010
		Baseline	Target
		<i>Percent</i>	
<b>8-1a.</b>	Ozone*	43	0
<b>8-1b.</b>	Particulate matter*	12	0
<b>8-1c.</b>	Carbon monoxide	19	0
<b>8-1d.</b>	Nitrogen dioxide	5	0
<b>8-1e.</b>	Sulfur dioxide	2	0
<b>8-1f.</b>	Lead	<1	0
		<i>Number</i>	
<b>8-1g.</b>	Total number of people	119,803,000	0

\*The targets of zero percent for ozone and particulate matter are set for 2012 and 2018, respectively.

**27-10. Reduce the proportion of nonsmokers exposed to environmental tobacco smoke.**

**Target:** 45 percent.

**Baseline:** 65 percent of nonsmokers aged 4 years and older had a serum cotinine level above 0.10 ng/mL in 1988–94 (age adjusted to the year 2000 standard population).

**Target-setting method:** Better than the best.

**Data source:** National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

## Immunization

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*AIDS is a disease that is hard to talk about. The ideal thing would be to have a 100 percent effective AIDS vaccine.*

Bill Gates

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Thanks to support from individuals like Bill Gates, researchers may one day find a vaccine for AIDS. While this is not yet available, there are many immunizations used to prevent life-threatening diseases across the lifespan. Vaccination (Latin: *vacca*—cow) is so named because the first vaccine was derived from a virus affecting cows—the cowpox virus—a relatively benign virus that, in its weakened form, provides a degree of immunity to smallpox, a contagious disease that is sometimes deadly to humans. “Vaccination” and “immunization” generally have the same meaning. The process of triggering immune response, in an effort to protect against infectious disease, works by “priming” the immune system with an “immunogen.” Stimulating immune response, via use of an infectious agent, is known as *immunization*. Vaccinations involve the administration of one or more immunogens, in the form of live, but weakened, infectious agents. These agents normally are derived from either weaker, but closely related, species (as with smallpox and cowpox), or strains weakened by some process. In such cases, an immunogen is called a *vaccine*.

In recent years, the Centers for Disease Control and Prevention (CDC) announced that the nation’s childhood immunization rates continue at record high levels, with about 81% of the nation’s 19-to-35-month-old children receiving all the vaccinations in the recommended series. This is the first time that coverage for the baseline series of vaccines in children has exceeded 80%, which also represents the Healthy People 2010 goal. Vaccines are not just for kids. Far too many adults become ill, disabled, or die each year from diseases easily prevented by vaccines. Thus, everyone, from young adults to senior citizens, can benefit from immunizations.

### *Vaccine-preventable adult diseases:*

- Diphtheria
- Haemophilus influenzae type b (Hib)
- Hepatitis A
- Hepatitis B
- Influenza (flu)

- Measles
- Mumps
- Pneumococcus
- Polio
- Rubella (German measles)
- Tetanus (lockjaw)
- Varicella\* (chicken pox)

\*You do *not* need the varicella vaccine if you have a reliable history of having had chicken pox.

*Vaccines needed for teenagers and college students:*

- Varicella (chicken pox) vaccine
- Hepatitis B vaccine
- Measles-Mumps-Rubella (MMR) vaccine
- Tetanus-Diphtheria vaccine
- Meningococcus vaccine

*Children's vaccine-preventable diseases:*

- Diphtheria
- Hepatitis A
- Hepatitis B
- Haemophilus influenzae type b (Hib)
- Influenza (flu)
- Measles
- Mumps
- Pertussis
- Pneumococcal
- Polio
- Rubella (German measles)
- Tetanus (lockjaw)
- Varicella (chicken pox)

## Sample Healthy People 2010 Objectives for Immunization

**14-24. Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years.**

**Target and baseline:**

Objective	Increase in Coverage Levels of Universally Recommended Vaccines	1998 Baseline Percent	2010 Target
<b>14-24a.</b>	Children aged 19 to 35 months who receive the recommended vaccines (4DTaP, 3 polio, 1 MMR, 3 Hib, 3 hep B)	73	80
<b>14-24b.</b>	Adolescents aged 13 to 15 years who receive the recommended vaccines	Developmental	

**14-29. Increase the proportion of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.**

**Target and baseline:**

Objective	Increase in Adults Vaccinated	1998 Baseline* (unless noted) Percent	2010 Target
<b>Noninstitutionalized adults aged 65 years and older</b>			
<b>14-29a.</b>	Influenza vaccine	64	90
<b>14-29b.</b>	Pneumococcal vaccine	46	90
<b>Noninstitutionalized high-risk adults aged 18 to 64 years</b>			
<b>14-29c.</b>	Influenza vaccine	26	60
<b>14-29d.</b>	Pneumococcal vaccine	13	60
<b>Institutionalized adults (persons in long-term care or nursing homes)<sup>†</sup></b>			
<b>14-29e.</b>	Influenza vaccine	59 (1997)	90
<b>14-29f.</b>	Pneumococcal vaccine	25 (1997)	90

\*Age adjusted to the year 2000 standard population.

<sup>†</sup>National Nursing Home Survey estimates include a significant number of residents who have an unknown vaccination status. See *Tracking Healthy People 2010* for further discussion of the data issues.

## Access to Health Care

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*The health care system is really designed to reward you for being unhealthy. If you are a healthy person and work hard to be healthy, there are no benefits.*

Mike Huckabee, Governor of Arkansas

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The debate about improving access to health care continues to rage on in conference rooms and living rooms across the nation. All the wonderful advances in primary, secondary, and tertiary prevention have little benefit to those individuals with no resources to access or pay for those services. The Census Bureau reported that 45 million Americans lacked health insurance in 2003, up by 1.4 million from 2002 and 5.2 million from 2000.

A combination of factors—including America's liability crisis and a decrease in employment-based health insurance coverage—has contributed to the increase in the number of uninsured. Medical liability is a legal practice to regulate and reduce medical malpractice, which is an act or omission by a healthcare provider which deviates from accepted standards of practice in the medical community, causing injury to the patient. The nation's medical liability crisis affects every patient and physician in some way. The cost of litigation per person in the United States is higher than any other major industrialized nation in the world. Skyrocketing medical liability premiums are forcing some physicians to limit services, retire early, or move to a state with reforms where premiums are more stable. The crisis is threatening access to care for patients in states without liability reforms. The cost of medical liability insurance for healthcare providers, then passed onto patients, escalates the cost for medical care, thus making health insurance more expensive. Higher insurance rates force some companies to stop offering or limit the health insurance benefits they provide for employees. In 2005, President Bush proposed a need for common-sense medical liability reform to make health care more affordable and accessible for all Americans, and to keep necessary services in communities that need them the most.

The percentage of people covered by government health insurance programs rose in 2003, from 25.7% to 26.6%, largely as the result of increases in Medicaid and Medicare coverage. Medicaid is the largest source of government funding for medical and health-related services for people with limited income. Medicare is publicly funded health insurance for the elderly and disabled only. Medicaid coverage rose 0.7 percentage points to 12.4% in 2003, and Medicare coverage increased 0.2 percentage points to 13.7%. The proportion of uninsured children did not change in 2003, remaining at 11.4%

of all children, or 8.4 million. Studies about access to care include the uninsured and those with low incomes as well as racial and ethnic minorities and people with chronic conditions.

## Sample Healthy People 2010 Objectives for Access to Health Care

### 1-1. Increase the proportion of persons with health insurance.

**Target:** 100 percent.

**Baseline:** 83% of persons under age 65 years were covered by health insurance in 1997 (age adjusted to the year 2000 standard population).

**Target-setting method:** Total coverage.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS.

### 1-4. Increase the proportion of persons who have a specific source of ongoing care.

**Target and baseline:**

Objective	Increase in Specific Source of Ongoing Care	1998	2010
		Baseline*	Target
		Percent	
1-4a.	All ages	87	96
1-4b.	Children and youth aged 17 years and under	93	97
1-4c.	Adults aged 18 years and older	85	96

\*Age adjusted to the year 2000 standard population.

**Target-setting method:** Better than the best.

**Data source:** National Health Interview Survey (NHIS), CDC, NCHS.

### 16-6. Increase the proportion of pregnant women who receive early and adequate prenatal care.

**Target and baseline:**

Objective	Increase in Maternal Prenatal Care	1998	2010
		Baseline	Target
		Percent of Live Births	
16-6a.	Care beginning in first trimester of pregnancy	83	90
16-6b.	Early and adequate prenatal care	74	90

**Target-setting method:** Better than the best.

## SUMMARY

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The 20th century brought remarkable and unprecedented improvements in the lives of the people of the United States. In spite of the dramatic increase in life expectancy seen in the last century, all members of our society do not equally enjoy the benefits of modern medicine, both in the United States and around the world. The discrepancies in health status noted between genders, races, ethnic groups, and socioeconomic groups continue to separate citizens within this country. Developed with the best scientific knowledge available, Healthy People 2010 is a comprehensive set of disease-prevention and health-promotion objectives for America. It reflects the best in public health planning and provides a comprehensive picture of the nation's health at the beginning of the decade, establishes goals and targets to achieve, and monitors national progress over time. Healthy People 2010 challenges all of us—individuals, communities, and healthcare professionals—to take steps to enjoy good health and a long life.

## ADDITIONAL RESOURCES

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### General

US Department of Health and Human Services  
240-453-8280  
<http://odphp.osophs.dhhs.gov/>

### Physical Activity

President's Council on Physical Fitness and Sports  
202-690-9000  
<http://www.fitness.gov>

Centers for Disease Control and Prevention (CDC)  
888-232-3228  
<http://www.cdc.gov/nccdphp/dnpa>

### Overweight and Obesity

Obesity Education Initiative, National Heart, Lung, and Blood Institute  
Information Center  
301-592-8573  
<http://www.nhlbi.nih.gov/about/oei/index.htm>

The Weight-Control Information Network  
National Institutes of Health (NIH)  
877-946-4627  
<http://www.niddk.nih.gov/health/nutrit/win.htm>

## Tobacco Use

Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC  
800-CDC-1311  
<http://www.cdc.gov/tobacco>

Cancer Information Service, NIH  
800-4-CANCER  
<http://cis.nci.nih.gov>

## Substance Abuse

National Clearinghouse for Alcohol and Drug Information Substance Abuse and Mental Health Services Administration (SAMHSA)  
800-729-6686; 800-487-4889 (TDD)  
<http://www.health.org>

National Institute on Drug Abuse, NIH  
301-443-1124  
<http://www.nida.nih.gov>

National Institute on Alcohol Abuse and Alcoholism, NIH  
301-443-3860  
<http://www.niaaa.nih.gov>

## Responsible Sexual Behavior

CDC National AIDS Hotline  
800-342-AIDS (800-342-2437)  
<http://www.cdc.gov/hiv/hivinfo/nah.htm>

CDC National Sexually Transmitted Diseases (STD) Hotline  
800-227-8922  
<http://www.cdc.gov/nchstp/std/dstdp.html>

CDC National Prevention Information Network  
800-458-5231  
<http://www.cdcnpin.org>

Office of Population Affairs  
301-654-6190  
<http://opa.osophs.dhhs.gov>

## Mental Health

Center for Mental Health Services, SAMHSA  
<http://www.mentalhealth.org/cmhs/index.htm>

National Mental Health Information Center, SAMHSA  
800-789-2647  
<http://www.mentalhealth.org>

National Institute of Mental Health Information Line, NIH  
800-421-4211  
<http://www.nimh.nih.gov/publicat/depressionmenu.cfm>

## Injury and Violence

National Center for Injury Prevention and Control, CDC  
770-488-1506  
<http://www.cdc.gov/ncipc/ncipc.htm>

Office of Justice Programs, U.S. Department of Justice  
202-307-0703  
<http://www.ojp.usdoj.gov/home.htm>

National Highway Traffic Safety Administration  
US Department of Transportation  
Auto Safety Hotline 888-DASH-2-DOT (888-327-4236)  
<http://www.nhtsa.dot.gov/hotline>

## Environmental Quality

Indoor Air Quality Information Clearinghouse  
US Environmental Protection Agency  
800-438-4318 (IAQ hotline)  
800-SALUD-12; (725-8312) Spanish  
<http://www.epa.gov/iaq/iaqinfo.html>

Information Resources Center (IRC)  
US Environmental Protection Agency  
202-260-5922  
<http://www.epa.gov/natlibra/hqirc/about.htm>

Agency for Toxic Substances and Disease Registry, CDC  
888-442-8737  
<http://www.atsdr.cdc.gov>

## Immunization

National Immunization Program/CDC  
800-232-2522 (English); 800-232-0233 (Spanish)  
888-CDC-FAXX (Fax-back)  
<http://www.cdc.gov/nip>

## Access to Health Care

Agency for Healthcare Research and Quality  
Office of Healthcare Information  
301-594-1364  
<http://www.ahrq.gov/consumer/index.html#plans>

”Insure Kids Now” Initiative  
Health Resources and Services Administration  
877-KIDS NOW (877-543-7669)  
<http://www.insurekidsnow.gov>

Maternal and Child Health Bureau  
Health Resources and Services Administration  
1-888-ASK-HRSA (HRSA Information Center)  
<http://www.mchb.hrsa.gov>

Office of Beneficiary Relations  
Centers for Medicare & Medicaid Services  
800-444-4606 (customer service center)  
800-MED-ICARE (Info Line)  
<http://www.Medicare.gov>

## OTHER RESOURCES

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**For more health promotion and disease prevention information:**

Search online for thousands of free federal health documents using healthfinder® at <http://www.healthfinder.gov/>

**For health promotion and disease prevention information in Spanish:**

Visit <http://www.healthfinder.gov/espanol/>

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