The U.S. Healthy People Initiative: Its Genesis and Its Sustainability

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Keywords
policy, health promotion, disease prevention, health objectives, sustainability, government

Abstract
Unlike most government initiatives in health, the Healthy People initiative of the U.S. federal government was crafted and sustained not as a federal initiative, but as a “national initiative” eliciting participation from nongovernmental national organizations, state health agencies, professional associations, multiple agencies of the U.S. Department of Health and Human Services, and other federal agencies, such as Agriculture, and increasingly engaging academia and state and local stakeholders in adapting the objectives for their own efforts to enact and evaluate state and local policies and programs. The quantified objectives at the center of the initiative were a product of continuous balancing of changing science and political or social concerns and priorities along with national and state or special population needs. The evolution from the first decade’s objectives to each subsequent set of objectives reflected changing societal concerns, evidence-based technologies, theories, and discourses of those decades. Such accommodations changed the contours of the initiative over time in attempts to make it more relevant to specific partners and other stakeholders.
INTRODUCTION

Government initiatives typically have a half-life no greater than the election or appointment cycle of the ranking officials who actively promoted them. Notable exceptions are those initiatives that had very explicit legislative mandates and stable appropriations. This commentary and retrospective celebrates one public health initiative that seems to have defied this governmental gravity and entropy: the Healthy People initiative of the U.S. Department of Health and Human Services (DHHS). In 1979, when it was still the Department of Health, Education, and Welfare (DHEW), it officially launched the initiative with its publication of Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention (39). The Healthy People initiative (http://www.healthypeople.org) has survived three decades and has embarked on its fourth this year with Healthy People 2020.

Other countries, notably in Europe, have pursued similar initiatives since the first decade of the Healthy People initiative demonstrated its feasibility and potential value in galvanizing and focusing support for a common set of objectives and quantifying what had previously been seen as too amorphous and speculative to be made into concrete, long-range targets. The World Health Organization (WHO) maintains a Web site with pages devoted to its Health for All initiative, with objectives, targets, and experiences from countries and its regional offices in other parts of the world (http://www.who.int), but the Healthy People experience is a rare example of U.S. federal government leadership in a health initiative across states and internationally without a compelling legislative mandate or budget, but with demonstrable public health benefits and continued momentum after three decades.

PURPOSE AND SCOPE OF THE REVIEW

We review here some of the major features of this national public health planning and monitoring story, particularly in its launch and first decade, and we speculate on why it has had such staying power and lessons that might be drawn from it for sustaining other public health initiatives or efforts to implement and institutionalize strategic planning processes. We refer to it here as an initiative, which it was when it was conceived and launched in the late 1970s, but it could be seen to have become institutionalized and no longer an initiative as it weathered and reinvented itself in successive administrations and decades. We do not attempt to attribute to the initiative the trends in vital statistics or the successes and failures in risk factor changes of these three decades or to trace specific changes in public health to specific programs or services spawned by the initiative. Nor do we examine the technical processes of setting quantified long-range (decennial) objectives, issues addressed in earlier Annual Review of Public Health papers on the initiative (4, 22), and implementing or tracking them, described elsewhere (8, 13, 20, 22, 27, 29, 36). We focus this review on the initiative’s organizational, developmental, and systems characteristics that attempted (a) to represent multiple sciences and to bridge science and practice; (b) to encourage accountability among parties and lead agencies of the DHHS for progress in relation to specific, quantifiable objectives (28, 36); (c) to engage an ever-widening circle of stakeholders to support, implement, and evaluate the products of the initiative; and (d) to adapt and expand the process, the criteria, and the objectives themselves in each decade to fit the prevailing national discourses of those eras. We reflect on these partly from experience as participants in the launch of the first and fourth decades’ initiatives and partly as participants in implementing and measuring progress on specific objectives at national, state, and local levels in the interim decades.

EARLY HISTORY, CONTEXTS, AND PRECEDENTS OF THE INITIATIVE

The formal release of Healthy People: The Surgeon General’s Report on Health Promotion and
Disease Prevention (39) took place in July 1979 at the request of Joseph Califano, Secretary of the DHEW, who wanted to have it appear under his watch, knowing that he would be gone by the time the final printing was ready. The report was decidedly a home-grown, made-in-America product of a prior decade of federal and collaborating national organizations' work focused on health education and prevention and several years of even more focused work on study documents as background to the Surgeon General's report.

The International Context

What might have made the initiative appear to be a product of international events was its confluence in time with several developments abroad that were related to but not directly influential on the U.S. Healthy People initiative.

On the same day in October 1979 that the World Health Organization announced the virtual eradication of smallpox (with but a few months remaining in the two-year period without a reported case (9)), Julius Richmond, then the U.S. Assistant Secretary for Health and Surgeon General, released the final printing of The Surgeon General's Report (39). The Healthy People initiative was not specifically patterned after the smallpox eradication experience. The confluence of global and national public health events, though fortuitous in its timing, was not entirely unrelated. The major architects for Richmond of the work that produced The Surgeon General's Report and its vision for the longer-range initiative, William Foege and J. Michael McGinnis, had led WHO smallpox eradication efforts respectively at the international and at the state level in India. However, the World Health Organization's global smallpox eradication program provided but one of many examples emerging from the “management by objectives” literature of the previous decade on how important explicit objectives can be, in contrast with the futile and illusory attempt to satisfy the demand for health care without explicit objectives when one recognizes “finite resources and infinite demand” (14). The Surgeon General's Report signaled the intent to pursue a quantitatively objectives-guided approach. It presented a bold ten-year goal for reduction of mortality in each of four broad age groups and morbidity reductions in the elderly. As McGinnis recalls, “when it came to doing an ‘American Lalonde’ report, it seemed natural to me that one of the potentially unique and distinguishing characteristics ought to be the expression of specific goals. The 10-year time frame was simply logical for the sake of convenience, practicality, and politics” (M. McGinnis, personal communication).

Another international context that set the stage for this initiative was the growing recognition—accentuated by the smallpox eradication success—that communicable diseases had declined dramatically in the Western world since the late nineteenth century and accelerated their decline in the early twentieth century. By mid-century, the declining trend line of communicable and infectious disease mortality rates had crossed the rising trend lines for mortality from chronic diseases. That recognition came with growing acknowledgment that very different public health and medical strategies and resources were required. Whole systems of infrastructure, organization, personnel, and allocations of resources that had grown up to cope with acute conditions were deemed by the 1970s to have become anachronistic in their readiness to address the new morbidity and mortality profiles of communities and nations. These included a new set of intentional injury-related problems associated with suicide, homicide, and domestic violence, replacing the trauma associated with declining motor vehicle and occupational injuries, but also included most dramatically the increase in chronic and degenerative diseases.

Buoyed by the success of its global smallpox eradication campaign, in 1978 the World Health Organization and UNICEF convened an international conference of member states at Alma Ata, in what was then the USSR, to look ahead to the next major global challenge (45). A declaration called “Health for All by
the Year 2000” was ratified at the conference and became a major touchstone for defining and guiding the central philosophies and methods of international public health cooperation among nations. The subsequent Health for All series of publications by the WHO (46) included model population health objectives that regional offices of the WHO and member states could emulate. It showed the way for countries to build national management of population health through setting and monitoring population health objectives and targets, but these came out after the United States was already under way with its formulation of quantitative goals for the nation and with model standards for state and local public health agencies.

It would be tempting to view the U.S. Healthy People initiative as a direct descendent of the Alma Ata Declaration because of its timing; however, as seen in the further chronology of the U.S. initiative, it was well under way in 1978. A 1978 Task Force Report was completed by the Institute of Medicine (IOM) (15), commissioned by the Assistant Secretary of Health to provide background documentation to the material in The Surgeon General’s Report and state-of-the-science assessments on each of the age groups and other elements outlined for the report. A more historically accurate characterization of these two initiatives might be that both were inspired by the success of the smallpox eradication experience, and both the WHO and the Centers for Disease Control and Prevention (CDC) had contributed substantially to its development and implementation; the CDC provided some of the epidemiological and public health leadership and staffing in the campaign. Richmond often made reference to Alma Ata because it was so philosophically in tune with his view. But it had virtually nothing to do with the decision to do The Surgeon General’s Report.

A third related international event that we judge in retrospect to have been the only one that was truly influential in setting the stage conceptually, frequently quoted in the various U.S. Task Force reports leading up to the Healthy People report, was the widely acclaimed Lalonde Report issued by the Minister of Health of Canada in 1974. A New Perspective on the Health of Canadians (19) presented a “health field concept” based on a model developed by Laframboise and published a year earlier (18). It sought to break the determinants of health into more meaningful and manageable categories for policy purposes, identifying the four health fields as human biology, environment, lifestyle, and health care organization. It then brought into sharper perspective the relatively small contributions to population health status of medical care relative to the gains possible from behavioral and environmental changes. This document continues to be a touchstone in the international development of the field of health promotion and in what came to be referred to, especially in Europe, as “the new public health” and in North America as “the third epidemiological revolution” (8, 9, 19, 30, 37). It provided a framework for the first decade’s objectives in disease prevention and health promotion. They were divided into three groups: health promotion directed at the lifestyle determinants, health protection directed at the (physical) environmental determinants, and preventive health services directed at the health care organizational and delivery determinants.

U.S. National Contexts

With the global context of communicable disease control as a precondition, the growing costs of health care as a stimulus, and the Canadian Lalonde report as a model for shifting priorities, much was afoot in the early 1970s in American thinking and worrying about chronic diseases as new leading causes of deaths and health care costs. The most immediate contextual factor, then, was the growing awareness of the preventability of deaths from many major chronic diseases, as well as infant mortality. The American discourse on health and investment in it reflected growing interest in prevention and health education as cost-containment and disease-management strategies. These concerns were paired with the lag between
resources going to treatment and resources going to prevention. More important politically than any of the international contexts described above might have been the frequent indviduous comparisons among Western countries showing the United States lagging behind other developed countries on longevity, infant mortality, controlled per capita expenditures on medical care, and other indicators of a health system falling behind those of other nations.

Congress had been frustrated in attempts to reform the health care delivery system following the passage of Medicare and Medicaid in 1965, watching with alarm as medical costs continued to escalate after 35 years of growth. The Congressional investments in basic research had produced dramatic successes with tuberculosis and polio, lobar pneumonia, tertiary syphilis, and several cancers, but they now seemed mainly to be creating technology that accelerated the increasing costs of diagnosis and treatment. These led to a national interest in self-care, spurred in part by the women’s health movement (3) and in part by insurance industry and government explorations of cost-containment strategies in medical care (12). The Assistant Secretary for Planning and Evaluation in DHEW also commissioned a review of the effectiveness and cost-benefit returns of health education (8). Such interests in cost containment were frequently voiced as the justification for pursuing health education and other prevention strategies.

In 1971, Ann Somers published an influential book called Health Care in Transition (35), addressing the spiraling health care cost issues with a refocused analysis on the root causes of the new leading causes of death: heart disease, cancer, stroke, injuries, diabetes, and other lifestyle-related, mostly chronic disease, problems. These root causes she traced to the irresponsibility or inability of poorly prepared individuals. Somers became the chairperson of the Task Force on Health Promotion and Consumer Health Education, one of eight Task Forces of the first federally sponsored analyses of preventive medicine, culminating in a national conference convened at the National Institutes of Health (NIH) in 1975. This and other federally sponsored studies and commissioned reports are examined below for their influence on informing the Healthy People initiative.

Prevention, at least the health education part of it, had already emerged as one potentially low-cost remedy; consequently, a political priority was signaled by the Nixon Administration, with his appointment in 1971 of the President’s Committee on Health Education (34). Their report had recommended the creation of a DHEW focal point to coordinate health education across all federal agencies to make it more effective. In a more prominent recommendation, the Committee devoted an entire section to its proposal for the creation of a National Center for Health Education as a private, nonprofit organization authorized by Congress, financed by federal and private sources, to stimulate, coordinate, and evaluate health education between public and private sectors. The matching of a designated federal focal point with a private, nonprofit national center was greeted by then DHEW Secretary Casper Weinberger with initial resistance, then acquiescence, to a plan calling for the establishment of, first, the National Center for Health Education, contingent upon matching funds from the private sector, and second, the new Bureau of Health Education within the CDC as the federal focal point as well as the staffing of an interagency Health Education Committee for oversight on the coordination of DHEW resources.

The national context soon became textured by the Congressional debates on and passage of the National Health Planning and Resources Development Act of 1974. Among other things, this law called for national health planning goals based on national health priorities. There was a growing interest in, and eventually concerted effort to assure, consistency between national prevention objectives and the national health planning goals. Soon after passing the Health Planning Act, Congress took up the issues that had been addressed by the President’s Committee on Health Education and its extensions in what was increasingly referred to as health
promotion with the passage of Public Law 94–317 (see next section).

In 1976, David J. Sencer, Director of the CDC, noted that the United States had standards for almost everything—including the number of stitches in a baseball’s cover—but there were no generally accepted standards for community preventive health services. The CDC began discussions with the Association of State and Territorial Health Officials, the county and city health officers associations, and the American Public Health Association (APHA), which led to the establishment of a collaborative work group to develop model standards for community-oriented preventive health services. The work group consisted of representatives from each of the associations and from the CDC. Its report was presented to Congress in 1979 (41). It became a template for the process of setting the national objectives for health promotion and disease prevention and provided a bottom-up process complementary to, and mutually supportive of, the national objectives.

The Carter Administration brought Joseph Califano to head the DHEW. His earlier government experience was with the Defense Department in the Kennedy and Johnson Administrations under Robert McNamara. McNamara was famous and infamous for his dedication to “management by objectives.” Califano’s commitments to objective-setting as well as to prevention were driving forces in what became The Surgeon General’s Report and the objectives for the nation in health promotion and disease prevention.

U.S. Public Law 94–317 Creating the Office of Health Information and Health Promotion

The Healthy People initiative had two significant legislative statutes to support its development. The passage of the National Health Planning and Resources Development Act of 1974 directed the Secretary of the DHEW to develop national health planning goals based on national health priorities, and Public Law 94–317 (Title XVII, Sec. 1701) in 1976 provided a mandate for the Secretary of the DHEW to formulate national goals, and a strategy to achieve such goals, with respect to health information and health promotion, preventive health services, and education in the appropriate use of health care. The latter also provided in Sec. 1706 for the creation, within the Office of the Assistant Secretary of Health, of the Office of Health Information and Health Promotion (OHIP). Two of its stipulated functions were to coordinate all activities within the Department which relate to health information and health promotion, preventive health services, and education in the appropriate use of health care and to coordinate its activities with similar activities of organizations in the private sector (PL 94–317).

These mandates were clearly aligned with major recommendations of the President’s Committee on Health Education, although they expanded the scope to include preventive health services. Health promotion was also taking on an expanded scope beyond consumer health education, although its definition was in flux during this period in the history of health promotion. Indeed, the terms health promotion and health information in the legislation were said to have been inserted in place of health education to avoid having the bill referred to the Congressional education committee, where it would have had to compete for attention with bills dealing with controversies surrounding the creation of the Department of Education and the funding of schools. It was also part of the adjustment of language in response to a contention of the Office of Management and Budget (OMB) that the term health education in the title was superfluous (44). The President quietly signed the bill on June 23, 1976, without a signing ceremony, without press, and without Congressional attendance.

Theodore Cooper established the OHIP in his Office of the Assistant Secretary of Health, but with the impending inauguration and arrival of a new Administration, he would assign an Acting Director. Cooper was a staunch supporter of prevention, having served as
Director of the National Heart, Lung, and Blood Institute at the NIH, which had proved itself one of the most prevention-oriented of the Institutes, especially with its National High Blood Pressure Education campaign. As Assistant Secretary of Health, his 1976 Forward Plan for Health, FY 1978–1982, made prevention its second highest priority after cost. In 1979, a director of the OHIP was appointed by Richmond, the new Assistant Secretary of Health. The OHIP was soon expanded to encompass the President’s Council on Physical Fitness and Sports Medicine, with a mere $1 million budget. It functioned, as required by the law, within the Office of the Assistant Secretary of Health, but under the Office of the Deputy Assistant Secretary for Disease Prevention and Health Promotion, the position held by Michael McGinnis. Eventually, the enabling legislation was amended to rename the OHIP the Office of Disease Prevention and Health Promotion, giving the broader office the legislative authority provided by Public Law 94–317 and expanding its scope to encompass both health promotion (including health education) and disease prevention.

The Federal Sponsorship of Studies and Deliberations Leading Up to Healthy People

The Healthy People initiative launched officially with the publication of Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention in 1979, a thin but highly crafted 143-page document (plus appendices) and a reader-friendly digest of numerous conceptual and scientific analyses by McGinnis and his staff. It was supported by separate background reports on the national situation and prospects in disease prevention and health promotion. But The Surgeon General’s Report was hardly a patchwork. It provided the conceptual framework, using the 15 prevention priority areas with 5 in each of the 3 broad arenas of health promotion, health protection, and preventive services. These five priority points of intervention in each of the three arenas gave specificity to the opportunities for governmental, voluntary, and private-sector action at a time when prevention remained for many an ethereal philosophy without a conceptual framework. Even the Lalonde report did little to add specificity to the notion, and Lalonde was reassigned to a portfolio other than Minister of Health soon after his report was published, so the Canadian initiative had lost steam. The Surgeon General’s Report also provided the measurable goals for the five life stages. Although naturally drawing from commissioned material as background reports, which in turn referenced other reports, little of the report was pieced together from other sources. A third contribution, not embedded in the report itself, was its setting the stage for the more detailed objectives process, which was well in progress at the time of the report’s release in 1979.

Following the President’s Committee on Health Education Report in 1971 (34), a trail of Forward Plans, Task Force reports, and commissioned papers marks the early rumblings of the need for a prevention initiative under the Ford Administration and the Carter Administration, but none gained much traction, nor did they have much direct influence on the decision to take on the initiative later in the 1970s, nor on its content and approach. As early as 1975, the Ford Administration had selected prevention as one of the five major themes for development in the six agencies of the Public Health Service in the DHEW programs, as detailed in The Forward Plan for Health, 1976–1980. In one of the earliest reflections on what would remain challenges for the Healthy People initiative, Assistant Secretary Theodore Cooper stated in 1975,

The prevention theme of our first Forward Plan was repeatedly criticized as being a great idea but having no substance. We have been sensitive to that response and we are attempting to define more specific program commitments to the area of prevention. This is not an easy task for we believe that the concepts of prevention must permeate every one of the programs of the Department. We have
resisted the easy organizational approach to this commitment; we shall not create a new agency for prevention or request new legislation on prevention. Rather we shall see to it that the concepts of prevention permeate every one of our programs be they educational or service or research. (6, pp. xvi–xvii)

The apparent crossroad faced by the administration of either pursuing this initiative with the customary organizational strategy of creating a new agency in which the resources for the initiative would be concentrated or pursuing it with Cooper’s strategy (and Assistant Secretary Charles Edward’s stated strategy before him) of dispersing the responsibility to all agencies was settled by Congress. Whether the administration wanted it or not, in 1976 Congress created with Public Law 94–317 the Office of Health Information and Health Promotion with assigned responsibility for coordination. But the Congressional interest was not so much in supporting a health promotion and disease prevention initiative as broad as Healthy People became. The law focused primarily on the health education and health information functions of the OHIP and the Bureau of Health Education at the CDC.

One document commissioned by Assistant Secretary Richmond, which accompanied the release of the report itself, shared the title, Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention—Background Papers. This bulkier document was an IOM (National Academy of Sciences) report to the Surgeon General. The IOM “Committee for a Report on Health Promotion and Disease Prevention for the U.S. Surgeon General” summarized a series of commissioned papers on the state of the art and science in 18 areas of prevention and health promotion. The IOM presented them in the outline provided by the Surgeon General’s office to align with the lay Surgeon General’s Report. Both reflected an early commitment to a vision of a turn in health policy—at least disease prevention and health promotion policies—toward priorities that would be science driven, with respect to population health needs and strategies to address them, and objectives-based with respect to achievable targets to which funding would be directed.

Also significant about the two-part Surgeon General’s Report as part of the sustainability story was the breadth of stakeholder involvement in their development. The IOM report was, like most IOM reports, a truly interdisciplinary, multiprofessional representation of perspectives and knowledge. It brought to the table some of the nation’s best minds and most experienced professionals from biomedical sciences, population health sciences, social and behavioral health sciences, public health, and allied health professions either as members of the IOM committee or as commissioned authors of background papers. This practice assured a degree of certainty that the Surgeon General’s report would be sensitive to the perspectives and concerns of these diverse and influential stakeholders. For example, a debate between the behavioral scientists and social scientists frequently arises on the importance of individual health behavior and personal agency in guiding one’s personal behavior voluntarily, on one side, and the importance of social, economic, and other environmental determinants of behavior on the other. The authors of the ultimate Surgeon General’s Report devoted a section of the report to “The Role of the Individual,” in which they acknowledge that

...although socioeconomic factors are powerful determinants, individuals have limited control over them. Nor can they readily decrease many environmental risks. The role of the individual in bringing about environmental change is usually restricted to that of the concerned citizen applying pressure at key points in the system or process. But the individual must rely in large part on the efforts of public health officials and others to reduce hazards. (39, p. 17)

In this way, the technical and scientific perspectives were blended strategically with political considerations at many junctures in the
documents to head off insensitivity and to preclude some of the criticism and, worse, dismissal of the reports as narrowly conceived, biomedically dominated, or politically unacceptable. Because of their broad sweep, of course, they remained vulnerable to the criticism that Assistant Secretary Cooper encountered with the early positioning of prevention as one of five themes of his Forward Plan for Health, 1976–1980, but much was avoided and many allies were gained among the sciences and professions in supporting the initiative through these interdisciplinary and interprofessional deliberations. The particular representation of some types of organizations, however, was lacking. In particular, hospitals, insurance companies, and physicians’ specialty associations were seen as underrepresented organizations in the preparation of the background reports. These came to be sources of powerful, although largely passive, resistance.

Another Task Force report (38), published just before the IOM report, reflected the fledgling initiative’s attempt to galvanize and represent perspectives and priorities across the federal agencies of the Department, “to review and analyze their existing activities in disease prevention and health promotion...to identify problems of highest priority and measures to address those problems” (p. v). It was characterized in the Preface as “the first comprehensive review of its sort in the history of the Department” (p. v). It also contained a chapter briefly reviewing the prevention-related programs of other departments. These interagency analyses eventually led to collaborations across departments (notably the Departments of Agriculture, Transportation, and Treasury), with independent agencies such as the Consumer Product Safety Commission, the Environmental Protection Agency (EPA), the Federal Trade Commission, the Veterans Administration, and with the quasi-official American National Red Cross. That this was more exclusively a bureaucratic document, however, meant that it did not represent the independent scientific judgments that the IOM report brought to bear and did not encompass the wide range of other nongovernmental perspectives that would fulfill the vision of Healthy People as a national initiative, not just a federal initiative. Perhaps for these reasons it was not bundled with the Surgeon General’s Report as the IOM report was.

These Task Force reports built on two other federally sponsored reports on disease prevention and health promotion. One was the 1975 National Conference on Preventive Medicine, cosponsored by the NIH and the American College of Preventive Medicine, published as a single volume with chapters containing the five Task Forces’ reports, under the title Preventive Medicine USA (37). Five of the Task Force reports and their numerous commissioned papers were each published also as a separate paperback volume, three of which were devoted to health promotion, health protection, and preventive health services. One of the three Task Force reports, Health Promotion and Consumer Health Education, reviewed the behavioral and lifestyle determinants of health and the state of the art of intervention strategies for what eventually became the health promotion pillar.

The other pertinent IOM report of the mid-1970s, Perspectives on Disease Prevention and Health Promotion (15), was a staff paper on perspectives and evidence, which served as background review and analysis for the other IOM and DHEW deliberations.

The report itself (39) made the case for the priorities that should be pursued in health promotion and disease prevention. It was the first clear signal that the initiative or strategy would be based on quantified goals and objectives. It introduced the “Risks to Good Health” (chapter 2) with a classification of three major risk categories that aligned with the influential model or framework introduced by the Lalonde report as “the health field concept” (19).

Healthy People and Its Implementation

Aside from the prolific construction of a scientific, conceptual, and professional foundation of consensus on needs and prospects for prevention and health promotion, the Carter...
Administration searched for a template or framework to guide its formulation of a planning and management process. William Foege, soon after his appointment as Director of the CDC, undertook a strategic planning process that resulted in a strategic and priority-setting document, referred to at the CDC as the “Red Book.” Assistant Secretary/Surgeon General Richmond liked it so much that he asked Foege to join forces with McGinnis [recently transferred from the Secretary’s Office to head the Office of the Deputy Assistant Secretary for Disease Prevention and Health Promotion (ODPHP)] to make it a major departmental effort. That document provided some of the guidance and inspiration for what became The Surgeon General’s Report and Healthy People: Objectives for the Nation in Health Promotion and Disease Prevention. Foege also devoted considerable CDC resources to the effort, given the limited resources and staffing of the coordinating ODPHP and OHIP.

In parallel with the development of The Surgeon General’s Report and the Objectives for the Nation was a CDC collaboration with the APHA, the Association of Schools of Public Health, and the state and local health officer associations to develop and publish a document called Model Standards for Community Preventive Health Services (41). This document’s innovation was its explicit development of metric-specific objectives for a wide range of public health topics or core services of public health agencies. These measurable objectives went beyond the usual public health goals (as timeless statements of aspiration) and provided another template or model for the national objectives. One could also consider the development of this grass roots constituency for quantitative objectives as one of the ingredients for the long-term sustainability of the national process of setting decennial objectives.

Even with the legislative cover and encouragement of the two Acts and the scientific grounding of the IOM reports, the 1979 launch of Healthy People required high-level administrative auspices for its managerial credibility within the Department and its initial attraction of supporters. It received the blessing (if not active engagement) of President Jimmy Carter, in a cover letter introducing the report, and of then Secretary of the Department, Joseph A. Califano, Jr. In his Foreword to Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention, Califano noted that releasing this report was “virtually my final official act as Secretary of Health, Education, and Welfare” (p. vii). Scarcely more than a year later—an interregnum or lame-duck year in which Patricia Harris served as Secretary of the DHEW in the wake of Califano’s departure—President Carter, Secretary Harris, and Assistant Secretary/Surgeon General Richmond were out of office, replaced by the Reagan Administration.

The new Administration had no specific legislative mandate to implement the Surgeon General’s report. The mandate described above under the Health Planning Act and Public Law 94–317 could have been pursued without specifically adopting the Healthy People template. It might, for example, have chosen to interpret the health information and health promotion legislative requirements strictly as interventions within the medical care sector. But there were promising signs. Before he was installed as the newly nominated Secretary of what was now renamed the Department of Health and Human Services, Richard Schweiker, in an interview on the Today Show, was asked about his priorities. He responded, “As a two-mile-a-day runner, health promotion is going to be my first priority.” A few weeks later, at the end of the Senate hearings on his confirmation, he was asked, “If you could look forward now to the end of your term as Secretary...?” He answered that he would want to be remembered as the Secretary who turned the emphasis of the Department from disease cure to disease prevention and health promotion (10, p. 7).

Even more encouraging was the appointment of Edward Brandt, a career public health professional and academic administrator, as the new Assistant Secretary for Health. The staff of
the ODPHP had braced itself for the prospect that the Reagan Administration would want to scrap the Healthy People initiative, including the newly minted ten-year objectives for 1990. In April 1981, soon after President Reagan’s inauguration, McGinnis and Lawrence Green were invited to brief the new Assistant Secretary on the Objectives and on the OHIP. Not only did Brandt eventually endorse the objectives, but he also took an additional step that might be the single most important stroke in giving the Healthy People initiative in general, and the objectives in particular, the implementation push they needed to take root in the Department. He instructed the agencies and staff offices of the Public Health Service to prepare their Fiscal 1983 budgets using the objectives as justification for their line-item requests (10, p. 13). It has been possible since then to institutionalize that procedure into the ongoing budget cycles, strategic planning, and implementation and evaluation of Department programs to varying degrees. This step probably accounts as much as any other factor for the sustainability of the decennial objective-setting process.

Let us then examine the objectives and objective-setting process itself for clues to their staying power, if not their effectiveness in long-term accountability and impact.

The Objectives for the Nation

Before the ink was dry on Healthy People: The Surgeon General’s Report on Health Promotion and Disease Prevention, McGinnis and his colleagues in the ODPHP and OHIP, together with the CDC and the Health Resources Administration, and with the cooperation of other agencies of the Public Health Service, convened a conference in June 1979 in Atlanta called Promoting Health/Preventing Disease. Within two months of the conference they issued a bound draft of the consensus from the fifteen groups who hammered out objectives in their respective areas that had been identified in Healthy People, five in health promotion, five in health protection, and five in preventive health services (40). The work group for each of these areas consisted of some 9–13 members representing the science, practice, and consumer communities relating to their topic. Only the recorders for each group were from federal agencies. An additional 80 invited observers participated in the conference; most of them were from federal health agencies, but some were from states and national stakeholder organizations.

On the title page and in their cover letters with the August 1979 draft document circulated for public comment, Assistant Secretary/Surgeon General Richmond and the three cosponsoring directors of the CDC, the Health Resources Administration, and the ODPHP emphasized that the draft did not yet represent official Department positions, and McGinnis specifically requested review and feedback to make them national prevention objectives. McGinnis also requested that the participants and some 3000 other people to whom the draft was sent give particular consideration and comment on five factors:

- the way the objectives were worded,
- the quantitative target selected,
- the feasibility of attaining the objective by 1990,
- their relationship to objectives in other topic areas, and
- new quantitative objectives that should be added to the document.

The instructions for review and comment amplified the previous fundamental instruction to the Work Group members in formulating each objective: that their statement of an objective on each outcome sought for 1990 should be based on what should be expected if the nation applied what is known today as prevention, promotion, and protection measures (educational, service, technological, legislative, regulatory, and economic), without assuming any scientific or technological breakthroughs during the decade.

The ink was hardly dry, in turn, on the objectives before work was under way to address the issues of gaps in the baseline measures and surveillance mechanisms necessary to set and monitor progress on the objectives. McGinnis
(20, 22, 23, 29) and his staff (13) worked continuously with the National Center for Health Statistics (28, 36) and other units at the CDC, the National Center for Health Services Research (now AHRQ), the Health Resources and Services Administration, the Environmental Protection Agency, the National Highway Traffic Safety Administration, the Department of Agriculture, the Department of Education, and other agencies to develop measures and surveillance tools to monitor and report on progress in achieving the objectives.

ISSUES CONFRONTED IN THE EARLY (AND CONTINUING) FORMULATION OF OBJECTIVES

Setting priorities for a manageable and credible set of objectives required considerable professional and scientific judgment in the absence of firm evidence and national baseline measures on many of the most important targets. These judgments, in turn, required some weighing of ethical, equity, and political considerations.

Evidence for Setting Targets

The instructions to the work groups and to the reviewers for the objectives revealed how thin were the science and evidence to support many of the areas of intervention that the most pressing health problems called for and that the quantification of objectives had to assume. These thin reeds on which to build the objectives and targets were further weakened by the absence of national baseline data on many of the most important measures against which progress and ten-year outcomes could be stated.

These stumbling blocks in the first round of formulating decennial objectives in health promotion and disease prevention did not stop the process, but they made it uncomfortable. They became major issues to be addressed in the early years of the first decade. Although these limitations were acknowledged, those responsible for this initiative did not allow them to stifle the formulation of objectives, however speculative some of the quantitative targets might have been, because the objectives and their tracking were to be the cornerstones for policy and priorities in the decade ahead. Because improving prevention data was a key motive of the process, they made a conscious decision in the 1990 objectives not to let the unavailability of the baseline data constrain the setting of the target, but to have the setting of the target drive the collection of the data. At the end of the decade (1990), this idea had worked for about one-third of those objectives without data. For that reason, they changed strategies for the 2000 objectives.

Establishing decennial objectives and intermediate targets has remained problematic throughout the four iterations of Healthy People. Among the many approaches to setting objectives, some are used in combination. One approach is to consider the objectives aspirational, not necessarily realistic, but a goal for which to strive. Another approach is to consider the current burden of the disease or risk factor and ask how much of this burden could be ameliorated if every evidence-based intervention were implemented throughout the nation. Although it can be argued that the latter is more scientific and therefore justifiable, the lack of sufficient evidence has impeded the latter approach. Striving for the statistical targets achieved by other countries, or by the best of the states in the United States, or the most favored population segments, is another method, and one that is implicit in the “elimination of disparities” push in later iterations. Furthermore, stakeholders have their own institutional political reasons for which objectives are set and how they are set. Every health-related organization wants to see an objective related to their mission, regardless of the overall contribution to population health.

The first problem—confronting the reality of limited evidence in disease prevention and health promotion on which to base the estimation of ten-year objectives—was particularly obvious during the process of setting the first round of objectives. It was a problem the work groups had to live with and work around, one that was the consequence of decades of neglect.
of these areas of research by the primary federal research agency, the NIH, and its funding priorities, which were dictated in part by Congress, in part by traditions of academic medicine. But the ODPHP could seek to remedy the problem over time through various efforts across the Department.

Besides encouraging the NIH, the CDC, and other agencies to give priority to research funding in the weakest areas of evidence on the highest-priority health problems, the Office also initiated the systematic review and synthesis of the diverse sources of evidence for clinical interventions with the commissioning of a U.S. Preventive Services Task Force in 1984. This 20-member, nonfederal panel was a multidisciplinary group patterned after the Canadian Task Force on the Periodic Health Examination in its charge and in the methods and criteria it adopted for systematic review and recommendations on clinical effectiveness of interventions. Its first four years of work was published in articles and compiled in a guidebook, *Guide to Clinical Preventive Services: An Assessment of the Effectiveness of 169 Interventions* (43). Twelve years after the clinical Task Force was established, a parallel Task Force on Community Preventive Services was established to review the evidence on effective application of preventive interventions in the broader public health context of organizational and community change (2, 26, 47). However, although that Task Force has provided evidence reviews and related recommendations for more than 200 interventions, it estimates that an additional 700+ interventions have yet to be considered because of resource constraints. In addition, many of the early reviews need to be updated periodically as new evidence emerges.

The demand for programs and policies toward making the objectives evidence-based created the recognition of a gap between science and practice and the need to fill that gap with evidence not just from controlled research, but also from the experience of national, state, and local programs. The first comprehensive effort to estimate likely effects of different programs and policies was developed for tobacco control. Growing recognition of the need to meld “scientific” research with practice-based evidence produced a CDC (5) document offering quantitative guidelines for the allocation of resources to each of the essential components of comprehensive, statewide programs to address tobacco control. The experiential portion of this comprehensive approach was based largely on the experience of California and Massachusetts. Similar efforts but with greater emphasis on practice-based evidence in the absence of other accepted forms of evidence include the IOM (16) guidelines to grapple with the obesity epidemic. As the IOM report illustrates, public health must take action in the face of very limited evidence of what will work and so must be committed to deriving evidence through systematic evaluation of the innovations in policy and practice (16).

**Baseline and Periodic Population Data for Monitoring Progress**

A most contentious issue faced early in the objective-setting process in 1980 was the question of whether it was realistic and sensible to set objectives where no baseline data existed on a national level to know where the nation stood at the beginning of the decade, and when there was no way, in the absence of such periodically collected data, to measure progress in meeting the objectives. The argument that helped overcome such objections was that if we set objectives only for those health problems for which data already existed on a national scale and for which periodic national data collection mechanisms were already in place, then we would have to omit from the planning strategy many of the most important health problems and risk factors or determinants of those problems. Efforts began immediately with the National Center for Health Statistics to work new questions into the national surveys and registries to collect data on the objectives for which tracking mechanisms were already in place, then we would have to omit from the planning strategy many of the most important health problems and risk factors or determinants of those problems. Efforts began immediately with the National Center for Health Statistics to work new questions into the national surveys and registries to collect data on the objectives for which tracking mechanisms already existed (13, 20). At the end of the first decade (22), and the second (36), an assessment of the data systems demonstrated progress but also persistent gaps.
Another struggle with the objectives that inevitably continued to complicate the process in subsequent decades was the leap demanded of the work group participants from the usual experience of formulating objectives for specific programs or other interventions to the simultaneous introduction of multiple programs, policy changes, regulations, and other interventions being implemented variously across the country on various timetables and with varying resources and capacities. This multiplicity of interacting and synergistic interventions made linking numerous causes and singular outcomes a grand exercise in averaging and speculating by the work group members using the social dynamic of compromise. This difficulty has persisted for all the Healthy People objective sets, despite a significant increase in the evidentiary base. It is, clearly, a problem of attribution of effects that could be anticipated, depending on which of many possible interventions would be at work in a given jurisdiction.

**Ethical, Equity, and Political Issues**

A major complaint following the publication of the 1990 objectives in 1980 (42) was the concern of people representing special populations, including ethnic and racial minorities and the elderly. Objectives for health and mortality for the whole U.S. population masked the considerable variations among specific population groups, particularly the vast discrepancies between rich and poor, black and white, young and old. The selection of problems for priority consideration was based largely on national average statistics for broad age groups. Recognizing this problem as the objectives went to press, the ODPHP immediately assigned a follow-up project to OHIP to carry out a series of consultation meetings with representatives of each of five special population groups and to identify their concerns (32). The published report seemed to mute the initial outcry, but there was little follow-up in implementing the high-risk population-specific suggestions with any attribution to this consultation process or its published product, even after reprinting it in 1987 (33).

One aspect of the disparities and high-risk population issues that began to receive considerable attention in the academic literature of the 1980s, with the Healthy People initiative often cited as a lightning rod for the debates, was the ethical question of government health promotion campaigns and programs emphasizing individual responsibility and behavior change. McGinnis (21) was grappling with these issues in the early 1980s, in search of the ethical and constitutional basis of public jurisdiction over private behavior. He argued that state policies to regulate individual health behaviors that can harm others (e.g., drunk-driving) are uncontroversial, whereas issues such as raising taxes on cigarettes raised equity issues. He concluded that policies designed to change individual behavior must be conscientiously crafted.

Much had been written in previous decades on “blaming the victim” (1), seen by some as inherent in health education campaigns, school health education, and patient or employee health counseling (24, 25). Faden (7) suggested the formal application of ethical principles to guide the compatibility of such campaigns with the central principle of respect for autonomy. She reviewed five justifications for state-sponsored health communications campaigns: the public’s health as an independent value, collective efficiency and respect for majority preferences, third-party interests, harm to the health of others, and the countering of marketing strategies of industries such as tobacco.

After the first decade demonstrated the political attention the objectives drew from states, professional interest groups, and other stakeholders, the White House may have felt a need to take a more active hand in shaping the final wording of some of the objectives. The final published objectives for Healthy People 2000, after White House and OMB clearance, contained some notable departures from the wording that had achieved consensus in the scientific, professional, and organizational reviews and ratification processes. These deviations were
most notable in the chapters on violence control, family planning, and access to preventive health services. Some examples noted in the Preface to an independently published version of Healthy People 2000 (11, p. x) are as follows:

- The original chapter on “Family Planning” was titled “Sexual Behavior,” specific objectives were altered in the final approved document, and the specific objective on achieving age-appropriate sex education in schools had disappeared in the final.
- Throughout the final document, what had been referred to as “comprehensive school health” was replaced with the term “quality school health,” apparently to skirt any suggestion of support for sex education and school contraceptive services.
- The original references to “firearm-injury death” in the Violent and Abusive Behavior chapter were replaced with “weapon-related violent death,” obscuring the role of handgun control.

The problem of equity and disparities was addressed more explicitly from the beginning of the Healthy People 2000 planning process than it had been in the 1990 objectives, and the Healthy People 2000 objectives themselves were extensively delineated by age and racial/ethnic population. Chapters 2 and 3 in the Healthy People 2000 document were devoted entirely to the age groups and high-risk “Special Populations.” A national consortium of more than 300 national membership organizations and all the State health departments solicited comments on the draft 2000 objectives. Advocacy groups for the racial and ethnic populations, however, remained disappointed that a separate category for minority health was not included. This trend has increased. In the 2010 objectives, under Surgeon General/Assistant Secretary Satcher, the reduction of disparities was replaced with a more aggressive set of objectives to eliminate disparities. In the 2020 objectives, the disabled population became an increasingly important issue.

SOME CONTINUING CHALLENGES AND NEW OPPORTUNITIES

Disparities

Addressing racial/ethnic and other special populations’ specific health needs has been a part of the national health promotion agenda since 1980 (10, 11, 32, 33) and a priority of other federal initiatives dating back most notably to the Roosevelt New Deal initiatives of the 1930s and the Kennedy New Frontier and Johnson New Society initiatives of the 1960s, including Medicare and Medicaid, Migrant Health Clinics, Rural Health Centers, and Indian Health. Reducing racial/ethnic disparities in health has been a more specific focus of public health and health services objectives in the Healthy People initiative since the formulation of the Healthy People 2000 objectives under Secretary of the DHHS Louis Sullivan and even more under the leadership of Surgeon General David Satcher in the 2010 objectives to eliminate disparities. Keppel and his National Center for Health Statistics associates (17) examined the changes in the relative disparities for the five leading causes of death—diseases of the heart, cancers, stroke, chronic respiratory diseases, and unintentional injuries—in the United States from 1990 to 2006. They found, despite continuous reductions in rates for specific racial/ethnic populations, very little evidence of reductions in relative disparities between these populations. Except for stroke deaths from 1990 to 1998, relative disparities among racial/ethnic populations did not decline between 1990 and 2006. In fact, disparities among racial/ethnic populations increased for heart disease deaths (1999 to 2006), chronic obstructive pulmonary disease deaths (1990 to 1998), and chronic lower respiratory disease deaths (1999 to 2006). The most notable decrease in disparities has been seen with childhood immunizations and vaccine-preventable diseases.

Surveillance

Surveillance systems depend for their power of evaluation and monitoring of progress on
consistency of measurement over time, with identical questions and measurement procedures in successive surveys or data collection procedures and between jurisdictions. With each change in objectives, there are temptations for academics and for sponsors of new programs to add more questions to surveys and to change some of the questions to obtain a more precise measure of progress on the new objectives. Such changes, however, undercut the comparability over time. The Behavioral Risk Factor Surveillance System developed by the CDC in collaboration with the 50 states that have adopted it over time has provided estimates of the relative progress of jurisdictions, offering yet another measure of disparities and disparity reductions. But the diversity of the states, their capacity to mount consistent methods and quality of surveys, and the ultimate skepticism surrounding the validity of self-reported behavior have called into question some of the tracking of objectives. Where national surveys such as the National Health Interview Survey (NHIS) and the National Health and Nutrition Examination Survey (NHANES) have been used, greater confidence resides in the quality of the data, but there is also less flexibility in adapting the questions to new objectives and less resolution to subnational jurisdictions except where sample sizes are large enough in states and some metropolitan areas.

Community, Voluntary and Other Sectors’ Involvement Under Health Care Reform

As the new decade dawns, the Patient Protection and Affordable Care Act (i.e., Health Reform) gives more attention to prevention and coverage of preventive health services than ever before in our medical care–oriented health system. The new law established and provides funding for the Public Health and Prevention Fund. It includes provisions to fund grants to help small businesses develop comprehensive wellness programs (31). The push for accreditation of local health departments also puts greater emphasis on development of community consensus on goals and objectives, as well as measurement of performance. It requires health insurance policies to cover A- and B-level evidence interventions from the U.S. Preventive Services Task Force.

As with health care reform, the issues of role delineation among various sectors, professions, and other stakeholders will continue to evolve with each new generation of leaders in the various organizations. Indeed, health care reform under the Affordable Care Act will complicate the sorting out of these roles insofar as the Act provides for greater resources and expectations of health care providers and employers in preventive health services and employee health promotion. These could enhance or complicate Healthy People management. Unless these new resources are coordinated with the Healthy People objectives and monitoring processes, they could produce a centrifugal force that disperses activity but that would threaten the continued viability of Healthy People as the focal point for national disease prevention and health promotion.

One very hopeful provision of the Patient Protection and Affordable Care Act is the establishment of the National Prevention, Health Promotion, and Public Health Council. Its charge is to provide coordination and leadership at the federal level for prevention, wellness, health promotion practices, the public health system, and integrative health care; to develop a national strategy spanning these areas and that incorporates the most effective and achievable means of improving Americans’ health status and reducing preventable illness and disability; and to provide related recommendations to the President and the Congress with particular attention to evidence-based models and innovative approaches at the individual and community levels. Chaired by the Surgeon General, the Council is composed of the Secretaries of Agriculture, Labor, Health and Human Services, Transportation, Education, and Homeland Security, as well as the EPA Administrator, the Chair of the Federal Trade Commission, the director of the National Drug Control Policy, the Domestic Policy Council Director, the
Assistant Secretary of the Interior for Indian Affairs, the Chair of the Corporation for National and Community Service, and the head of any other executive department or agency that the Chair determines appropriate. After producing an initial report due by March 2011, the Council is to submit annual reports. The hope is that this body will consider carefully how intersectoral cooperation can increase emphasis on a “health in all policies” approach, drawing more scrutiny to the health impact or implications of decisions in all other sectors.

SOME CONCLUSIONS AND LESSONS

Public health, disease or injury prevention, and health promotion are often, and sometimes necessarily, long-range strategies that require sustained commitment to policies directed at complex system and social change determinants and at distant goals. Success of a broad, multiyear initiative hinges on cultural and normative changes in the ways of relating among stakeholders and actors, based on collaboration, a comprehensive innovation strategy for system redesign, and systems integration. Not all of these elements have yet been shown to have succeeded in the national Healthy People initiative of the U.S. federal government, but enough of them have been tried and sustained over three decades to review, once again, how they have fared and what we can learn from them. Policy makers seek guidance on such considerations as successful models and strategies, partnership principles, system transformation, and monitoring and evaluation. With all these considerations, there is an emphasis on the role of government, but government in the case of the Healthy People initiative took great pains to be known as a national initiative, not a federal initiative.

This history of the development and launch of Healthy People notes its enduring features, but it is more than that—it is the tale of turning national policy from an almost exclusive focus on medical care to a broader focus on the health production function. It has not succeeded in changing our pattern of spending in the larger sense, but it has increased attention and resources to upstream health determinants as well as the intermediate ones that account for the leading causes of death (smoking, nutrition, physical activity, violence, substance abuse, etc.). It is a history of turning the Queen Mary at least a little bit toward a new course and periodically adjusting that course with maximum feasible participation and data.

From this selective review of some salient and some more subtle aspects of the Healthy People initiative, especially its launch and first decade, and the trail of surviving aspects after three decades, we offer a few conclusions, or at least possible lessons for the planning and implementation of large-scale initiatives to assure their greater sustainability:

- Find or create a legislative or other legal, policy, or regulatory mandate to underpin and justify the undertaking.
- Assure the intellectual and philosophical commitment and support of a high official, or better, a collaborating, interdependent group of high officials, for at least the development and launch years.
- Strive to make the initiative nonpartisan and inclusive, representing it as much as possible as a consensus product, in every way possible to assure that the high official who replaces the one who supported its development and launch can embrace it without fear of contradiction or political backlash.
- Lead up to the formal launch of an initiative with broad engagement of the multiple scientific disciplines and professions and other stakeholders that will have evidence, theory, professional experience, perspectives, and resources to contribute to the initiative, with even-handed representation of all whose ultimate support would be needed to sustain the initiative.
- Reflect the differences of those sources of evidence, theories, experience, and perspectives in the writing of the document(s) that launch(es) the initiative and in subsequent writing about it, with
sensitivity to the differences that could cause some to perceive it as privileging one perspective over others.

- Position the objectives as part of an ongoing budget, management, and evaluation cycle, such that budget requests must be justified on the basis of how the amounts requested would contribute to the achievement of specific objectives and targets.

- Minimize the tendency to emphasize priorities that force some objectives to compete with each other; distribute the goals and objectives across all the health problems and strategies seen as important to different groups, and give those groups responsibilities for implementing them.

- Distribute the responsibilities and accountability for different objectives to different groups of stakeholders, maintaining subgroups for each set that are large enough in their collective resources and capacities to collaborate and implement effectively but small enough to be able to act without excessive meetings, bureaucratic counterweights, and red tape.

- Assign coordinating responsibility across subgroups of stakeholders and official agencies to an agency or office with legislative authority to renew and recycle the process periodically.

- Avoid assigning blame to organizations for failure to reach distant targets that depend on multiple mediating variables to change; limit accountability to immediate and intermediate targets.

- Quality of life should be factored into most health programs and policy changes because it gives a rationale beyond health and relates effort to terminal values, not just the instrumental value of health, and, not incidentally, may appeal particularly to aging policy makers.

- Provide for flexibility in revising and molding objectives periodically to the changing conditions of the time.

- Periodically reduce the number of objectives because they tend to proliferate over time, dispersing effort, resources, and focus.

- Celebrate successes; revisit the logic models and other assumptions where progress has been slow or where disparities increase; redistribute resources to stimulate action where movement has been slow.

Finally, a postscript is in order with the passage of the Patient Protection and Affordable Care Act as this review was in preparation. It could be a major game changer, tapping into the prevention and health promotion objectives, giving them greater prominence or distortion, or diverting attention from them. What might have accounted for the sustainability of the objectives to 2010 in their early genesis and decennial processes of review and revisions might change radically in the context of health care reform.

**DISCLOSURE STATEMENT**

Dr. Green was Director of the federal Office of Health Information and Health Promotion from 1979–1981. Dr. Fielding was Co-Chair of the Secretary’s Advisory Committee for Healthy People 2020. These roles could produce some biases in the authors’ perspectives in writing this review.

**ACKNOWLEDGMENTS**

We are deeply indebted to J. Michael McGinnis, Martha Katz, and Dennis Tolsma, both for their helpful comments on drafts of this manuscript and for their central roles in the early genesis, launch, and nurturing of the Healthy People initiative described in this review. McGinnis, now Senior Scholar at the Institute of Medicine, was the initiative’s most senior federal implementing official.
with responsibility throughout the first decades, from 1977 to 1995, as Assistant Surgeon General, Deputy Assistant Secretary of Health, and founding director of the Office of Disease Prevention and Health Promotion through the Carter, Reagan, Bush, and Clinton administrations. Martha Katz was his deputy director for the earlier years, then deputy to a succession of CDC directors and director of its planning office, with frequent liaison for CDC to the Healthy People initiative. Dennis Tolsma was deputy director for the planning office at the CDC during the initial years, loaned by CDC Director William Foege to the Washington office to help with the development of the initiative, and author of its naming, “Healthy People.”

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