

# Target Setting: How Low or High Do We Aim?

By Valerie Welsh

Senior Health Policy Analyst, Office of Minority Health, HHS  
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One of the toughest challenges of Healthy People 2010 is how to target policy attention and resources to Americans with the poorest health in order to achieve improved health for all. The approach to target-setting that has been generally used to date in the Healthy People initiative is one of setting targets at a level of improvement (e.g., 30 percent) over a total population average. The major drawback of this approach is that it hides the fact that, in some instances, one or more groups (often Whites, but sometimes racial and ethnic minorities) are actually doing better than the target.

For example, the year 2000 infant mortality objective was an overall target for the total population of 7 deaths per 1,000 live births. The targets for those racial and ethnic populations depicted are 11 for Blacks, 8.5 for American Indians/Alaska Natives, and 8 for Puerto Ricans. Current rates for Chinese, Japanese, and Filipino Americans (6.2, 6.6, and 6.6 per 1,000 live births, respectively), are better than the 2000 target and give these groups no room for improvement.

Thus, current discussions related to the 2010 objectives support an option to set targets at levels that are “better than the best,” allowing room for improvement for all groups. This approach is more consistent with President Clinton’s initiative to *eliminate* racial and ethnic disparities and set the same targets for all groups. It is also consistent with the guidelines used to develop the Healthy People 2010 draft for public comment.

The “better than the best” approach has drawbacks as well. It moves the targets even farther away for populations which suffer the greatest disparities.

The guidelines being used to develop targets in the draft Healthy People 2010 document are as follows:

- A single target for the year 2010 should be set—one that would be applicable to all populations. The target-setting methodology should support the goal of eliminating health disparities. Targets should be set so that there will be an improvement for all segments of the population.

- For those six objectives contained in the HHS Initiative to Eliminate Racial and Ethnic Disparities in Health, the goal would be a health outcome better than the best currently achieved by any population group.
- For those objectives that in the short-term can be influenced by lifestyle choices, behaviors and health services, the target also would be better than the existing best. Examples include physical activity, modifiable risk factors, specifically those relating to smoking and blood pressure, and access to services including prenatal care and mammography.
- For objectives for which we are unlikely to achieve an equal health outcome within 10 years by applying the health interventions currently available, the target would be set at a level that represents an improvement for a substantial proportion of the population. This target would be regarded as a minimally acceptable improvement. An example would be occupational exposure and the resultant lung cancer. Even with such a goal, we still would expect to achieve health status improvements for those population groups whose health is already better than the 2010 target.

Is it realistic to think we can eliminate racial and ethnic health disparities by the year 2010 when, in many instances, the gaps are so wide? If not by 2010, then when?

*The upcoming public comment period on the proposed Healthy People objectives opens September 15, 1998 and closes December 15, 1998. We strongly encourage you and your colleagues to participate. For more information, visit the Healthy People Web site: <http://web.health.gov/healthypeople>. ❖*

