Using Healthy People as a Tool to Identify Health Disparities and Advance Health Equity
Deborah Hoyer, MPH; Elizabeth Dee, MPH

ABSTRACT

Background: As research into the health of different segments of the American population continues to advance, data show inequalities in health outcomes depending on a variety of characteristics, including income and education levels, gender identity, race and ethnicity, and disability status. The Healthy People initiative explores how specific population groups perform for 10-year objectives, including the Leading Health Indicators, which are a broad set of metrics that track issues from health behaviors to determinants of one's health.

Findings: The data show that, when it comes to health, the playing field for all Americans is not even. At the close of Healthy People 2020, an assessment of the Healthy People 2020 Leading Health Indicators showed that threats to the health of every American vary dependent on who they are, where and how they live, and the community they were born into.

Discussion: Healthy People 2030 places an emphasis on continued research into these health indicators to uncover how different these realities are for different population groups and to inform and guide effective health policies and interventions in the years ahead.

KEY WORDS: health equity, Healthy People 2030, Leading Health Indicators

Since 1980, Healthy People has set measurable objectives with 10-year targets to improve the health of all people nationwide. Healthy People tracks progress toward meeting the national disease prevention and health promotion goals and objectives, and it monitors differences across populations. The US Department of Health and Human Services’ (HHS) Office of Disease Prevention and Health Promotion (ODPHP) manages Healthy People, and the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC) provides statistical expertise for Healthy People’s data. Healthy People 2030, the fifth and most recent iteration of the initiative, builds on the knowledge from the previous decades and incorporates new science and innovation, as well as emerging health priorities.

Healthy People data, which include data from a number of nationally representative or valid and reliable data systems, are reported continuously throughout the 10-year period and are formally summarized in midcourse and final assessments. These assessments include looking at how specific populations progressed toward achieving Healthy People’s national targets and highlight the importance of implementing systems-level approaches that create optimal conditions to promote health for all. Healthy People's timely data reporting can serve as a guide to inform public health programs, including policies and interventions.

These data demonstrate that threats to the health of every American person vary depending on who they are, where and how they live, or the community where they were born. Continued research into health outcomes, behaviors, and risks must identify how different these realities are for different population
groups to inform and guide effective health policies and interventions in the years ahead.

Healthy People can and should guide health promotion and disease prevention efforts to improve health outcomes for these different population groups by offering a pathway toward health equity—the attainment of the highest level of health of all people. Healthy People facilitates collaborative, data-driven efforts to implement evidence-based policies and interventions that impact the social determinants of health (SDOH) and advance health equity and address health disparities. To do so, Healthy People’s Leading Health Indicators (LHIs), which are a subset of Healthy People objectives, address issues of national importance and are selected to focus action on high-priority health issues and challenges. These indicators focus on upstream measures—such as the conditions in people’s environment. Ongoing data updates and dissemination of information on the LHIs are intended to motivate activities that will exert a positive impact on pressing public health issues and, in turn, improve the overall health and well-being of the nation. Individuals, organizations, and communities committed to improving health and well-being of the nation can use the LHIs to prioritize resources and efforts to address these issues and optimize health for all.

This article reviews the differences in health outcomes, behaviors, and risks over the last decade for the LHIs identified for Healthy People 2020. These differences underscore the importance of focusing on efforts to advance health equity. This article also highlights Healthy People 2030 features that can be utilized in disease prevention and health promotion work to address disparities and make strides toward achieving health equity.

Healthy People’s Commitment to Addressing SDOH, Health Disparities, and Health Equity

Addressing SDOH, health equity, and health disparities is a central tenet of Healthy People 2030 and a guiding principle in developing the initiative’s framework, including the overarching goals and objectives. The Healthy People 2030 framework guides the nation toward the Healthy People vision—a society in which all people can achieve their full potential for health and well-being across the life span. Healthy People 2030’s 5 overarching goals for the decade are to:

1. Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
2. Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
3. Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
4. Promote healthy development, healthy behaviors, and well-being across all life stages.
5. Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Healthy People 2030 prominently features the concepts of SDOH, health equity, and health disparities, which have been priority areas for the initiative for decades. Since Healthy People 2020, the initiative has offered an SDOH framework, which defines SDOH and organizes determinants into 5 place-based domains (Figure 1). This framework can be leveraged to identify how to create equal opportunities for all people to achieve the highest level of health and well-being possible. Addressing SDOH requires multisector collaboration at every level of society (individual and community levels) and across environments (social, built, and economic environments). Healthy People continues to emphasize that environmental, economic, and sociocultural factors such as structural racism or systemic bias contribute to health disparities by race, ethnicity, sex, sexual orientation, gender identity, age, disability, socioeconomic status, geographic location, or other characteristics historically linked to discrimination or exclusion.

Over the decades, the Healthy People initiative has evolved to reflect the most current science and address

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**Healthy People 2030 Priority Areas Definitions**

**Social Determinants of Health**: conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

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**FIGURE 1** Healthy People 2030 Priority Areas Definitions—Social Determinants of Health

This figure is available in color online (www.JPHMP.com).
Healthy People 2030 Priority Areas Definitions

**Health Disparities**: a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

**Health Equity**: the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, social determinants of health, and the elimination of health and health care disparities.

FIGURE 2 Healthy People 2030 Priority Areas Definitions—Health Disparities and Health Equity
This figure is available in color online (www.JPHMP.com).

the latest public health priorities, and it has strengthened its focus on health equity. Healthy People defines both health equity and health disparities, which can help guide collective action and collaboration through a shared understanding of these concepts (Figure 2).

Healthy People examines progress by population groups for objectives, which help identify areas for focused action and offer the opportunity to assess what may be driving or impeding progress for these specific populations.

For Healthy People 2020, HHS developed an online tool to help Healthy People 2020 users describe and analyze health disparities data. The health disparities tool displayed health disparities data as well as changes in disparities over time for all measurable Healthy People 2020 objectives with available population data. It also displayed detailed pairwise comparisons, summaries of health disparities by population groups (eg, by sex, race and ethnicity, educational attainment, or family income), and graphical displays to visualize disparities, as well as changes in disparities over time.

User-friendly data tools, such as the health disparities tool, were a key component of Healthy People 2020 and provided practical data for a broad set of users. Such tools can highlight where there are differences in health among populations and help users to explore drivers of these differences, including the social determinants, that may prevent populations from attaining the highest level of health. These types of tools will be enhanced for Healthy People 2030, continuing the initiative’s commitment to making accurate, relevant, and timely data accessible for a wide variety of users. Data availability and tracking are critical for identifying disparities and supporting the development and implementation of collaborative approaches to improve health and well-being for all.

### Findings From the Nation’s High-Priority Health Issues

In August 2020, the Healthy People initiative transitioned to Healthy People 2030, marking the closeout of Healthy People 2020 objectives, including its LHIs. Healthy People 2020 included 26 LHIs organized under 12 topics. These 26 LHIs were selected and organized using a “Health Determinants and Health Outcomes by Life Stages” conceptual framework. This approach signified the important role that individual and societal factors play across the life span.

To regularly communicate progress on the LHIs throughout the decade, ODPHP released a “Who’s Leading the Leading Health Indicators?” series, which included timely data assessments. This series highlighted the impact of SDOH on these pressing public health issues and included data assessments exploring differences in objective progress across population groups.

The progress made toward the LHIs’ national targets at the end of the Healthy People 2020 decade was assessed in ODPHP’s Healthy People 2020: An End of Decade Snapshot and NCHS’ Healthy People 2020 Final Review. These end-of-decade assessments offer the opportunity to identify successes and areas for improvement to inform Healthy People 2030. At the end of the decade, a review of the national progress showed that of the 26 LHIs for Healthy People 2020:

- 5 (19.2%) LHIs met or exceeded their target;
- 9 (34.6%) LHIs improved;
- 8 (30.8%) LHIs had little or no detectable change; and
- 4 (15.4%) LHIs got worse.

While more than half of LHIs “met or exceeded” or moved toward their national targets, a deeper look at the data highlights disparities across population groups. Healthy People 2020 objective-level

*Detailed information on the status of the LHIs is available at https://www.cdc.gov/nchs/healthy_people/hp2020/progress-tables.htm
data were analyzed by different populations, such as race and ethnicity, sex, income level, education level, and geographic location throughout the decade. An interactive Web-based chart and a table summarizing changes in disparities over time by 6 population characteristics for a subset of population-based measurable objectives were developed as part of the Healthy People 2020 Final Review. Healthy People data disaggregated by various population categories are used to assess and identify health disparities.

For example, the Healthy People 2020 LHI for the age-adjusted proportion of adults 18 years and older who were current cigarette smokers (TU-1.1) decreased from 20.6% in 2008 to 13.9% in 2018, moving toward the 2020 national target of 12.0%. However, these proportions for 2018 in relation to meeting the 12.0% national target varied by family income categories. While the proportion of current cigarette smoking among adults with family incomes below (6.1%) the national target, the corresponding proportion (23.9%) for those with family incomes at less than 100% of the poverty threshold was notably higher than this national target. Looking across the decade, the Healthy People 2020 Final Review reported that the overall disparity by family income as measured by the summary rate ratio for this objective statistically significantly increased between the baseline (2008) and final data points (2018).

The Table provides the final status of progress toward target attainment for individual population groups, aggregated across the Healthy People 2020 LHIs. Access to population data can help identify populations that may be disproportionately affected by certain health risks or outcomes. This can ensure resources are adequately distributed so that everyone has an equal opportunity to be as healthy as possible.

Data for specific population groups, defined by factors such as demographic and socioeconomic characteristics, will be available for the Healthy People 2030 LHIs; this will allow for the identification of health disparities, which acted upon, can advance health equity. Despite progress made in Healthy People 2020, efforts to address these high-priority health issues need to continue into Healthy People 2030.

Using Healthy People 2030 to Address Health Disparities and Advance Health Equity

Since its inception, Healthy People has been utilized by agencies and individuals at the federal, state, territorial, tribal, and local levels to improve the health and well-being of the nation. Federal agencies often align grant funding opportunities with Healthy People priority areas, including the SDOH and health equity. Locally, states often use Healthy People as a resource for their state health improvement plans. In addition, Healthy People is used broadly as a resource to explore priority populations for specific areas of interest and find evidence-based resources to help address these priorities. As we build on the knowledge from Healthy People 2020, Healthy People 2030 can be leveraged to advance health equity and respond to identified health disparities and inequities that emerge throughout the decade (Figure 3).

Some of the Healthy People 2030’s features that can be leveraged are as follows:

- **Data:** To implement informed programs and policies that address disparities and their root causes, it is important to identify which populations are experiencing higher burdens of mortality and morbidities, as well as risk factors for health outcomes of interest. Healthy People 2030 has expanded its data template, now tracking additional population categories, to highlight differences by population groups and calculate disparities data. For this decade, Healthy People also has an improved Web site, to support faster data deployment, a tool for building custom lists of objectives, a more sophisticated search tool, and more intuitive navigation.

- **Evidence-based resources:** Healthy People 2030 also features evidence-based resources focused on strategies that are proven to improve health. These resources include interventions to address public health issues among specific population groups and improve the health of all people.

- **Healthy People 2030 Champion Program:** Recognizing that it is a shared responsibility to promote and achieve health and well-being nationwide, Healthy People 2030 offers the Healthy People 2030 Champion Program. This program recognizes the work that organizations do to improve health and well-being for all.

- **Healthy People 2030 webinar series:** This decade, Healthy People 2030 will host webinars that feature the initiative’s latest data on LHIs, Overall Health and Well-Being Measures, and Healthy People 2030 objectives.

- **Healthy People in Action:** Healthy People 2030 features a Healthy People in Action series that features organizations, states, and communities committed to improving health and well-being for all leveraging data and the initiative to promote evidence-based health and disease prevention efforts.

- **SDOH framework:** Consistent with the previous decade, Healthy People 2030 includes an SDOH...
### TABLE

| Population Group                        | Got Worse | Little or No Detectable Change | Improved | Target Met or Exceeded | Total |
|-----------------------------------------|-----------|-------------------------------|----------|------------------------|-------|
|                                        | n         | %                             | n        | %                      |       |
| **Sex**                                 |           |                               |          |                        |       |
| Male                                    | 4         | 17.4                          | 7        | 30.4                   |       |
| Female                                  | 3         | 13.0                          | 6        | 26.1                   |       |
| **Race and ethnicity**                  |           |                               |          |                        |       |
| American Indian or Alaska Native        | 4         | 22.2                          | 8        | 44.4                   |       |
| Asian                                   | 1         | 5.6                           | 3        | 16.7                   |       |
| Native Hawaiian or other Pacific Islander| 0        | 0.0                           | 5        | 50.0                   |       |
| 2 or more races                         | 1         | 8.3                           | 6        | 50.0                   |       |
| Hispanic or Latino                      | 3         | 12.0                          | 7        | 28.0                   |       |
| Black, not Hispanic or Latino           | 4         | 16.0                          | 10       | 40.0                   |       |
| White, not Hispanic or Latino           | 4         | 16.0                          | 7        | 28.0                   |       |
| **Educational attainment**              |           |                               |          |                        |       |
| Less than high school                   | 3         | 21.4                          | 5        | 35.7                   |       |
| High school graduate                    | 4         | 28.6                          | 6        | 42.9                   |       |
| Some college                            | 2         | 14.3                          | 6        | 42.9                   |       |
| Associates degree                       | 1         | 14.3                          | 2        | 28.6                   |       |
| 4-y college degree                      | 0         | 0.0                           | 6        | 50.0                   |       |
| Advanced degree                         | 0         | 0.0                           | 3        | 33.3                   |       |
| **Family income**                       |           |                               |          |                        |       |
| Poor                                    | 2         | 11.8                          | 9        | 52.9                   |       |
| Near-poor                               | 2         | 11.8                          | 6        | 35.3                   |       |
| Middle                                  | 3         | 17.6                          | 8        | 47.1                   |       |
| Near-high                               | 3         | 18.8                          | 3        | 18.8                   |       |
| High                                    | 4         | 26.7                          | 4        | 26.7                   |       |
| **Disability status**                   |           |                               |          |                        |       |
| Persons with disabilities or activity limitations | 1    | 9.1                           | 4        | 36.4                   |       |
| Persons without disabilities or activity limitations | 1  | 9.1                           | 5        | 45.5                   |       |
| **Location**                            |           |                               |          |                        |       |
| Urban or metropolitan                   | 4         | 26.7                          | 3        | 20.0                   |       |
| Rural or nonmetropolitan                | 3         | 20.0                          | 5        | 33.3                   |       |

**Abbreviations:** LHI, Leading Health Indicator; NCHS, National Center for Health Statistics.

*The assessment of final progress was based on the final year of data collected for each Leading Health Indicator during the Healthy People 2020 tracking period, in relation to the baseline value for the tracking period. The target was set based on the baseline for the total population, and the same target was used for all population groups shown here. Therefore, some population groups may have already met the target at baseline. For further information on how progress was evaluated in Healthy People 2020, see the Healthy People 2020 Final Review Progress by Population Group product and NCHS Statistical Note 27: Measuring Progress Towards Target Attainment and the Elimination of Health Disparities in Healthy People 2020. Note, the number of population groups included for each objective varied on the basis of data availability.

framework (Figure 4), which can be leveraged to help develop a shared understanding on determinants of health, encourage collective action, and identify how to create equal opportunities for all people to achieve highest level of health and well-being possible.

### Discussion

Healthy People’s science-based objectives represent national priorities, serve as a rich and comprehensive data resource, and provide transparent and timely assessments of progress. Timely data that can track
FIGURE 3 Leveraging Healthy People to Advance Health Equity
This figure is available in color online (www.JPHMP.com).

FIGURE 4 Healthy People 2030 Social Determinants of Health Framework
This figure is available in color online (www.JPHMP.com).
differences by population group allow for real-time, responsive solutions to public health issues. The critical need for data accessibility, including disaggregated data, has been illuminated during the pandemic. Data show that exposure to COVID-19; illness, hospitalization, and death resulting from COVID-19; and other effects of the pandemic are higher among certain population characteristics, race and ethnicity, and income.12,13 The Healthy People initiative continues to report timely data on national priorities, including the LHIs. Where available, data are reported by populations and characteristics, offering a tool for identifying disparities and targeting strategies to reduce health inequities. As Healthy People 2030 continues to build on the work from the previous decades, there is a need to examine challenges and inequities that impeded improvement in health outcomes so that resources can be applied against such inequities and their drivers.

Access to data highlighting differences by population group can help identify strategies to address LHIs and focus efforts on the elimination of health disparities. Evidence-based resources, which include science-based methods to improve health and prevent disease, can be used to effectively impact change on health disparities. For example, culturally appropriate anti-smoking health marketing strategies and mass media campaigns such as CDC’s Tips From Former Smokers national tobacco education campaign, as well as CDC-recommended tobacco prevention and control programs and policies, can help reduce the burden of disease among people of low socioeconomic status, including low-income populations.14 More generally, knowing which populations have a higher prevalence of risk factors or rates of health outcomes can help focus policies and interventions including efforts related to persistent public health challenges for specific populations, to drive action toward eliminating health disparities. Healthy People will continue its focus to identify and communicate the areas of need. Examining progress from Healthy People 2020 continues to build on the work from the previous decades, there is a need to examine challenges and inequities that impeded improvement in health outcomes so that resources can be applied against such inequities and their drivers.

Healthy People’s national targets can align efforts on important public health threats and promote collective action, and the initiative’s framework can serve as a model for nationwide health promotion and disease prevention program planning. New and emerging public health issues will continue to test the resilience of the nation’s public health system and health care system. Healthy People will continue to monitor the initiative for gaps throughout the decade to respond, adapt, and evolve to pressing issues. Healthy People information and resources, including definitions for health equity and health disparities, can motivate collaborative action that synergizes resources and ensures public health investments flow to the areas of need. Examining progress from Healthy People 2020 can help the nation explore solutions for this decade to further improve the health of all Americans, regardless of race, sex, ability, or socioeconomic status.

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