

with an age-adjusted mortality rate of 355 per 100,000 persons. Figure 2 shows although Wisconsin's mortality rate is projected to improve to 318 by 2010, our rank is projected to drop to 18th. Based on the trend estimate, New York is expected to rank first by 2010.

Using this information, we created five scenarios which could serve as a basis for setting Wisconsin 2010 objectives for this measure (See Table below). For our goal of improving under-75 mortality rates, it can be seen that continuing at WI's current trend would provide the most conservative target (-10% change), followed by maintaining current rank (-12%) and continuing at the current US pace (-14%). Improving the state's rank to #8 (halfway to #1) by 2010 would require an 18% improvement from 2000, and moving to #1 a 24% improvement. We have done similar analyses of age specific mortality rates, mortality disparities, percent of population in fair or poor health, and percent uninsured.

This analysis does not identify the "right" objective for Wisconsin, nor does it identify the best ways to achieve any of them. Once measures have been selected and targets set, setting priorities for the most important health determinants, such as the 11 State health priority areas impacting these measures, will be necessary to facilitate improvement.

The fact that the projected 2010 values rely to a certain extent on the stability of state trends could potentially limit this method. It is also important to be aware that there may not be sufficient data available for certain values in some states. For example, the rapid apparent improvement of a small state to a high ranking may largely be a reflection of random or sampling variability in a health measure. It would then be inappropriate to use this state as a benchmark. State mortality data—based on relatively robust non-sampled large numbers—is among the least limited health indicators in this regard. However, care is required in the use and interpretation of this method when setting goals for less-precisely measured population health indicators such as those based on sample data (e.g., smoking prevalence estimated from telephone-based sample surveys).

Identifying specific objective levels in the quest to meet the state health goals of *Healthiest Wisconsin 2010*⁷ not only helps to evaluate progress but also gives public health agents and community members an end towards which to strive. An examination of expected state trends and the state's rank can assist in setting objectives that are optimistic yet feasible.

We hope such approaches may be useful to public and private policy makers, including the new Public Health Council, as they attempt to make progress on well informed health objectives.

References

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Acknowledgement

This work was supported in part by a Blue Cross program grant (2004-2008) to the Institute titled "Making Wisconsin the Healthiest State". We anticipate several Issue Briefs each year to report on work from this grant.

Table 1

Objective type	Objective description	Percent change needed from 2000-2010	Corresponding 2010 objective (age-adj. deaths per 100,000)
Minimum	WI 2010 predicted mortality based on WI's 1990-2000 trend	-10%	318
	Maintain WI's 2000 rank (#16) in 2010	-12%	314
	Improve WI's mortality at the pace of the US 1990-2000 trend	-14%	304
Optimistic	Improve WI's mortality to #8 in 2010 (halfway to #1)	-18%	292
Ambitious	Improve WI's mortality to #1 in 2010	-24%	271