

## INTRODUCTION

An understanding of the health status of a population is necessary to plan, implement, describe, and evaluate public health programs that control and prevent adverse health events. A 1988 Institute of Medicine committee,<sup>1</sup> in a report entitled, *The Future of Public Health* (Institute of Medicine, 1988) recommended that...

“...every public health agency regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems.”

The U.S. Public Health Service also stresses the need for accurate and timely public health surveillance data to be available in a usable form, and has included surveillance activities among its *Healthy People 2000 National Health Promotion and Disease Prevention Objectives*. (U.S. Public Health Service, 1991)

Health Status can be measured in a variety of ways, including rates of mortality from various causes, incidence or prevalence of disease and disability, utilization of health care, and self-reports from individuals. Each method has strengths and weaknesses on a variety of dimensions, such as how well it represents the actual current health status of a population, whether it can be applied at the individual level, whether it focuses on the health of individuals in a health care system versus the system itself, and how easy it is to produce and analyze.

The survey included a variety of measures of health status, including disease prevalence, disability, behavioral risk factors, health care utilization, and perceived general health status. One measure in particular, the *Medical Outcomes Study SF-12* (a 12-item short-form health survey) (Ware, Kosinski, & Keller, 1996), was used to summarize the general physical and mental health status of individuals in the survey. The SF-12 measures a person’s perceived health on a number of dimensions (e.g., general health status, pain, depression, etc.). It was designed to measure patient outcomes in medical practice and clinical research, to monitor transitions in health status over time for diverse groups, to measure the burden of populations suffering from chronic medical and psychiatric conditions compared to well populations, to evaluate the relative benefits of different treatments, and to compare health outcomes across different health care delivery systems. (McHorney et al., 1993, 1994)

The SF-12 results reported here were derived from the responses of 6,131 randomly-selected adult survey respondents. They have been weighted to represent all persons in Utah age 18 or over.

***Health Status in Utah*** uses the SF-12 as a focal point from which other health conditions and behaviors are viewed. The Summary of Findings is followed by a Highlights section, which presents major findings

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<sup>1</sup> In 1970 The Institute of Medicine was chartered by the National Academy of Sciences to examine policy and advise the federal government on matters related to public health. In 1986 the Institute formed The Committee for the Study of the Future of Public Health to examine issues such as the current definition of “Public Health” and the appropriate role of government in assuring the health of the population. The committee’s report, entitled *The Future of Public Health*, was published in 1988. The report concluded that there are three core functions of public health agencies at all levels of government: assessment, policy development, and assurance.

with figures and accompanying text. The statistical estimates used to generate the graphs in the Highlights section are located in the Reference Tables, which also contain additional information that does not appear in the graphs. The Highlights and the Reference Tables are organized around the following topics:

- I. ***Interpreting the SF-12*** compares Utah results on the SF12 with national norms, explores results of the 12 individual SF-12 items, and describes the meaning of the physical health (PCS) and mental health (MCS) composite scale scores. This section is designed to provide Utah norms on the SF-12 and other information to assist persons using the SF-12 in clinical and research settings in Utah.
- II. ***The Influence of Disease and Lifestyle on Quality of Life*** compares the relative quality of life of persons with various health conditions (such as diabetes and heart disease) and lifestyle characteristics (such as smoking and exercise).
- III. ***The Health Status of Populations in Utah*** compares respondent's scores on the SF-12 across various demographic populations in Utah, including groups based on age, sex, education, employment, marital status, Hispanic status, race, income, religion, and geographic area.
- IV. ***A Profile of Utahns With Poor Health Status*** explores the characteristics of respondents with low scores on the SF-12 physical or mental health composite scales using demographic and health system characteristics reported in the *Health Status Survey*.

Readers interested in learning about the survey's sampling design, estimation procedures and weighting schemes may consult the ***Technical Notes: General Technical Background to the 1996 Health Status Survey*** section at the end of the report.

Readers interested in learning more about the background of the SF-12 and SF-36 health status measures may consult the ***Analysis of the SF-12 Scale*** section also in the *Technical Notes* at the end of this report.