Abstract

The purpose of this study is to evaluate factors influencing states' success in reaching the goals of *Healthy People 2000, National Health Promotion and Disease Prevention Objectives*. Scholarly literature supports three factors that influenced states' success in reaching *Healthy People 2000* goals. The three factors are gubernatorial power, health expenditure per capita, and policy liberalism. To determine the effects these three factors had on *Health People 2000,* a multiple regression testing the impact of the three factors was run. The results of the study show that only policy liberalism effects states' success in reaching *Healthy People 2000* goals. The relationship between the number of goals achieved and state policy liberalism was positive. This research study is helpful in guiding politicians, administrators, and health professions by showing them what factors do and do not affect states' success in reaching national health goals.

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Chapter One [1]
Introduction

In September 1990, the United States Department of Health and Human Services released the *Healthy People 2000, National Health Promotion and Disease Prevention Objectives* (hereafter *Healthy People 2000* report)*. Healthy People* 2000 acted as a map that guided the nation to better health from 1990 to 2000. The purpose of *Healthy People 2000* was to provide goals and objectives to the United States as a way to promote health awareness and monitor health goals over ten years. *Healthy People 2000* not only organized the nation to work together to achieve national health goals, it also helped identify priority areas for improvement (*Healthy People 2000: Final Review* 2001). One such goal (Objective 1.1) was to reduce coronary health disease deaths to no more than 100 per 100,000 people (*Healthy People 2000: Final Review 2001*). This national goal was part of the physical activity and fitness objectives priority area (Priority Area 1). Another goal, which was part of education and community-based programs objectives (Priority Area 8), was to increase the high school graduation rate to at least 90 percent, thereby reducing risks for multiple problem behaviors and poor mental and physical health (Objective 8.2) (*Healthy People 2000: Final Review* 2001).

Healthy People 2000 was the second installment of the Federal plan to organize health goals by setting objectives. The first phase began in 1979 when the Surgeon General issued *Healthy People, the Surgeon General's Report on Health Promotion and Disease and Prevention*. This first phase outlined specific objectives for the next ten years and monitored their success over time. The implementation of the 1979 *Health*

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[1] To see other Texas State Applied Research Projects dealing with health issues see Glen Neal, 2002; Rossana Barrios, 2001; Melody Crain Kuhns, 1998; Rebecca Berryhill, 1998; and Albert Ruiz, 2004.

People established targets for health improvements in the five life stages of infancy, childhood, adolescence, adulthood, and older age (*Health People 2000: Leading Health Indicators* 2000).

By 1990, the health of the nation was described as "better than ever" and for the first time health progress was being tracked and monitored (Scott, Tierney and Waters 1991).

After the installment of the "management by objectives" technique, the health status of the nation began to improve, showing the benefits of an organized health plan (Scott, Tierney and Waters 1991). The "management by objectives" technique proved that the Nation's health could be monitored and evaluated to ensure health goals are met. The ability to quantify and assess progress on health objectives is at the heart of the *Healthy People* initiative (*Healthy People 2000: Final Review* 2001).

Research Purpose

Given the success of the first phase of *Healthy People* and the excitement of the installing a continual "management by objectives" plan, *Healthy People 2000* was designed to be a success. Even with the previous accomplishments not all states were successful in reaching and maintaining *Healthy People 2000* goals and objectives. The purpose of this research is to identify factors influencing states' success in reaching *Healthy People 2000* goals.

Chapter Summaries

To achieve the research purpose, this study is divided into five chapters. Chapter Two, Setting, provides information about the history and structure of the *Healthy People 2000* study. Chapter Three, Literature Review, evaluates scholarly literature that

identifies factors influencing states' success in reaching *Health People 2000* goals. This chapter also develops the hypotheses used in the research project. Chapter 4, Methodology, provides the steps and procedures used to collect the data for this study as well as an operationalization of the conceptual framework. Chapter 5, Results, presents the results and findings of this research project. Finally, Chapter 6, Conclusions, wraps up the study, by summarizing the paper and the research findings.

Chapter 2
Setting

In 1979, a publication known as *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* was published. This publication was a first-ever nationwide health initiative that requested all health professionals and citizens of the United States work together to "reduce preventable death and disease for all Americans." The 1979 publication was the first plan expressing national public health goals the United States ever had. The plan presented goals for each population group and challenged Americans to reach the goals by 1990. The following year, 1980, *Healthy People* was followed by *Objectives for the Nation*, which presented more specific and quantifiable objectives. The "Objectives" were tracked and a review of the progress was published. By the middle of the 1980s, it was apparent that states varied in the ability to address and work toward the objectives. This occurrence reinforced the need for greater focus, improved capacity, and sustained efforts across all jurisdictions to reach health goals (The National Health Objective Act, 1998).

As the overall results of *Healthy People* were generally impressive and close to the targets set a decade previously, the goals became a compelling testimony to the notion of establishing health objectives and monitoring the results (*Healthy People 2000*: *Leading Health Indicators* 2000). Realizing the country needed to work toward health goals and improve health standards, the Surgeon General developed and implemented the second installment of the national health plan. *Healthy People 2000, National Health Promotion and Disease Prevention Objectives* was the second of the health objectives

plans. *Health People 2000* presented goals and objectives that challenged states to work toward the year 2000.

Healthy People 2000* acted as a map or a guide for Americans; it presented goals and objectives and provided quantifiable targets for the year 2000. The plan presented a strategy devised to move the countries citizens toward better health. Three broad goals were used: 1) increase the span of healthy life, 2) reduce health disparities, and 3) achieve access to preventative services (*Healthy People 2000: Final Review* 2001).

To help reach these three broad goals, 319 national objectives were identified. The national objectives were chosen to address a wide array of health issues. One example of a national health objective is to reduce pregnancies among females aged 15-17 to no more than 50 per 1000 adolescents (Objective 5.1). The national objectives were organized into 22 priority areas[2]. Objective 5.1 was assigned to Priority Area 5 titled Family Planning. *Healthy People 2000* divided the 22 priority areas into four health promotion areas: health promotion, health protection, preventative services, and surveillance and data. Family Planning (Priority Area 5) was under the Health Promotion Priority Area. Objectives identified as "sentinel objectives" were representative of the scope and magnitude of the improvements envisioned in *Healthy People 2000* (*Healthy People 2000*: Final Review).

 Healthy People 2000: Final Review (2001) asserts that teenage pregnancy rates had declined considerably in the 1990s. The pregnancy rate was 80.3 for women ages 15-17 years in 1990 and had decreased to 67.8 by 1996 (*Healthy People 2000: Final Review 2001). In this example the baseline was 80.3 pregnancies per 1,000 adolescents.

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[2] The activities of each of the 22 priority areas were coordinated by at least one agency of Public Health Service.

The goal was to reduce the pregnancies among females to no more than 50 per 1,000 adolescents. Although the goal was not met progress toward the goal was achieved and the baseline was reduced by 41 percent.

Planners and developers of *Healthy People 2000* were optimistic and anxious to see the nation's success in reaching the national goals set forth by the plan.   The Secretary of Health and Human Services, Louis W. Sullivan, MD, stated, "the success of the plan can be measured "by increasing life expectancy, reducing health status disparities among American, and improving access to care, health education, and preventive services for all Americans" (Scott, Tierney, and Waters 1991, 145).

Sentinel Objectives

Forty-seven selected "sentinel objectives" narrowed and focused the study as a way to monitor states' success in reaching *Healthy People* 2000 goals.   Sentinel objectives are selected objectives that are representative of the study. By narrowing the focus from 319 total objectives to a select 47, researchers were able to report progress and compare statistics on the chosen objectives. The identification of sentinel objectives made *Healthy People 2000* data more manageable for researchers.[3]   The sentinel objectives increased the usefulness of the study by serving as a focus of national attention and as a tool for monitoring America's health (Leading Indicators, *Healthy People 2000*). The example objective, Objective 5.1, was one of the 47 sentinel objectives.

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[3] Objective 22.1 (Develop Health Status Indicators) was the only objective under the Surveillance and Data Systems Priority Area. This objective developed a set of Health Status Indicators (HIS). The purpose of the HSIs was to make data both measurable and comparable at national, state, and local levels. The goal for Objective 22.1 was to "develop a set of health status indicators appropriate for Federal, State, and local health agencies , and establish use of the set in at least 40 states" (*Healthy People 2000: Final Review* 2001, 311). If this goal is reached, future health data will be comparable on all levels providing a better idea of which states reached health goals.

Purpose of *Healthy People 2000*

The purpose of *Healthy People 2000* was to promote public health understanding and engage the country on a mission of achieving healthier lives. The approach represented and addressed a broad array of health issues and employed a variety of Public Health Services to get the job done. *Health People 2000* organized the objectives and goals into a scientific approach used to reach optimal health for the country (*Health People 2000 Leading Health Indicators* 2000).

Results of Health People 2000

Results at the national level revealed that over half of the 319 objective goals in *Healthy People 2000* were met or movement toward the goal was noticed. More specifically, 22 percent of the objectives were reached or surpassed by states by the year 2000 and 41 percent of the objects showed significant movement in the direction of the goals. Of the 38 percent of objectives remaining, 15 percent showed movement away from the targets, 11 percent showed mixed results, and two percent showed no change from the baseline. The remaining eight percent could not be assessed (*Healthy People 2000: Final Review* 2001, 2). Table 2.1 shows the progress of the objectives by priority area. The table shows how many objectives from each priority area met and moved toward the national goal as well as the number of objectives with mixed results, no change or movement away from the targets.

Table 2.2
Progress of the Objectives by Priority Area

Area	Priority Area Title	Met	Moved toward target	Mixed progress	No Change	Moved away from target	Cannot assess	Total
1	Physical Activity and Fitness	1	6	0	1	4	1	13
2	Nutrition	6	13	2	0	6	0	27
3	Tobacco	7	10	5	1	1	2	26
4	Substance Abuse: Alcohol and Other Drugs	3	7	4	0	2	4	20
5	Family Planning	0	8	3	0	0	1	12
6	Mental Health and Mental Disorders	5	1	1	0	7	1	15
7	Violent and Abusive Behavior	7	4	0	0	5	3	19
8	Educational and Community-Based Programs	5	2	2	1	1	3	14
9	Unintentional Injuries	7	11	2	2	2	2	26
10	Occupational Safety and Health	7	7	1	1	4	0	20
11	Environmental Health	4	9	2	0	1	1	17
12	Food and Drug Safety	2	5	0	0	1	0	8
13	Oral Health	1	12	1	1	2	0	17
14	Maternal and Infant Health	1	8	2	1	3	2	17
15	Heart Disease and Stroke	3	12	0	0	2	0	17
16	Cancer	7	8	2	0	0	0	17
17	Diabetes and Chronic Disabling Conditions	2	6	3	0	11	1	23
18	HIV Infection	5	5	1	0	3	3	17
19	Sexually Transmitted Diseases	4	7	2	0	1	3	17
20	Immunization and Infections Diseases	3	7	5	0	2	2	19
21	Clinical Preventive Services	1	2	2	0	1	2	8
22	Surveillance and Data Systems	2	4	1	0	0	0	7
Total[4]		83	154	41	8	59	31	376
Percent		22%	41%	11%	2%	15%	8%	100%

Source: National Center for Health Statistics. 2001. *Healthy People 2000*: Final Review

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[4] Because some priority areas share identical objectives, certain objectives are presented in more than one priority area, which increases the total number of objectives to 376 including the duplicates.

Future of Healthy People

The original *Healthy People* (1979) study began a process of developing national health goals and bringing the country together to reach optimal health. It presented a basis for the newer version in 1990; as the millennium drew to an end, plans for a newer *Health People* study were under way. *The Healthy People 2010: Objectives for Improving Healthy* was released in January of 2000. This new plan is devised to carry health initiatives into the new millennium. As the studies before, the new plan was developed by evaluating the previous studies and creating new goals and objectives for the future. The new study has two broad goals: 1) increase quality and years of life and 2) eliminate health disparities (*Healthy People* 2010*). Healthy People 2010* is the framework for 467 objectives divided into 28 focus areas. The latest edition of the *Healthy People* series is dedicated to meeting national health goals. In developing the plan, coordinators evaluated baseline statistics and developed new goals to challenge the nation over the next ten years.

Chapter Summary

As a whole *Healthy People 2000* was successful in helping the nation identify and work to reach health goals. Over half of the national goals were met or showed positive movement. Even with level of success the national objectives were not all met. Every state in the nation did not meet all 319 national objectives. States' success in reaching health goals is important when evaluating national health, and the next chapter reviews scholarly literature that identifies factors influencing states' success in reaching *Healthy People 2000* goals.

Chapter 3
Literature Review

The purpose of this literature review is to examine factors affecting states' ability to reach *Healthy People 2000* goals. The literature review discusses policy priorities and factors that effect the likelihood that a state is successful in reaching targeted health goals. Formal gubernatorial powers, health care expenditure, and level of liberalism are three factors examined and reviewed as possible determinants effecting state's success in reaching the *Healthy People 2000* goals. The literature identifies three hypotheses as factors effecting states' success.

Policy Priorities

The federalist structure of the United States often results in wide variation in policy outcomes. Within the United State there are 50 separate governing bodies that respond to citizens with differing tastes, preferences, incomes, and political orientations. States across the country allocate varying amounts of money and attention to different programs based on policy priorities, social needs, economic condition, federal assistance, and political culture (Schneider and Jacoby 2003). Health is one such area of concern that is addressed and evaluated differently in each state. Some states devote a great deal of attention to problems that are ignored or downplayed in other states (Jacoby and Schneider 2001, 544).

The development of the *Healthy People 2000* agenda provided states with objectives and goals for obtaining optimal state health. Baseline scores were evaluated and target goals were developed. National baselines represent the rate for the United States at the beginning of the monitoring decade (*Health People 2000: Final Review*

2001). For example, Objective 6.1, this objective's national goal was to reduce the rate of suicide to no more than 10.5 per 100,000 people by the year 2000. The baseline for this objective was 11.7 per 100,000 in 1987. By the year 1998, the target was met with a rate of 10.4 incidents of suicide per 100,000 people (*Healthy People 2000: Final Review* 2001, 132).

States were challenged with reaching and maintaining the goals by the year 2000. The *Healthy People 2000* plan provides a "management by objectives" approach of gathering and analyzing states' health status, which can be used to evaluate states' health policy and expenditure amounts. This information is useful to compare states successful in reaching *Healthy People* 2000 goals with states that failed. By studying success and evaluating factors that influence states' success in reaching *Healthy People 2000,* researchers and politicians can better understand the factors that contribute to a states' likelihood of reaching health policy priorities.

The literature identifies three factors that explain variations in health policy outcomes. The factors are gubernatorial power, state health expenditures, and public policy opinion. Policy priorities outline governmental decision agendas and operationalize the way law makers plan to address public state-level issues (Jacoby and Schneider 2001). Health policy is an area affected by legislators' policy priorities and varies from state to state. The purpose of this chapter is to identify and examine factors that influence state health policy.

Gubernatorial Power

At the top of each state's political and governmental hierarch is the governor – the person who personifies the state to many (Beyle 1999, 191). A governor's job is to take

responsibility for the state's needs by leading the two legislative houses through the steps of policymaking. State constitutions outline various levels of gubernatorial power. The best way to compare executive power in states is to focus on the formal powers of the governor (Dye 1969). Formal powers, or institutional powers, of the governor are powers given to the governor by the states' constitutions, statutes, and the voters when they vote on constitutional referenda (Beyle 1999).

In 1965, Joseph M. Schlesinger wrote an article comparing strengths of governors. In the article *The Politics of the Executive,* Schlesinger shows that powers of the governor vary from state to state: some strong, some weak, and some in between (Beyle, 1999). In this article Schlesinger reviewed four institutional powers of governors and developed an index number to compare the strengths of the top executives. The four institutional powers Schlesinger uses to compose the index are the governor's tenure potential, the ability of the governor to appoint agency administrators, governor's budget and veto powers. The use of multiple indicators, calls for an index score, because the researcher has definite theoretical concepts that he wishes to relate (McCally 1966).

The level of gubernatorial power influences the governor's control over the state. The powers of the governors in state politics vary among the fifty states. In Schlesinger's index, the highest possible score was 19, and at the time the index was developed only New York's governor was given the highest score. The lowest score, seven, was given to four states: Mississippi, South Carolina, Texas and North Dakota. Dye (1969) maintains that governor's powers can have an observable impact on policy outcomes. Schlesinger's index helps scholars to conceptualize and measure gubernatorial power since it was developed in 1965. Since Schlesinger developed the index discussing and proving

gubernatorial powers many scholars have used the Schlesinger's research to adapt, replicate and update the index.

Thad Beyle (1983) developed one such adaptation of Schlesinger's original gubernatorial power index number. According to Beyle (1968) the replication of an index is one of the hallmarks of scientific research. Replication enhances the validity of original results especially if similar results are obtained by the use of a slightly different mode of research or data collection (Beyle 1968). This adaptation takes into account many states' constitutional changes from the 1950 to 1990. Wes Clarke (1998) used Beyle's (1983) replication of Schlesinger's gubernatorial index to test the relationship between powers of a governor and conflicts within legislatures. In this study Clarke (1998) used Beyle's (1983) gubernatorial index number to test the hypothesis that as the power of the governor increases conflict within legislators decreases. Using an index score Clarke (1998, 16) was able to show that moving one point higher on Beyle's scale of gubernatorial power results in a decrease in conflict of nearly two percentage points.

Rebecca Hendrick and James Garand (1991) also used Beyle's (1983) replication of Schlesinger's original gubernatorial index to explain state's differences in tradeoffs among spending areas of highways, education, health and welfare. In this research Hendrick and Garand (1991) used Beyle's (1983) gubernatorial power index as an independent variable to test the relationship between tradeoff behaviors for each combination of spending areas. "An expenditure tradeoff is a pattern of yearly shifts in spending priorities between policy areas such that an increase in priority of one area is accompanied by a decrease in the priority of another and vice versa" (Hendrick and Garand 1991, 298). Beyel's (1983) index number tests the hypothesis that gubernatorial

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power should be negatively related to the tradeoff behaviors between spending areas. With the use of Beyele's (1983) gubernatorial power index, Hendrick and Garand (1991) were able to have a better understanding of budget tradeoffs between spending areas among states.

Institutional Powers of the Governor

Gubernatorial power is multidimensional; limitations in one dimension, such as budgetary control, can certainly be overcome by having greater appointment or veto authority (Clarke 1998, 14). Schlesinger's (1965) original gubernatorial power index score evaluated governors' tenure, veto, appointive and budget powers. These four institutional powers present a multidimensional index of gubernatorial power. The index was developed by providing individual scores to each of the four powers and combining the scores to develop the index (Schlesinger 1965).

Tenure Potential

Tenure potential is the amount of time a governor can possibly stay in office. States vary in their constitutional provisions for the length of a term and how many times a governor is reelected. "A long tenure enables a governor to influence the actions of other political actors" (Dometrius 1979, 592). The more secure a governor seems with his or her position and job, the more stable the state political system will be (Beyle 1999). During periods of stability, governments are less likely to experience change in policies and law. The length of time governors can serve and whether they can succeed themselves for more than one term are important factors in determining how much power they have (Beyle 1999).

Tenure limits result in substituting experienced politicians for inexperienced ones

(Adams and Kenny 1986). With the change of the state's chief executive comes new ideas, plans and relationships. As a new governor comes to govern a state, he must establish new relationships between legislators and agency heads. Sharansky (1968) expects that a governor with long tenure and extensive veto power will have a relatively strong position vis-à-vis agencies and the legislature. The familiarity between governors, agency heads, and legislatures can result in a smooth and respectful government system. Longer tenure potential helps to strengthen governors' positions with both agencies and legislators (Sharansky 1968). A frequent change in governors may weaken the balance and may cause and uneasy situation to develop.

Thad Beyle (1995, 230) examines the arguments for and against a long gubernatorial tenure of office. One argument for a lengthy stay in the governor's seat is that a long term with the possibility of reelection gives the governor and advisors time to carry out programs. On the other had, if limits are put on gubernatorial terms, governors might move faster and more decisively to achieve their goals and not be afraid of the voters' retribution at the ballot box when an unpopular decision is made (Beyle 1995, 230). In 1994, eleven states allowed governors a four-year term with no restraint on reelection; one state allowed four-year terms with only three re-elections permitted; 35 states allowed four-year terms with two re-elections permitted; one state allowed a four-year term and no consecutive reelections; and two states allowed a two-year term with no restraint on re-election (Beyle 1995).

Veto Power

Veto power is another formal power available to governors that can affect their ability to influence state policy. Governors may have the power to veto whole bills and or

parts of bills that are passed by legislators (Beyle 1999). The veto gives the governor power over legislatures and prevents laws from being passed without the governor's approval. There are differences in the veto power extended to governors: total bill veto, item veto of selected words, and item veto to change the meaning of words (National Association of State Budget Officers 1999).

Governors are able to prohibit spending and program development with the state by stopping an idea before it comes law. Veto power enables governors to be more fiscally responsible by allowing them to stop the spending or allocation of funds in a particular area. Veto power is the prerogative to disallow a piece of legislation passed by the assembly (Clarke 1998). The line-item veto allows the governor to stop or veto only one portion of a bill rather than the entire bill. The purpose of the line-item veto is to curtail spending and promote efficiency in government (Abney and Lauth 1985).

Other types of veto include the item veto and pocket or total bill veto. An item veto is a provision that allows a governor to reject particular items in a piece of legislation such as a sentence, paragraph, or a syntax (NASBO 1999). This type of veto allows the governor to make changes in laws without stopping the bill altogether. A pocket veto occurs when a governor does not sign a bill within the appropriate amount of time. All bills require the signature of the governor before a bill can become a law. If the governor does not sign the bill in time, the bill has been "pocketed" or stopped from becoming law (Prescott, 1950). In the Summer of 1994, 37 state governors possessed the power to item veto and three-fifths of legislators elected or two-thirds of legislators present were needed to override the veto. Six governors have item veto, for which a majority of legislators is needed to override the veto. Five governors had no item veto,

but required special legislative majority to override the governor. One state had no item veto and only a simple legislative majority was needed to override the governor; one state had no veto of any kind (Beyle 1995).

Vetos also provide governors with the power to control the legislative entities within the state. Governors use the veto as a way to ensure leverage over legislation preventing agencies from going over the governor's head and obtaining support from the legislature (Domitrius 1979). The governor's ability to veto bills lets legislators know governors can and will stop or reduce spending and the development of programs. Veto power ensures the governor's influence on spending and program development in policy priority areas.

Appointive Powers

The power to appointment state officials is another institutional power of the governor. Appointment power offers further forms of control' governors may appoint agency heads with congenial policy preferences, and the ability to hire implies the ability to fire (Dometrius 1979, 592). Appointed agency heads work at the pleasure of the governor and generally submit budgets that reflect the governor's policy priorities.

There are wide variations from state to state in the number of appointed and elected officials. Sharansky argues that when there are a large number of separately elected executive officials, greedy agencies will use the elected officials as allies in order to enhance their chances of getting the governor and legislature to approve their budgets (1968, 1223). Some states permit governors to appoint all personnel to key positions in their administration. Other state constitutions outline that governors are not involved in the appointment of state officials and allow a separate body to fill the positions. In these

situations appointments are made either by the legislative houses or nominating committees. Some states allow governors only to approve appointments rather than initiate them (Beyle, 1999). In 1994, only two state governors appoint with out approval of the legislature; in ten states governors appoint and a board approves the nomination; in 28 states someone else appoints and the governor approves or shares the appointment; seven governors along with the legislature approve an appointment made by a nominating committee of the legislature; and in three states someone else appoints and no approval is needed from the governor (Beyle 1995).

States with appointed government officials exhibit different policies than states with elected officials (Sharansky 1968). Sharansky explains that in states with appointed agency heads and states with independent officials, policy outcomes in the area of health and welfare will be more conservative in states with independent agency heads (1968, 123). In these particular states health, and welfare policy will be less in the area of benefits, spending, and number of recipients when compared to states with appointed officials (1968). According to Sharansky in states with officials independent of government appointment less, health policy and programs will have less time and money devoted to them.

Budget Powers of the Governor

An executive budget encompasses, under the chief executive's control, all the agency and department requests for legislatively appropriated funds. It also reflects the governor's policy priorities (Beyle 1999). The executive budget depicts the amount of money allotted to each department and expenditure area for the fiscal period. Building and creating the budget is one of the institutional powers of the governor. Control over

the state budget is useful because the budget is often considered the prime policy document of any administration (Dometrius 1979, 592). The budget is the financial road map for the governing entity until the end of the budget cycle. Power over the budget allows the governor to determine which policy area receives what amount of money.

Abney and Lauth (1998) examine the evolution of the current state budget process. In the middle of the twentieth century, the introduction of the executive budget in some states gave governors the capacity to direct and control financial matters. Over the next sixty years, most states adopted the executive budget, giving the majority of the responsibility to the chief executor, the governor. At the beginning of the 1970s, gubernatorial dominance in the appropriations process was not as pronounced as it had once been. Abney and Lauth (1998) determined that by 1987, legislatures were beginning to take over some of the gubernatorial dominance of the states' appropriations process. This study done by Abney and Lauth (1998) showed that the budget process which had once been the job of the governor was being delegated to other entities of the state government. This phenomenon displays how governors' power to create the executive budget varies from state to state.

As with all other intuitional powers of the governor, each state has different budgeting powers. Some states allow the governor to create and write the entire budget while other states only allow the governor to be part of a budgeting board. In most states (40) the governor has full responsibility to determine the budget, but the legislature has unlimited power to change the executive budget.   In two states the governor has full responsibility to create the executive budget; the legislature may not make changes. In two states the governor has full responsibility; the legislature can increase the budget by a

special majority vote or subject to item veto. On the other end of the spectrum, in four states the governor shares the budget responsibility; the legislature has unlimited power to make changes to the executive budget. In two states the governor shares the responsibility of creating the budget with other elected officials and the legislature can make unlimited changes.

The power to assemble and propose an executive budget gives governors a distinct advantage over legislatures, especially in the area of defining the legislative agenda (Abeny and Lauth 1998). Assembling the executive budget is the governor's way of letting legislatures and agency administrators know the policy priorities. The "budget message" is a vehicle for communicating governors' programmatic and policy preferences (Clarke 1998, 11). Clarke (1998) found that the more power the governor has over creating the executive budget, the more likely it will be for the governor's priority spending areas to receive the funds needed to carry out his/her plans for the fiscal year. Governors' recommendations can change due to policy philosophy, campaign promises, and possibly from personal relationships with agency heads and other state officials (Clarke 1998).

Use of Schlesinger's Gubernatorial Index

The empirical studies that explore influence of gubernatorial power on policy reveal mixed evidence. Thomas Dye (1969) used Schlesinger's gubernatorial index to research the link between major structural characteristics of state governors and public policies in the state. Dye looked at the formal powers of governors to determine if there were any differences in public policy between states with strong and states with weak governors. With the use of Schlesinger's gubernatorial power index, Dye found that

policy outcomes between states generally vary due to economic factors rather than the strength of the governor. His finding shows that the strength of the governor only minimally affects state policy and the real difference between state policies is based on the economy.

Ira Sharkansky used Schlesinger's gubernatorial power index score as an independent variable to identify and measure mechanisms that influence incremental budgeting in state governments (1968). Sharkansky tested the hypotheses that in most states there is a correlation between short term agency success and the willingness of legislatures to provide each agency with budget increases. With the use of Schlesinger's index, Sharansky examines relationships between governors, agencies, and legislators. The research shows that governors' power influences legislative and agency requests for money therefore affecting policy. According to Sharansky (1968, 1230) "a favorable recommendation from the governor seems essential for agency budget success in the legislature." The "favorable recommendation" from the governor provides legislatures permission or a right to grant the agency the funds they requested. In this example gubernatorial power influences policy. It is not clear which direction gubernatorial powers would lean because the governor could support or question policies for or against health. Given governors' potential influence on policy one would expect some influence. Thus, gubernatorial power influences states' success in reaching *Health People 2000* goals.

H1: Gubernatorial power influences states' success in reaching *Healthy People 2000* goals.

Health Expenditures

The amount of money spent in a policy area is the primary way to determine legislatures' priorities. When relative health expenditures are high, legislators express a positive preference toward health policy. When more money is available to health administrators more, they can develop better for screening, education, and treatment. Some states devote a great deal of attention and money to problems that are ignored or downplayed in other states (Jacoby and Schnieder 2001). Expenditure on health policy is an area that varies from state to state. Health expenditures are obviously the policy area associated with *Healthy People* goals.

State budgeting is different from national budgeting because states are legally restricted from increasing state revenues as well as acquiring debt. As a result shifts in policy priority at the state level are evident in the shifting of funds from one spending area to another (Garand and Hendrick 1991). The more money directed to an expenditure area, the more programs created. State expenditures are the most direct empirical manifestation of their policy priorities (Jacoby and Schnieder 2001). When money is allocated to health agencies, in health programs exhibit improvements. More money directed to the area of healthcare will result in more effective and successful state health programs and result in improvement in reaching health goals.

In October of 1990, United States Congress passes the Health Objective 2000 Act, making it law. The purpose of the law was to harness and funnel the energies of sate and local health agencies to achieve Year 2000 Health Objectives. The passing of the Act established that each state would receive financial assistance to collect and analyze relevant health status data, to develop health objective plans, to implement critical

intervention programs, and to evaluate health objectives, state priorities and local programs (Scott, Tierney, and Waters 1991). Later in 1990, Congress passed an amendment to the Health Objective 2000 Act which provided the states with grants to collect and analyze data as well as develop health objective plans, but provided no funds for implementation.

The passing of the Health Objective 2000 Act and the amendment, titled Year 2000 Health Objectives Planning Act, showed that lawmakers understood the importance of financial support but were unable to provide the funding necessary to get all parts of the Health Objectives 2000 Act into full swing. The amendment cut some of the money that was intended to support the *Healthy People 2000* plan. By denying states federal funds needed to execute the programs necessary to meet the health goals, states were left to make budget adjustments to fund health programs. Without resources to complement currently under-funded efforts and to fill obvious gaps, health objective plans will not achieve their potential impact (Scott, Tierney, and Waters 1991).

States strive to reach health goals, but the amount of money available to develop screening, education, and treatment programs affects their success. Laws restrict states from accruing debt and higher taxes are an unwelcome answer (Nicholson-Crotty, Theobald and Wood 2006). Limits on the amount of money available force states to make budget cuts in spending areas to compensate for needs in other expenditure categories. Budgets that are cut in one spending area to fund another are called budget tradeoffs. Budget tradeoffs occur when priorities shift from one spending category to another. Priorities are higher in the areas receiving additional funding, and policy makers show interest in areas receiving additional revenues (Garand and Hendrick 1991)

Higher per-capita health care expenditure indicates that state lawmakers are funneling more money toward health efforts. This additional money addresses health needs and develops programs necessary to reach health goals. Klein (1976) states that public expenditure is the most visible and quantifiable measure of government activity. Devoting money to health needs indicates that legislators recognize health disparities should be addressed and health programs developed. State expenditures are the most direct empirical manifestation of policy makers' and legislators policy priorities (Jacoby and Schneider 2001). Programs, on any level, require adequate funding in order to be effective. How legislators and policy makers allocate funds and the amount of money allotted to an expenditure area will effect the success of the program

Spending levels provide the clearest, most unambiguous indicator of government commitments to address various problems and social issues (Elling 1983; Garand and Hendrick; Hensen 1990; Raimondo 1996; Jacoby and Schnider 2001). The amount of money spent and to which expenditure category it is directed is an indicator of lawmakers' policy priorities. The amount of money allotted in the area of health policy, programs, and development in the state will affect the success of states in achieving health targets and goals.

Working to improve health requires dedication and commitment from legislators, administrators, and all other government entities. Money creates programs and provides resources; without funds there is no way to improve the health of citizens. States that engage more of their funds in health related programs can expect to see better results in

reaching health-related goals. Healthcare expenditure per capita therefore positively affects the results of *Healthy People 2000*.

> H2: Healthcare expenditure per capita positively affects the results of *Health People 2000* results.

Level of Liberalism

The final state characteristic anticipated to influence the number of *Health People* goals achieved by a state is the states' level of liberalism. Literature establishes that states' level of liberalism affects policy outcomes. States with a higher level of public liberalism are generally more likely to promote expenditures for public good. Wright, Erikson and McIver (1987) find that public opinion relates strongly to the liberal versus conservative content of state policies. States with strong liberal opinion tend to be positively associated with health related concerns, such as Medicaid reimbursements, eligibility, services and recipients. States with more liberal citizens and law makers tend to focus their resources on social programs, such as health and welfare rather than education and highways (Nicholson-Crotty, Theobald and Wood 2006).

Frederick J. Boehmke (2005) studied factors determining the number of initiatives that appear on state wide ballots. Boehmke tests the hypothesis that liberal states will have more initiatives due to liberal states' history as progressive institutions and having a greater concern with post-material, quality of life issues (Boehmke 2005). When doing this study, Boehmke (2005, 573) found that the number and type of initiative included on statewide ballots is affected by the citizens' ideology of the state rather than the governor's political party affiliation. This research demonstrates that Republican controlled legislatures have fewer total initiatives while liberal states had multiple types

of initiatives. Further, moralistic initiatives are more likely to be passed and implemented by Republican controlled legislatures.

The research shows that legislators of liberal states are more likely to present initiatives to be voted on. These proposals presented to citizens can range from any area of policy, but Boehmke found that liberal states are more likely to present and pass civil rights and environmental laws (Boehmke 2005, 573). This finding shows that there is a difference between liberal and conservative states in the number and type of laws proposed to citizens. These findings suggest that the presentation of initiatives concerning health policy on state ballots will also vary across liberal and conservative states.

Steven G. Koven and Christopher Mausolff (2002, 72) study the relationship between political culture and public expenditures by dividing states into moralistic, individual and traditionalist groups and by comparing the public expenditures of states in each category. Ira Sharansky's (1969) numerical rating of Elazar's culture types operationalized state political culture. Koven and Mausolff (2002, 71) hypothesized that spending differs considerably among moralistic, individual and traditionalist states and that traditional states placed more emphasis on functions that served to maintain order (corrections and police) and less emphasis on redistributive areas of spending (education and public welfare). Their findings revealed a negative relationship between the political culture and public expenditure (Koven and Mausolff 2002, 75).

Koven and Mausolff's research demonstrated that public expenditures in the United States are not only based on objectives, politics, and economic factors but also political culture. The significant relationship between political culture and public

expenditures suggests that political culture and states' level of liberalism will influence the amount of spending in an expenditure area. Hence, health expenditures should be affected by states' level of liberalism.

William G. Jacoby and Saundra K. Schneider (2001, 545) examine the variability of policy priorities across the United States. This study establishes that policy priorities are the component of governmental decision making in which officials allocate scarce resources, in the form of expenditures, to different programs. They maintain that policy priorities are the "bridge" between public demands and governmental services and are best determined by the amount of money governmental officials dedicate to the policy area. Garand and Hendrick (1991) maintain that all astute observers of the political system know that adequate financing is a necessary precondition for any meaningful policy activity. In this study Jacoby and Schneider (2001) used the Wright, Erickson, and McIver's (1993) measure of state electorate partisanship and ideology score to determine a relationship between public opinion and policy priorities among states.

Jacoby and Schneider (2001, 559) found that state public opinion influences state policy choices. States with larger numbers of Democratic Party identifiers within their electorates tend to focus their resources on programs that provide particularized benefits to needy groups. This relationship, established by Jacoby and Schneider, shows that astate's level of liberalism affects policy and expenditure priorities. Health policy is an expenditure area affected by a lack of funds available to develop screening and treatment programs for needy underserved citizens. The study by Jacoby and Schneider supports the hypothesis that a state's level of liberalism influenced the outcome of *Healthy People 2000*.

States with higher levels of liberalism are more likely to favor healthcare spending than their conservative counterparts. States with higher levels of liberalism would expect policy priorities focused around social concerns. In governing bodies where liberal legislatures create policies and laws expenditure tradeoffs favor social welfare and health (Nicholson-Crotty, Theobald and Wood 2006). A states' level of liberalism should increase the number of *Healthy People 2000* goals met because liberal voters are more likely support health initiatives. Thus, a state's level of liberalism positively affects the results of *Healthy People 2000* goals.

> H3: The states' level of liberalism positively affects the results of the *Healthy People 2000* goals.

Conceptual Framework

A review of the literature identified three factors that may influence states' success in reaching health goals and objectives. Literature findings have developed a set of hypotheses. The literature supports gubernatorial power, state health expenditure, and state's level of liberalism as factors influencing the likelihood of achieving the *Healthy People 2000* goals. The purpose of this research is to determine if these three factors do affect states' success in reaching the *Healthy People 2000* goals.

This research is explanatory and uses three formal hypotheses. Explanatory research and the formal hypothesis are the mainstay of social and policy science (Shields and Tajalli 2006, 34). According to Shields and Tajalli, the research hypothesis is the organizing engine that drives explanatory research (2006, 34). Table 3.1 summarizes the hypotheses and links them to the literature.

Table 3.1
Conceptual Framework Linked to Literature

Hypothesis	Supportive Sources
H1: Gubernatorial power influences states' success in reaching goals in Healthy People 2000 goals.	Dye 1969 Dometrius 1979 Abney and Lauth 1985 Sharansky 1968 Clarke 1998 Beyle 1968
H2: Average healthcare expenditure per capita from 1990-2000 influences states' success in reaching Healthy People 2000 goals.	Jacoby and Schnieder 2001 Nicholoson-Crotty, Theobald, and Wood 2006 Garand and Hendrick 1991 Scott, Tierney and Waters 1991 Matteo 2003 Klein 1976
H3: States' level of liberalism influences results in Healthy People 2000 goals.	Miller 2005 Hendrick and Garand 1991 Jacoby and Schnieder 2001 Budget and Hofferbert 1990 Nicholoson-Crotty, Theobald, and Wood 2006 Koven and Mausolff 2002 Wright, Erikson and McIver 1987

Summary

Healthy People 2000 was a health plan for the country. The plan presented goals and objectives for medical professionals, citizens, and law makers of the country to try to reach by the year 2000. States' success in reaching the goals varies across the nation. The literature suggests that formal gubernatorial powers, health expenditure, and policy liberalism are three factors which affected states' success in reaching *Healthy People 2000* goals. This research project will determine if the three factors did in fact influence states' success in reaching *Healthy People 2000* goals. The next chapter describes the steps taken to test the three hypotheses.

Chapter 4
Methodology

This chapter describes the steps taken to test the hypothesis of this study and discusses the methodology used to test the research purpose of this study. The hypotheses are operationalized through variables found in the literature. This chapter contains definitions of each variable and discusses the sources of the existing data. The hypotheses are operationalized in Table 4.1.

Table 4.1
Operationalization of the Conceptual Framework

Dependent Variable	Direction of Hypothesis	Definition	Data Source
State Success in reaching goals		Number of sentential goals each state reached range (0-25)	Healthy People 2000: Review
Independent Variables			
Formal Gubernatorial Powers		Gubernatorial Power Index Number Score ranging from 4-20. Includes governor's: - Veto Power - Budget Power - Tenure Potential - Appointive Power	Joseph Schlesinger: *The Politics of the Executive* – Gubernatorial Index method with Thad Beyel's scores inserted.
Health Expenditure	+	Average Health Expenditure per capita from years 1991 - 1998	National Institute of Health: Health Expenditure Data
Level of Liberalism	-	A numerical score indicating state's Policy Liberalism Index. Index number composed of policy based 5 state-level issues. Lower numbers represent more liberal state and higher numbers represents more conservative state.	Virginia Gray, David Lowery , Matthew Fellowes and Andrea McAtee: *Public Opinion, Public Policy, and Organized Interests in the American States* – Policy Liberalism Index

Dependent Variable

States' success in reaching the goals of the *Healthy People 2000* serves as the dependent variable. Of the 319 objectives of the study 47 were selected as sentinel objectives. A sentinel objective is an objective representative of the scope and magnitude

of the improvement envisioned in *Healthy People 2000* (Healthy People 2000: Final Review 2000, 30). Of the 47 sentinel objectives, 25 had data comparable from state to state. The dependent variable is the number of sentinel objectives reached by each state. The number of sentinel objectives achieved by the states range from two (Arkansas and Mississippi) to 16 (Massachusetts). The data for states' success in reaching the sentinel goals is obtained from the *Healthy People 2000: Final Review*[5]. Table 4.2 lists the sentinel objectives used for this study and the national goal for the objective. Table 4.5 lists the number of sentinel objectives met by each state.

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[5] For a state to "reach" the *Health People 2000* goal the target must be met for 2 years in a row or in two successive surveys.

Table 4.2
Sentinel Objectives

Objective	Objective Number	Objective Description	Objective Met If …
1	1.5	Sedentary lifestyle	Reduce to no more than 15 percent the proportion of people aged 6 and older who engage in no leisure-time physical activity
2	3.4	Cigarette smoking prevalence	Reduce cigarette smoking to a prevalence of no more than 15 percent among people age 18 and older
3	4.1	Alcohol-related motor vehicle crash deaths	Number of annual deaths caused by alcohol-related motor vehicle crashes to o more than 5.5 per 100,000 people
4	5.1	Adolescent pregnancy	Number of annual pregnancies among females aged 15-17 to no more than 50 per 1,000 adolescents
5	6.1	Suicide	Number of annual suicides were reduced to no more than 10.5 per 100,000 people
6	7.1	Homicide	Number of annual homicides were reduced to no more than 7.2 per 100,000 people
7	9.1	Unintentional injury deaths	Number of annual unintentional injuries were reduced to no more than 29.3 per 100,000 people
8	9.12	Motor vehicle occupant protection systems	Increased use of safety belts and child safety seats to at least 85 percent of motor vehicle occupants.
9	10.1	Work-related injury deaths	Number of annual work-related injuries to no more than 4 per 100,000 full-time workers.
10	10.2	Work-related injuries	Number of annual work-related injuries resulting in medical treatment, lost time from work, or restricted-work activity to no more than 6 cases per 100 full time workers.
11	11.5	Air quality	Number of human exposure to criteria air pollutants were reduced to at least 85 percent in the proportion of people who live in counties that have not exceeded any Environmental Protection Agency standard for air quality in the previous 12 months.
12	14.1	Infant morality	Number of annual infant morality rate to no more than 7 per 100,000 live births
13	14.5	Low birth rate	Number of annual low birthweights to an incidence of no more than 5 percent of live births and very low birthweights no more than 1 percent of live births
14	14.11	Prenatal care in first trimester	Increase the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy to at least 90 percent of pregnancies
15	15.1	Coronary heart disease deaths	Number of annual coronary heart disease deaths to 100 per 100,000 people
16	15.2	Stroke deaths	Number of annual stroke deaths to no more than 20 per 100,000 people
17	16.1	Cancer deaths	Reverse the rise in cancer deaths to achieve an annual rate of no more than 130 per 100,000 people
18	16.11	Breast examination and mammograms	Increase the percent of women aged 50 and older who have a clinical breast exam to at least 60 percent
19	16.12	Pap tests	Increase the percent of women aged 18 and older who have ever received a Pap test to 95 percent and to at least 85 percent of those who have receive a Pap test within the preceding 1 to 3 years
20	17.9	Diabetes-related deaths	Number of annual diabetes-related deaths to no more than 34 per 100,000 people
21	19.1	Gonorrhea	Number of annual gonorrhea incidence to no more than 100 per 100,000 people
22	19.3	Primary and secondary syphilis	Number of annual primary and secondary syphilis incidence to no more than 4 per 100,000 people

23	20.1	Measles	Numbers of annual indigenous cases of vaccine-preventable diseases reduce[6]
24	20.11	Childhood immunization	Increase immunization levels [7]
25	21.4	Financial barriers to receipt of clinical preventative services	Improve financing and delivery of clinical preventive services so that virtually no American has a financial barrier to receiving the screening, counseling and immunization services recommended by U.S. Preventative Services Task Force

[6] National Objective 20.1, to reduce indigenous cases of vaccine-preventable diseases, to: 0 cases of Diphtheria among people aged 25 and younger; 0 cases Tetanus among people age 25 and younger; 0 cases of Polio' 0 cases of Measles; 0 cases of Rubella; o cases of Congenital Rubella Syndrome; 500 cases of Mumps and 1,000 cases of Pertussis (annually).

[7] National Objective 20.11, to increase immunization levels, to:
- Basic immunization series among children age 2: at least 90 percent
- Basic immunization series among children in licensed child care facilities and kindergarten through post-secondary education institutions: at least 95 percent
- Hepatitis B immunization among high-risk populations, including infants of hepatic B surface antigen positive mothers to at least 90 percent; occupationally exposed workers to at least 90 percent; injecting drug users in drug treatment programs to at least 50 percent; and men who have sex with men to at least 50 percent.
- Pneumococcal pneumonia and influenza immunization among institutionalized chronically ill or older people: at least 80 percent
- Pneumococcal pneumonia and influenza immunization among noninstitutionalized, high risk populations, as defined by the Immunization Practices Advisory Committee: at least 60 percent.

Independent Variables

    Gubernatorial Powers

This study measures formal gubernatorial powers by using Joseph Schlesinger's gubernatorial index. Schlesinger's index is primarily useful as an indicator of the governor's influence over administrative agencies (Dometrius 1979). Schlesinger's article titled "The Politics of the Executive" reviews the formal powers of governors and develops an index. Schlesinger evaluates governors' tenure potential, the appointive powers of governors, governors' control over the state budget, and governors' veto powers. Because the index was devised in 1965, many state constitutions have changed formal powers of the governor. To account for these changes, the four institutional powers of the governor are used, but different numbers are inserted to compute the index. The index in this study uses the same institutional powers as Schlesinger discussed in 1965 but incorporates Beyle's (1999) updated scores for each of the four powers.

Thad Beyle (1999) devised a replication of Joseph Schlesinger's gubernatorial index score in an article titled "The Governors". The article, written in 1999, uses the four institutional powers Schlesinger included in his original index. Beyle updates the index and makes concessions and changes where necessary. This study uses the point system devised by Thad Beyle to operationalize governors' tenure potential, the appointive powers of governor, governors' control over the state budget, and the governors' veto powers.

An index uses multiple indicators and is useful when definite theoretical concepts need to be related and there is no "single, unambiguous, direct, operational definitions" (McCally 1996). The gubernatorial index scores range from 5-20. Table 4.3 shows the

breakdown of the gubernatorial power index and Table 4.4 shows the actual scores and

totals for the index of each state.

Table 4.3
Gubernatorial Power Scale

Element	Definition	Scale
Tenure Power	Scale of 5-1 points is assigned to states based on the tenure power of the governor.	4 year-term, no restraint on re-election: 5 points 4 year term, only three terms permitted: 4.5 points 4 year-year term, only two terms permitted: 4 points 4 year-term, no consecutive re-election: 3 points 2 year-term, no restraint no re-election: 2 points 2 year-term, only two permitted: 1 point
Appointive Potential	Governor's appointment powers in six major functional areas. The six individual office scores are totaled and then averaged and rounded to the nearest .5 or for the state score. That average score is then rounded to the nearest .5 between 0 and 5.	Governor appoints, no approval needed: 5 points Governor appoints, a board council, or legislature approves: 4 points Someone else appoints, governor approves or shares appointment: 3 points Someone else appoints, governor and others approve: 2 points Someone else appoints, no approval or confirmation needed: 1 point
Budget Powers	Scale of 1-5 assigned to states based on the control the governor has over the budget process.	Governor has full responsibility; legislature may not increase executive budget: 5 points Governor has full responsibility; legislature can increase special majority vote or subject to item veto: 4 points Governor has full responsibility; legislature has unlimited power to change executive budget: 3 points Governor shares responsibility; legislature has unlimited power to change executive budget: 2 points Governor shares responsibility with other elected official; legislature has unlimited power to change executive budget: 1 point
Veto Powers	Scale of 1- 5 points based on Governor's veto powers.	Governor has the item veto and a special majority vote of the legislature is needed to override a veto: 5 points Governor has item veto with a majority of the legislators elected needed to override: 4 points Governor has item veto with only a majority of the legislators present needed to override: 3 points No item veto, with special legislative majority needed to override: 2 points No item veto, only simple legislative majority needed to override: 1 point
Total Gubernatorial Power Score	Total of the 4 elements	Scores can range from 5-20 points

Source: Beyle, Thad. 1999. "The Governors" in Virginia Gray, Russell Hanson, and Herbert Jacob *Politics in the American States, A Comparative Analysis*. (Washington, D.C.: CQ Press, 1999).

Table 4.4
Gubernatorial Power Index Totals

State	Tenure Potential	Appointative Power	Budget Power	Veto Power	Total
Alabama	4	2	3	4	13
Alaska	4	3.5	3	5	15.5
Arizona	4	2.5	3	5	14.5
Arkansas	4	2.5	3	4	13.5
California	4	3	3	5	15
Colorado	4	4	3	5	16
Connecticut	5	3	3	5	16
Delaware	4	3	3	5	15
Florida	4	1.5	3	5	13.5
Georgia	4	0.5	3	5	12.5
Hawaii	4	2.5	3	5	14.5
Idaho	5	2	3	5	15
Illinois	5	3	3	5	16
Indiana	4	4	3	2	13
Iowa	5	3	3	5	16
Kansas	4	3	3	5	15
Kentucky	4	3	3	4	14
Louisiana	4	3.5	3	5	15.5
Maine	4	3.5	3	4	14.5
Maryland	4	2.5	5	5	16.5
Massachusetts	4	1	3	4	12
Michigan	4	3.5	3	4	14.5
Minnesota	5	2.5	3	4	14.5
Mississippi	4	2	3	4	13
Missouri	4	2.5	3	4	13.5
Montana	4	2.5	3	4	13.5
Nebraska	4	3	4	4	15
Nevada	4	3.5	3	2	12.5
New Hampshire	2	3	3	2	10
New Jersey	4	3.5	3	5	15.5
New Mexico	4	4	3	5	16
New York	5	3.5	4	5	17.5
North Carolina	4	3	3	2	12
North Dakota	5	2.5	3	5	15.5
Ohio	4	4.5	3	5	16.5
Oklahoma	4	1	3	5	13
Oregon	4	2.5	3	5	14.5
Pennsylvania	4	4.5	3	5	16.5
Rhode Island	4	4	3	2	13
South Carolina	4	2	2	5	13
South Dakota	4	3.5	3	5	15.5

Tennessee	4	4	3	4	15
Texas	5	3.5	2	5	15.5
Utah	4.5	3.5	3	5	16
Vermont	2	4	3	2	11
Virginia	3	3.5	3	5	14.5
Washington	4	2.5	3	5	14.5
West Virginia	4	4.5	5	5	18.5
Wisconsin	5	5	3	5	18
Wyoming	4	4	3	5	16

Source: Beyle, Thad. 1999. "The Governors" in Virginia Gray, Russell Hanson, and Herbert Jacob *Politics in the American States, A Comparative Analysis*. (Washington, D.C.: CQ Press, 1999).

Health Expenditures

The average healthcare expenditure per capita from 1991-1998 is also an independent variable. This number will be an average of each of the states' health expenditure from 1991-1998. The average healthcare expenditures per capita ranges from $2340 in Utah to $4095 in Massachusetts, the data provided by the National Institute of Health. Table 4.6 lists the average per capita health care expenditure by each state.

Level of Liberalism

The level of liberalism is the third independent variable used in the research project. The variable is constructed as an index. A 2004 article by Virginia Gray, David Lowery, Matthew Fellowes, and Andrea McAttee titled "Public Opinion, Public Policy, and Organized Interest in the American States*"* explains the index used to measure a states' level of liberalism. The policy-based index measures policy liberalism in states.

The liberalism index is a revision of the Erikson, Wright, McIver (EWR) index number developed in 1993. The EWR model looked at state opinion on liberalism and legislative liberalism by using a CBS telephone poll. The new liberalism index developed by Gray, Lowery, Fellowes, and McAttee used five state issues: gun control,

abortion, welfare eligibility, right to work laws, and progressitivy of the tax structure (2004). This new index includes social issues and expenditures; liberal states have high values and conservative states have low values. The index number does not include scores from Alaska and Hawaii; therefore, the states are not incorporated into the regression analysis.

Statistics

This research uses existing data to test three formal hypotheses. The research technique used to test the hypotheses is a multiple regression analysis. Multiple regression estimates the effects of independent variables on one dependent variable. Multiple regression controls other factors and shows the unique influence of independent variables on a dependent variable. Multiple regression results will show how gubernatorial power, health expenditure per capita, and level of liberalism affects state's success in reaching *Healthy People 2000* goals. The following table (4.5) presents the value of each of the variables used in the study for each state.

Table 4.6
Data Used to Determine Factors Affecting States' Success in Reaching *Health People 2000* Goals

State	Number of Sentential Objectives Met	Formal Power of the Governor Index Score	Per Capital Health Expenditure	Policy Liberalism Index Score
Alabama	3	13	3,151	38
Alaska	7	15.5	2,952	.
Arizona	6	14.5	2,747	32
Arkansas	2	13.5	2,950	42
California	9	15	3,083	1
Colorado	10	16	2,910	19
Connecticut	8	16	3,995	5
Delaware	8	15	3,596	10
Florida	6	13.5	3,553	47
Georgia	5	12.5	3,068	45

Hawaii	12	14.5	3,283	.
Idaho	8	15	2,553	37
Illinois	7	16	3,310	18
Indiana	4	13	3,072	28
Iowa	11	16	3,111	23
Kansas	7	15	3,157	30
Kentucky	5	14	3,046	33
Louisiana	3	15.5	3,255	44
Maine	11	14.5	3,202	15
Maryland	8	16.5	3,344	12
Massachusetts	16	12	4,095	4
Michigan	8	14.5	3,191	22
Minnesota	12	14.5	3,315	6
Mississippi	2	13	2,826	40
Missouri	5	13.5	3,177	21
Montana	10	13.5	2,775	8
Nebraska	7	15	3,012	26
Nevada	5	12.5	2,814	36
New Hampshire	9	10	3,174	16
New Jersey	12	15.5	3,675	14
New Mexico	8	16	2,713	11
New York	10	17.5	4,041	2
North Carolina	4	12	2,936	29
North Dakota	9	15.5	3,250	46
Ohio	8	16.5	3,270	24
Oklahoma	3	13	2,900	34
Oregon	7	14.5	2,849	7
Pennsylvania	4	16.5	3,599	25
Rhode Island	12	13	3,725	9
South Carolina	5	13	2,912	20
South Dakota	9	15.5	2,997	48
Tennessee	2	15	3,271	41
Texas	5	15.5	2,911	31
Utah	11	16	2,340	39
Vermont	9	11	3,014	3
Virginia	4	14.5	2,815	35
Washington	11	14.5	2,990	17
West Virginia	6	18.5	3,341	13
Wisconsin	8	18	3,230	27
Wyoming	8	16	2,776	43

Chapter Summary

This chapter presented the methodology for testing the three hypotheses by using

a multiple regression analysis was used to determine if states' success in reaching

Healthy People 2000 goals were affected by gubernatorial power, health expenditure per capita, or level of liberalism.   The next chapter discusses the results of the multiple regression analysis.

Chapter 5
Results

This chapter provides the results of the multiple regression analysis that tested the influence of gubernatorial power, average health expenditure, and level of liberalism on the number of *Healthy People 2000* sentinel goals met by each state. Table 5.1 shows the results of a correlation analysis between the independent variables. Table 5.2 presents the results of the regression analysis.

Correlation

Running correlations determined whether multiple regression analysis is an appropriate statistical technique for this study. Correlations between independent variables determine the extent, if any, of the relationships between the independent variables are so strong they provide the same information (Neal 2002). Table 5.1 shows there are negative and relatively weak relationships between formal gubernatorial powers and both health expenditure and policy liberalism. The strongest and most positive relationship is between health expenditure and policy liberalism (.405). The correlations are weak enough to show a multiple regression analysis is an appropriate mode of statistical analysis for theresearch question.

Table 5.1
Correlation

	Formal Gubernatorial Powers	Per Capita Health Expenditure	Policy Liberalism Score
Formal Gubernatorial Powers	1.00	-.193	-.033
Per Capita Health Expenditure		1.00	.405
Policy Liberalism Score			1.00

Multiple Regression Results

Table 5.2 displays the multiple regression analysis results that test the influence of gubernatorial power, health expenditure, and policy liberalism on states success in reaching *Healthy People 2000* goals,. The adjusted R squared proves that 36.1% in the results of the *Healthy People 2000* study are explained by the independent variables. The significance of the F statistic illustrates that there is a linear relationship between the number of sentinel objectives reached and the three independent variables.

The table reveals that of the three independent variables, only policy liberalism significantly affected states' success in reaching *Healthy People 2000* goals. Neither health expenditure per state nor gubernatorial power influenced states' success in reaching the goals by the year 2000. The policy liberalism value is significant, which indicates that the hypothesis that a state's level of liberalism positively affects the results of the *Healthy People 2000* study.

Table 5.2
Multiple Regression Results

Independent Variable	Coefficient	Significance
Formal Power of the Governor	.117	.598
Per Capita Health Expenditure	**.**.001	.343
Policy Liberalism	-.117	**.**.000
Constant	5.282	.236
R Square	.361	
F Statistic	8.277	.000

Chapter Summary

       This chapter discussed the results of the multiple regression analysis. The results showed that only one of the independent variables significantly affected the results of the *Healthy People 2000* study. The next chapter discusses conclusions made from this study. The chapter summarizes the findings of the research, future possible research topics in this area, and weaknesses in this study.

Chapter 6
Conclusions

The purpose of this research was to determine factors affecting states' success in reaching health targets. *Healthy People 2000*, *National Health Promotion and Disease Prevention Objectives,* developed in 1990, presented the nation with health goals and objectives. The national health plan provided states with health targets to try to achieve by the year 2000. This research project discussed factors that may have contributed to states' success in reaching health goals outlined by *Healthy People 2000*. The first chapter of this study introduced the research topic, and Chapter 2, Setting, outlined the *Healthy People 2000* study.

Chapter Three, Literature Review, discusses scholarly literature that supports three factors that affected states' success in reaching Healthy *People 2000* goals. The three factors supported by the literature are the formal powers of the governor, health expenditure per capita, and policy liberalism. Chapter Three also presents the conceptual framework and three formal hypotheses used in this research. The three formal hypotheses are:

H1: Gubernatorial power influences states' success in reaching *Healthy People 2000* goals.

H2: H2: Healthcare expenditure per capita positively affects the results of *Health People 2000* results.

H3: The states' level of liberalism positively affects the results of the *Healthy People 2000* goals.

Chapter Four, Methodology, introduces the steps done to test the three formal hypotheses. A multiple regression analysis evaluates the existing data to determine if the three factors affected states' success in the *Healthy People 2000* study.

Chapter Five, Results, presents the results of the multiple regression analysis. The results the research shows that formal gubernatorial (H1) and healthcare expenditure per capita (H2) has no influence on states' success in reaching *Healthy People 2000* goals. There is however, a relationship between a state's level of liberalism (H3) and the success of reaching *Healthy People 2000* goals. The relationship between policy liberalism and *Healthy People 2000* was positive. The positive relationship between states' success and policy liberalism indicates that the more liberal the state was the more health goals they were able to achieve. Table 6.1 provides the number of sentinel objectives each state reached and their policy liberalism score[8].

Table 6.1
Sentinel Objectives and Policy Liberalism

State	Number of Sentinel Objectives Met [9]	Policy Liberalism Index Score
Arkansas	2	42
Mississippi	2	40
Tennessee	2	41
Alabama	3	38
Louisiana	3	44
Oklahoma	3	34
Indiana	4	28
North Carolina	4	29
Pennsylvania	4	25
Virginia	4	35
Georgia	5	45
Kentucky	5	33
Missouri	5	21
Nevada	5	36
South Carolina	5	20
Texas	5	31
Arizona	6	32
Florida	6	47
West Virginia	6	13
Alaska	7	.
Illinois	7	18

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[8] Lower scores indicate more liberal states.
[9] The number of Sentinel Objectives is out of the 25 comparable Sentinel Objectives used for this study.

Kansas	7	30
Nebraska	7	26
Oregon	7	7
Connecticut	8	5
Delaware	8	10
Idaho	8	37
Maryland	8	12
Michigan	8	22
New Mexico	8	11
Ohio	8	24
Wisconsin	8	27
Wyoming	8	43
California	9	1
New Hampshire	9	16
North Dakota	9	46
South Dakota	9	48
Vermont	9	3
Colorado	10	19
Montana	10	8
New York	10	2
Utah	11	39
Iowa	11	23
Maine	11	15
Washington	11	17
Hawaii	12	.
Minnesota	12	6
New Jersey	12	14
Rhode Island	12	9

This study was useful in determining what factors affect states' success in reaching the *Healthy People 2000* goals. By knowing and understanding what influences states' success in reaching health targets, politicians and administrators are able to make adjustments necessary to obtain optimal health for the citizens of the states and nation.

Suggested Future Research

This research reviews factors affecting states' success in reaching health goals and objectives. One suggestion to extend this research is to evaluate states' success in reaching *Healthy People 2000* goals by region. Dividing the United States into regions is

a common way to evaluate the county.[10]   Steve Spacek (2004) states that political cultures in American regions explain behavior and policy toward environmental quality. Spacek's findings open the door for future research in the area of health policy. Dividing the country into regions allow researchers to determine if the geography and policies of the region affect outcomes. Extending this study about states' success in reaching *Healthy People 2000* by region would allow a researcher to know and understand regional impacts on health policy.

Weaknesses and Strengths of Data

This research provides information about affecting states' success in reaching health goals. As with all research, there are strengths and weaknesses associated with this study. The collection of existing data provided the necessary information to run perform the multiple regression analysis. One weakness associated with the existing data for this research are incomplete and outdated data. The level of liberalism index did not provide scores for Hawaii and Alaska; not having the data results in an analysis of 48 rather than 50 states. Outdated scores are also a threat for analysis of existing data. When attempting to locate existing data, it is important to find data that is relevant to the period and dates of the research.

There are also strengths associated with existing data research. Researchers can focus study to a specific region, area, or population by simply eliminating the data they do not wish to use. This research limits the data to the sentinel objectives of the *Healthy People 2000* study. This type of research is also inexpensive and allows for a study of trends and historical happenings.

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[10] For more regional studies see an Applied Research Paper written by Stephen (Steve) Spacek titled Do Mess With It!: A Sociopolitical Study of Littering and the Role of Southern and Nearby States.

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