AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

EXECUTIVE BRIEF

Health Disparities Report 2021*

*Data in the *Health Disparities Report* are based on the most recent publicly available data, which were collected prior to the pandemic.

About the *America's Health Rankings® Health Disparities Report*

The inaugural *America's Health Rankings Health Disparities Report* provides a comprehensive portrait of the **breadth, depth and persistence of health disparities across the nation**:

- **Breadth:** Documents health disparities across 30 health-related measures that include core social and economic factors, clinical care indicators, physical environment, health behavior and health outcome measures critical to addressing health disparities and advancing health equity.
- **Depth:** Measures the magnitude of health disparities by educational attainment, gender, geography and race and ethnicity for the nation, all 50 states and the District of Columbia.
- **Persistence:** Identifies where health disparities have remained despite progress or lack thereof, and where they have grown over time.

"The *America's Health Rankings Health Disparities Report* provides a unique, data-driven analysis that identifies disparities not only according to race and ethnicity, but also gender, geography and education level. Through new analyses, this report provides public health officials and lawmakers with state-specific findings on their state's largest disparities so they can plan better strategies to address them."

Judy Monroe, MD, President and CEO, CDC Foundation

Overview

The health and well-being of communities across America have improved significantly over the past century. Public health advancements, medical breakthroughs and increased access to health care have led to better health outcomes — and as a result, more Americans are living longer. However, health disparities continue to exist by gender, geography, socioeconomic status, race and ethnicity and other factors. In some instances, disparities have grown in recent years, shortening lives and profoundly impacting our collective health and well-being.

For over three decades, *America's Health Rankings*® has assessed the nation's health and provided data-driven insights to support better health outcomes and build healthier communities. The inaugural *America's Health Rankings Health Disparities Report*, produced by the United Health Foundation, documents the **breadth, depth and persistence of health disparities** across the nation to provide objective data to inform action for advancing health equity.

The COVID-19 pandemic exposed and exacerbated longstanding health disparities in the U.S. This report provides a first-of-its-kind national and state-by-state portrait of the disparities in health and well-being that existed across the U.S. prior to the COVID-19 pandemic. In doing so, it sheds important new light on the difficult and disparate realities facing many Americans in the years leading up to the pandemic.

The *America's Health Rankings Health Disparities Report* was developed with guidance from a National Advisory Committee — comprised of leading public health and health equity experts — who informed the selection of health measures and other methodological features of the report.

Building on 31 years of data and reporting from *America's Health Rankings*, this new report provides objective data documenting the constant and changing contours of disparities for the nation, all 50 states and the District of Columbia by gender, geography, educational attainment and race and ethnicity. The report's findings underscore the broad and deep nature of health disparities, while documenting their persistence over time, despite progress in some areas.

Model for Measuring America's Health

America's Health Rankings is built upon the World Health Organization's definition of health: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Over the past three decades, the model and measures used in *America's Health Rankings* have evolved as the understanding of health and the root causes of health outcomes have advanced.

This report analyzes 30 measures of health from four publicly available data sources: the American Community Survey (ACS), the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), the Current Population Survey's Food Security Supplement (CPS-FSS) and the National Vital Statistics System (NVSS). Depending on the source, three to five years of data were pooled across three time periods between 2003 and 2019 to produce reliable estimates. Time periods were selected based on data availability and, where possible, to have some consistency across measures. The measures included are indicators of social and economic factors, physical environment, clinical care, health behaviors and health outcomes.

While the country has made some notable health improvements in recent years, deep and widespread health disparities persist — and, in some instances, have grown.

Key Findings

Prior to the COVID-19 pandemic, the nation made progress in several key health measures. However, not all populations experienced these improvements equally.

Uninsured Rate

Over the last decade, and prior to the COVID-19 pandemic, the national rate of uninsured declined 37%, from 14.6% to 9.2%, with all subpopulation groups experiencing improvements. Despite this progress, gaps remained between different population groups. For example, in 2015-2019 the uninsured rate was 3.5 times higher for those with only a high school degree (13.6%) than for college graduates (3.9%) and 3 times higher among Hispanic (18.5%) and American Indian/Alaska Native populations (20.2%) than white populations (6.2%).

In 2015-2019, the racial gap in rates of uninsured was particularly wide across states. American Indian/Alaska Native populations in Wyoming (who had the highest rate of uninsured in the U.S. — 38.4%) had a rate 24 times higher than the uninsured rate of white populations in the District of Columbia (who had the lowest rate in the U.S. — 1.6%).

Prior to the COVID-19 pandemic, access to health care improved within and across states, though disparities continued.

Uninsured Rate

37% ▼

decline among all subpopulation groups from 2010-2014 to 2015-2019.

Source: U.S. Census Bureau, American Community Survey

24x

The rate of uninsured among the American Indian/Alaska Native populations in Wyoming was 24x higher than the rate of uninsured among the white populations in the District of Columbia in 2015-2019.

Source: U.S. Census Bureau, American Community Survey

Though **Black infant mortality rates declined in 22 states** between 2003-2006 to 2015-2018, Black infants continued to have the highest infant mortality rate in the nation — almost 2.8x higher than Asian/Pacific Islander infants.

Rate calculated per 1,000 births

Black infants

Asian/Pacific Islander infants

2.8x
higher infant mortality rate

Source: National Vital Statistics System

Infant Mortality

In recent years, the U.S. made notable progress in reducing the racial gap in infant mortality. The infant mortality rate among Black infants decreased 19% from 2003-2006 to 2015-2018. However, Black infants (11.0 per 1,000 births) had the highest infant mortality rate — which was 2.8 times higher than Asian/Pacific Islander infants (4.0 per 1,000 births) — in 2015-2018.

During this period, progress varied substantially among states. Black infant mortality rates declined across 22 states and the District of Columbia, ranging from a 12% decline in Ohio to a 46% decline in Colorado. White, Asian/Pacific Islander and Hispanic populations also experienced 11-16% declines in infant mortality rates during this time.

Severe Housing Problems

Before the COVID-19 pandemic, some progress was made in reducing the rate of severe housing problems, which includes: lack of kitchen or plumbing facilities, overcrowding or severely cost-burdened occupants. Between 2005-2009 and 2013-2017, households headed by Hispanic individuals experienced the greatest decline (11%) in severe housing problems, followed by households headed by Asian/Pacific Islander (8%) and Black individuals (5%).

Despite progress in reducing the percentage of households facing severe housing problems, households headed by Hispanic (29.9%), Black (25.3%) and American Indian/Alaska Native (24.2%) individuals had a rate of severe housing problems roughly 2 times higher than households headed by white (13.4%) individuals.

Wide disparities in mental health and chronic disease persist.

Mental Health

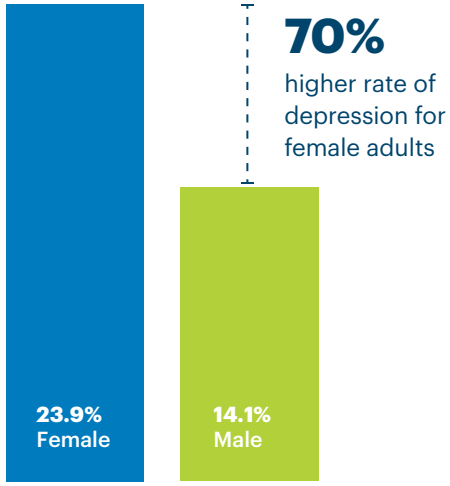
Over the years, deep and persistent disparities in mental and behavioral health have existed by gender, educational attainment and race and ethnicity — and have worsened for some subpopulation groups. Adults with less than a high school education (17.6%) had a rate of frequent mental distress that was 123% higher than college graduates (7.9%) and females (23.9%) had a 70% higher rate of depression compared to males (14.1%) in 2017-2019.

Mental health challenges were more prevalent among some racial and ethnic groups. For example, the rate of depression was 3 times higher for multiracial (27.1%) and American Indian/Alaska Native adults (24.6%) and 2.5 times higher for white adults (21.1%) than Asian/Pacific Islander adults (8.6%). Despite performing better than other groups, Asian/Pacific Islander adults experienced the highest increase (23%) in the rate of depression from 7.0% in 2011-2013 to 8.6% in 2017-2019.

Chronic Disease

Disparities in rates of chronic disease — asthma, cancer, cardiovascular disease and diabetes — have remained wide and persistent over the years, with rates of multiple chronic conditions rising for many subpopulation groups prior to the COVID-19 pandemic. Between 2011-2013 and 2017-2019, rates of multiple chronic conditions increased for many populations: 15% for adults with some college or a college degree, 14% for white adults, 10% for Black and female adults and 9% for American Indian/Alaska Native adults.

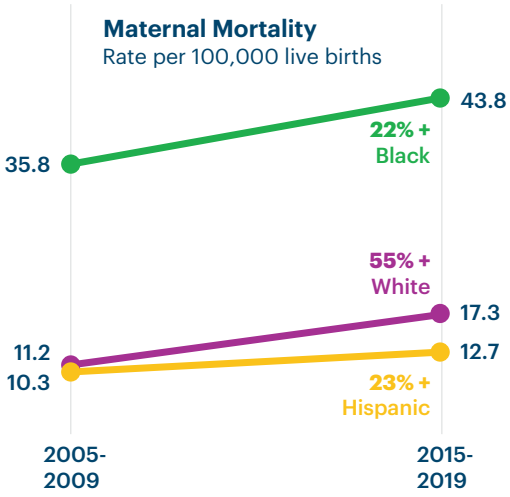
Notable disparities in the prevalence of chronic disease persisted by race and ethnicity. In 2017-2019, the percentage of adults with multiple chronic conditions was 6 times higher for American Indian/Alaska Native adults (18.4%), 4 times higher for multiracial adults (14.1%) and 3 times higher for Black adults (10.7%) than for Asian/Pacific Islander adults (3.2%).



Females had a higher rate of depression than males in 2017-2019.

Source: CDC, Behavioral Risk Factor Surveillance System

Disparities in maternal mortality and food insecurity worsened in recent years.



Maternal mortality rates increased between 2005-2009 and 2015-2019.

Gaps between subpopulation groups persist. While Black mothers experienced the highest rate of maternal mortality, white mothers faced the largest rate of increase (55%).

Source: National Vital Statistics System

Maternal Mortality

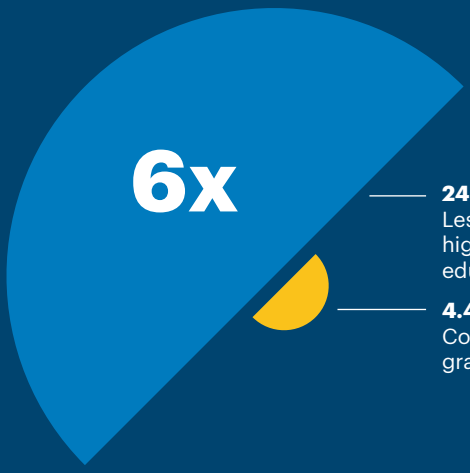
The report demonstrated persistent and growing disparities in maternal mortality. In 2015-2019, Black mothers (43.8 deaths per 100,000 live births) had a maternal mortality rate that was 3.4 times higher than Hispanic mothers (12.7 deaths per 100,000 live births). Between 2005-2009 and 2015-2019, maternal mortality rates increased 22% among Black mothers, from 35.8 to 43.8 deaths per 100,000 live births. The maternal mortality rate also increased 55% for white mothers (from 11.2 to 17.3 deaths per 100,000 live births) and 23% for Hispanic mothers (from 10.3 to 12.7 deaths per 100,000 live births) during this time period.

Food Insecurity

Even prior to the COVID-19 pandemic, disparities in household food insecurity — percentage of households unable to provide adequate food for one or more household members due to lack of resources — were wide, with gaps further widening between 2003-2007 and 2015-2019 as some subpopulation groups experienced a significant increase in food insecurity rates. During this time period, food insecurity rates increased 39% for American Indian/Alaska Native households (from 19.2% to 26.7%) — a 5 times higher rate of food insecurity than Asian/Pacific Islander (5.6%) households.

Disparities in food insecurity were also significant by education. In 2015-2019, households headed by an adult without a high school education (24.8%) had nearly a 6 times higher rate of food insecurity than households headed by college graduates (4.4%). Since the 2003-2007 time period, food insecurity rates increased 15% in households headed by those with less than a high school education, and 19% in households headed by college graduates.

Educational attainment is an important determinant of food insecurity. In 2015-2019, households headed by those with less than a high school education had a 6 times higher rate of food insecurity than those headed by college graduates.



Source: Current Population Survey
Food Security Supplement

Food insecurity increased 15% in households headed by those with less than a high school education, and **19%** in households headed by college graduates between 2003-2007 and 2015-2019.

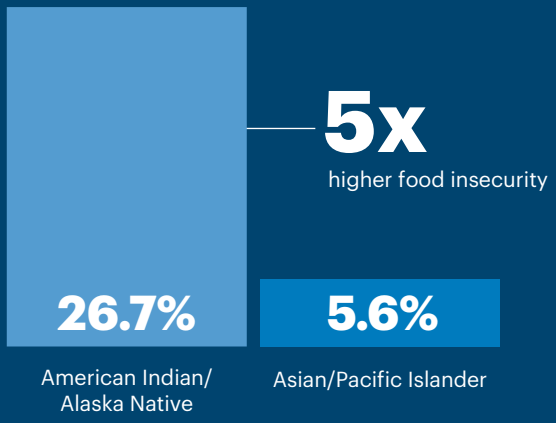
Source: Current Population Survey
Food Security Supplement

American Indian/Alaska Native households had the highest rate of food insecurity in 2015-2019 — a rate that increased 39% since 2003-2007.

39%

increase in food insecurity among America Indian/ Alaska Native households.

Source: Current Population Survey
Food Security Supplement



Broad Disparities Across Populations Highlight Connection Between Education and Health

The report documented a strong link between educational attainment and health, demonstrated across several measures where adults who have attained higher levels of education have better health. Notably, adults lacking a high school education face the greatest social, economic and health challenges across the nation. **For example, households headed by individuals with less than a high school education had a poverty rate of 30.7%, which was 6 times higher than households headed by college graduates (5.2%).** Further, even prior to the COVID-19 pandemic, more than 1 in 4 households headed by adults with less than a high school education faced food insecurity.

The report found those with less than a high school education face substantial barriers to health care access as well. Compared to college graduates, the uninsured rate for individuals with less than a high school education is nearly 3 times higher (10.9% vs. 3.9%). The rate of avoiding care due to cost was also 3 times higher for those with less than a high school education when compared with college graduates (22.1% vs. 7.9%).

Key health outcomes were also correlated with educational attainment; those with less than a high school education faced poorer health outcomes. Compared to college graduates, adults with less than a high school education faced a rate of multiple chronic conditions nearly 3 times higher (16.2% vs. 5.7%). Adults with less than a high school education (25.4%) had a rate of reporting high health status almost 3 times lower than college graduate adults (65.2%).

Addressing Health Disparities to Promote Health Equity in Our Communities

Achieving the highest level of health for all people will require communities, states and the nation to understand and identify how disparities impact the health of everyone. Race and ethnicity, gender, geography, educational attainment and income level should not decide one's access to health care, or the determinants and outcomes that contribute to our holistic well-being.

The United Health Foundation invites national, state and community leaders, policymakers, advocates and others to use the data in the inaugural *America's Health Rankings Health Disparities Report* to identify and address the **breadth, depth and persistence** of disparities affecting the health and well-being of Americans in states and communities across the U.S. These new data provide critical direction for closing longstanding gaps and building a stronger, more equitable America where all individuals have the opportunity to thrive.

UNITED HEALTH FOUNDATION®

About the United Health Foundation

Through collaboration with community partners, grants and outreach efforts, the United Health Foundation works to improve our health system, build a diverse and dynamic health workforce and enhance the well-being of local communities. The United Health Foundation was established by UnitedHealth Group (NYSE: UNH) in 1999 as a not-for-profit, private foundation dedicated to improving health and health care. To date, the United Health Foundation has committed more than $500 million to programs and communities around the world. To learn more, visit www.unitedhealthgroup.com/what-we-do/building-healthier-communities.html.

About *America's Health Rankings*®

As the longest-running state-by-state analysis of our nation's health, the platform provides actionable, data-driven insights that stakeholders can use to effect change either in a state or nationally and continue the dialogue of improving our nation's health.

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