2023 Annual Report

AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

In partnership with
APHA
AMERICAN PUBLIC HEALTH ASSOCIATION®

Contents

The *America's Health Rankings® 2023 Annual Report*, released in partnership with the American Public Health Association, continues to provide a comprehensive look at health across the nation.

This report highlights the record-high and rising prevalence of chronic conditions, as well as stark disparities by geography and nearly every demographic group.

The *Annual Report*, first published in 1990, is the longest-running state-by-state analysis of the nation's health. This edition examines 87 measures of health from 28 data sources. The report, released in partnership with the American Public Health Association, is supplemented with new data related to chronic condition management and insights from the Texas Association of Community Health Centers, as well as an analysis of Organization for Economic Co-operation and Development (OECD) international health data.

In 2022, more than 29 million adults reported having three or more chronic conditions. The prevalence of all eight chronic conditions measured — arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, cardiovascular disease, cancer, depression and diabetes — reached its highest level recorded since *America's Health Rankings* added these measures. There were striking disparities in each chronic condition by nearly every demographic group, particularly among the new subpopulations in this year's report: disability status, veteran status and sexual orientation.

The premature death rate increased for a second consecutive year, reaching its highest rate in *America's Health Rankings* history. Chronic conditions played a significant role in driving this rate, contributing to six of the top 10 leading causes of death before age 75. Other measures of mortality also worsened, with increases in drug deaths, firearm deaths and homicide.

Recent improvement continued in the increasing supply of mental health providers, but frequent mental distress also continued to increase. Other improvements include a decline in occupational fatality and unemployment rates and increases in per capita income. The uninsured rate and the supply of dental care providers improved, while the prevalence of avoiding care due to cost increased and the supply of primary care providers decreased.

Additionally, many measures that appeared to be pandemic-era successes have returned to 2019 levels. For example, between 2021 and 2022 excessive drinking increased 6% from 17.3% to 18.4% of adults (compared with 18.6% in 2019), and frequent physical distress increased 14% from 10.9% to 12.4% (compared with 12.5% in 2019). Between 2020 and 2021, suicide increased 4% from 14.0 deaths per 100,000 population back to the 2019 rate of 14.5. Air pollution also worsened in 2020-2022 and exceeded pre-pandemic levels.

Finally, three new physical environment measures were added to the report this year: climate risks, transportation health risks and renewable energy. Improvements were made in renewable energy generation, while approximately 115.3 million people lived in areas of high climate risks, and 78.0 million people lived in areas of high transportation health risks.

Objective

America's Health Rankings aims to inform and drive action to build healthier communities by offering credible, trusted data that can guide efforts to improve population health and health care. To achieve this, *America's Health Rankings* continues to collaborate with an advisory group to determine the selection of a comprehensive set of measures. The *2023 Annual Report* is based on:

- **Eighty-seven measures.** These include 49 ranking and 38 additional measures (not included in overall rank). Seven new measures are introduced this year, including breast cancer screening, cancer screenings, climate risks, homicide, housing cost burden, renewable energy and transportation health risks. For a full list of measures, definitions and source details, see the Measures Table.
- **Five categories of health.** These include health outcomes and four other categories that are determinants of health: social and economic factors, physical environment, behaviors and clinical care.
- **Twenty-eight sources.** Data are from many sources, including the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System, the Council on Environmental Quality's Climate and Economic Justice Screening Tool Index and the U.S. Census Bureau's American Community Survey.
- **International comparison.** This report features a look at the health of the United States compared with other OECD countries in three measures: infant mortality, life expectancy and total health spending.

The *America's Health Rankings Annual Report* aims to improve population health by:

- **Presenting a holistic view of health.** This report goes beyond measures of clinical care and health behaviors by considering social, economic and physical environment measures, reflecting the impact of social determinants of health.
- **Providing a benchmark for states.** Each year, the report presents strengths, challenges and highlights for every state and the District of Columbia. Public health advocates can monitor health trends over time and compare their state with other states and the nation. State Summaries containing data on all 49 ranking measures are available on the website as a separate download.
- **Highlighting disparities.** The report shows differences in health between states and among demographic groups at state and national levels, with groupings based on race/ethnicity, gender, age, educational attainment, income level and metropolitan status. New demographic groups added to this year's report include disability status, sexual orientation and veteran status. These analyses often reveal differences among groups that national or state aggregate data may mask.
- **Stimulating action.** The report aims to drive change and improve health by promoting data-driven discussions among individuals, community leaders, public health workers, policymakers and the media. States can incorporate the report into their annual review of programs, and many organizations use it as a reference when assigning goals for health improvement plans.

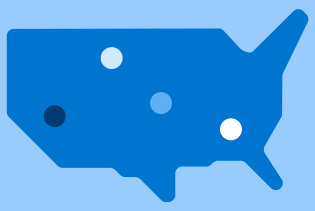
For details on demographic subpopulation group definitions and limitations, including the new disability status, sexual orientation and veteran status stratification groups, please refer to the appendix on page 33. For information on data sources, methodology and additional measures, please visit AmericasHealthRankings.org.

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." The model was developed under the guidance of the *America's Health Rankings* Advisory Council and committees, with insights from other rankings and health models, particularly County Health Rankings & Roadmaps and Healthy People. The model serves as a framework across all *America's Health Rankings* reports for identifying and quantifying the drivers and outcomes that impact state and national population health.

"Efforts like *America's Health Rankings* and Healthy People underscore the importance of having high-quality demographic population data for benchmarking, as well as for tracking where we are and where we need to go."

Dr. David Huang, PhD, MPH, CPH
Chief of Health Promotion Statistics Branch at National Center for Health Statistics, CDC



Recent notable shifts in key health indicators

Asthma

6% ▲

increased from 9.8% to 10.4% of adults between 2021 and 2022.

Diabetes

6% ▲

increased from 10.9% to 11.5% of adults between 2021 and 2022.

Source: CDC, Behavioral Risk Factor Surveillance System.

National Highlights

Health Outcomes

11.2%

Multiple Chronic Conditions

11.2% of adults had three or more chronic conditions in 2022.

Source: CDC, Behavioral Risk Factor Surveillance System.

9% ▲

Premature Death

increased from 8,659 to 9,478 years lost before age 75 per 100,000 population between 2020 and 2021.

Source: CDC WONDER, Multiple Cause of Death Files.

15% ▲

Drug Deaths

increased from 27.9 to 32.1 deaths per 100,000 population between 2020 and 2021.

Source: CDC WONDER, Multiple Cause of Death Files.

8% ▲

Frequent Mental Distress

increased from 14.7% to 15.9% of adults between 2021 and 2022.

Source: CDC, Behavioral Risk Factor Surveillance System.

Social and Economic Factors

33% ▲

Homicide

increased from 5.8 to 7.7 deaths per 100,000 population between 2018-2019 and 2020-2021.

Source: CDC WONDER, Multiple Cause of Death Files.

11% ▼

Occupational Fatalities

decreased from 4.4 to 3.9 deaths per 100,000 workers between 2016-2018 and 2019-2021.

Source: U.S. Bureau of Labor Statistics, Census of Fatal Occupational Injuries.

9% ▲

Per Capita Income

increased from $38,332 to $41,804 between 2021 and 2022.

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

32% ▼

Unemployment

decreased from 6.3% to 4.3% of the civilian workforce ages 16-64 between 2021 and 2022.

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

National Highlights

Physical Environment

4%▲

Air Pollution

increased from 8.3 to 8.6 micrograms of fine particles per cubic meter between 2017-2019 and 2020-2022.

Source: U.S. Environmental Protection Agency.

35.5%

Climate Risks

35.5% of the U.S. population was living in communities with high climate risks in 2022.

Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool Index.

8%▲

Renewable Energy

increased from 19.0% to 20.5% of electricity generated between 2021 and 2022.

Source: Energy Information Administration.

24.0%

Transportation Health Risks

24.0% of the U.S. population was living in communities with high transportation health risks in 2022.

Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool Index.

Clinical Care

15%▲

Avoided Care Due to Cost

increased from 8.8% to 10.1% of adults between 2021 and 2022.

Source: CDC, Behavioral Risk Factor Surveillance System.

7%▲

Dental Care Providers

increased from 60.6 to 64.6 providers per 100,000 population between 2022 and 2023.

Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System.

7%▲

Mental Health Providers

increased from 305.0 to 324.9 providers per 100,000 population between 2022 and 2023.

Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System.

13%▼

Primary Care Providers

decreased from 265.3 to 232.0 providers per 100,000 population between 2022 and 2023.

Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System.

Trending back to pre-pandemic levels

Excessive Drinking

6%▲

increased from 17.3% to 18.4% of adults between 2021 and 2022.

Suicide

48,183

adults died by suicide in 2021, an increase of 2,204 adults since 2020.

Frequent Physical Distress

14%▲

increased from 10.9% to 12.4% of adults between 2021 and 2022.

Sources: CDC, Behavioral Risk Factor Surveillance System.

CDC WONDER, Multiple Cause of Death Files.

Findings

Rates of chronic conditions, premature death, drug deaths and frequent mental distress all continued to rise, reaching historically high levels.

HEALTH OUTCOMES | PHYSICAL HEALTH

The rates of eight chronic conditions reached their highest levels since *America's Health Rankings* began tracking them, with striking disparities across nearly all subpopulations.

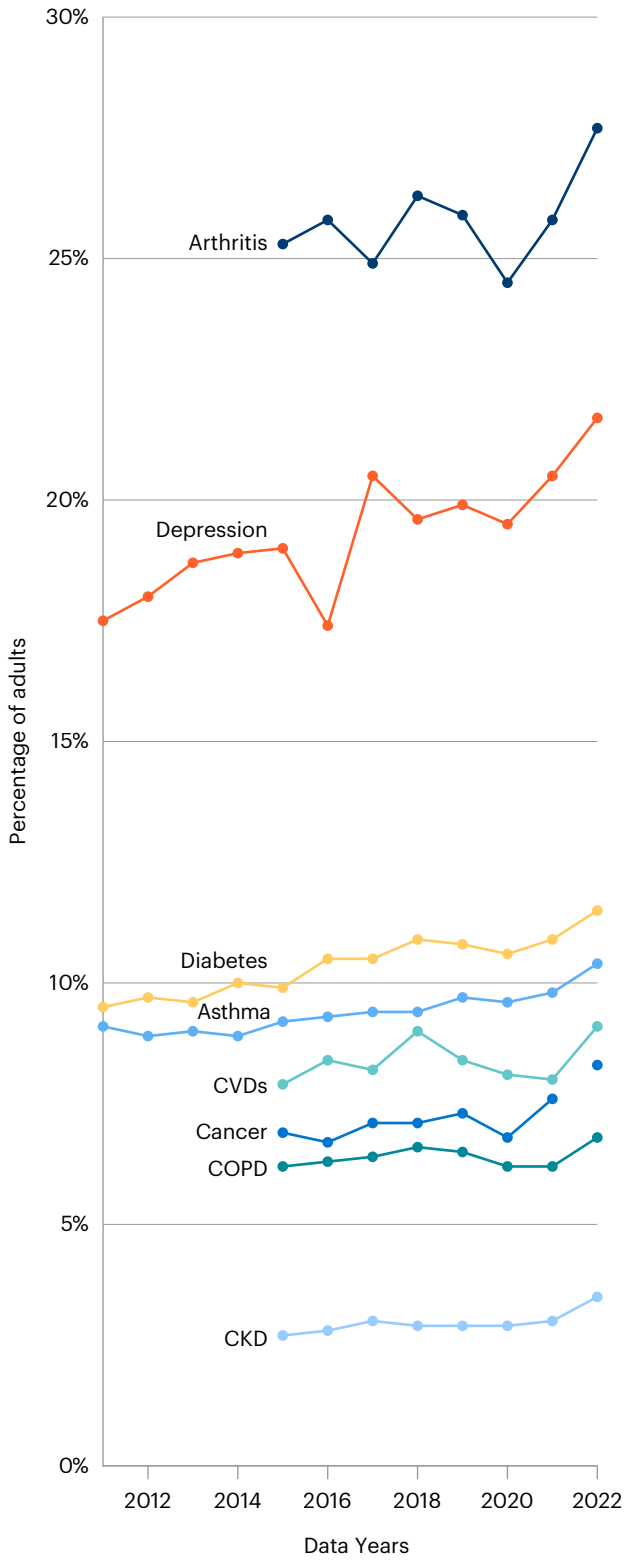
Multiple Chronic Conditions

Chronic conditions are medical conditions that last more than a year, require ongoing medical attention and/or limit daily life activities.[1] Adults with multiple chronic conditions represent one of the highest-need populations for the U.S. health care system.

In 2022, 11.2% of U.S. adults, more than 29.3 million, had three or more of the following chronic health conditions: arthritis, asthma, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), cardiovascular diseases (CVDs), cancer (excluding non-melanoma skin), depression and diabetes.

Changes over time. All eight chronic conditions reached their highest values in *America's Health Rankings* history in 2022. This peaking reversed such prior successes as multiyear improvements in arthritis, COPD and CVDs. Current prevalences either returned to or exceeded pre-pandemic levels. Nationally, between 2021 and 2022, arthritis increased 7% (25.8% to 27.7%), affecting nearly

Prevalence of Chronic Conditions Continues to Increase



Source: CDC, Behavioral Risk Factor Surveillance System, 2011 – 2022.

70.0 million adults; asthma increased 6% (9.8% to 10.4%), affecting nearly 26.0 million adults; CVDs increased 14% (8.0% to 9.1%), affecting 24.2 million adults; CKD increased 17% (3.0% to 3.5%), affecting 9.7 million adults; COPD increased 10% (6.2% to 6.8%), affecting 17.8 million adults; depression increased 6% (20.5% to 21.7%), affecting nearly 54.2 million adults; and diabetes increased 6% (10.9% to 11.5%), affecting nearly 31.9 million adults. In 2022, 8.3% of adults (nearly 21.4 million) reported they had any form of cancer other than non-melanoma skin cancer.

Disparities. In 2022, the prevalence of multiple chronic conditions significantly varied by disability status, age, race/ethnicity, income, geography, educational attainment, veteran status, gender and metropolitan status.

Disability status. The prevalence of multiple chronic conditions was **9.7 times higher among adults with self-care difficulty** (46.5%) than those without a disability (4.8%). Adults without a disability had the lowest prevalence of all eight chronic conditions.

- The largest disparity by disability status was among adults with **COPD**. The prevalence was 7.7 times higher among adults with self-care difficulty (26.3%) than those without a disability (3.4%).
- Adults with self-care difficulty also had high prevalences of **arthritis** (64.3%), **CVDs** (31.6%), **diabetes** (30.8%), **asthma** (23.4%), **cancer** (16.2%) and **CKD** (13.7%). **Depression**, however, was highest among those with cognitive difficulty (57.9%).

Race/Ethnicity. The prevalence of multiple chronic conditions was **5.2 times higher among American Indian/Alaska Native** (17.8%) than Asian (3.4%) adults. Multiracial adults (15.6%) also had a higher prevalence. Asian adults had the lowest prevalence of all eight chronic conditions.

- The largest disparity by race/ethnicity was among adults with **COPD**. The prevalence was 7.1 times higher among American Indian/Alaska Native (10.6%) than Asian (1.5%) adults.
- Besides COPD, American Indian/Alaska Native adults had the highest prevalences of **CVDs** (14.6%), **CKD** (5.1%) and **diabetes** (17.9%). Diabetes prevalence was also high among Black (15.9%) and Hawaiian/Pacific Islander (15.0%) adults. The prevalence among American Indian/Alaska Native adults was also high for **arthritis** (30.9%), **asthma** (13.1%) and **cancer** (9.3%).
- White adults had the highest prevalences of **cancer** (10.8%), 3.9 times higher than Asian adults (2.8%), and **arthritis** (31.2%).
- Multiracial adults had the highest prevalence of **asthma** (15.8%). The prevalence was also high for **depression** (31.0%), **arthritis** (29.3%) and **COPD** (9.5%).

Income. The prevalence of multiple chronic conditions was **3.7 times higher among adults ages 25 and older with an annual household income less than $25,000** (24.4%) than those with incomes of $75,000 or more (6.6%). Adults with the highest household income level ($75,000 or more) had the lowest prevalence of all eight conditions.

- The largest disparity by income level was among adults with **COPD**. The prevalence of COPD was 4.4 times higher among adults with a household income less than $25,000 (15.5%) than those with incomes of $75,000 or more (3.5%).
- Adults with the lowest income level (less than $25,000) had the highest prevalence of all the chronic conditions except for **cancer**, which was highest among those with a household income of $50,000-$74,999 (10.0%), those with incomes of $25,000-$49,999 (9.9%) and those with incomes less than $25,000 (9.8%).

Geography. The prevalence of multiple chronic conditions was **3.0 times higher in West Virginia** (21.1%) than Hawaii and the District of Columbia (both 7.0%).

- West Virginia had the highest prevalences of **diabetes** (17.4%), 2.1 times higher than in Colorado (8.1%); **CVDs** (14.6%), 2.2 times higher than in Utah (6.6%); and **arthritis** (40.1%), **COPD** (14.0%) and **cancer** (10.8%).
- **Asthma** was highest in Rhode Island (13.3%), and **depression** was highest in Tennessee (29.2%).
- Hawaii had the lowest prevalence of **cancer** (6.6%) — but the District of Columbia had the lowest value, at 6.2% — **COPD** (3.5%) and **depression** (12.5%).
- **Arthritis** was lowest in California (20.4%) and the District of Columbia (18.0%), **asthma** was lowest in Texas (7.9%), **CVDs** were lowest in Utah (6.6%) and the District of Columbia (6.3%), **CKD** was lowest in Alaska (2.4%), and **diabetes** was lowest in Colorado (8.1%) and the District of Columbia (8.0%).

Disparity by Educational Attainment

3.7x

higher **COPD** rate among adults with less than a high school education (12.5%) than college graduates (3.4%).

Disparity by Gender

1.9x

higher **Asthma** rate among women (12.8%) than men (6.9%).

Disparity by Veteran Status

2.1x

higher **CVDs** rate among adults who have served (17.6%) than those who have not served (8.3%).

Source: CDC Behavioral Risk Factor Surveillance System, 2022.

Educational attainment. The prevalence of multiple chronic conditions was **2.6 times higher among adults ages 25 and older with less than a high school education** (19.1%) compared with college graduates (7.4%). College graduates had the lowest prevalence of all conditions except cancer.

- The largest disparity by educational attainment was among adults with **COPD**. COPD was 3.7 times higher among adults with less than a high school education (12.5%) than college graduates (3.4%).
- This less-than-high-school vs. college-graduate disparity existed for **asthma** (11.3% vs. 8.4%), **CVDs** (15.9% vs. 6.7%), **CKD** (6.2% vs. 2.9%) and **diabetes** (21.7% vs. 9.0%).
- Adults with less than a high school education (7.7%) had the lowest prevalence of **cancer**, and those with some post–high school education (10.0%) and high school graduates (8.9%) had the highest prevalence of cancer.
- **Arthritis** was highest among those with a high school degree or GED (33.1%), those with less than a high school education (32.8%) and those with some post–high school education (33.0%).
- Adults with some post–high school education (23.0%) and those with less than a high school education (21.7%) had the highest prevalence of **depression**.

Veteran status. The prevalence of multiple chronic conditions was **1.6 times higher among those who have served** (16.6%) compared with those who have not served (10.5%) in the U.S. armed forces. Those who have served in the U.S. armed forces had higher prevalences across all conditions except **asthma** (10.3% vs. 6.8%) and **depression** (20.9% vs. 19.7%), which were higher among adults who have not served than those who have served.

- The largest disparity by veteran status was among adults with **CVDs**. The prevalence was 2.1 times higher among adults who have served (17.6%) than those who have not served (8.3%).
- **Cancer** was 1.8 times higher among adults who have served (13.5%) than those who have not served (7.6%).

Gender. The prevalence of multiple chronic conditions was **higher among women** (13.1%) than men (9.0%). Women had higher prevalences of all the conditions except for CVDs and diabetes, which were higher among men.

- The largest disparity by gender was among adults with **asthma**. Asthma was 1.9 times higher among women (12.8%) than men (6.9%).

Metropolitan status. The prevalence of multiple chronic conditions was **higher among those living in a non-metropolitan** (14.9%) than a metropolitan (10.4%) area. Adults living in non-metropolitan areas had a higher prevalence of all eight conditions than those living in metropolitan areas.

- The largest disparity by metropolitan status was among adults with **COPD**. The prevalence of COPD was 1.5 times higher among adults living in non-metropolitan (9.6%) than metropolitan (6.3%) areas.

Sexual orientation. The prevalence of multiple chronic conditions was similar between LGBQ+ (11.1%) and straight (11.5%) adults. However, straight adults had higher prevalences of the individual conditions, except asthma and depression.

- The largest disparity by sexual orientation was among adults with **depression**. Depression was 2.4 times higher among LGBQ+ (45.4%) than straight (19.2%) adults.
- **Cancer** was 1.7 times higher among straight (8.7%) than LGBQ+ (5.0%) adults.
- **Asthma** was 1.6 times higher among LGBQ+ (15.2%) than straight (9.7%) adults.

Age. Age is a non-modifiable risk factor for many chronic conditions. The prevalence of multiple chronic conditions was **6.6 times higher among adults ages 65 and older** (23.2%) than those ages 18-44 (3.5%).

- The largest disparity by age group was among adults with **cancer**. Cancer was 11.2 times higher among adults ages 65 and older (20.1%) than those ages 18-44 (1.8%).
- Besides cancer, the prevalences of **arthritis** (53.4%), **CVDs** (22.4%), **CKD** (8.3%), **COPD** (13.1%) and **diabetes** (23.9%) were highest among adults ages 65 and older and lowest among those ages 18-44.

However, for **asthma** (9.2%) and **depression** (15.5%), the oldest age group (65 and older) had the lowest prevalences. For asthma, the prevalence among the oldest age group was similar to those ages 18-44 (9.8%), and adults ages 45-64 (10.6%) had the highest prevalence. Adults ages 18-44 (23.7%) had the highest prevalence of depression.

In 2023, the United Health Foundation began a three-year philanthropic partnership with the Mary Bird Perkins Cancer Center to reduce disparities in cancer education, screening and support.

"**Breaking down barriers to care, screening and early detection can be a game-changer** when it comes to lessening the burden of chronic conditions like cancer. It's critical that we meet the communities experiencing disparities where they are and provide screening and care in an accessible, welcoming environment. Our programming at Mary Bird Perkins Cancer Center seeks to **promote early screenings in safe and trusted places** like barbershops where we have made a difference in closing disparities among Black men — who tend to have later-stage diagnoses of prostate cancer and tend to die at higher rates than other groups. **Our goal is to close the gaps and ensure equity for everyone**."

Renea Austin-Duffin
Vice President, Cancer Support & Outreach
Mary Bird Perkins Cancer Center | Louisiana

Racial and Ethnic Disparities in Chronic Condition Care

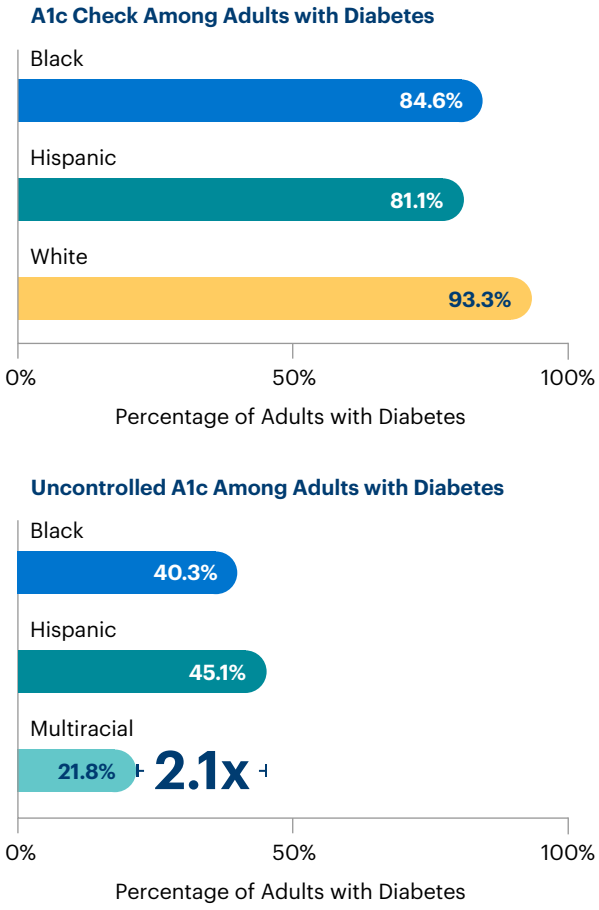
Newly available data on chronic condition care from *America's Health Rankings* highlight broad racial/ethnic disparities in the management of certain chronic conditions, notably diabetes, high blood pressure and asthma.

Between 2011 and 2021, the percentage of adults with diabetes who had their A1c checked improved; however, the most significant improvements were among white, college-educated and higher-income adults. Hispanic (81.1%) and Black (84.6%) adults with diabetes were less likely to have their have their A1c checked compared to white (93.3%) adults with diabetes. Without proper monitoring in the form of an A1c check, the most commonly used test to control and treat diabetes, adults may need additional care for their diabetes. Hispanic (45.1%) and Black (40.3%) adults were significantly more likely to have uncontrolled A1c compared with white (27.7%) adults with diabetes, and 2.1 times and 1.8 times more likely, respectively, compared with multiracial (21.8%) adults.

Black adults had a higher prevalence of high blood pressure and were less likely to have their blood pressure "controlled" (less than 130/80 mm Hg). White (55.4%) adults were 1.5 times more likely to have controlled blood pressure compared with Black (37.4%) adults with high blood pressure.

In 2013-2016, asthma-related emergency room visits were 2.5 times higher among Black (22.6%) compared with white (9.2%) adults and 2.3 times higher among high school graduates (16.8%) compared with college graduates (7.3%).

Racial and Ethnic Disparities in Diabetes Management Between 2017 and March 2020



Source: CDC, National Health and Nutrition Examination Survey 2017 – March 2020.

A Data-driven, Community-centered Approach to Addressing Disparities in Chronic Conditions

Dr. Roxana Cruz
Director of Medical & Clinical Affairs
Texas Association of Community Health Centers (TACHC)

Community health centers' mission is to provide affordable care to all, regardless of income level or insurance status. They are governed by boards that include at least 51% patients, helping each center truly understand the needs of the communities they serve. The history of the health center movement that is rooted in equity, with a unique focus on the ability to address health disparities, is what motivated me to become involved in this work at the Texas Association of Community Health Centers (TACHC) — to support those who have been historically underserved or marginalized for a variety of reasons. We represent community health centers and their staff across the state of Texas, supporting them through training, technical assistance and guidance in both the clinical and policy spaces.

Findings from the most recent *America's Health Rankings® Annual Report* that chronic conditions are at the highest level and gaps are widening among subpopulations are daunting, but not surprising. The patients we serve in Texas — predominantly communities of color, low-income individuals and uninsured populations — face a variety of barriers to accessing health services. The COVID-19 pandemic only added to these complications through unemployment, gaps in insurance coverage, deferral of preventive care, increased need for behavioral or mental health services and more.

Our members at TACHC and community health centers across the country have made huge strides in improving access to care, addressing social determinants of health (also called non-medical drivers of health) and reducing overall patient costs. However, we believe there is more work to be done, particularly for those with chronic conditions. TACHC aims to help members take a data-driven and patient-centered approach to identifying health needs across the state, evolving our programs and tackling health disparities.

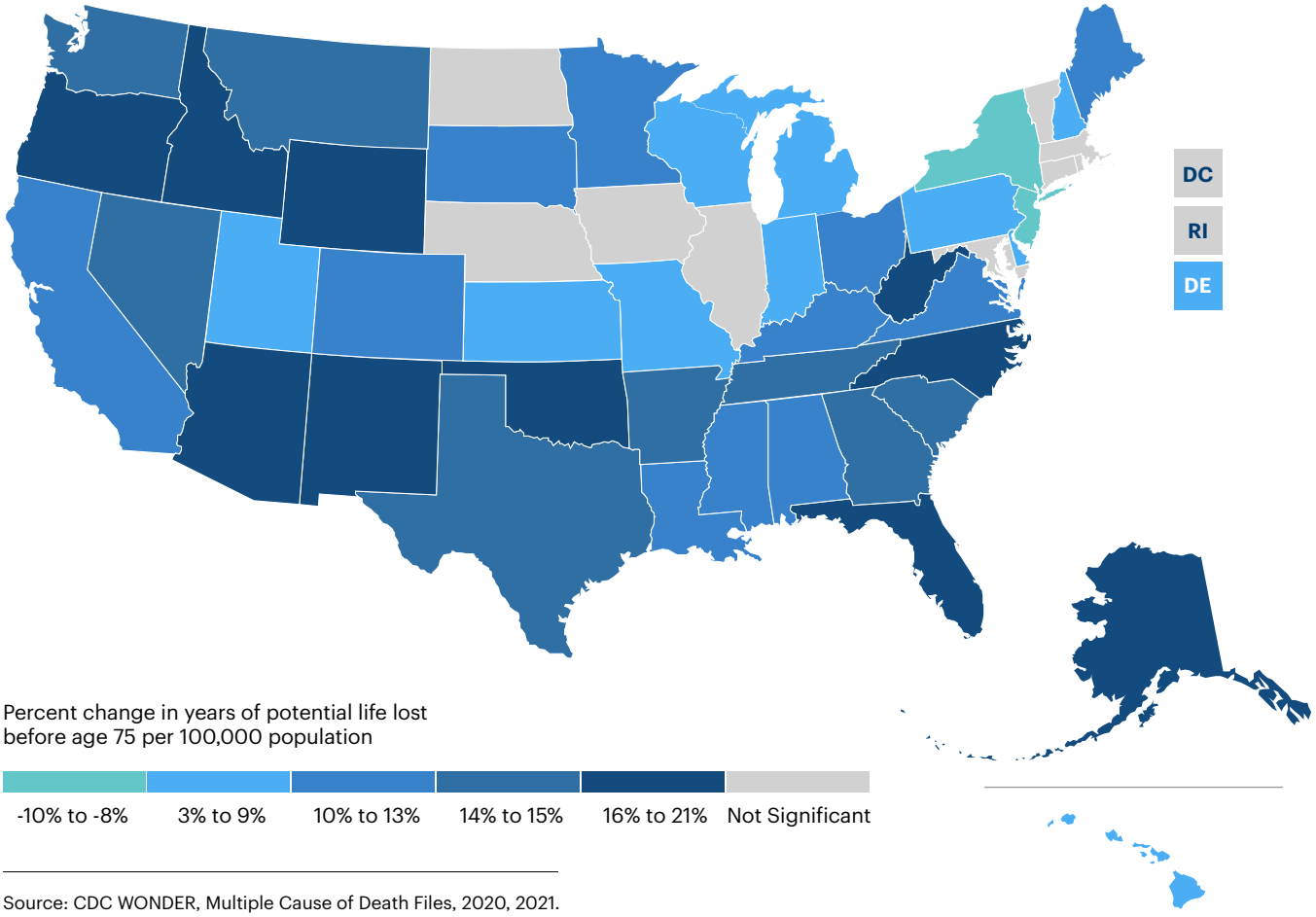
In this way, our partnership with United Health Foundation has expanded access and improved health outcomes for individuals with poorly controlled diabetes, a challenge identified by Texas communities and by data sources like *America's Health Rankings*. The partnership has also expanded our Optimizing Comprehensive Clinical Care program, now called the Quality Axis Program, which teaches health centers to simultaneously use data to drive better quality of care and advance patient-centered care practices.

> "A collaborative, data-driven approach is the only way we're going to create substantial change in improving chronic disease outcomes and reducing health disparities."

When we have access to quality data, we can work together to address the pressing issues facing our communities. A collaborative, data-driven approach is the only way we're going to create substantial change in improving chronic disease outcomes and reducing health disparities. I am proud of the work that TACHC and our member health centers have accomplished using public health data to address health equity and encourage others to use the insights from this report to drive change.

Changes in the Premature Death Rate Between 2020 and 2021

The rate significantly **increased** in 39 states, led by Alaska, Oklahoma, New Mexico and Idaho, and **decreased** in New Jersey and New York.



Source: CDC WONDER, Multiple Cause of Death Files, 2020, 2021.

HEALTH OUTCOMES | MORTALITY

Premature Death

Unintentional injury, cancer, heart disease, COVID-19, suicide, homicide, liver disease, diabetes, perinatal period and chronic lower respiratory disease were, in order, the leading causes of years of potential life lost before age 75 in 2020.[2] While accidents, including drug overdose, COVID-19, suicide and homicide, contributed to the current increase in premature death, chronic conditions accounted for six of the top 10 causes of mortality among those younger than 75 in 2020.

Changes over time. Nationally, premature death significantly increased 9% from 8,659 to 9,478 years lost before age 75 per 100,000 population between 2020 and 2021, the highest rate since 1987. This is the second straight year that there has been a stark increase in premature deaths. In 2021, the premature death rate significantly increased in 39 states, led by 21% in Alaska (9,409 to 11,430 years lost before age 75 per 100,000 population) and 17% in Idaho (7,145 to 8,365), New Mexico (11,896 to 13,946) and Oklahoma (10,873 to 12,764). During this time, the rate significantly decreased 10% in New Jersey (7,759 to 7,013) and 8% in New York (7,651 to 7,008).

Disparities. The premature death rate was 2.4 times higher in Mississippi (15,250 years lost before age 75 per 100,000 population) than Massachusetts (6,454) in 2021.

HEALTH OUTCOMES | BEHAVIORAL HEALTH

Drug Deaths

Deaths resulting from drug overdoses place an enormous burden on individuals, families, communities, the health care system and the economy. Drug overdoses are a leading cause of injury death and have soared in recent years.[3]

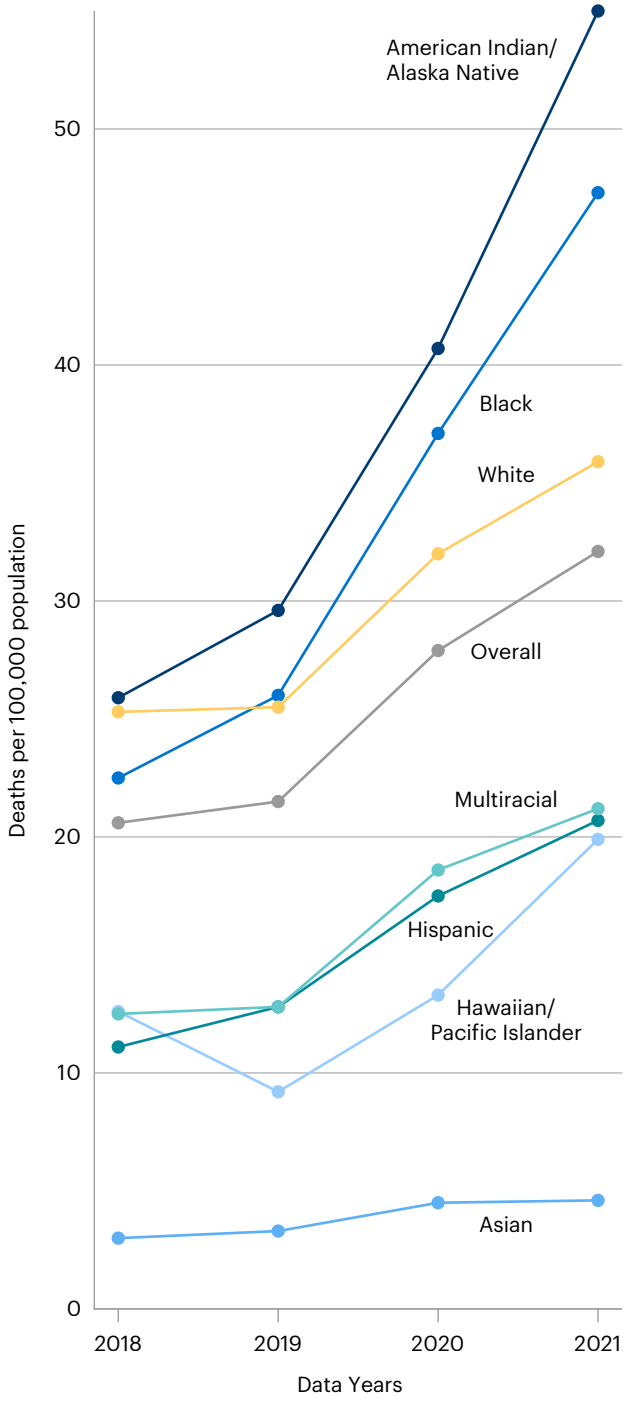
Changes over time. Nationally, deaths due to drug injury (unintentional, suicide, homicide or undetermined) significantly increased 15% from 27.9 to 32.1 deaths per 100,000 population between 2020 and 2021 — exceeding the Healthy People 2030 target of 20.7 deaths per 100,000.[4] In 2021, nearly 106,700 people died from a drug overdose, an increase of 14,900 deaths since 2020. Since 2018, the rate has increased 56%, from 20.6 deaths per 100,000 population. Between 2020 and 2021, the drug death rate significantly increased in 29 states, led by 62% in Alaska (21.5 to 34.9 deaths per 100,000 population), 46% in Oregon (18.6 to 27.1) and 38% in Kansas (17.4 to 24.0). The rate significantly increased among most racial/ethnic and age groups, and all gender groups. By group, the largest increases were 35% among American Indian/Alaska Native populations (40.7 to 55.0), 27% among adults ages 65-74 (13.2 to 16.8) and 15% among both females (16.9 to 19.5) and males (38.9 to 44.9).

Disparities. In 2021, the drug death rate significantly varied by race/ethnicity, geography, age and gender. The rate was:

- 12.0 times higher among American Indian/Alaska Native than Asian populations (4.6 deaths per 100,000 population).
- 7.7 times higher in West Virginia (87.1) than Nebraska (11.3).
- 3.7 times higher among adults ages 35-44 (62.0) than those ages 65-74.*
- 2.3 times higher among males than females.

* The estimates for those ages 65-74 and those ages 15-24 (17.2) were not significantly different from each other based on non-overlapping 95% confidence intervals.

Increases in Drug Deaths by Race/Ethnicity

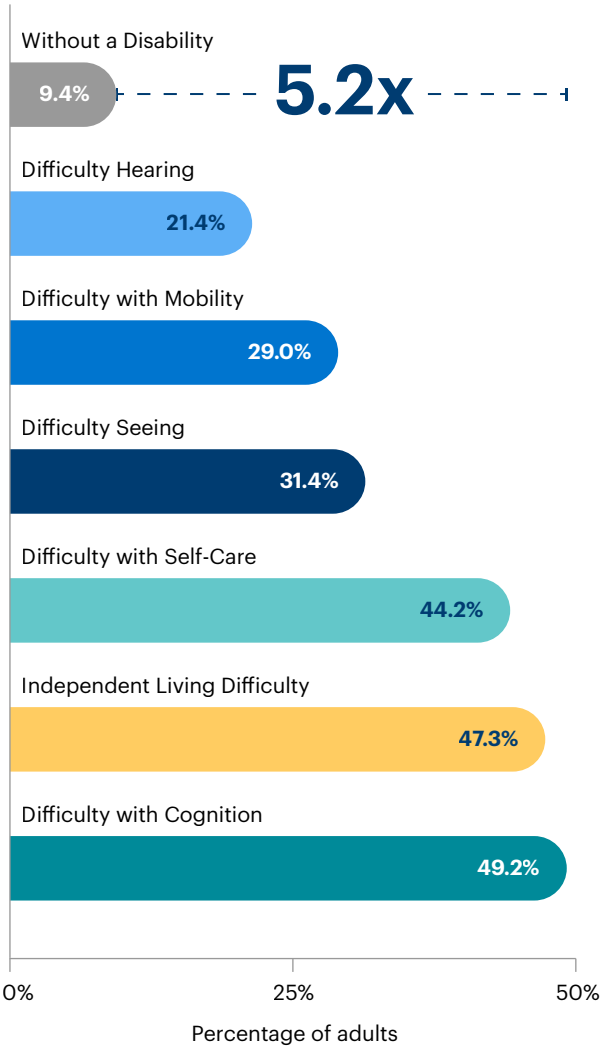


Source: CDC WONDER, Multiple Cause of Death Files, 2018 – 2021.

Note: All racial groups are non-Hispanic. Hispanic ethnicity includes members of all racial groups.

Disparities in Frequent Mental Distress by Disability

5.2 times higher among adults with cognitive difficulty than those without a disability.



Source: CDC, Behavioral Risk Factor Surveillance System, 2022.

Note: The estimates for adults with difficulty with cognition and adults with independent living difficulty were not significantly different from each other based on non-overlapping 95% confidence intervals.

* The estimates for adults who identify their race as multiracial, American Indian/Alaska Native (22.2%) and Hawaiian/Pacific Islander (20.1%) were not significantly different from each other based on non-overlapping 95% confidence intervals.

Frequent Mental Distress

A healthy mental state is essential to overall positive health and well-being. Frequent mental distress — defined as the percentage of adults who reported their mental health was not good 14 or more days in the past 30 days — is associated with smoking, physical inactivity, housing insecurity, food insecurity and insufficient sleep.[5,6]

Changes over time. Nationally, the prevalence of frequent mental distress increased 8% from 14.7% to 15.9% of adults between 2021 and 2022, a continued trend since 2020. In 2022, nearly 40.7 million adults experienced frequent mental distress, an increase of almost 6.6 million adults since 2020. Between 2021 and 2022, the prevalence of frequent mental distress significantly increased 20% in Minnesota (12.3% to 14.8%), 18% in New York (13.0% to 15.4%) and 12% in Ohio (16.3% to 18.3%). During this time, the prevalence significantly increased among some income, educational attainment and age groups, and all gender and metropolitan status groups. By group, the largest increases were 19% among adults with an annual household income of $50,000-$74,999 (12.2% to 14.5%), 15% among adults with less than a high school education (16.6% to 19.1%), 11% among adults ages 65 and older (8.5% to 9.4%), and 8% among men (12.0% to 13.0%) and adults living in both metropolitan (14.6% to 15.7%) and non-metropolitan (15.2% to 16.4%) areas.

Disparities. In 2022, frequent mental distress significantly varied by disability status, sexual orientation, income, race/ethnicity, age, geography, educational attainment, gender and veteran status. The prevalence was:

- 5.2 times higher among adults with cognitive difficulty (49.2%) than those without a disability (9.4%).
- 2.5 times higher among LGBQ+ (34.2%) than straight (13.9%) adults, and among adults with an annual household income less than $25,000 (25.0%) than those with incomes of $75,000 or more (9.9%).
- 2.3 times higher among multiracial (24.4%) than Asian (10.5%) adults.*
- 2.1 times higher among adults ages 18-44 (20.1%) than those ages 65 and older.
- 1.8 times higher in West Virginia (21.1%) than Hawaii (11.5%), and among adults with less than a high school education than college graduates (10.5%).
- Higher among women (18.3%) than men, and among adults who have not served (15.9%) than those who have served (14.4%) in the U.S. armed forces.

SOCIAL AND ECONOMIC FACTORS | COMMUNITY AND FAMILY SAFETY

Rates of homicide and firearm deaths increased, while improvements occurred in the rate of occupational fatalities as well as per capita income and unemployment.

Homicide

Losing a friend, family or community member through such violent means as homicide can have significant psychological implications.[7] Personal security is a core element of well-being. Homicide events can cause a sense of insecurity in communities.[8]

Changes over time. Nationally, the number of deaths due to homicide (injuries inflicted by another person with intent to injure or kill) significantly increased 33% from 5.8 to 7.7 deaths per 100,000 population between 2018-2019 and 2020-2021 — exceeding the Healthy People 2030 target of 5.5 deaths per 100,000.[9] In 2020-2021, about 50,600 people died due to homicide, an increase of approximately 12,600 deaths since 2018-2019. Between 2018-2019 and 2020-2021, the homicide rate significantly increased in 32 states and the District of Columbia, led by 67% in Delaware (5.7 to 9.5 deaths per 100,000 population), 59% in Oregon (2.7 to 4.3) and 58% in Kentucky (5.7 to 9.0). During this time, the rate significantly decreased 50% in New Hampshire (2.2 to 1.1). The rate significantly increased among most racial/ethnic and age groups and all gender groups. By group, the largest increases were 41% among the Black population (23.7 to 33.4), 39% among both those ages 15-24 (11.0 to 15.3) and 25-34 (11.5 to 16.0) and 35% among males (9.3 to 12.6).

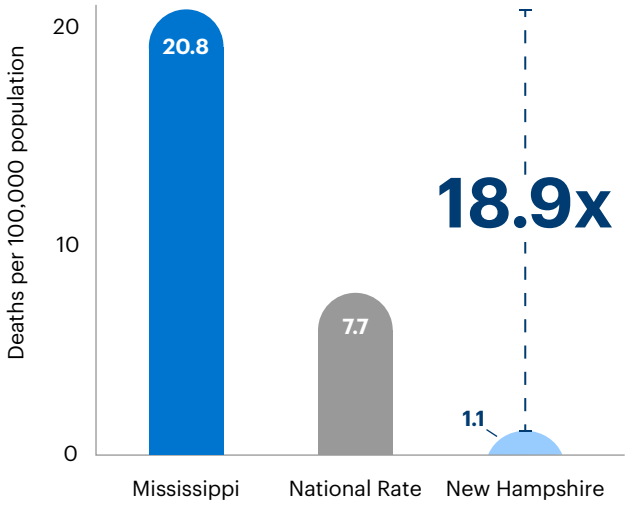
Disparities. In 2020-2021, the homicide rate significantly varied by race/ethnicity, geography, age and gender. The rate was:

- 22.3 times higher among Black than Asian (1.5 deaths per 100,000 population) populations.
- 18.9 times higher in Mississippi (20.8) than New Hampshire (1.1). The rate was highest in the District of Columbia (29.6).
- 8.9 times higher among adults ages 25-34 than those ages 85 and older (1.8).*
- 4.3 times higher among males than females (2.9).

* The estimates for those ages 85 and older and those ages 75-84 (2.0) were not significantly different from each other based on non-overlapping 95% confidence intervals.

Disparity in Homicide Rates by State

The rate was 18.9 times higher in Mississippi than New Hampshire. D.C. had the highest rate at 29.6.



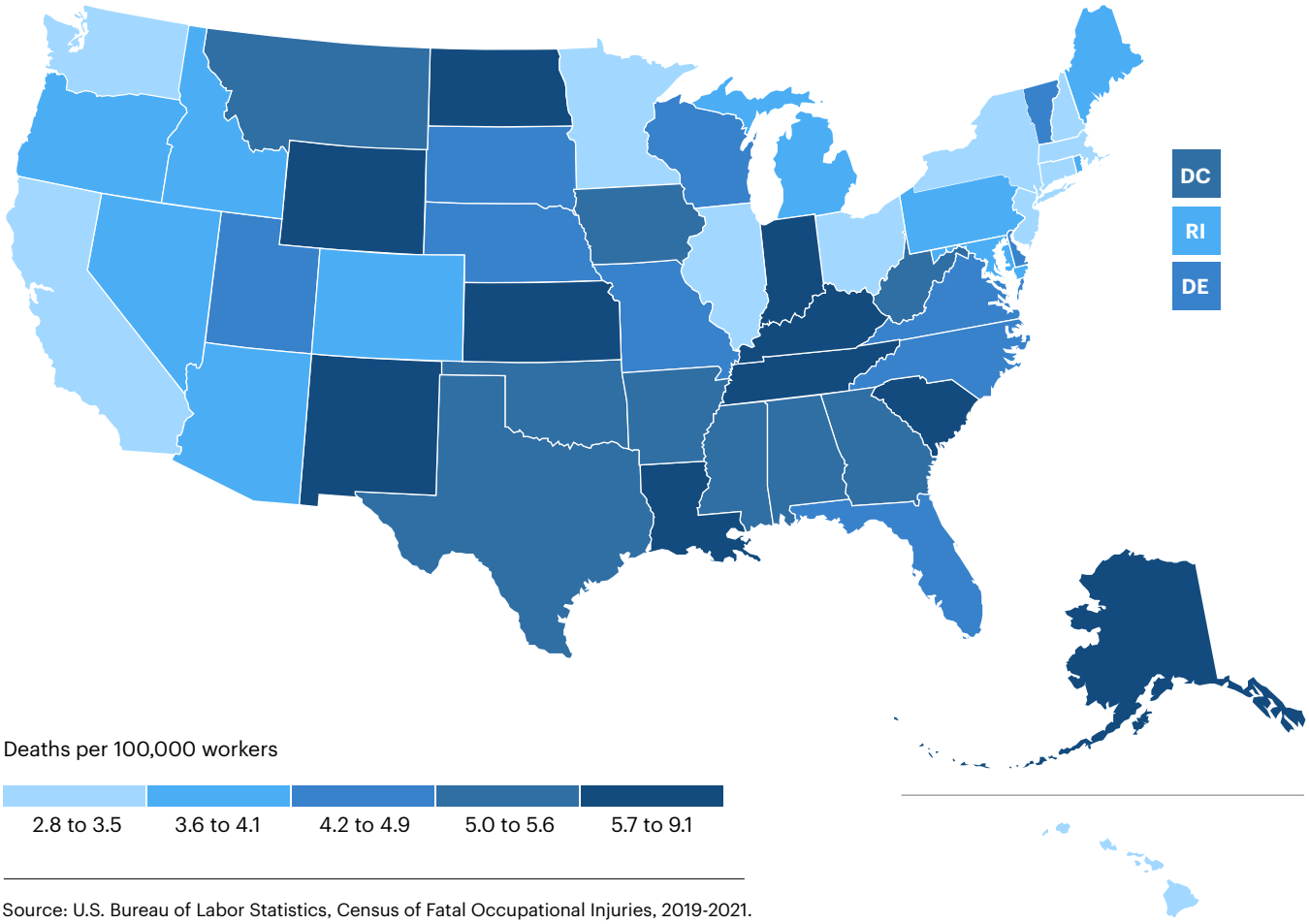
Source: CDC WONDER, Multiple Causes of Death Files, 2020-2021.

Related Measure: Firearm Deaths

Nationally, the number of deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) significantly increased 7% from 13.7 to 14.7 deaths per 100,000 population between 2020 and 2021 — exceeding the Healthy People 2030 target of 10.7 deaths per 100,000.[10] In 2021, 48,800 people died from firearms, an increase of approximately 3,600 since 2020. Between 2020 and 2021, the rate significantly increased in seven states, led by 21% in New Mexico (22.9 to 27.6 deaths per 100,000 population), 18% in Mississippi (28.0 to 33.0) and 16% in Colorado (15.7 to 18.2). In 2021, the firearm death rate significantly varied by race/ethnicity, geography, gender and age. It was 12.2 times higher among Black (34.2) than Asian (2.8) populations, 9.7 times higher in Mississippi than Massachusetts (3.4), 6.1 times higher among males (25.6) than females (4.2) and 2.1 times higher among those ages 25-34 (24.8) than those ages 65-74 (11.7).**

** The estimates for those ages 65-74 and 55-64 (12.1) were not significantly different from each other based on non-overlapping 95% confidence intervals.

Occupational Fatality Rates in 2019-2021



Source: U.S. Bureau of Labor Statistics, Census of Fatal Occupational Injuries, 2019-2021.

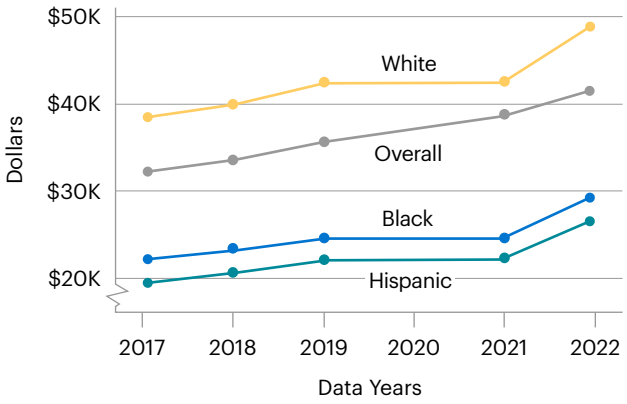
Occupational Fatalities

Occupational fatalities, also known as workplace fatalities, represent unsafe working conditions and personal risks faced by workers. Workplace fatalities are largely preventable, making them an important target for interventions.[11]

Changes over time. Nationally, the number of fatal occupational injuries in construction, manufacturing, trade, transportation and utility industries as well as professional and business services significantly decreased 11% from 4.4 to 3.9 deaths per 100,000 workers between 2016-2018 and 2019-2021. The rate remains higher than the Healthy People 2030 target of 2.9 deaths per 100,000 workers for work-related deaths.[12] Between 2016-2018 and 2019-2021, the occupational fatality rate significantly decreased 44% in West Virginia (9.9 to 5.5 deaths per 100,000 workers), 36% in Mississippi (8.5 to 5.4), 30% in Arkansas (8.0 to 5.6) and 16% in Florida (5.1 to 4.3).

Disparities. In 2019-2021, the occupational fatalities rate was 3.3 times higher in Wyoming (9.1 deaths per 100,000 workers) than New York and Washington (both 2.8).

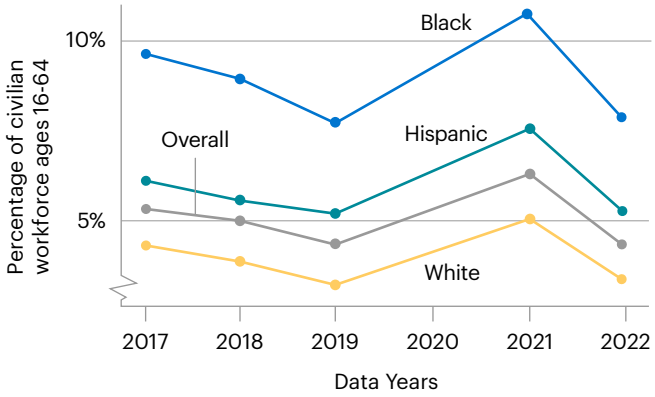
Changes in Per Capita Income by Race/Ethnicity



Source: U.S. Census Bureau, American Community Survey, 2017 – 2022.

Note: All racial groups are Hispanic-inclusive (except for white, which is non-Hispanic). Hispanic ethnicity includes members of all racial groups.

Changes in Unemployment by Race/Ethnicity



Source: U.S. Census Bureau, American Community Survey, 2017 – 2022.

Note: All racial groups are Hispanic-inclusive (except for white, which is non-Hispanic). Hispanic ethnicity includes members of all racial groups.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Per Capita Income

Per capita income is the total income of a population divided by the number of people in that population and is often used to show the relative wealth of a state or nation.[13] Individuals with low household incomes have lower life expectancy and higher rates of disease than people in higher-income households.[14]

Changes over time. Nationally, per capita income increased 9% from $38,332 to $41,804 between 2021 and 2022. During this time, it increased at a rate equal to or greater than the nation in 27 states and the District of Columbia, led by 15% in North Dakota ($36,497 to $41,800) and 11% in Kentucky ($30,728 to $33,980), Hawaii ($38,614 to $42,710) and Florida ($36,196 to $40,278). Per capita income increased 9% or more among all racial/ethnic groups, including 22% among Hispanic ($22,002 to $26,830), 20% among Black ($24,509 to $29,385) and 16% among white ($42,106 to $49,045) populations between 2021 and 2022.

Disparities. In 2022, per capita income varied by geography and race/ethnicity. The rate was:

- 1.9 times higher in Massachusetts ($54,025) than Mississippi ($29,045). It was highest in the District of Columbia ($71,699).
- 1.9 times higher among white than Hispanic populations.

Unemployment

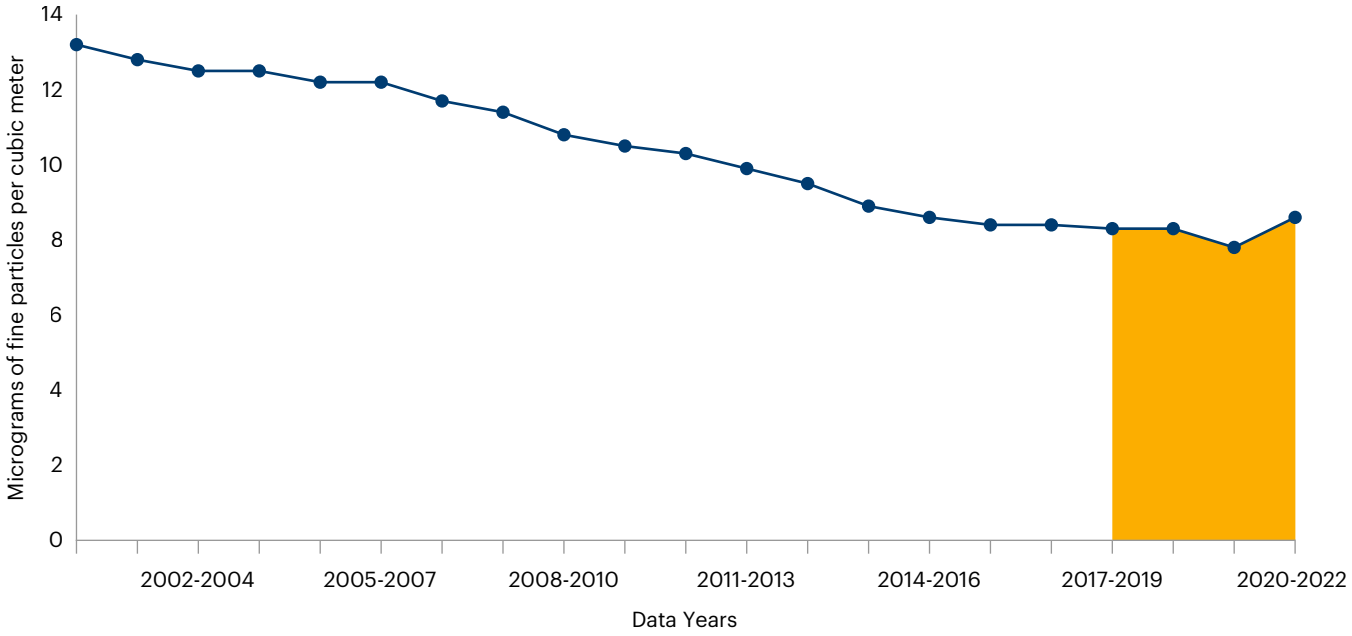
There is a strong relationship between employment status and mental and physical health.[15] A stable, safe and well-paying job makes it easier for people to live in healthier neighborhoods, access health insurance benefits and afford quality child care, education and nutritious food — all critical factors to maintaining good health that are jeopardized by unemployment.[16,17]

Changes over time. Nationally, the percentage of the civilian workforce ages 16-64 that was unemployed significantly decreased 32% from 6.3% to 4.3% between 2021 and 2022; this was lower than the pre-pandemic rate of 4.5% in 2019. In 2022, nearly 7.3 million workers were unemployed, a decrease of approximately 3.3 million since 2021. Between 2021 and 2022, the rate significantly decreased in 43 states and the District of Columbia, led by 53% in Hawaii (7.7% to 3.6%), 43% in Nevada (9.7% to 5.5%) and 42% in Rhode Island (7.7% to 4.5%). During this time, the unemployment rate significantly decreased among all racial/ethnic groups, including 32% among both Hispanic (7.5% to 5.1%) and white (5.0% to 3.4%) civilian workers, and 27% among Black civilian workers (10.7% to 7.8%).

Disparities. In 2022, the unemployment rate significantly varied by geography and race/ethnicity. The rate was:

- 2.5 times higher in Nevada than North Dakota (2.2%).
- 2.1 times higher among Black than white civilian workers.

Air Pollution Increased 4% ▲ Between 2017-2019 and 2020-2022



Source: U.S. Environmental Protection Agency, 2000 – 2022.

PHYSICAL ENVIRONMENT | AIR AND WATER QUALITY

Three new physical environment measures were added this year: climate risks, transportation health risks and renewable energy. Improvements were made in renewable energy generation, while air pollution worsened and exceeded pre-pandemic levels. Meanwhile, approximately 115.3 million people lived in areas with high climate risks, and 78.0 million people lived in areas with high transportation health risks.

Air Pollution

Exposure to fine particle air pollution has been linked to heart and lung problems, including decreased lung function, asthma, irregular heartbeat and heart attack.[18] According to a 2019 study, fine particle air pollution originating from human activity was responsible for an estimated 107,000 premature deaths in 2011.[19]

Changes over time. Nationally, the average exposure of the general public to particulate matter of 2.5 microns or less increased 4% from 8.3 to 8.6 micrograms of fine particles per cubic meter between 2017-2019 and 2020-2022. During this time, air pollution increased at a rate equal to or greater than the nation in 31 states, led by 29% in Arizona (8.6 to 11.1 micrograms of fine particles per cubic meter), 25% in Nevada (8.3 to 10.4) and 24% in Idaho (6.6 to 8.2); it decreased 4% or more in eight states and the District of Columbia, led by 19% in Connecticut (7.0 to 5.7), 16% in Nebraska (7.0 to 5.9) and 15% in Hawaii (4.8 to 4.1).

Disparities. In 2020-2022, air pollution was 3.3 times higher in California (13.4 micrograms of fine particles per cubic meter) than Hawaii.

PHYSICAL ENVIRONMENT | CLIMATE AND HEALTH

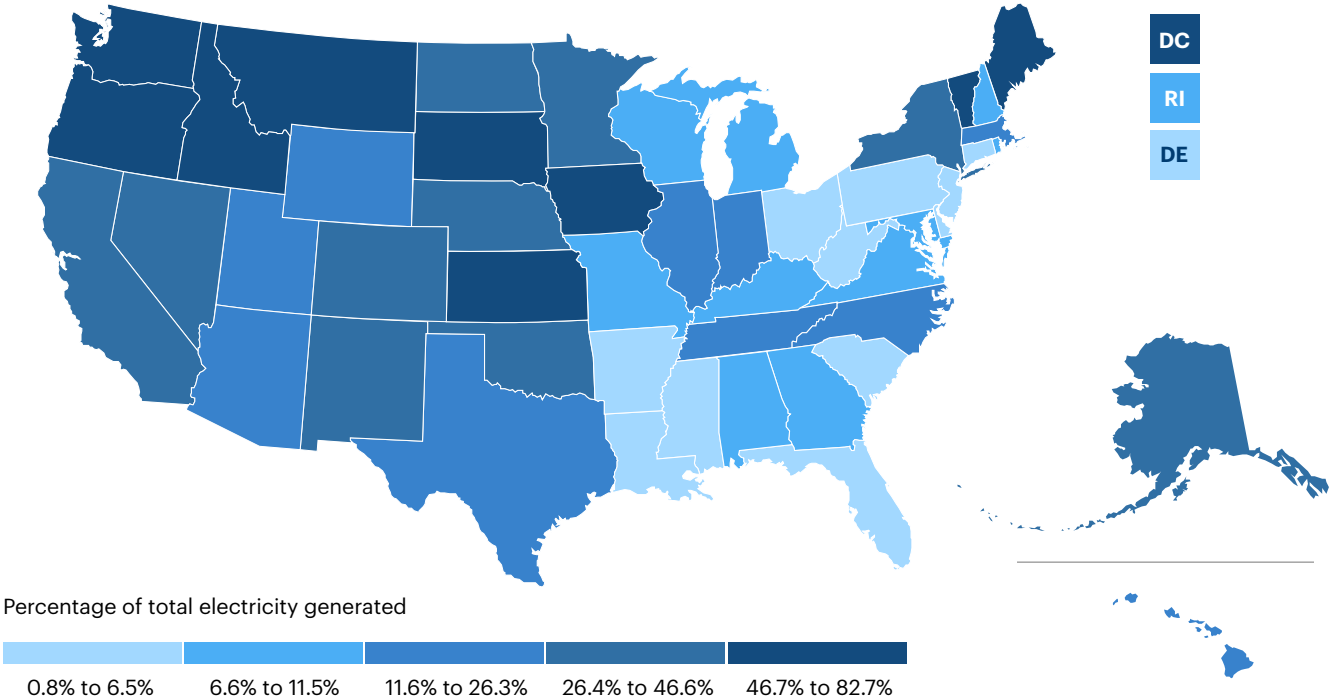
Renewable Energy

Renewable energy is used to generate electricity and is produced from naturally replenishing sources, such as wind, solar, water (hydroelectric), biomass (plants, wood or waste) or geothermal (heat).[20] Generating electricity from clean, sustainable and affordable energy sources can improve health outcomes by reducing air and water pollutants emitted by coal and natural gas plants.[21]

Changes over time. Nationally, the percentage of electricity generated from renewable sources increased 8% from 19.0% to 20.5% between 2021 and 2022. During this time, renewable energy generation increased at a rate equal to or greater than the nation in 18 states and the District of Columbia, led by 43% in the District of Columbia (35.0% to 49.9%), 42% in Rhode Island (7.2% to 10.2%) and 33% in Mississippi (0.6% to 0.8%); it decreased 8% or more in five states, led by 21% in Louisiana (1.4% to 1.1%) and 13% in both Arkansas (7.5% to 6.5%) and Delaware (3.2% to 2.8%). Between 2021 and 2022, the percentage of electricity generated by solar and wind increased 21% (2.8% to 3.4%) and 12% (9.2% to 10.3%), respectively. Biomass and geothermal energy generation stayed the same (both at 0.4%), and hydroelectric energy decreased 2% (6.1% to 6.0%).

Disparities. In 2022, renewable energy generation was highest in Vermont (82.7%), South Dakota (81.3%) and Washington (74.7%), and lowest in Mississippi (0.8%), Louisiana (1.1%) and Connecticut (2.7%).

Renewable Energy in 2022



Source: Energy Information Administration, 2022.

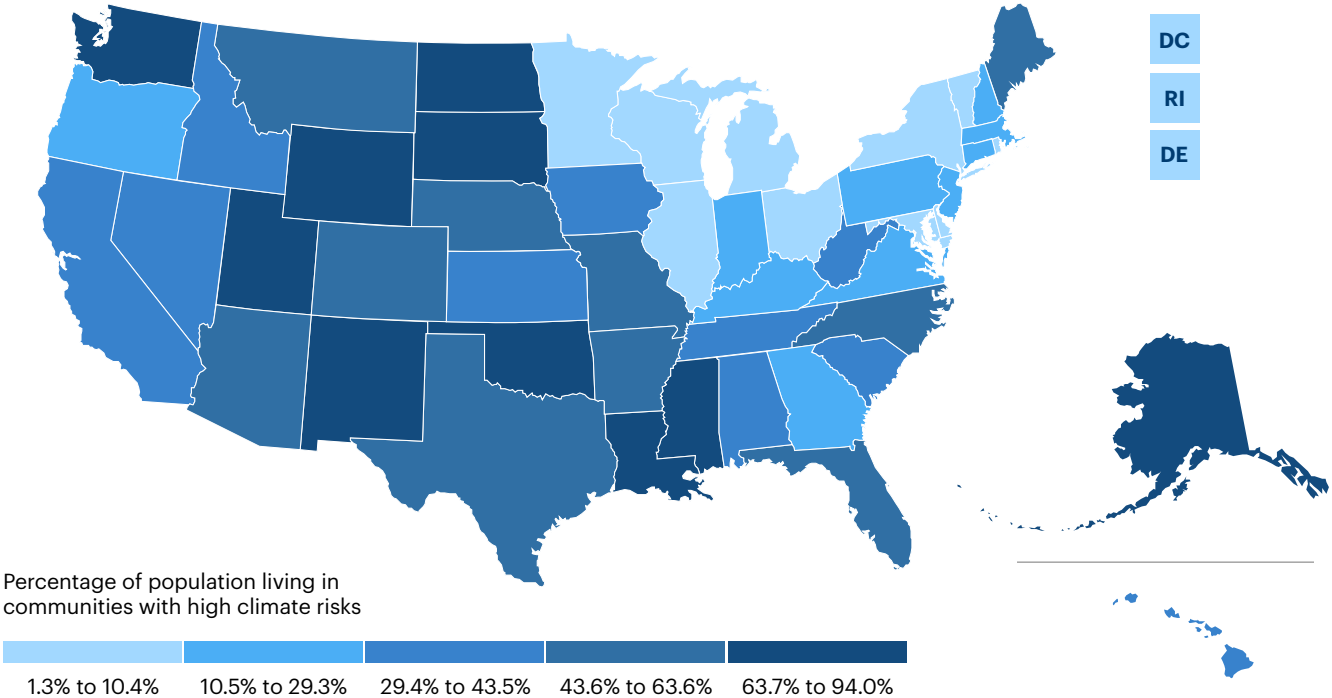
Climate Risks

Natural hazards, including extreme weather events, can worsen existing medical conditions and cause injury and death, as well as stress and mental health issues.[22] Natural disasters can also affect infrastructures that support public health, safety and medicine.[23]

Nationally in 2022, 35.5% of the population lived in areas with high climate risks, which is defined as disadvantaged census tracts (at or above the 90th percentile) based on any of the following risks: agricultural value losses, building value losses, or fatalities and injuries due to 14 types of natural hazards (avalanche, coastal flooding, cold wave, drought, hail, heat wave, hurricane, ice storm, landslide, riverine flooding, strong wind, tornado, wildfire and winter weather) or projected flood or wildfire risk. Almost 115.3 million people were living in census tracts with high climate risks in 2022.

Disparities. In 2022, states with the highest percentage of the population living in census tracts with high climate risks included South Dakota (94.0%), Wyoming (83.3%), Utah (82.0%), Louisiana (78.7%) and Alaska (75.0%). States with the lowest percentage included Rhode Island (1.3%), Michigan (3.0%), Wisconsin (3.6%), Ohio (4.4%) and Vermont (5.6%). The percentage was also low in the District of Columbia (2.3%).

Climate Risks in 2022



Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool Index, 2022.

PHYSICAL ENVIRONMENT | HOUSING AND TRANSIT

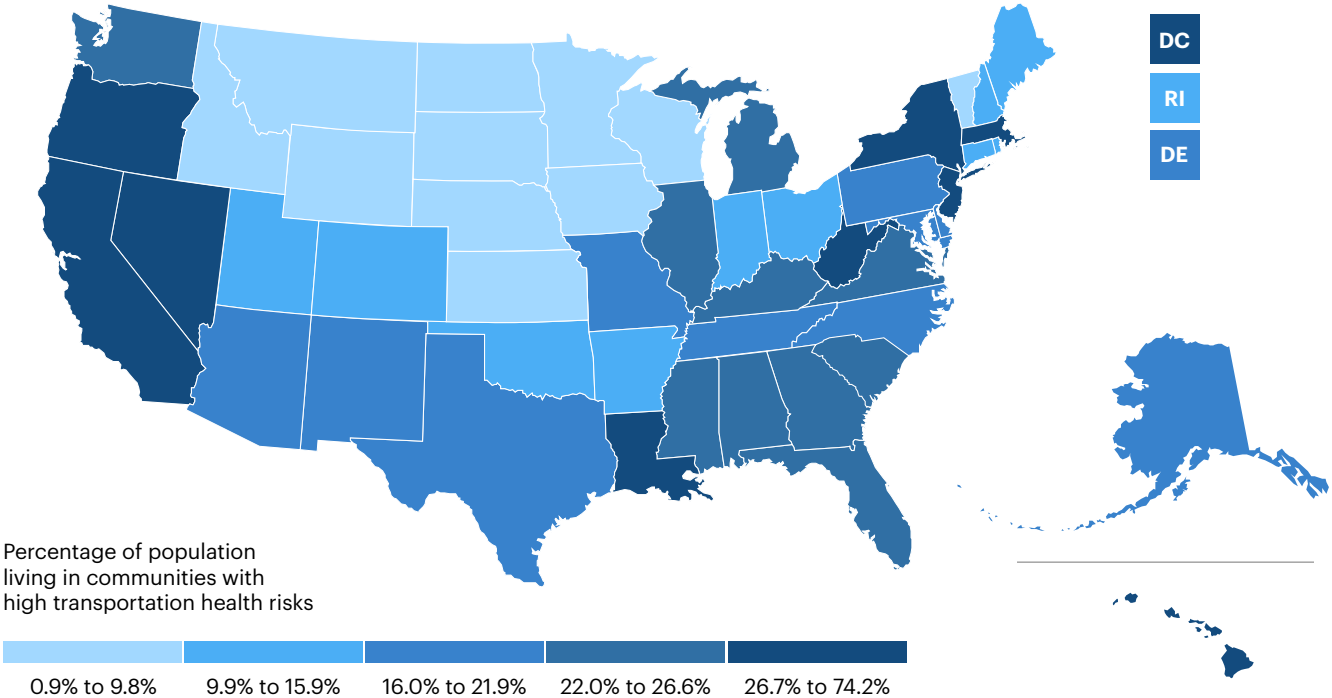
Transportation Health Risks

Traffic-related congestion creates concentrated areas of air and noise pollution, which disproportionately affect those with lower socioeconomic status.[24] Cardiovascular disease and respiratory conditions such as wheezing and childhood asthma are associated with traffic-related air pollution.[25]

Nationally in 2022, 24.0% of the population lived in areas with high transportation health risks, which is defined as disadvantaged census tracts (at or above the 90th percentile) based on any of the following risks: diesel particulate matter exposure, transportation barriers (related to cost and time) or traffic proximity and volume. Approximately 78.0 million people lived in census tracts with high transportation health risks in 2022.

Disparities. In 2022, states with the highest percentage of the population living in census tracts with high transportation health risks included New York (51.5%), Hawaii (47.5%), New Jersey (40.1%), Nevada (36.1%) and Louisiana (35.6%). The percentage was highest in the District of Columbia (74.2%). States with the lowest percentage included Wyoming (0.9%), South Dakota (1.0%), North Dakota (2.3%), Kansas (3.5%) and Montana (4.8%).

Transportation Health Risks in 2022



Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool Index, 2022.

CLINICAL CARE | ACCESS TO CARE

The uninsured rate as well as the supply of dental care and mental health providers improved, while avoided care due to cost increased and the supply of primary care providers dropped.

Avoided Care Due to Cost

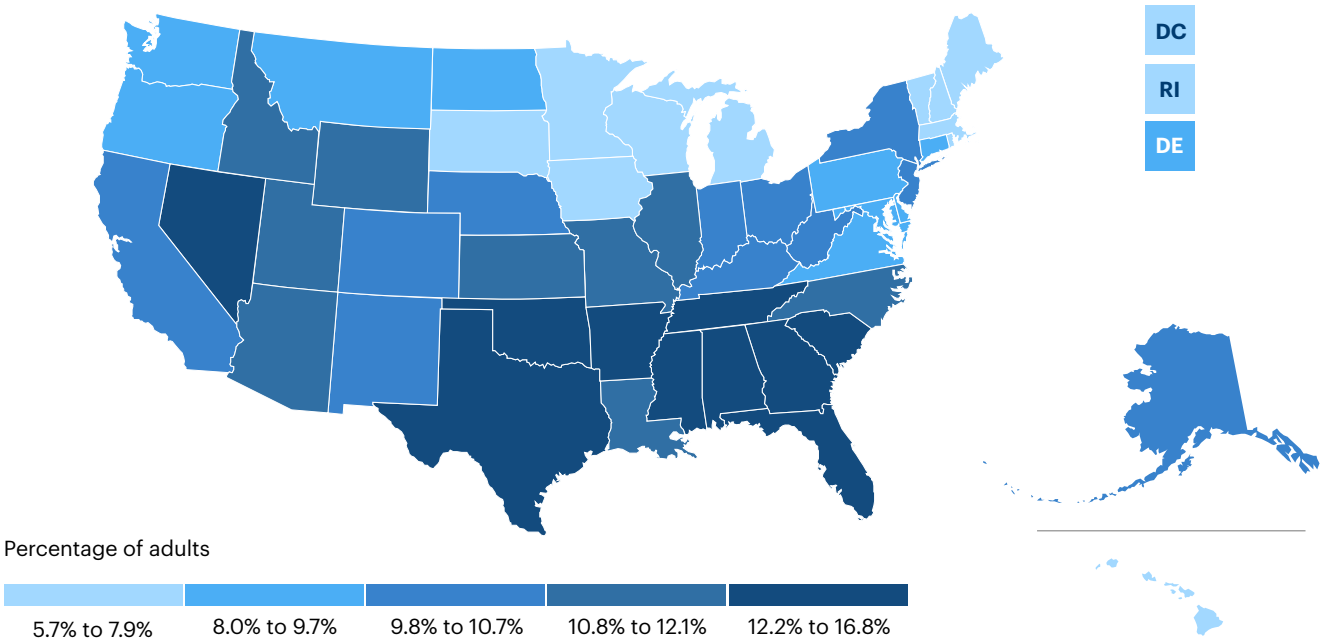
The high cost of health care in the U.S. is a major reason why individuals avoid seeking needed care.[26] People who don't get needed care are at risk of preventable hospitalizations and missed opportunities to prevent disease and manage chronic conditions — all of which can lead to worse and more expensive health outcomes.[27-29]

Changes over time. Nationally, the percentage of adults who reported a time in the past 12 months when they needed to see a doctor but could not because of cost increased 15% from 8.8% to 10.1% between 2021 and 2022. In 2022, nearly 29.3 million adults avoided care due to cost. Avoided care due to cost significantly increased in six states, led by 28% in Alabama (11.1% to 14.2%), 24% in Connecticut (7.4% to 9.2%) and 23% in both New York (8.0% to 9.8%) and Idaho (9.2% to 11.3%). The prevalence significantly increased among most income, educational attainment and age groups, and all metropolitan status and gender groups. By group, the largest increases were 28% among adults ages 25 and older with an annual household income of $75,000 or more (3.6% to 4.6%), 21% among adults ages 25 and older with less than a high school education (18.1% to 21.9%), 16% among adults ages 18-44 (13.1% to 15.2%), 13% among adults living in metropolitan areas (9.9% to 11.2%) and 12% among both women (10.6% to 11.9%) and men (9.1% to 10.2%).

Disparities. In 2022, avoided care due to cost significantly varied by income, age, educational attainment, disability status, geography, race/ethnicity, sexual orientation, veteran status and gender. The prevalence was:

- 4.8 times higher among adults ages 25 and older with a household income less than $25,000 (22.2%) than those with incomes of $75,000 or more.
- 4.1 times higher among adults ages 18-44 than those ages 65 and older (3.7%).
- 3.6 times higher among adults ages 25 and older with less than a high school degree than college graduates (6.1%).

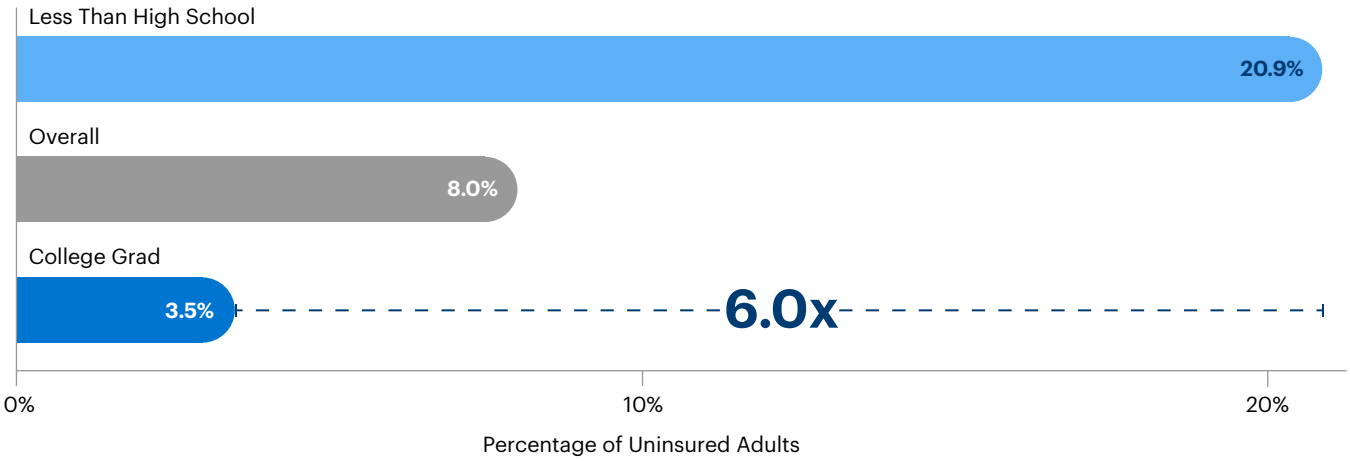
Avoided Care Due to Cost in 2022



Source: CDC, Behavioral Risk Factor Surveillance System, 2022.

Disparities in Uninsured Rates by Education

The rate was 6.0 times higher among those with less than a high school education than college graduates.



Source: U.S. Census Bureau, American Community Survey, 2022.

- 3.3 times higher among adults with cognitive difficulty (25.9%) than those without a disability (7.8%).*
- 2.9 times higher in Texas (16.8%) than Hawaii (5.7%).
- 2.5 times higher among Hispanic (18.9%) than Asian (7.7%) adults.*
- 2.3 times higher among LGBQ+ (21.5%) than straight (9.5%) adults.
- 1.9 times higher among adults who have not served (11.6%) than those who have served (6.0%) in the U.S. armed forces.
- Higher among women than men.

* The estimates for adults with cognitive difficulty, self-care difficulty (24.8%) and independent living difficulty (24.7%) were not significantly different from each other based on non-overlapping 95% confidence intervals; the same was true for those who identify their race/ethnicity as Hispanic and Hawaiian/Pacific Islander (13.3%) as well as Asian and white (8.4%).

Uninsured

Individuals who are uninsured or experience inconsistent health care coverage encounter more interruptions in accessing care and difficulties in covering medical expenses than individuals with continuous insurance coverage.[30]

Changes over time. Nationally, the percentage of the population not covered by private or public health insurance significantly decreased 7% from 8.6% to 8.0% between 2021 and 2022, reaching its lowest value in *Annual Report* history. The uninsured rate significantly decreased in 13 states, led by 18% in New Mexico (10.0% to 8.2%), 15% in Oklahoma (13.8% to 11.7%) and 11% in Alabama (9.9% to 8.8%), Colorado (8.0% to 7.1%) and North Carolina (10.4% to 9.3%). The rate significantly decreased among most educational attainment and racial/ethnic groups and all age groups. By group, the largest decreases were 10% among those with some post–high school education (8.1% to 7.3%); 9% among the Black population (9.6% to 8.7%); and 8% among those ages 19-25 (14.2% to 13.0%), ages 35-44 (13.0% to 12.0%) and ages 55-64 (8.3% to 7.6%).

Disparities. In 2022, the uninsured rate significantly varied by geography, educational attainment, race/ethnicity and age. The prevalence was:

- 6.9 times higher in Texas (16.6%) than Massachusetts (2.4%).
- 6.0 times higher among those with less than a high school education (20.9%) than college graduates (3.5%).
- 3.6 times higher among populations who identify as other race (19.1%) than white populations (5.3%).*
- 1.9 times higher among those ages 26-34 (14.1%) than those ages 55-64.

* The estimates for white and Asian (5.5%) populations were not significantly different from each other based on non-overlapping 95% confidence intervals; the same was true for populations who identify as other race and American Indian/Alaska Native populations (18.5%).

7% ▲
increase in **dental care providers** from 60.6 to 64.6 providers.*

7% ▲
increase in **mental health providers** from 305.0 to 324.9 providers.*

13% ▼
decrease in **primary care providers** from 265.3 to 232.0 providers.*

*Per 100,000 population between 2022 and 2023.
Source: U.S. HHS, Centers for Medicare & Medicaid Services, National Plan and Provider Enumeration System, September 2022 – September 2023.

Dental Care Providers

Despite projections of steady growth in the number of working dentists, many areas and populations, particularly rural communities, in the U.S. have an inadequate supply to meet current or future oral health needs.[31-33]

Changes over time. Nationally, the number of general dentists and advanced practice dental therapists increased 7% from 60.6 to 64.6 providers per 100,000 population between 2022 and 2023. There were over 215,000 dental care providers in 2023, an increase of approximately 14,000 since 2022. The supply of dental care providers increased at a rate equal to or greater than the nation in 28 states, led by 10% in Maine (57.6 to 63.1 providers per 100,000 population) and 9% in South Carolina (48.6 to 52.8), Massachusetts (85.0 to 92.3), Florida (51.9 to 56.6) and Colorado (69.8 to 76.4).

Disparities. In 2023, the supply of dental care providers was 2.4 times higher in Alaska (96.8 providers per 100,000 population) than Delaware (40.5).

Mental Health Providers

Mental health providers offer essential care to adults and children with mental or behavioral disorders through assessments, diagnoses, treatments, medications and therapeutic interventions.[34]

Changes over time. Nationally, the number of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care increased 7% from 305.0 to 324.9 providers per 100,000 population between 2022 and 2023. There were nearly 1.1 million mental health providers in 2023, an increase of about 70,600 since 2022.

The supply of mental health providers increased at a rate equal to or greater than the nation in 29 states and the District of Columbia, led by 12% in West Virginia (165.1 to 185.5 providers per 100,000 population) and 10% in the District of Columbia (670.5 to 737.6).

Disparities. In 2023, the supply of mental health providers was 5.4 times higher in Massachusetts (758.7 providers per 100,000 population) than Alabama (140.0).

Primary Care Providers

Having a better or sufficient supply of primary care physicians in a community has many benefits, including lower rates of low birth weight among infants, lower all-cause mortality, longer life spans and reductions in health system costs and health disparities.[35]

Changes over time. Nationally, the number of active primary care providers (including general practice, family practice, obstetrics and gynecology, pediatrics, geriatrics, internal medicine, physician assistants and nurse practitioners) decreased 13% from 265.3 to 232.0 providers per 100,000 population between 2022 and 2023. There were more than 773,000 primary care providers in 2023, a decrease of over 107,000 since 2022. The supply of primary care providers decreased at a rate equal to or greater than the nation in 23 states and the District of Columbia, led by 25% in the District of Columbia (546.4 to 411.3 providers per 100,000 population) and 17% in both Connecticut (300.2 to 248.9) and New Jersey (217.4 to 181.4).

Disparities. In 2023, the supply of primary care providers was 1.8 times higher in Massachusetts (322.1 providers per 100,000 population) than California (178.9). The supply was highest in the District of Columbia.

State Rankings

Rankings included in the *2023 Annual Report* are derived from 49 measures across five categories of health: social and economic factors, physical environment, behaviors, clinical care and health outcomes. For a more detailed description of how the overall rank is calculated, visit the *America's Health Rankings* Methodology page.

New Hampshire Ranks No. 1

New Hampshire is the healthiest state in this year's report for the second consecutive year. It ranks among the top five states in Social and Economic Factors (No. 1) and Behaviors (No. 2). New Hampshire is No. 6 in Clinical Care, No. 8 in Health Outcomes and No. 12 in Physical Environment.

Strengths: Low economic hardship index score, low household food insecurity, low homicide rate

Challenges: High prevalence of frequent mental distress, high prevalence of multiple chronic conditions, low percentage of community water supply with fluoridated water

Massachusetts (No. 2), Vermont (No. 3), Connecticut (No. 4) and Minnesota (No. 5) complete the top five healthiest states. Minnesota returned to the top five, switching spots with Hawaii (No. 6).

Louisiana Ranks No. 50

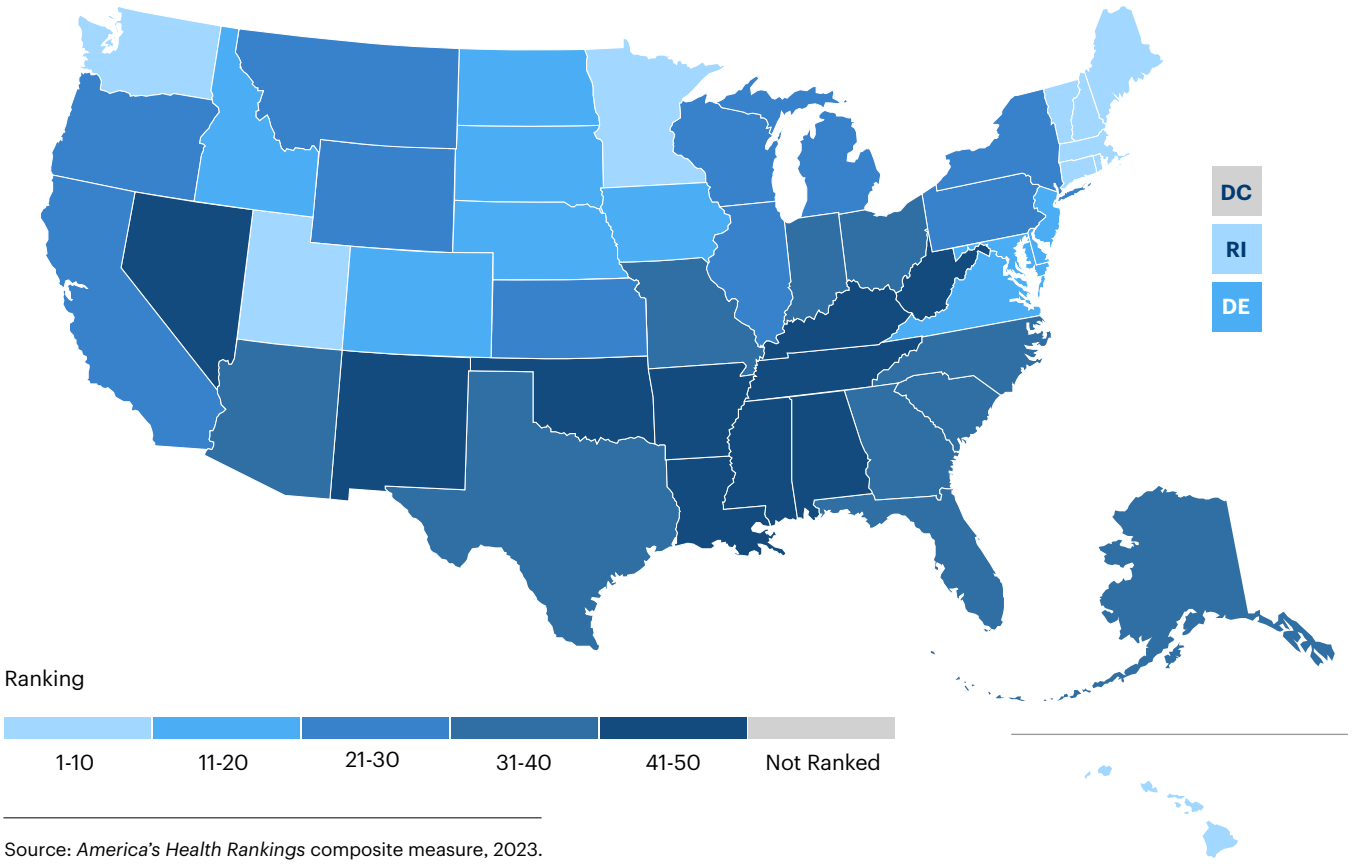
Louisiana is the least healthy state in this year's report, after also ranking No. 50 in the *2022 Annual Report*. It ranks in the bottom five states in Social and Economic Factors (No. 50), Physical Environment (No. 47), Behaviors (No. 49) and Health Outcomes (No. 48). Louisiana is No. 38 in Clinical Care.

Strengths: Low Black/white residential segregation, high prevalence of colorectal cancer screening, low levels of air pollution

Challenges: High premature death rate, high economic hardship index score, low prevalence of high school completion

Mississippi (No. 49), Arkansas (No. 48), Oklahoma (No. 47) and Alabama (No. 46) complete the five least healthy states. Oklahoma returned to the bottom five, replacing West Virginia (No. 45).

2023 Annual Report State Rankings



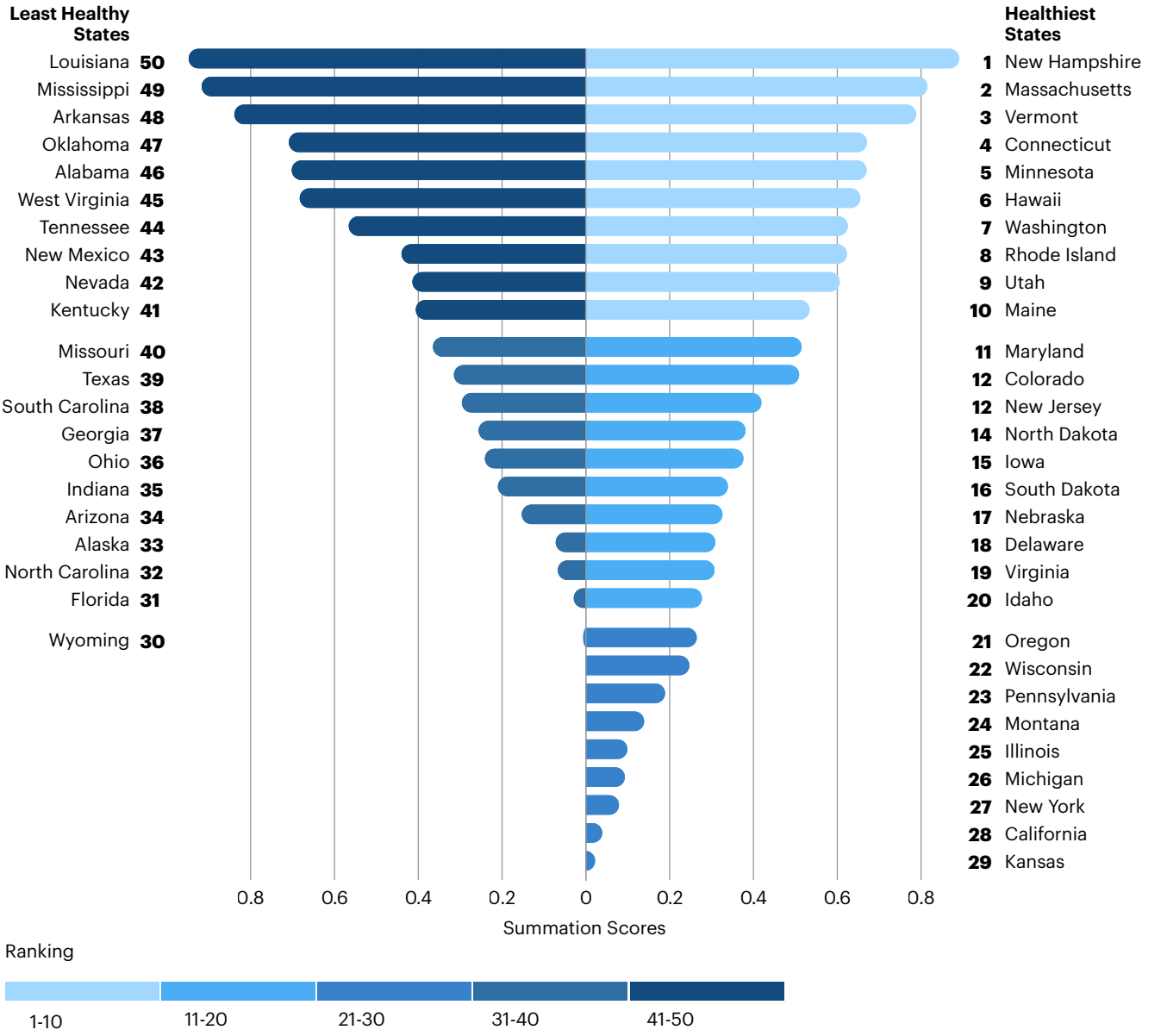
Source: *America's Health Rankings* composite measure, 2023.

Measure Impact

This graph displays the state scores in order of rank, with the least healthy states on the left and the healthiest states on the right. The distance between bars shows the difference between state scores. For example, Arkansas (No. 48) and Oklahoma (No. 47), while close in ranking, have a sizable difference in score, meaning a lot of progress would need to be made in order for Arkansas to improve its score and move up in the rankings. There is also a large gap in score between Tennessee (No. 44) and the next highest state, New Mexico (No. 43), as well as Connecticut (No. 4) and Vermont (No. 3).

To further explore state-level data, see Explore Data. The website features downloadable State Summaries for each state and the District of Columbia. Each summary describes state-specific strengths, challenges, trends and rankings for individual measures, allowing users to identify which measures positively or negatively influenced each state's overall rank. This can also be visualized by selecting a state in the Explore Data section. The website also features an Adjust My Rank tool that allows users to explore how progress and challenges across key measures can affect a state's overall rank.

2023 Annual Report State Rankings and Scores*



Source: *America's Health Rankings* composite measure, 2023. *Sum of weighted z-scores of all ranked measures.

International Comparison

Comparing the health of the U.S. to that of other countries can help indicate areas of progress and areas where improvement is needed at a national level. The Organization for Economic Co-operation and Development (OECD), the data source for this section, is composed of 38 member countries, including the United States.[36] OECD's mission is to promote the economic development and social well-being of people worldwide. OECD collects and analyzes data from each member country on a wide range of social, economic and health-related topics.

The following analysis compared data from the U.S. with other OECD countries using three health measures: infant mortality, life expectancy at birth and total health spending. Data presented were from 2021 unless otherwise specified. For infant mortality, the top and bottom states from the *2023 Health of Women and Children Report* were included for reference. Top and bottom states were also included for life expectancy, using data from the National Center for Health Statistics' National Vital Statistics System.

The U.S. had a higher infant mortality rate and lower life expectancy than most other OECD countries. Even the best-performing U.S. states ranked poorly among member countries for the infant mortality and life expectancy measures, despite the U.S. having the highest total health spending of all OECD countries.

Infant Mortality

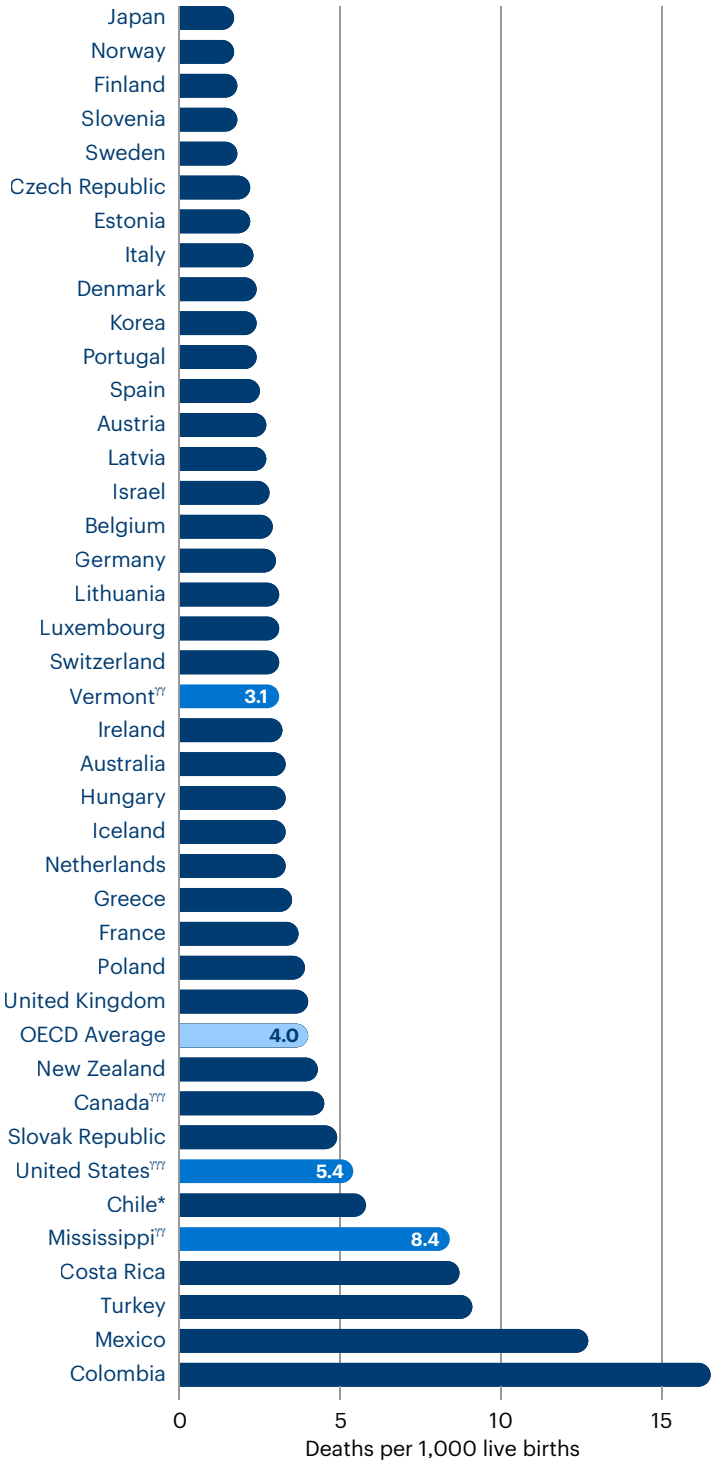
Infant mortality includes all deaths among children younger than 1 year of age.[37] Over the past 50 years, the U.S. infant mortality rate has not improved at the same pace as that of other OECD countries.[38]

The average rate of infant mortality among OECD countries was 4.0 deaths per 1,000 live births in 2021. At 5.4 deaths per 1,000 live births, the U.S. ranked No. 33 of the 38 OECD countries, falling between the Slovak Republic (4.9 deaths per 1,000 live births, No. 32) and Chile (5.8 deaths per 1,000 live births, No. 34). Japan and Norway (both No. 1) had the lowest rates, with 1.7 deaths per 1,000 live births. Mexico (No. 37) and Colombia (No. 38) had the highest infant mortality rates of OECD countries at 12.7 and 16.5 deaths per 1,000 live births, respectively.

There were large racial/ethnic disparities among U.S. infants. In 2019-2020, the U.S. infant mortality rate was 3.2 times higher among Black infants at 10.5 deaths per 1,000 live births compared with Asian infants at 3.3 deaths per 1,000 live births.

According to the *2023 Health of Women and Children Report*, Vermont had the lowest infant mortality rate at 3.1 deaths per 1,000 live births, placing it on par with Lithuania, Luxembourg and Switzerland (also 3.1, No. 18). The state with the highest rate, Mississippi, had an infant mortality rate of 8.4 deaths per 1,000 live births, more than twice the OECD average.

The U.S. Ranks No. 33 out of 38 OECD Countries in Infant Mortality



Source: Organization for Economic Co-operation and Development, 2021 or most recent year available; CDC WONDER, Linked Birth/Infant Death Files, 2019-2020.

* Provisional data, ** Estimated, ϒ 2018 data, ϒϒ 2019-2020 data, ϒϒϒ 2020 data

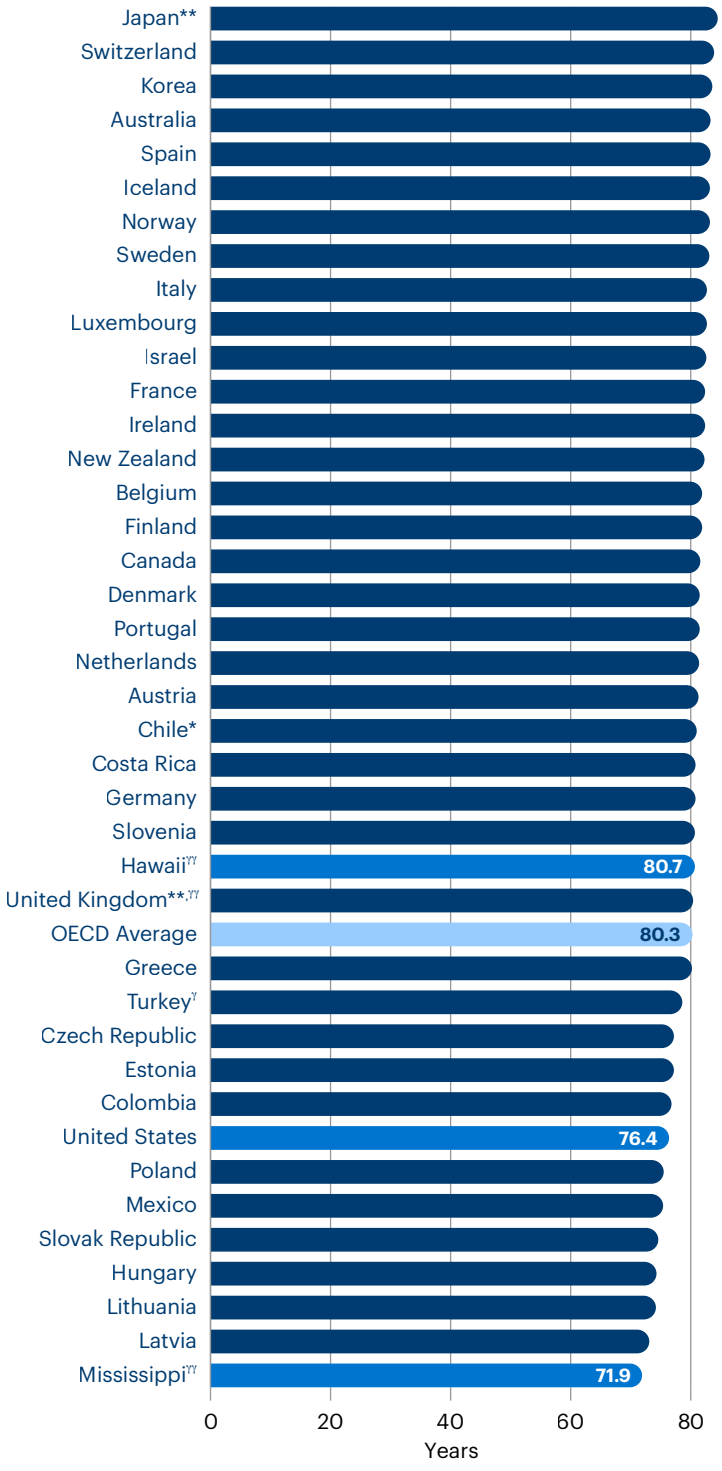
Life Expectancy

Life expectancy at birth describes how long a newborn can expect to live, on average, assuming current death rates remain the same.[39] Life expectancy has increased over the past 50 years in all OECD countries.[40] However, the COVID-19 pandemic has had profound global effects on life expectancy due to the high number of deaths from COVID-19 and other related causes.

The average life expectancy at birth in OECD countries was 80.3 years in 2021. The U.S. life expectancy at birth was 76.4 years and ranked No. 32 out of the 38 OECD countries, falling between Colombia (76.8 years, No. 31) and Poland (75.5 years, No. 33).

Hawaii, the U.S. state with the highest life expectancy at 80.7 years, tied with Slovenia (No. 25) and fell between both Costa Rica and Germany (80.8 years, No. 23) and the United Kingdom (80.4 years, No. 26). Mississippi, the state with the lowest life expectancy at 71.9 years, fell below Latvia (73.1 years, No. 38), the OECD country with the lowest life expectancy.

The U.S. Ranks No. 32 out of 38 OECD Countries in Life Expectancy at Birth



Source: Organization for Economic Co-operation and Development, 2021 or most recent year available; NVSS, 2020.

* Provisional data, ** Estimated, Ŷ 2019 data, ŶŶ 2020 data

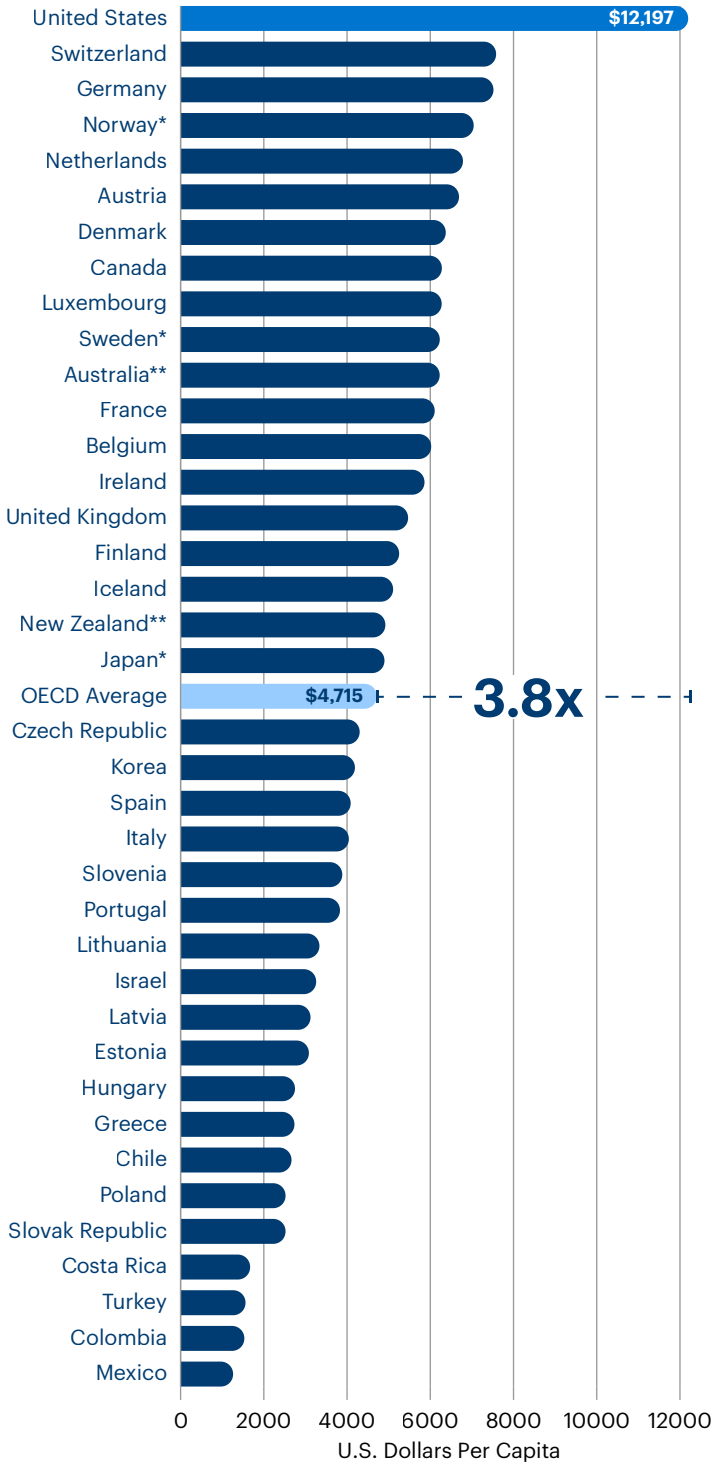
Total Health Spending

Total health spending represents the consumption of health-related goods and services; this includes personal health care (such as curative, rehabilitative and long-term care) and collective services (such as prevention and public health services).[41]

The average total spending on health in OECD countries was $4,715 U.S. dollars per capita in 2021. The U.S. spent nearly three times that amount, totaling $12,197 U.S. dollars per capita, earning a spot as top health spender of all OECD countries. Switzerland, which spent the second most on health among OECD countries ($7,582), still spent only about two-thirds the amount the U.S. spent per capita.

Spending on inpatient and outpatient care accounted for the largest share of the difference between the U.S. and other countries, and represented a greater share of health spending in 2018.[42] Roughly 56% of total health spending in the U.S. came from public funds in 2021, which was much less than the OECD average of 73%.[43]

The U.S. Spends More on Health Care Than Other OECD Countries



Source: U.S. Environmental Protection Agency, 2000-2022.

* Provisional data, ** Estimated

United States

Health Department Website: hhs.gov

Summary

Highlights

Homicide

33% ▲

from 5.8 to 7.7 deaths per 100,000 population between 2018-2019 and 2020-2021.

Occupational Fatalities

11% ▼

from 4.4 to 3.9 deaths per 100,000 workers between 2016-2018 and 2019-2021.

Premature Death

9% ▲

from 8,659 to 9,478 years lost before age 75 per 100,000 population between 2020 and 2021.

Asthma

8% ▲

from 9.6% to 10.4% of adults between 2020 and 2022.

Diabetes

8% ▲

from 10.6% to 11.5% of adults between 2020 and 2022.

Renewable Energy

8% ▲

from 19.0% to 20.5% of total electricity generated between 2021 and 2022.

Measures

		U.S. Value
Social & Economic Factors		
Community and Family Safety	Homicide (Deaths per 100,000 population)	7.7
	Occupational Fatalities (Deaths per 100,000 workers)	3.9
	Public Health Funding (Dollars per person)	$183
Economic Resources	Economic Hardship Index (Index from 1-100)	—
	Food Insecurity (% of households)	11.2%
	Income Inequality (80-20 Ratio)	4.92
Education	Fourth Grade Reading Proficiency (% of public school students)	32.1%
	High School Completion (% of adults ages 25+)	89.6%
Social Support and Engagement	Adverse Childhood Experiences (% of children ages 0-17)	14.0%
	High-Speed Internet (% of households)	92.9%
	Residential Segregation - Black/White (Index from 0-100)	—
	Volunteerism (% of population ages 16+)	23.2%
	Voter Participation (% of U.S. citizens ages 18+)	59.5%
Physical Environment		
Air and Water Quality	Air Pollution (Micrograms of fine particles per cubic meter)	8.6
	Drinking Water Violations (Average number of violations per community water system)	2.7
	Water Fluoridation (% of population served)	72.7%
Climate and Health	Climate Policies (Number of four policies)	—
	Climate Risks (% of population)*	35.5%
	Renewable Energy (% of total electricity generated)*	20.5%
Housing and Transit	Housing with Lead Risk (% of housing stock)	16.5%
	Severe Housing Problems (% of occupied housing units)	16.7%
	Transportation Health Risks (% of population)*	24.0%
Clinical Care		
Access to Care	Avoided Care Due to Cost (% of adults)	10.1%
	Dental Care Providers (Number per 100,000 population)	64.6
	Mental Health Providers (Number per 100,000 population)	324.9
	Primary Care Providers (Number per 100,000 population)	232.0
	Uninsured (% of population)	8.0%
Preventive Clinical Services	Childhood Immunizations (% of children by age 24 months)	70.0%
	Colorectal Cancer Screening (% of adults ages 45-75)	61.8%
	Dental Visit (% of adults)	66.0%
	Flu Vaccination (% of adults)	45.6%
	HPV Vaccination (% of adolescents ages 13-17)	62.6%
Quality of Care	Dedicated Health Care Provider (% of adults)	83.8%
	Preventable Hospitalizations (Discharges per 100,000 Medicare beneficiaries ages 18+)	2,681
Behaviors		
Nutrition and Physical Activity	Exercise (% of adults)	23.0%
	Fruit and Vegetable Consumption (% of adults)	7.4%
	Physical Inactivity (% of adults)	23.4%
Sexual Health	Chlamydia (Cases per 100,000 population)	495.5
	High-Risk HIV Behaviors (% of adults)	5.7%
	Teen Births (Births per 1,000 females ages 15-19)	13.9
Sleep Health	Insufficient Sleep (% of adults)	35.5%
Tobacco Use	Smoking (% of adults)	14.0%
Health Outcomes		
Behavioral Health	Drug Deaths (Deaths per 100,000 population)*	32.1
	Excessive Drinking (% of adults)	18.4%
	Frequent Mental Distress (% of adults)	15.9%
	Non-medical Drug Use (% of adults)	15.9%
Mortality	Premature Death (Years lost before age 75 per 100,000 population)	9,478
	Premature Death Racial Disparity (Ratio)	1.6
Physical Health	Frequent Physical Distress (% of adults)	12.4%
	Low Birth Weight (% of live births)	8.5%
	Low Birth Weight Racial Disparity (Ratio)	2.1
	Multiple Chronic Conditions (% of adults)	11.2%
	Obesity (% of adults)	33.6%

* Additional measure (not included in overall rank). For measure definitions, source details and methodology, visit www.AmericasHealthRankings.org.

— Data not available, missing or suppressed.

Subpopulation Group Definitions

Subpopulation analyses were performed to illuminate disparities by age, disability status, education, gender and sexual orientation, income, metropolitan status, race/ethnicity and veteran status. Not all subpopulations were available for all data sources and measures. Individual estimates were suppressed if they did not meet the reliability criteria laid out by the data source or by internally established criteria. Some values had wide confidence intervals, meaning the true value may be far from the estimate listed.

Age. Age data in this report were available for measures from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and CDC WONDER. BRFSS groupings included the following age ranges: 18-44, 45-64 and 65+. CDC WONDER groupings included the following age ranges: 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84 and 85+.

Disability status. Disability status data in this report were available for measures from BRFSS. Groupings were based on responses to the questions in the core Disability section: "Are you deaf or do you have serious difficulty hearing?", "Are you blind or do you have serious difficulty seeing, even when wearing glasses?", "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?", "Do you have serious difficulty walking or climbing stairs?", "Do you have difficulty dressing or bathing?" and "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" Responses of no or missing to all questions, with at least one response being no, were coded as without disability.

Education. Education data in this report were available for measures from BRFSS and the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS®) System. BRFSS groupings were limited to ages 25 and older and were based on responses to the question, "What is the highest grade or year of school you completed?" RADARS groupings were limited to ages 18 and older and were based on responses to the question, "What is the highest degree or level of school you have completed?"

Gender. This report stratified gender as men and women for adults and female and male for data including children, as available through public data sources — even though not all people identified with these two categories. Data did not differentiate between assigned sex at birth and current gender identity. While sex and gender influence health, the current data collection practices of many national surveys limited the ability to describe the health of transgender or gender nonbinary individuals, especially at the state level.

Sexual orientation. Sexual orientation data in this report were available for measures from BRFSS. Groupings were based on responses to the question, "Which of the following best represents how you think of yourself?" Responses of lesbian or gay, gay, bisexual or something else were summed and classified as LGBQ+. Responses of straight were summed and classified as straight (heterosexual or not gay).

Income. Income data in this report were available for measures from BRFSS and RADARS. BRFSS groupings were limited to ages 25 and older and were based on responses to the question, "[What] is your annual household income from all sources?" RADARS groupings were limited to ages 18 and older and were based on responses to the question, "What was your combined household income during the last 12 months?"

Metropolitan status. Metropolitan status data in this report were available for measures from BRFSS. Groupings were coded based on residence geography. Identification as large central metro, large fringe metro, medium metro and small metro were classified as metropolitan, and identification as micropolitan and noncore were classified as non-metropolitan.

Race/Ethnicity. Data were provided where available for the following racial and ethnic groups: American Indian/Alaska Native, Asian, Black or African American (classified in this report as Black), Hispanic or Latino (classified as Hispanic), Native Hawaiian or Other Pacific Islander (classified as Hawaiian/Pacific Islander), white, multiracial and those who identify as other race. Hispanic ethnicity includes members of all racial groups. While American Community Survey data were presented as Hispanic-

inclusive (except for white, which is non-Hispanic), all other sources presented race data as non-Hispanic. Those include BRFSS; CDC National Center for HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP); CDC WONDER; the U.S. Department of Housing and Urban Development (HUD) and RADARS.

Veteran status. Veteran status data in this report were available for measures from BRFSS. Groupings were based on responses to the question, "Have you ever served on active duty in the United States armed forces, either in the regular military or in a National Guard or military reserve unit?"

Limitations

Data presented in this report were aggregated at the state level and cannot be used to make inferences at the individual level. Additionally, estimates cannot be extrapolated beyond the population upon which they were created.

Caution is suggested when interpreting data on certain health and behavioral measures. Many were self-reported and relied on an individual's perception of health and behaviors. Additionally, some health outcome measures were based on respondents being told by a health care professional that they had a disease and may have excluded those who have not received a diagnosis or sought or obtained treatment.

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Questions and comments on the report should be directed to the United Health Foundation at unitedhealthfoundationinfo@uhg.com.

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