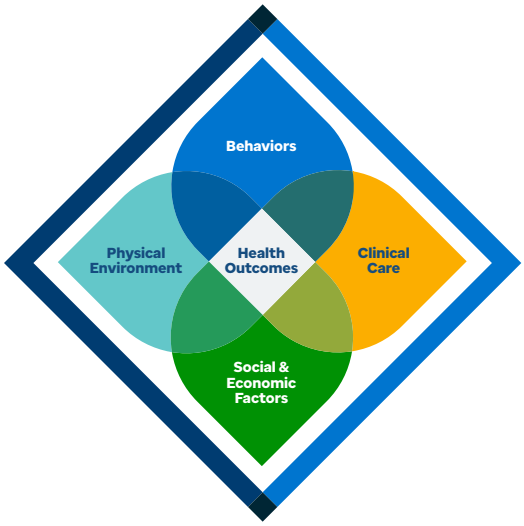
AMERICA'S HEALTH RANKINGS®
UNITED HEALTH FOUNDATION

2025 Annual Report



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."[1]

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.

Supporting Healthy People 2030

Healthy People 2030 is an initiative led by the Office of Disease Prevention and Health Promotion within the U.S. Department of Health and Human Services (HHS) that sets data-driven national objectives for the nation's health and well-being over the next decade, with a key focus on addressing the social determinants of health. For nearly five decades, Healthy People's national-level objectives have served as valuable benchmarks for advancing health and well-being at the state level. It also provides data to track the nation's progress toward achieving those goals, as well as tools that help guide individuals, organizations and communities to do so.

As a long-standing champion of public health and the HHS Healthy People 2030 goals, the United Health Foundation is honored to be recognized as a Healthy People 2030 Champion.

Contents

Call to Action

To advance health and well-being nationwide, community and health leaders alike can use the data in this report to implement data-driven solutions that build on improvements in mortality and prevention, while addressing the unique challenges and gaps facing specific populations, including rural communities.

Definitions, Limitations and Methodology

For details on demographic group definitions and limitations, data sources and methodology, please refer to the Appendix on page 40 and visit AmericasHealthRankings.org.

"As we reflect on the findings in this year's *Annual Report*, we must rededicate ourselves to improving health care in this country and creating a healthier nation for all."

Reflecting on the Latest Data

Margaret-Mary Wilson, MD
Executive Vice President & Chief Medical Officer, UnitedHealth Group

As we reflect on the findings in this year's *Annual Report*, we must rededicate ourselves to improving health care in this country and creating a healthier nation for all.

United Health Foundation's goal has always been to help build healthier communities. That work begins with information – data that quantifies profoundly human experiences – and it is propelled by people who want to create positive change. *America's Health Rankings* provides actionable, data-driven insights to help policymakers, community leaders and health officials better understand the health and well-being of their communities so that together they can help improve them.

In this year's *Annual Report*, we see progress across the nation, including improvements in mortality, stabilizing trends in measures of behavioral health and progress in several measures of clinical care. These are encouraging findings. As a physician, I know good quality clinical care and prevention are the cornerstones of healthy outcomes.

The report also reveals areas for improvement within the social and economic domains that shape health. The data also show the distinct challenges faced by different communities, including rural America, that must be addressed through tailored interventions.

The value of data is purposeful action. Each of us has a role to play in turning these insights into a healthier future: for individuals, communities, states and the nation. *America's Health Rankings* provides the demographic, state-based and national data that are critical to build on progress and identify areas of opportunity to improve well-being.

The United Health Foundation® is proud to release the *America's Health Rankings 2025 Annual Report*, which provides a comprehensive look at the health of the population nationwide and on a state-by-state basis.

First published in 1990, the *Annual Report* is the longest-running state-by-state analysis of the nation's health. As a leader in public health data analysis, *America's Health Rankings* has advanced its model for measuring health over the past three-plus decades to reflect the evolving understanding of the factors that shape population health and community well-being.

This year's report analyzes 99 measures drawn from 31 data sources to provide a comprehensive view of the health of the nation, the 50 states and the District of Columbia. The report also examines differences across populations by age, income, educational attainment and other demographic factors, and includes a closer look at how the health of those living in rural (nonmetropolitan) areas compares with that of their metropolitan counterparts.

The 2025 report reveals encouraging signs of progress. Mortality rates improved, including reductions in premature death and drug death rates. National rates of cancer screenings, physical inactivity and volunteerism also improved. At the same time, these gains were offset by a rising prevalence in multiple chronic conditions among adults and worsening socioeconomic challenges such as homelessness and unemployment.

National findings from the *2025 Annual Report* include:

- Premature death, drug death, firearm and homicide rates all improved.
- The prevalence of multiple chronic conditions increased.
- Behavioral health measures depression, excessive drinking, frequent mental distress, non-medical drug use and suicide remained stable.
- Volunteerism increased, while homelessness and unemployment rose.
- The supply of mental health providers continued to grow, and the prevalence of adults who received recommended cancer screenings increased. However, more adults avoided needed care due to cost, and the percentage of people who were uninsured increased.
- Physical inactivity among adults improved. Cigarette smoking continued to decrease, but e-cigarette use increased.
- Air pollution increased after reaching a low during the COVID-19 pandemic. Drinking water violations decreased, and renewable energy production continued to rise.

Jonathan Fielding, MD
Distinguished Professor of Health Policy and Management, UCLA Fielding School of Public Health

For decades, *America's Health Rankings* has compiled reliable information from a variety of sources to inform the nation's understanding of key drivers of health, helping assess the progress we've made and the critical opportunities that remain. This unique resource equips public health leaders with actionable information and trends they can use to understand the key differences in health and well-being between states and populations across our great nation. What makes *America's Health Rankings* especially valuable is its ability to turn complex data into clear, actionable insights to help leaders move between evidence and impact.

By translating information into action, *America's Health Rankings* continues to be an essential cornerstone underlying the progress that has been made in advancing the health and well-being of all Americans.

New in 2025

This year, *America's Health Rankings* added three new measures: heat-coded emergency department visits, homelessness and neighborhood racial/ethnic segregation. Also new this year is the ability to break down measures sourced from the Behavioral Risk Factor Surveillance System by six levels of income. For a detailed description of these and other demographic groups, see Methodology (page 51).

Users can explore population data by metropolitan status for a variety of measures by looking for this icon throughout the Executive Brief, State Summaries and report.

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. To achieve this, *America's Health Rankings* collaborates with an advisory committee to determine the selection of a comprehensive set of measures. The *2025 Annual Report* is based on:

- **Ninety-nine measures.** These include 50 ranking and 49 unweighted measures (not included in a state's overall rank). For a complete list of measures, definitions and source details, see the Measures Table and Data Source Descriptions (page 43).
- **Five categories of health.** These comprise Health Outcomes and four categories of health determinants: Social and Economic Factors, Physical Environment, Behaviors and Clinical Care.
- **Thirty-one sources.** Data are from multiple sources, including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and the U.S. Census Bureau's American Community Survey.

The *America's Health Rankings 2025 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 drivers of health.
- **Providing a benchmark for states.** Each year, the report presents strengths, challenges and key findings for every state and the District of Columbia. Public health leaders can monitor health trends over time and compare their state with other states and the nation. State Summaries containing data on all 50 ranking measures are available on the website as a separate download.
- **Highlighting differences**. 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, disability status, educational attainment, income level, metropolitan status, sexual orientation and veteran status.
- **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.

National Snapshot

Health Outcomes

Premature Death*

8% ▼

decrease from 8,522 to 7,862 years lost before age 75 per 100,000 population between 2022 and 2023.

Multiple Chronic Conditions**

6% ▲

increase from 10.7% to 11.3% of adults between 2023 and 2024.

Drug Deaths*

3% ▼

decrease from 32.4 to 31.4 deaths per 100,000 population between 2022 and 2023.

Social and Economic Factors

Volunteerism†

22% ▲

increase from 23.2% to 28.3% of the population age 16 and older between 2021 and 2023.

Homicide*

13% ▼

decrease from 7.7 to 6.7 deaths per 100,000 population between 2020-2021 and 2022-2023.

Unemployment††

7% ▲

increase from 4.3% to 4.6% of the civilian workforce between 2023 and 2024.

Firearm Deaths*

3% ▼

decrease from 14.5 to 14.0 deaths per 100,000 population between 2022 and 2023.

* Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER.
** Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.
† Source: U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement.
†† Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset.

Behaviors

Physical Inactivity*

10% ▼

decrease from 24.2% to 21.8% of adults between 2023 and 2024.

E-Cigarette Use*

4% ▲

increase from 7.7% to 8.0% of adults between 2023 and 2024.

Cigarette Smoking*

4% ▼

decrease from 12.1% to 11.6% of adults between 2023 and 2024.

Physical Environment

Homelessness**

16% ▲

increase from 19.4 to 22.6 people per 10,000 population between 2023 and 2024.

Air Pollution†

13% ▲

increase from 7.8 to 8.8 micrograms of fine particles per cubic meter between 2019-2021 and 2022-2024.

Drinking Water Violations††

11% ▼

decrease from 2.8 to 2.5 average violations per community water system between 2023 and 2024.

Renewable Energy‡

6% ▲

increase from 20.6% to 21.9% of total electricity generated between 2023 and 2024.

Clinical Care

Avoided Care Due to Cost*

8% ▲

increase from 10.6% to 11.5% of adults between 2023 and 2024.

Mental Health Providers‡‡

5% ▲

increase from 344.9 to 362.6 providers per 100,000 population between September 2024 and September 2025.

Flu Vaccination*

4% ▼

decrease from 42.9% to 41.3% of adults between 2023 and 2024.

Uninsured§

4% ▲

increase from 7.9% to 8.2% of the population between 2023 and 2024.

* Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System.
** Source: U.S. HUD, Annual Homelessness Assessment Reports to Congress.
† Source: U.S. EPA.
†† Source: U.S. EPA, Safe Drinking Water Information System via ECHO.
‡ Source: U.S. EIA, State Energy Data System.
‡‡ Source: U.S. HHS, CMS, National Plan and Provider Enumeration System.
§ Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset.

Cancer Screenings

Cancer Screenings*

15% ▲

increase from 56.0% to 64.5% of adults between 2022 and 2024.

Colorectal Cancer Screenings*

15% ▲

increase from 61.8% to 71.1% of adults ages 45-75 between 2022 and 2024.

Breast Cancer Screenings*

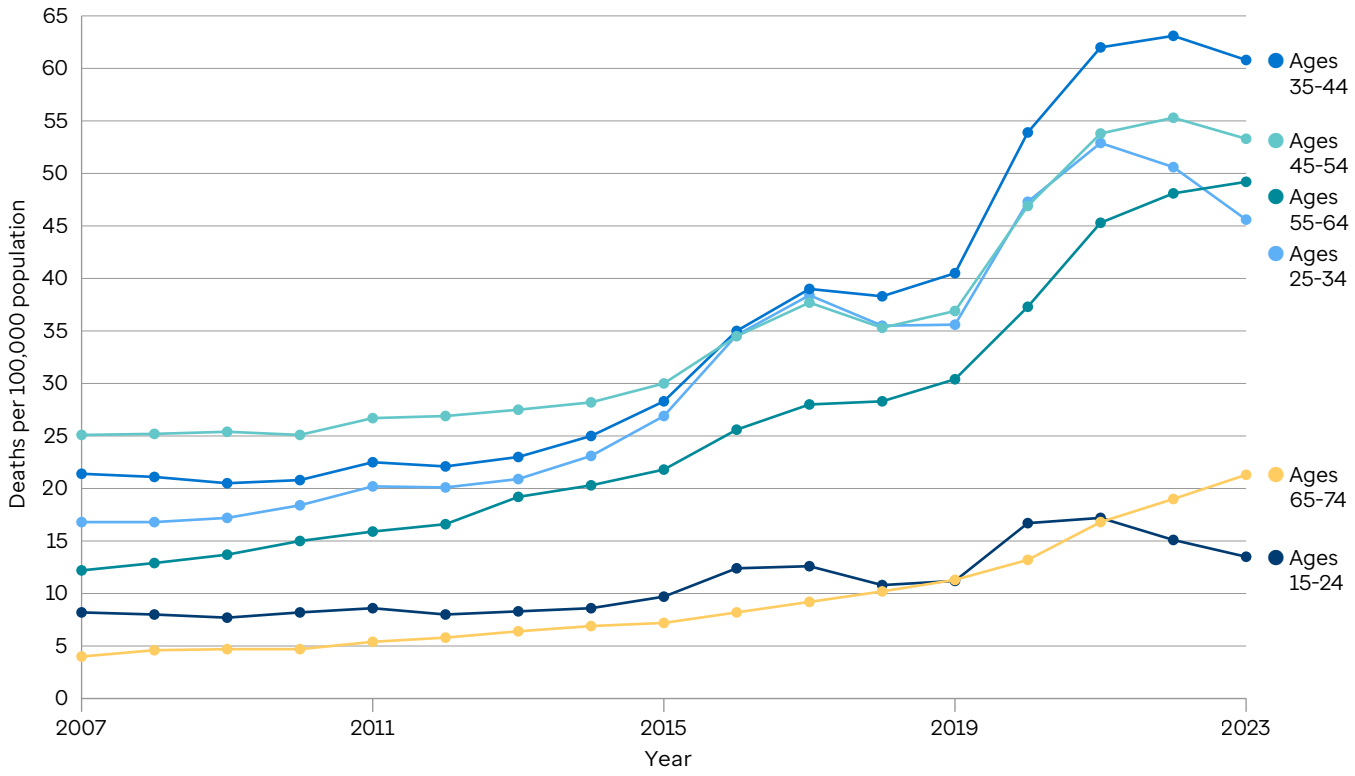
3% ▲

increase from 72.1% to 74.5% of women ages 40-74 between 2022 and 2024.

Findings

Drug Deaths

By Age Group



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2007-2023.

HEALTH OUTCOMES | BEHAVIORAL HEALTH

Drug Deaths

Drug overdose deaths in the United States decreased between 2022 and 2023, after two decades of near-continuous increases.[2] Provisional 2024 data suggest that this positive trend is continuing.[3] However, not all regions, racial/ethnic groups or age groups experienced improvements in overall drug deaths.[4]

Changes over time. Nationally, the drug death rate decreased 3% from 32.4 to 31.4 deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 population between 2022 and 2023. This rate still exceeds the Healthy People 2030 target to reduce drug overdose deaths to 20.7 deaths per 100,000 population.[5] In 2023, 105,000 people in the U.S. died of a drug overdose, 2,900 fewer deaths than in 2022.

Between 2022 and 2023, the drug death rate significantly decreased:

- 11% among those ages 15-24 (15.1 to 13.5 deaths per 100,000 population), 10% among those ages 25-34 (50.6 to 45.6), and 4% among both those ages 35-44 (63.1 to 60.8) and those ages 45-54 (55.3 to 53.3).
- 6% among white populations (34.6 to 32.6).
- 5% among females (19.1 to 18.2) and 2% among males (45.9 to 44.8).

However, during the same period, the drug death rate significantly increased:

- 12% among those ages 65-74 (19.0 to 21.3 deaths per 100,000 population).
- 3% among Black populations (49.3 to 50.9).

Between 2022 and 2023, the drug death rate significantly decreased in 14 states but increased in five states. The largest decreases were: 19% in North Carolina (40.3 to 32.5 deaths per 100,000 population), 17% in both Arkansas (20.3 to 16.8) and Indiana (39.3 to 32.7), and 16% in Maine (51.0 to 42.8). The drug death rate increased 41% in Alaska (34.6 to 48.9), 31% in Oregon (32.1 to 42.1), 27% in both Washington (35.0 to 44.5) and Nevada (31.6 to 40.1), and 4% in California (28.1 to 29.2).

Differences. The drug death rate significantly varied by race/ethnicity, geography, age and gender in 2023. The rate was:

- 11.8 times higher among American Indian/Alaska Native (63.6 deaths per 100,000 population) compared with Asian (5.4) populations.
- 8.9 times higher in West Virginia (77.8) than in Nebraska (8.7).
- 4.5 times higher among those ages 35-44 (60.8) than those ages 15-24 (13.5).
- 2.5 times higher among males (44.8) compared with females (18.2).

Related Measure: Non-Medical Drug Use

Nationally, the percentage of adults who reported using prescription drugs non-medically (including pain relievers, stimulants and sedatives) or illicit drugs (excluding cannabis) in the last 12 months did not change significantly between 2024 and 2025 (17.6% to 16.8%). In 2025, almost 44.2 million adults reported non-medical drug use. Over the longer term, non-medical drug use increased 49% from 11.3% to 16.8% between 2019 and 2025.

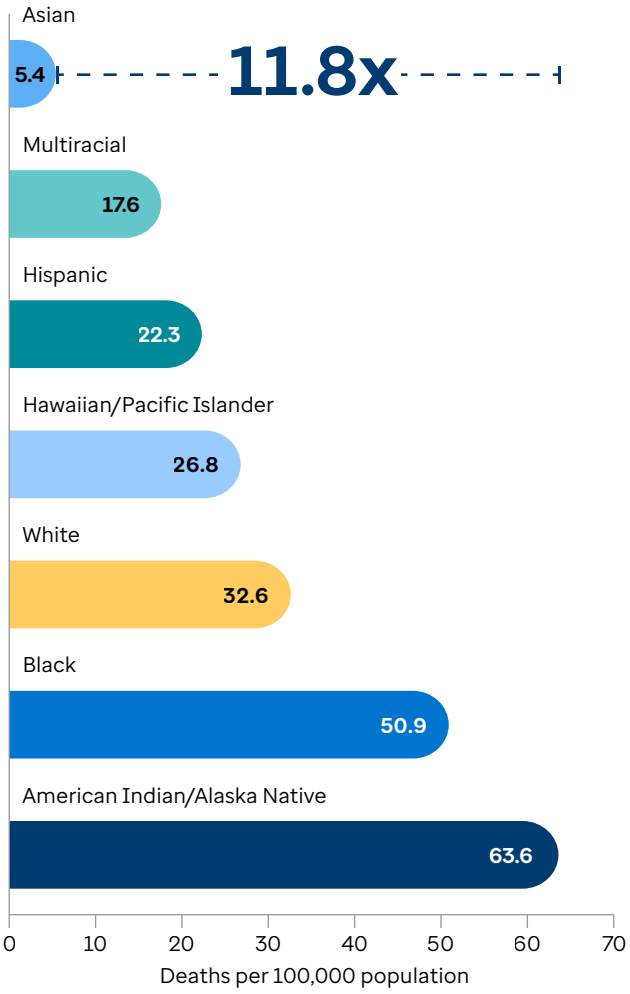
Between 2024 and 2025, non-medical drug use prevalence significantly decreased:

- 9% among adults with incomes of $75,000 or more (11.2% to 10.2%).
- 9% among college graduates (19.7% to 18.0%).
- 8% among white adults (17.9% to 16.5%).

During the same period, non-medical drug use significantly changed in one state. Use decreased 37% in Nevada (39.3% to 24.9%).

Drug Deaths

By Race/Ethnicity in 2023



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2023.

Excessive Drinking

Excessive alcohol use is one of the leading preventable causes of death in the U.S., causing an estimated 178,000 deaths every year, behind tobacco use and poor diet/physical inactivity.[6] Excessive drinking can lead to alcohol poisoning, unintentional injuries, hypertension, heart disease, stroke, liver disease, several different cancers and alcohol use disorder.[7-11]

Changes over time. Nationally, the percentage of adults who reported excessive drinking remained stable (16.7% to 17.0%) between 2023 and 2024. Excessive drinking includes both binge drinking (four or more drinks on one occasion in the past 30 days for females or five or more for males) and heavy drinking (eight or more drinks per week for females or 15 or more for males). Long-term, the prevalence decreased 14% (from 19.8%) between 2011 and 2024.

Between 2023 and 2024, excessive drinking prevalence significantly decreased 15% in Hawaii (20.1% to 17.1%). During the same time period, the prevalence significantly increased 10% among adults age 65 and older (6.9% to 7.6%) and 7% among adults ages 45-64 (15.1% to 16.2%).

Differences. Excessive drinking significantly varied by age, geography, race/ethnicity, disability status, income, gender, sexual orientation and educational attainment. In 2024, the prevalence was:

- 2.9 times higher among adults ages 18-44 (21.9%) compared with those age 65 and older (7.6%).
- 2.3 times higher in the District of Columbia (27.2%) and 1.9 times higher in Montana (22.5%) than in Utah (11.9%).
- 2.0 times higher among multiracial (19.1%) than Asian (9.7%) adults.
- 1.9 times higher among adults who have difficulty with cognition (18.7%) compared with adults who have difficulty with mobility (9.9%).
- 1.8 times higher among adults with an annual household income of $150,000 or more (22.3%) than those with incomes less than $25,000 (12.6%).
- 1.6 times higher among men (20.5%) than women (13.1%).
- 1.3 times higher among lesbian, gay, bisexual and queer (LGBQ+) (21.4%) than straight (16.2%) adults.

1.1 times higher among college graduates (16.5%) than adults with less than a high school education (14.9%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for multiracial (19.1%), Hispanic (17.9%), white (17.7%), Hawaiian/Pacific Islander (17.0%) and American Indian/Alaska Native (15.6%) adults may not differ significantly based on overlapping 95% confidence intervals. The same is true for adults who have difficulty with cognition (18.7%) and those without a disability (17.6%); adults who have difficulty with mobility (9.9%) and adults who have difficulty with self-care (11.3%); and college graduates (16.5%), adults with some post-high school education (16.1%) and high school graduates (16.1%). Disability groups are not mutually exclusive.

Suicide

Suicide is a troubling public health issue that leaves a lasting impact on families and communities.[12] In 2024, 14.3 million adults seriously thought about suicide, 4.6 million made a plan and 2.2 million attempted suicide.[13]

Changes over time. Nationally, the suicide rate did not significantly change between 2022 and 2023 (14.8 to 14.7 deaths due to intentional self-harm per 100,000 population) and remains higher than the Healthy People 2030 target to reduce the suicide rate to 12.8 deaths per 100,000 population.[14] In 2023, more than 49,300 suicide deaths occurred in the U.S. Long-term, the suicide rate increased 23% from 12.0 to 14.7 between 2009 and 2023.

Differences. The suicide rate significantly varied by geography, gender, race/ethnicity and age in 2023. The rate was:

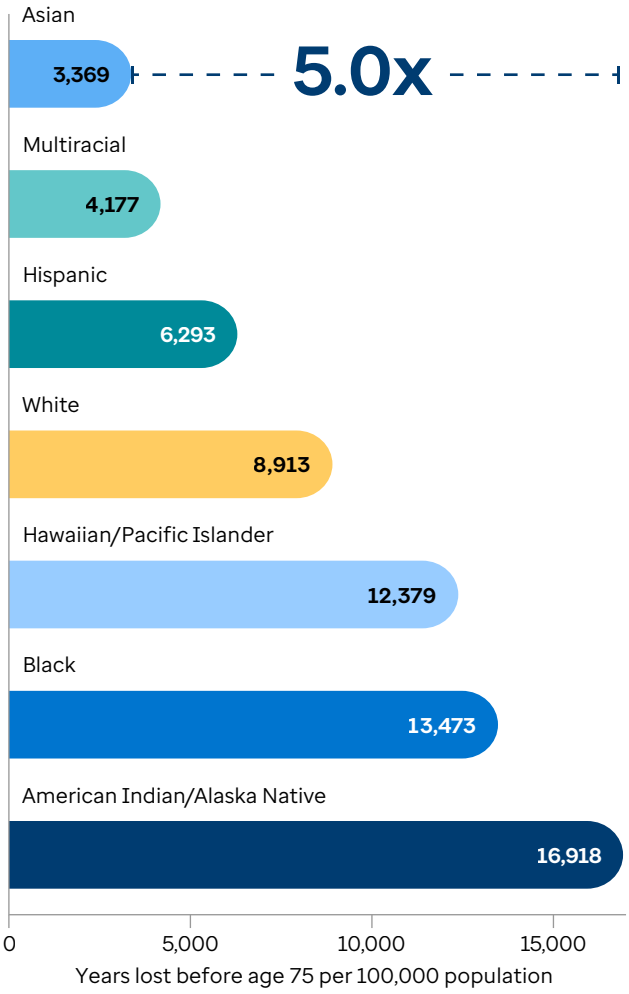
- 4.7 times higher in Alaska (28.1 deaths per 100,000 population) than in the District of Columbia (6.0), and 3.7 times higher in Alaska than in New Jersey (7.6).
- 3.9 times higher among males (23.6) compared with females (6.1).
- 3.5 times higher among American Indian/Alaska Native (23.7) than Asian (6.8) populations.
- 1.7 times higher among those age 85 and older (22.7) than those ages 15-24 (13.5).

Related Measure: Frequent Mental Distress

Nationally, the percentage of adults who reported their mental health was not good 14 or more days in the past 30 days remained stable nationally (15.4% to 15.6%) and significantly increased in one state between 2023 and 2024 (Wisconsin, 14.7% to 17.2%). However, since 2011, the prevalence of frequent mental distress has increased 33% nationally (from 11.7%).

Premature Death

By Race/Ethnicity in 2021-2023



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 2021-2023.

HEALTH OUTCOMES | MORTALITY

Premature Death

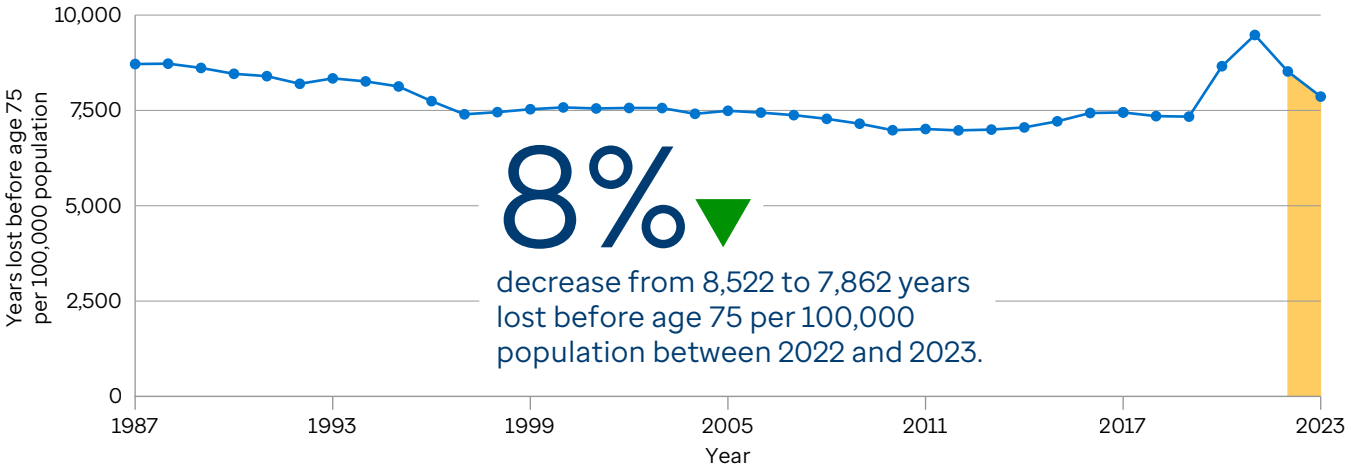
Premature death is a measure of years of potential life lost due to death occurring before the age of 75. Deaths at younger ages contribute more to the premature death rate than deaths occurring closer to age 75. For example, a person dying at age 70 would lose five years of potential life, whereas a child dying at age five would lose 70 years of potential life. The top five causes of premature death in 2023 were unintentional injuries, cancer, heart disease, suicide and homicide.[15] In 2023, homicide replaced COVID-19 in the top five and COVID-19 dropped out of the top 10.[16]

Changes over time. Nationally, premature death decreased 8% from 8,522 to 7,862 years lost before age 75 per 100,000 population between 2022 and 2023. During this time frame, the premature death rate decreased in 44 states, led by: 13% in Maine (9,327 to 8,082), 12% in both South Dakota (9,120 to 8,047) and West Virginia (13,647 to 12,053), and 11% in both Indiana (10,167 to 9,093) and Missouri (10,446 to 9,303).

Differences. The premature death rate varied by race/ethnicity and geography. It was:

- 5.0 times higher among American Indian/Alaska Native (16,918 years lost before age 75 per 100,000) compared with Asian (3,369) populations in 2021-2023.
- 2.1 times higher in Mississippi (12,071) than in Massachusetts (5,760) in 2023.

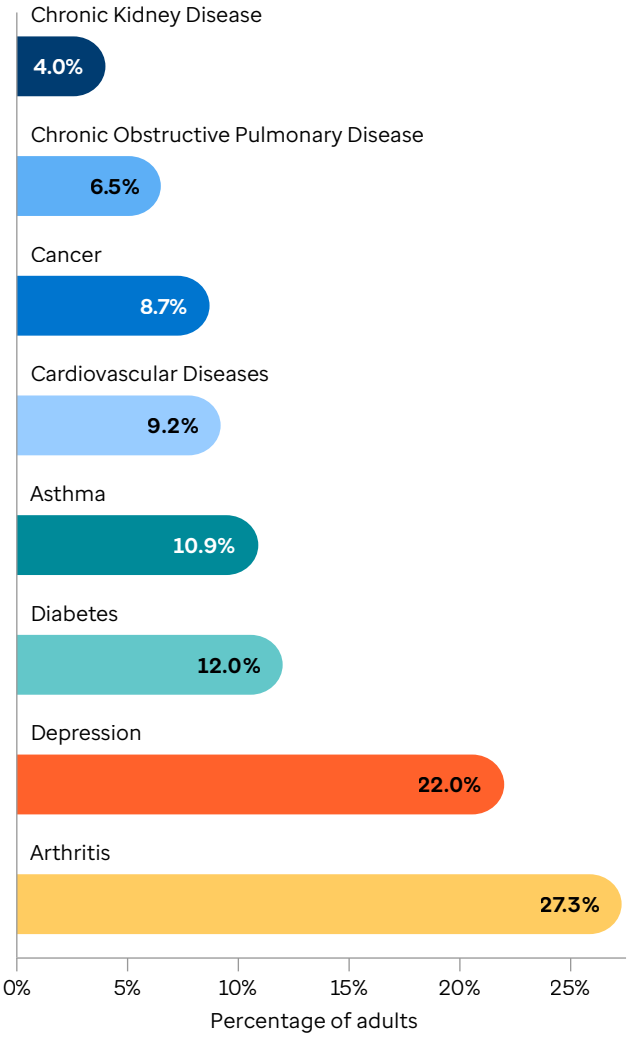
Premature Death



Source: U.S. HHS, Multiple Cause of Death Files via CDC WONDER, 1987-2023.

Chronic Conditions

In 2024



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2024.
Note: No data were available for Tennessee in 2024.

Multiple Chronic Conditions

Chronic conditions are health conditions lasting more than a year that require ongoing medical attention and/or limit daily functions such as eating, bathing and mobility.[17] The more chronic conditions an individual has, the higher their risk of physical, social and cognitive limitations, longer hospital stays, adverse drug events and mortality.[17-19]

Changes over time. Nationally, the percentage of adults who have three or more of these chronic conditions – arthritis, asthma, cancer (excluding nonmelanoma skin cancer), cardiovascular diseases (heart disease, heart attack or stroke), chronic kidney disease, chronic obstructive pulmonary disease (COPD), depression or diabetes – increased 6% from 10.7% to 11.3% of adults between 2023 and 2024. During this time arthritis increased 4% (26.3% to 27.3%), asthma increased 6% (10.3% to 10.9%), cancer increased 4% (8.4% to 8.7%), cardiovascular diseases increased 8% (8.5% to 9.2%), chronic kidney disease increased 8% (3.7% to 4.0%), COPD increased 2% (6.4% to 6.5%) and diabetes increased 4% (11.5% to 12.0%). Depression was the only chronic condition that did not change, remaining at 22.0% in 2024.

Between 2023 and 2024, the prevalence of multiple chronic conditions significantly increased:

- 17% among adults ages 18-44 (3.0% to 3.5%), 12% among those ages 45-64 (12.3% to 13.8%) and 5% among those age 65 and older (22.2% to 23.2%).
- 16% among adults without a disability (4.5% to 5.2%), 8% among those who have difficulty hearing (28.3% to 30.7%) and 7% among those who have difficulty with cognition (23.7% to 25.4%).
- 12% among both adults with some post-high school education (13.5% to 15.1%) and college graduates (7.3% to 8.2%).
- 12% among adults with incomes of $50,000 to $74,999 (11.3% to 12.7%) and 8% among those with incomes of $25,000 to $49,999 (15.3% to 16.5%).
- 11% among straight adults (10.8% to 12.0%).
- 9% among adults living in metropolitan areas (9.7% to 10.6%) and 7% among adults living in nonmetropolitan areas (14.4% to 15.4%).
- 9% among adults who have not served in the U.S. armed forces (9.8% to 10.7%).
- 8% among white adults (12.2% to 13.2%).
- 8% among both women (12.2% to 13.2%) and men (8.6% to 9.3%).

During this time frame, the prevalence of multiple chronic conditions significantly increased in six states, with the largest increases being 24% in Texas (8.3% to 10.3%), 20% in Michigan (12.8% to 15.3%), and 17% in both Nebraska (8.4% to 9.8%) and Oklahoma (12.8% to 15.0%).

Differences. The prevalence of multiple chronic conditions significantly varied by disability status, age, race/ethnicity, income, geography, educational attainment, veteran status, metropolitan status, gender and sexual orientation in 2024. It was:

- 8.8 times higher among adults who have difficulty with self-care (45.8%) than those without a disability (5.2%).
- 6.6 times higher among adults age 65 and older (23.2%) compared with those ages 18-44 (3.5%).
- 5.2 times higher among American Indian/Alaska Native (16.5%) compared with Asian (3.2%) adults.
- 4.7 times higher among adults with an annual household income less than $25,000 (23.3%) compared with those with incomes of $150,000 or more (5.0%).
- 2.5 times higher in West Virginia (20.6%) than in California (8.1%).
- 2.0 times higher among adults with less than a high school education (16.6%) than college graduates (8.2%).
- 1.6 times higher among adults who have served in the U.S. armed forces (17.4%) than those who have not served (10.7%).
- 1.5 times higher among adults living in nonmetropolitan areas (15.4%) than those in metropolitan areas (10.6%).
- 1.4 times higher among women (13.2%) compared with men (9.3%).
- 1.2 times higher among straight (12.0%) compared with LGBQ+ (10.4%) adults.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for American Indian/Alaska Native (16.5%), other race (15.1%), multiracial (15.0%) and Hawaiian/Pacific Islander (11.0%) adults may not differ significantly based on overlapping 95% confidence intervals.

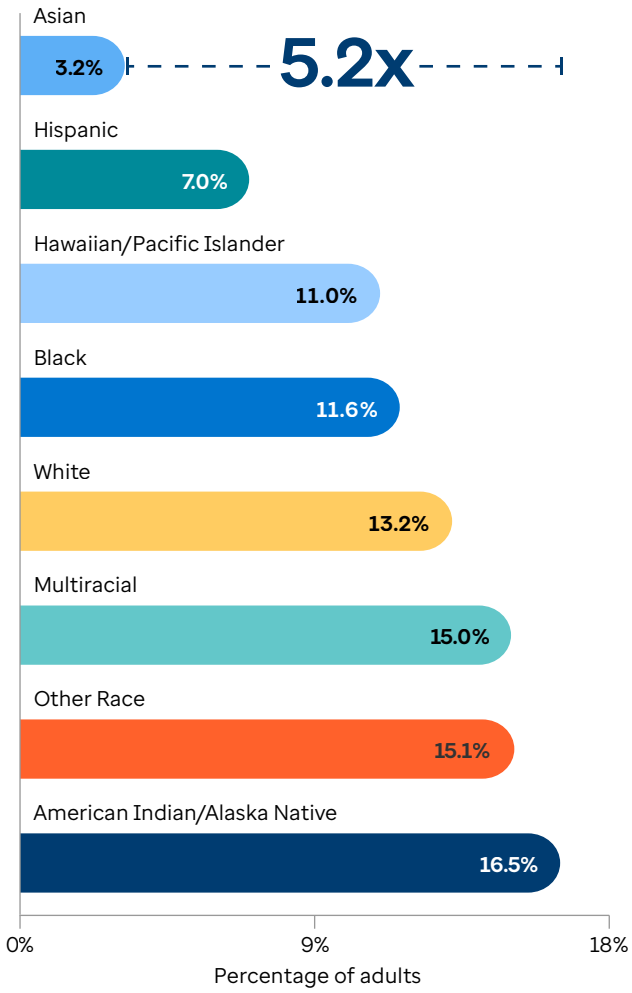
Related Measure: Obesity

After increasing 23% between 2011 and 2023 (27.8% to 34.3%), the national obesity prevalence among adults remained stable between 2023 and 2024 at 34.2%. The prevalence did not significantly change in any states during this recent period, but it did significantly increase 4% among adults ages 18-44, from 30.0% to 31.3%.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Multiple Chronic Conditions

By Race/Ethnicity in 2024



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2024.
Note: No data were available for Tennessee in 2024. The values for American Indian/Alaska Native (16.5%), other race (15.1%), multiracial (15.0%) and Hawaiian/Pacific Islander (11.0%) adults may not differ significantly based on overlapping 95% confidence intervals.

Firearm Deaths

Gun violence continues to be a significant public health issue in the U.S.[20] In 2023, firearms were responsible for more than half (55%) of all suicide deaths nationally.[21] Furthermore, the U.S. has a significantly higher rate of firearm deaths than 30 other populous high-income countries as defined by the Organization for Economic Co-operation and Development.[22] In 2023, firearm deaths accounted for more than 1.1 million years of potential life lost before age 65.[23]

Changes over time. Nationally, the firearm death rate decreased 3% from 14.5 to 14.0 deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 population between 2022 and 2023. The current rate does not meet the Healthy People 2030 target to reduce firearm-related deaths to 10.7 per 100,000 population and is 16% higher than it was in 2019 (12.1).[24] In 2023, there were 46,700 deaths by firearm. Homicides by firearm decreased 8% nationally from 5.9 to 5.4 between 2022 and 2023. The firearm suicide rate (8.2) did not significantly change.

Between 2022 and 2023, the firearm death rate decreased:

- 9% among Black populations (33.8 to 30.9 deaths per 100,000 population).
- 8% among those ages 25-34 (22.9 to 21.1).
- 4% among males (25.0 to 24.1).

During the same time, the firearm death rate decreased 11% in Missouri (24.1 to 21.4 deaths per 100,000 population) and 8% in California (8.9 to 8.2). However, the rate increased 45% in the District of Columbia (22.9 to 33.1).

Differences. The firearm death rate varied by race/ethnicity, geography, gender and age in 2023. It was:

- 9.7 times higher among Black (30.9 deaths per 100,000 population) compared with Asian (3.2) populations.
- 8.5 times higher in the District of Columbia (33.1) and 7.4 times higher in Mississippi (28.7) than in Massachusetts (3.9).
- 6.0 times higher among males (24.1) than females (4.0).
- 1.8 times higher among those ages 25-34 (21.1) compared with those ages 65-74 (11.8).

Note: The values for those ages 25-34 (21.1 per 100,000 population) and 15-24 (20.3) may not differ significantly based on overlapping 95% confidence intervals.

Homicide

In 2023, there were 22,830 homicides committed in the U.S., of which nearly 18,000 – or almost 80% – involved a firearm.[25,26]

Changes over time. Nationally, the homicide rate decreased 13% between 2020-2021 and 2022-2023, from 7.7 to 6.7 deaths due to injuries inflicted by another person with intent to injure or kill per 100,000 population. In 2022-2023, nearly 44,900 homicides occurred, a decrease of more than 5,700 deaths compared with 2020-2021. The current rate does not meet the Healthy People 2030 target to reduce homicides to 5.5 deaths per 100,000 population.[27]

Between 2020-2021 and 2022-2023, the homicide rate significantly decreased:

- 28% among those age 85 and older (1.8 to 1.3 deaths per 100,000 population), 20% among those ages 75-84 (2.0 to 1.6), 16% among those ages 25-34 (16.0 to 13.4), 12% among those ages 15-24 (15.3 to 13.4), 10% among those ages 55-64 (4.2 to 3.8), 9% among those ages 45-54 (6.6 to 6.0) and 8% among those ages 35-44 (10.9 to 10.0).
- 16% among white (3.1 to 2.6), 13% among Black (33.4 to 29.0) and 6% among Hispanic (6.8 to 6.4) populations.
- 14% among females (2.9 to 2.5) and 13% among males (12.6 to 11.0).

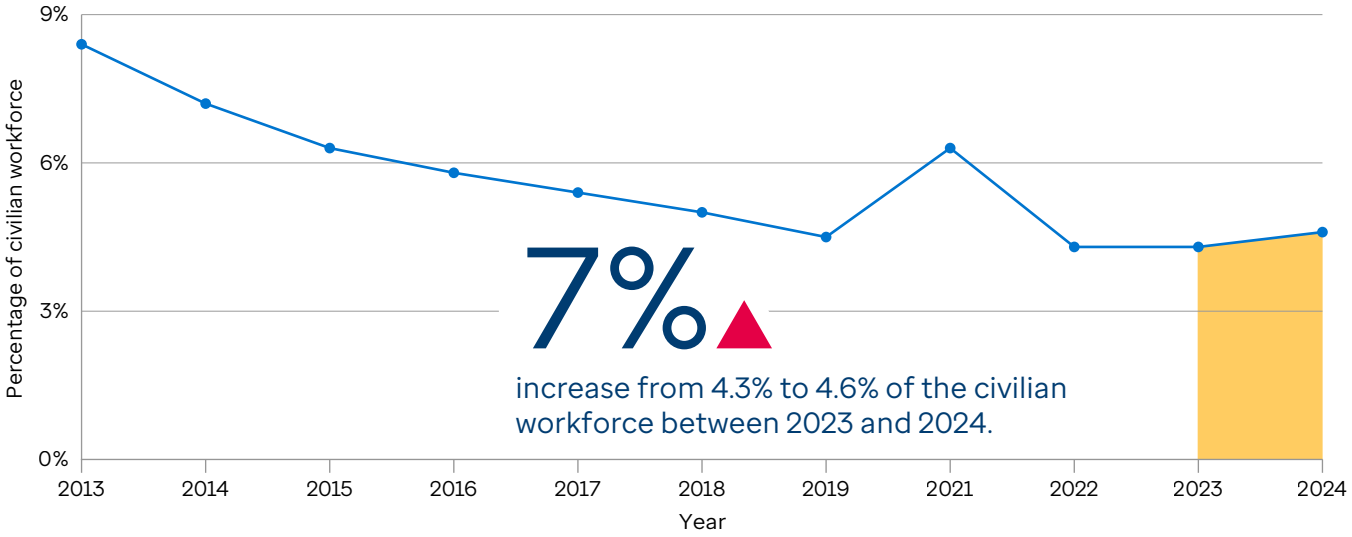
During the same period, the homicide rate significantly decreased in 19 states, led by: 44% in Delaware (9.5 to 5.3 deaths per 100,000 population), 32% in Utah (2.8 to 1.9) and 26% in New Jersey (4.2 to 3.1).

Differences. Homicide varied significantly by race/ethnicity, geography, age and gender in 2022-2023. The rate was:

- 20.7 times higher among Black (29.0 deaths per 100,000 population) compared with Asian (1.4) populations.
- 17.5 times higher in the District of Columbia (29.7) and 10.8 times higher in Mississippi (18.3) than in New Hampshire (1.7).
- 10.3 times higher among those ages 15-24 and those ages 25-34 (both 13.4) than those age 85 and older (1.3).
- 4.4 times higher among males (11.0) compared with females (2.5).

Note: The values for those age 85 and older (1.3 deaths per 100,000 population) and 75-84 (1.6) may not differ significantly based on overlapping 95% confidence intervals.

Unemployment



Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2013-2024.

SOCIAL AND ECONOMIC FACTORS | ECONOMIC RESOURCES

Unemployment

Unemployment can lead to lower self-esteem, higher levels of depression and strained or lost personal relationships, and it is associated with a higher risk of all-cause mortality.[28-30] Meanwhile, 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.[31,32]

Changes over time. Nationally, the percentage of the civilian workforce that is unemployed increased 7% from 4.3% to 4.6% of workers ages 16-64 between 2023 and 2024. In 2024, more than 8.1 million civilians in the workforce were unemployed, 720,000 more than in 2023.

Between 2023 and 2024, unemployment significantly increased 8% among both Black (7.4% to 8.0%) and Hispanic (5.3% to 5.7%) civilian workers, and 6% among white (3.5% to 3.7%) civilian workers. The rate also increased in 11 states, with the largest increases being 46% in Delaware (3.5% to 5.1%), 37% in Nevada (4.6% to 6.3%) and 23% in Minnesota (3.0% to 3.7%).

Differences. Unemployment varied significantly by geography and race/ethnicity in 2024. The rate was:

- 3.3 times higher in Nevada (6.3%) than in North Dakota (1.9%).
- 2.2 times higher among Black (8.0%) than white (3.7%) civilian workers.

Volunteerism

States With the Largest Increases in Volunteerism Among Those Age 16+ Between 2021 and 2023

Hawaii

49% ▲

increase from 19.7% to 29.4%.

Massachusetts

43% ▲

increase from 23.1% to 33.1%.

Tennessee

39% ▲

increase from 23.8% to 33.2%.

Vermont

39% ▲

increase from 29.1% to 40.5%.

Source: U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement, 2021-2023.

Volunteerism

Volunteering is a form of civic participation that can improve individual, community and societal health.[33,34]

Changes over time. Nationally, the percentage of the population age 16 and older that reported volunteering increased 22% from 23.2% to 28.3% between 2021 and 2023.

Between 2021 and 2023, volunteerism increased:

- 48% among Asian (16.4% to 24.3%), 34% among Hispanic (12.6% to 16.9%), 28% among Black (17.9% to 22.9%) and 19% among white (27.8% to 33.1%) populations.
- 31% among those with less than a high school education (13.7% to 17.9%), 28% among those with some post-high school education (21.1% to 27.0%), 21% among high school graduates (13.5% to 16.4%) and 19% among college graduates (33.0% to 39.2%).
- 30% among those with an annual household income less than $25,000 (12.5% to 16.3%), 19% among those with incomes of $50,000 to $74,999 (20.7% to 24.6%), 17% among those with incomes of $25,000 to $49,999 (16.5% to 19.3%), 14% among those with incomes of $100,000 to $149,999 (29.3% to 33.5%), and 13% among both those with incomes of $75,000 to $99,999 (26.2% to 29.7%) and those with incomes of $150,000 or more (36.7% to 41.4%).
- 23% among those living in metropolitan areas (23.0% to 28.4%).
- 23% among adults who have not served in the U.S. armed forces (23.1% to 28.3%) and 16% among those who have served (23.3% to 27.0%).
- 22% among both females (25.3% to 30.9%) and males (21.0% to 25.6%).

Volunteerism significantly increased in 10 states during this period, led by Hawaii, Massachusetts, Tennessee and Vermont.

Differences. Volunteerism varied significantly by geography, income, educational attainment, race/ethnicity and gender in 2023. The prevalence was:

- 2.5 times higher in Utah (46.6%) than in Rhode Island (18.5%).
- 2.5 times higher among those with an annual household income of $150,000 or more (41.4%) compared with those with incomes less than $25,000 (16.3%).
- 2.4 times higher among college graduates (39.2%) than high school graduates (16.4%).
- 2.0 times higher among multiracial (33.9%) compared with Hispanic (16.9%) populations.
- 1.2 times higher among females (30.9%) compared with males (25.6%).

Note: The values for high school graduates (16.4%) and those with less than a high school education (17.9%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for multiracial (33.9%), white (33.1%) and Hawaiian/Pacific Islander (30.4%) populations.

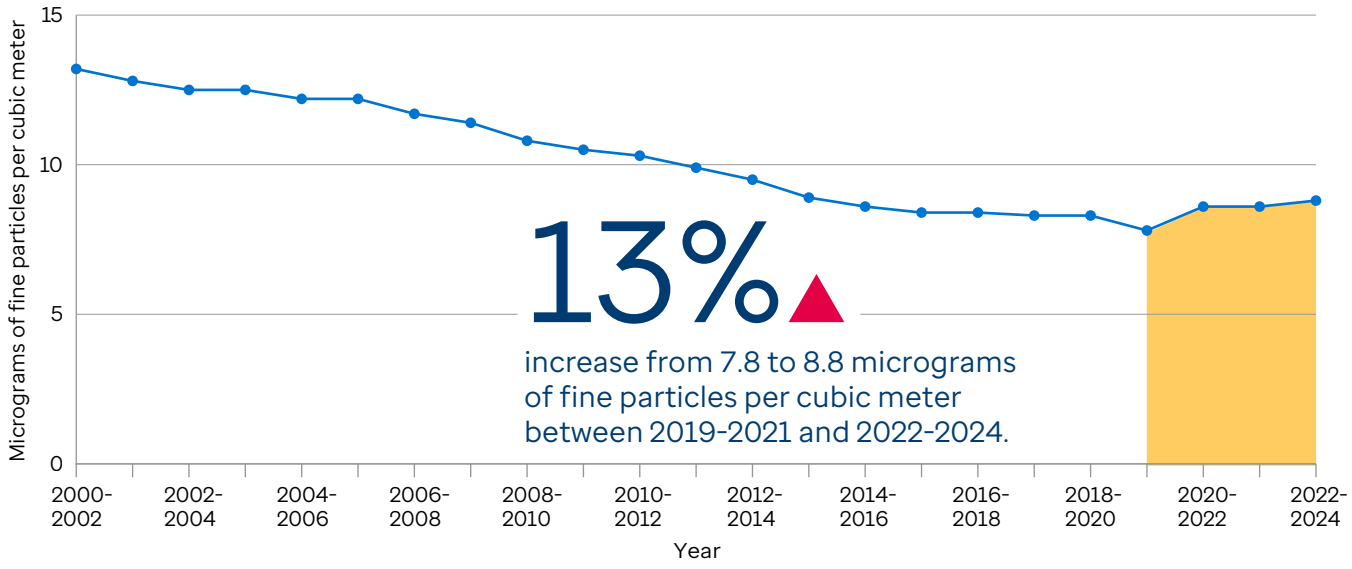
Voter Participation

Voting is a form of active civic engagement, which is associated with better health, reduced violence and lower unemployment rates.[35,36]

Changes over time. Nationally, the percentage of U.S. citizens age 18 and older who voted in the last presidential election decreased 2% from 66.8% to 65.3% between 2020 and 2024. During the same period, voter participation significantly decreased 14% in Arizona (71.9% to 61.7%), and 9% in both New York (64.7% to 59.2%) and Texas (63.9% to 57.9%).

Differences. Voter participation varied significantly by geography in 2024, with participation 1.4 times higher in Minnesota (75.9%) than in Arkansas (52.8%).

Air Pollution



Source: U.S. EPA, 2000-2024.

PHYSICAL ENVIRONMENT | AIR AND WATER QUALITY

Air Pollution

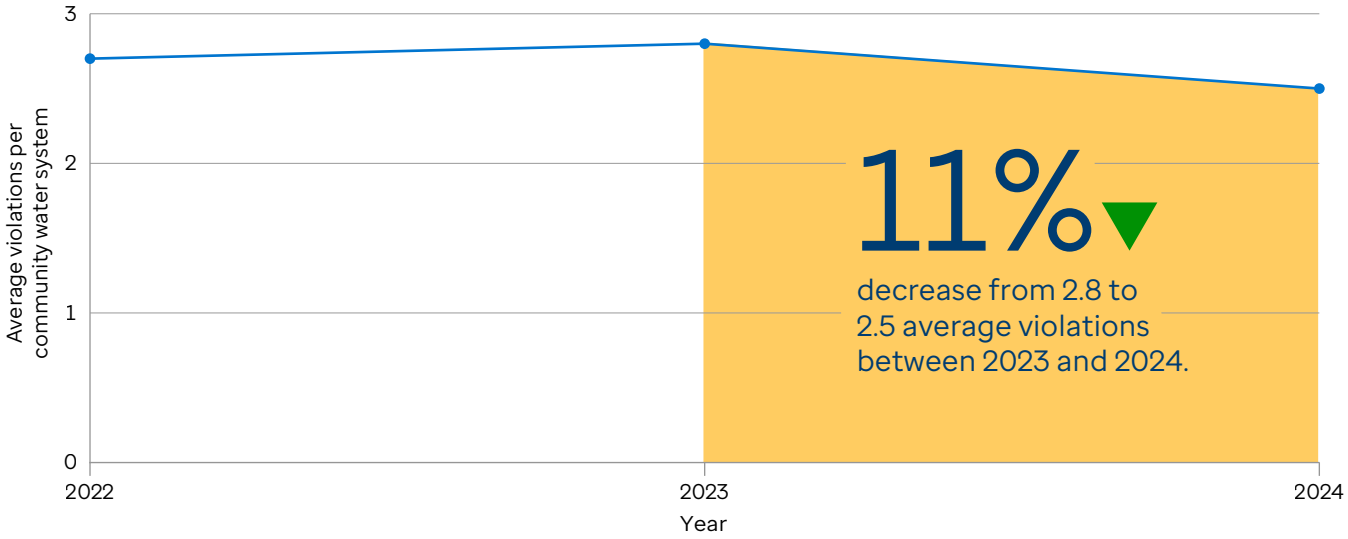
Air pollution was responsible for 7.9 million deaths worldwide in 2023.[37] Particulate matter with a diameter of 10 microns or less (PM_{10}) poses a threat to human health because it can penetrate deep into lung tissue and enter the bloodstream.[38] Exposure to fine particle air pollution has been linked to heart and lung problems, including decreased lung function, asthma, irregular heartbeat and heart attack.[38]

Changes over time. Nationally, the average exposure of the general public to particulate matter of 2.5 microns or less, measured in micrograms of fine particles per cubic meter, increased 13% from 7.8 to 8.8 between 2019-2021 and 2022-2024. This increase in air pollution occurred after two decades of continuous improvement, including a historic low during the COVID-19 pandemic (2019-2021).

Between 2019-2021 and 2022-2024, 12 states had increases in air pollution of 13% (the national change) or more. The largest increases were: 66% in North Dakota (5.0 to 8.3 micrograms of fine particles per cubic meter), 33% in Connecticut (6.1 to 8.1) and 27% in Michigan (8.2 to 10.4). During the same time period, air pollution decreased 13% or more in five states, led by: 18% in Colorado (7.3 to 6.0), 17% in Arizona (10.5 to 8.7) and 16% in Alaska (7.0 to 5.9).

Differences. Air pollution varied by geography in 2022-2024, with levels 2.9 times higher in California (11.7 micrograms per cubic meter) than in Wyoming (4.1).

Drinking Water Violations



Source: U.S. EPA, Safe Drinking Water Information System via ECHO, 2022-2024.

Drinking Water Violations

Safe drinking water is important to overall health and can help prevent certain birth defects, infectious diseases and exposure to harmful chemicals.[39-41] Water contaminants such as arsenic, lead and nitrates have been strongly linked to gastrointestinal illnesses, cancer and neurodevelopmental damage in children.[42-44]

Changes over time. Nationally, the average number of health-based drinking water violations per community water system decreased 11% from 2.8 to 2.5 between 2023 and 2024.

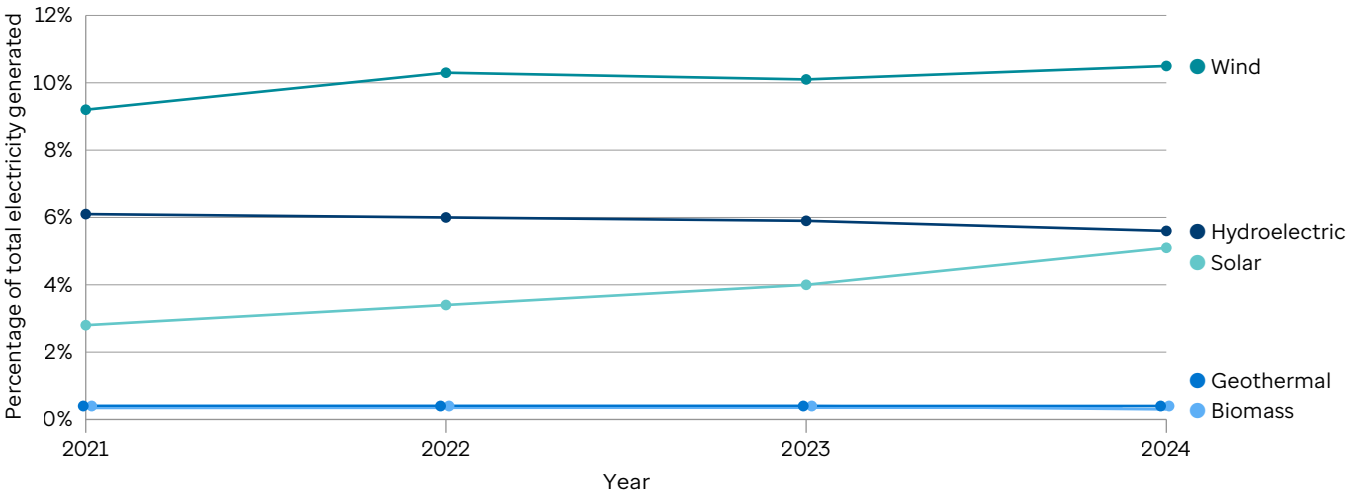
Between 2023 and 2024, drinking water violations decreased 11% (the national change) or more in 18 states, led by: 36% in Nebraska (2.8 to 1.8 average violations per community water system), 26% in Texas (3.5 to 2.6), and 25% in both Iowa (2.0 to 1.5) and New Hampshire (2.0 to 1.5).

During the same time period, drinking water violations increased 11% or more in 12 states and the District of Columbia, led by: 90% in Rhode Island (2.9 to 5.5 average violations per community water system), 55% in Arkansas (3.3 to 5.1), 33% in the District of Columbia (1.5 to 2.0), and 20% in Tennessee (1.5 to 1.8), North Dakota (1.0 to 1.2) and Missouri (1.5 to 1.8).

Differences. Drinking water violations ranged from zero in Hawaii to 5.5 average violations per community water system in Rhode Island.

Renewable Energy

By Energy Source



Source: U.S. EIA, State Energy Data System, 2021-2024.

PHYSICAL ENVIRONMENT | CLIMATE AND HEALTH

Renewable Energy

Unlike fossil fuels, renewable energy sources are clean and reduce carbon emissions and air pollution.[45] 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.[46]

Changes over time. Nationally, the percentage of electricity generated from renewable sources (wind, solar rays, hydroelectric energy, biomass or geothermal heat) increased 6% from 20.6% to 21.9% between 2023 and 2024. During this period, electricity from solar (4.0% to 5.1%) and wind (10.1% to 10.5%) sources increased 28% and 4%, respectively, while electricity from biomass (0.4% to 0.3%) and hydroelectric (5.9% to 5.6%) sources decreased 25% and 5%, respectively.

Between 2023 and 2024, renewable energy increased 6% (the national change) or more in 27 states, led by: 189% in Mississippi (0.9% to 2.6%), 100% in Louisiana (1.1% to 2.2%) and 41% in Ohio (3.7% to 5.2%).

During the same time period, renewable energy decreased 6% or more in five states, led by: 20% in Maine (54.1% to 43.1%), 13% in Connecticut (3.1% to 2.7%) and 10% in Massachusetts (21.5% to 19.3%).

Differences. Renewable energy varied by geography in 2024. It was 38.4 times higher in Vermont (84.4%) than in Louisiana (2.2%).

Homelessness

16% ▲

increase from 19.4 to 22.6 people per 10,000 population between 2023 and 2024.

Source: U.S. HUD, *Annual Homelessness Assessment* Reports to Congress, 2023-2024.

PHYSICAL ENVIRONMENT | HOUSING AND TRANSIT

Homelessness

Families that struggle to afford housing may face eviction, foreclosure and homelessness.[47] Households with housing instability are exposed to increased stress that affects physical and mental health.[48] Being homeless puts people at higher risk of health problems like respiratory infections, diabetes, substance use disorders and associated viruses, and heart and lung disease.[49] The stress and safety concerns of homelessness also increase risk of mental illnesses such as anxiety, depression and post-traumatic stress disorder (PTSD).[49]

Changes over time. Nationally, the rate of people experiencing homelessness – based on point-in-time counts conducted on a single night in January each year – increased 16% from 19.4 to 22.6 people per 10,000 population between 2023 and 2024. In 2024, approximately 767,900 people experienced homelessness in the U.S., an increase of 118,300 since 2023.

Of those who were homeless in 2024, 65% (approximately 496,500 people) were sheltered in transitional housing programs, safe havens or shelters and 35% (271,400 people) were unsheltered, meaning their primary nighttime location was a public or private place not designated for sleeping (cars, public parks, abandoned buildings, bus or train stations, airports, camping grounds, or outside on the street). Between 2023 and 2024, the rate of people experiencing homelessness in shelters increased 24% (11.8 to 14.6 people per 10,000 population), and unsheltered homelessness increased 5% (7.6 to 8.0). During this time, homelessness increased 13% or more in 13 states. The largest increases were 114% in Illinois (9.5 to 20.3), 85% in Hawaii (43.4 to 80.5), and 51% in both New York (52.7 to 79.5) and Massachusetts (27.3 to 41.1).

Differences. Homelessness varied by geography in 2024, with the rate 23.0 times higher in Hawaii (80.5 people experiencing homelessness per 10,000 population) than in Mississippi (3.5).

CLINICAL CARE | ACCESS TO CARE

Avoided Care Due to Cost

Cost is a central barrier to accessing care for many Americans.[50] Avoiding or delaying needed health care has been associated with increased preventable hospitalizations and missed opportunities to prevent disease and manage chronic conditions, all of which can lead to worse and more expensive health outcomes.[51-53]

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 8% from 10.6% to 11.5% between 2023 and 2024.

Between 2023 and 2024, the percentage of adults who could not afford care due to cost increased:

- 15% among college graduates (6.0% to 6.9%) and 14% among adults with some post-high school education (11.1% to 12.7%).
- 14% among adults with incomes of $50,000 to $74,999 (10.7% to 12.2%) and 9% among adults with incomes of $25,000 to $49,999 (16.0% to 17.4%).
- 10% among adults without a disability (8.1% to 8.9%).
- 9% among women (12.4% to 13.5%).
- 9% among straight adults (10.0% to 10.9%).
- 8% among adults ages 45-64 (11.1% to 12.0%) and 6% among those ages 18-44 (16.1% to 17.0%).
- 7% among adults who have not served in the U.S. armed forces (12.1% to 13.0%).
- 7% among adults living in metropolitan areas (11.6% to 12.4%).

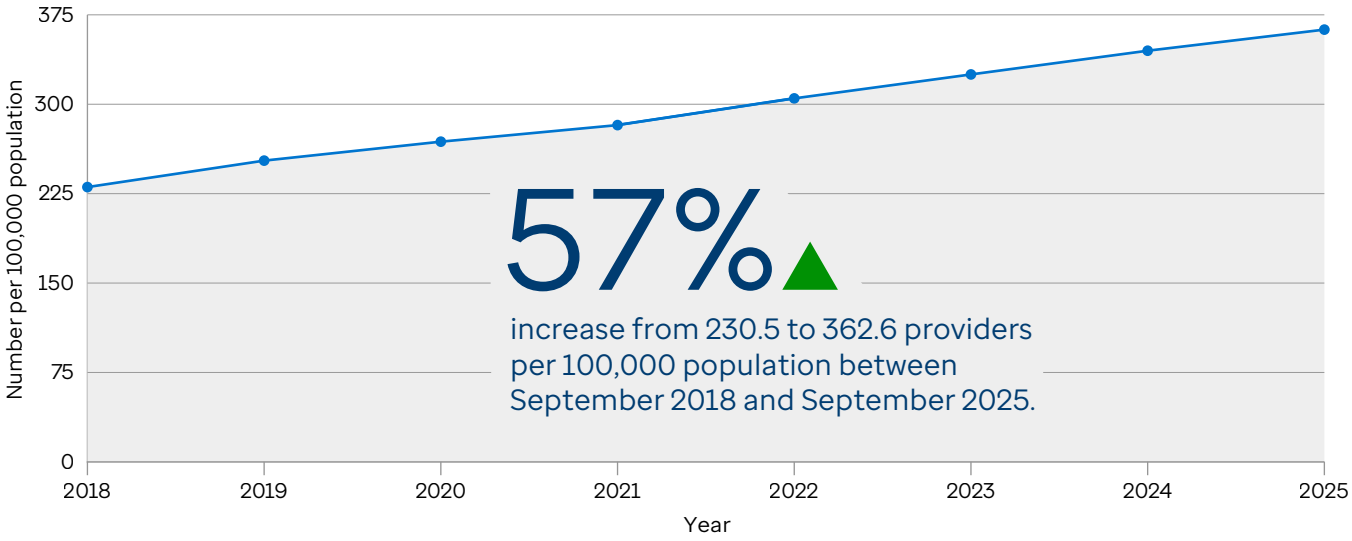
During this time frame, the prevalence of avoiding care due to cost increased in eight states. The largest increases were 30% in Nebraska (8.8% to 11.4%), 29% in Louisiana (11.5% to 14.8%) and 24% in Montana (9.7% to 12.0%).

Differences. The prevalence of avoiding care due to cost varied significantly by income, age, educational attainment, disability status, geography, race/ethnicity, veteran status, sexual orientation and gender in 2024. The prevalence was:

- 7.8 times higher among adults with incomes less than $25,000 (23.3%) compared with those with incomes of $150,000 or more (3.0%).
- 4.5 times higher among adults ages 18-44 (17.0%) compared with those age 65 and older (3.8%).
- 3.2 times higher among adults with less than a high school education (22.1%) compared with college graduates (6.9%).
- 3.1 times higher among adults who have difficulty with cognition (27.5%) compared with those without a disability (8.9%).
- 2.7 times higher in Texas (17.4%) than in Hawaii (6.4%).
- 2.4 times higher among Hispanic (20.5%) compared with Asian (8.4%) adults.
- 2.0 times higher among adults who have not served in the U.S. armed forces (13.0%) compared with those who have served (6.4%).
- 1.9 times higher among LGBQ+ (20.6%) compared with straight (10.9%) adults.
- 1.2 times higher among women (13.5%) compared with men (11.2%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for adults who have difficulty with cognition (27.5%) and adults who have independent living difficulty (26.3%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for Hispanic (20.5%), Hawaiian/Pacific Islander (19.0%) and other race (17.6%) adults; as well as Asian (8.4%) and white (9.2%) adults. Disability groups are not mutually exclusive.

Mental Health Providers



Source: U.S. HHS, CMS, National Plan and Provider Enumeration System, 2018-2025.

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.[54] A 2024 analysis found that more than 122 million Americans were living in areas with a shortage of mental health care professionals, and only 26.4% of the population's mental health care needs were met.[55]

Changes over time. Mental health providers – psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care – increased 5% nationally from 344.9 to 362.6 providers per 100,000 population between September 2024 and September 2025, and 57% (from 230.5) since September 2018.

Between September 2024 and September 2025, the rate of mental health providers increased 5% or more in 34 states, led by: 10% in both Nebraska (346.9 to 380.7) and North Dakota (258.3 to 284.2), 9% in Montana (410.3 to 448.9), and 8% in West Virginia (206.2 to 223.2), Virginia (273.1 to 294.6) and Maryland (380.1 to 412.1).

Differences. The number of mental health providers per 100,000 population varied by geography in September 2025 and was 5.0 times higher in Alaska (822.0 providers per 100,000 population) than in Alabama (162.9).

Uninsured

Health insurance coverage has been shown to promote positive health outcomes, increase appropriate use of health care services and offer financial protection against high medical expenses.[56] Nearly two-thirds of uninsured adults ages 18-64 report being uninsured because they cannot afford coverage.[57]

Changes over time. Nationally, the percentage of the population not covered by private or public health insurance increased 4% from 7.9% to 8.2% between 2023 and 2024. In 2024, nearly 27.5 million people in the U.S. were uninsured, an increase of 1.3 million since 2023.

Between 2023 and 2024, the uninsured rate significantly increased:

- 7% among those ages 19-25 (13.1% to 14.0%) and 2% among those ages 26-34 (13.8% to 14.1%).
- 5% among Black populations (8.5% to 8.9%).
- 3% among high school graduates (10.8% to 11.1%).

Between 2023 and 2024, the uninsured population significantly increased in eight states and the District of Columbia. The largest increases were: 67% in the District of Columbia (2.7% to 4.5%), 36% in North Dakota (4.5% to 6.1%), 26% in Kentucky (5.4% to 6.8%) and 21% in Minnesota (4.2% to 5.1%). During the same period, the uninsured rate significantly decreased 8% in California (6.4% to 5.9%).

Differences. The uninsured rate varied significantly by geography, educational attainment, race/ethnicity and age in 2024. The rate was:

- 6.0 times higher in Texas (16.7%) than in Massachusetts (2.8%).
- 5.7 times higher among those with less than a high school education (20.6%) compared with college graduates (3.6%).
- 3.7 times higher among other race (19.3%) compared with Asian (5.2%) populations.
- 1.9 times higher among those ages 26-34 (14.1%) compared with those ages 55-64 (7.4%).

Note: The values for other race (19.3%) and American Indian/Alaska Native (18.9%) populations may not differ significantly based on overlapping 95% confidence intervals. The same is true for Asian (5.2%) and white (5.3%) populations; as well as those ages 26-34 (14.1%) and 19-25 (14.0%).

CLINICAL CARE | PREVENTIVE CLINICAL SERVICES

Cancer Screenings

Cancer screenings can help detect cancer early, when treatment is most effective.[58] Both mammography and colorectal screening have been found to be cost-effective methods of reducing deaths from breast and colorectal cancers, which are among the most common types of cancers.[59-61]

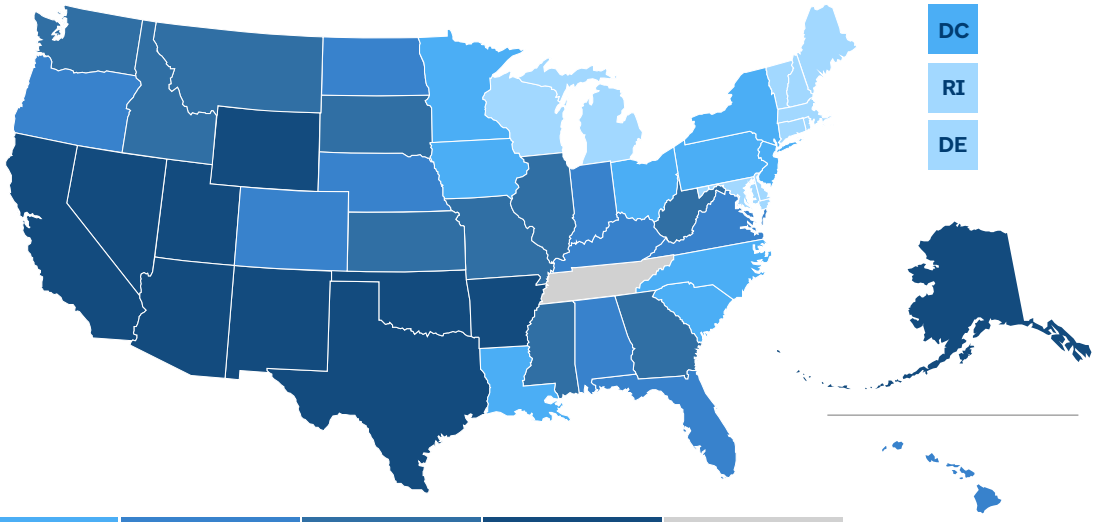
Changes over time. Nationally, cancer screenings (a combined measure of breast cancer and colorectal cancer screenings) increased 15% from 56.0% to 64.5% between 2022 and 2024. Looking at the two cancer screening components separately, breast cancer screening increased 3% (72.1% to 74.5% of women ages 40-74 who reported receiving a mammogram in the past two years) and colorectal cancer screening increased 15% (61.8% to 71.1% of adults ages 45-75 who reported receiving colorectal cancer screening within the recommended time period). Despite improvements, screening rates remain lower than Healthy People 2030 targets to increase the proportion of females who get screened for breast cancer to 80.3% and increase the proportion of adults who get screened for colorectal cancer to 72.8%.[62,63]

Between 2022 and 2024, the prevalence of cancer screenings significantly increased:

- 29% among adults with less than a high school education (37.5% to 48.4%), 18% among high school graduates (51.6% to 60.9%), and 16% among both adults with some post-high school education (56.0% to 64.9%) and college graduates (61.2% to 70.8%).
- 22% among adults ages 45-64 (48.2% to 58.7%), 14% among those age 65 and older (68.0% to 77.6%) and 8% among those ages 18-44 (52.6% to 56.6%).
- 18% among women (51.3% to 60.6%) and 17% among men (58.4% to 68.4%).
- 18% among adults living in metropolitan areas (54.6% to 64.5%) and 14% among adults living in nonmetropolitan areas (53.6% to 61.3%).
- 17% among adults who have not served in the U.S. armed forces (53.7% to 62.9%) and 12% among adults who have served (67.6% to 75.4%).
- 15% among LGBQ+ (51.5% to 59.3%) and 14% among straight (57.8% to 66.1%) adults.

Cancer Screenings

By State in 2024



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2024.
Note: No data were available for Tennessee in 2024.

- 15% among adults who have difficulty seeing (48.3% to 55.6%), those who have difficulty with self-care (51.8% to 59.6%) and those who have independent living difficulty (48.9% to 56.4%), 14% among adults who have difficulty with mobility (55.9% to 63.8%), 13% among both adults who have difficulty hearing (61.3% to 69.5%) and adults without a disability (57.9% to 65.2%), and 12% among adults who have difficulty with cognition (49.8% to 55.9%).
- 14% among adults with incomes less than $25,000 (46.2% to 52.8%), 10% among those with incomes of $25,000 to $49,999 (53.7% to 59.2%) and 9% among those with incomes of $50,000 to $74,999 (60.6% to 66.3%).

During the same time, the prevalence of cancer screenings significantly increased in 47 states and the District of Columbia, led by: 28% in New Jersey (52.0% to 66.7%), 26% in Vermont (55.0% to 69.2%), and 24% in both New Hampshire (57.9% to 71.7%) and California (47.3% to 58.5%).

Differences. Cancer screenings varied significantly by educational attainment, geography, age, race/ethnicity, income, disability status, veteran status, metropolitan status, gender and sexual orientation. The prevalence was:

- 1.5 times higher among college graduates (70.8%) compared with adults with less than a high school education (48.4%).
- 1.4 times higher in Rhode Island (75.2%) than in Wyoming (54.7%).
- 1.4 times higher among adults age 65 and older (77.6%) compared with those ages 18-44 (56.6%).
- 1.3 times higher among white (67.7%) and Black (67.4%) compared with Hispanic (52.8%) adults.
- 1.3 times higher among adults with incomes of $150,000 or more (70.8%) compared with adults with incomes less than $25,000 (52.8%).
- 1.3 times higher among adults with difficulty hearing (69.5%) compared with adults who have difficulty seeing (55.6%).
- 1.2 times higher among adults who have served in the U.S. armed forces (75.4%) compared with adults who have not served (62.9%).
- 1.1 times higher among adults living in metropolitan areas (64.5%) compared with adults living in nonmetropolitan areas (61.3%).
- 1.1 times higher among men (68.4%) compared with women (60.6%).
- 1.1 times higher among straight (66.1%) compared with LGBQ+ (59.3%) adults.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for adults ages 18-44 (56.6%) and 45-64 (58.7%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for white (67.7%) and Black (67.4%) adults; as well as Hispanic (52.8%), Asian (53.9%), American Indian/Alaska Native (54.1%), Hawaiian/Pacific Islander (55.1%) and other race (58.3%) adults; adults with incomes of $150,000 or more (70.8%), those with incomes of $100,000 to $149,999 (70.1%) and those with incomes of $75,000 to $99,999 (68.6%); and adults who have difficulty seeing (69.5%), those who have difficulty with cognition (55.9%), those with independent living difficulty (56.4%) and those who have difficulty with self-care (59.6%). Disability groups are not mutually exclusive.

Spotlight
Rural Communities

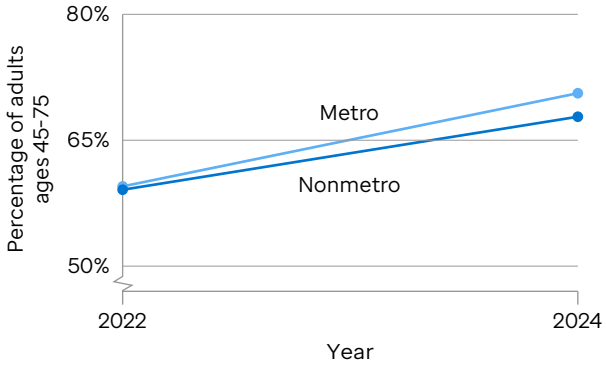
Notable improvements were made among adults living in rural areas, but differences in cancer screenings and physical inactivity persist compared with metropolitan peers

Adults living in rural areas experienced meaningful improvements across some measures of clinical care and health behaviors, yet they continued to face distinct and persistent challenges that shape their health outcomes.

Cancer screening prevalence (which includes both colorectal and breast cancer screenings) improved 14% among adults in rural areas, from 53.6% to 61.3%, between 2022 and 2024. However, cancer screenings in metropolitan areas improved more during this time period, increasing 18% from 54.6% to 64.5%. Colorectal cancer screenings increased 15% in rural areas (59.1% to 67.8%) among adults ages 45-75, but 19% in metropolitan areas (59.5% to 70.6%). Additionally, breast cancer screening rates were 1.1 times higher among metropolitan (75.3%) compared with rural (70.8%) women ages 40-74 in 2024, a gap in prevalence that has persisted over time.

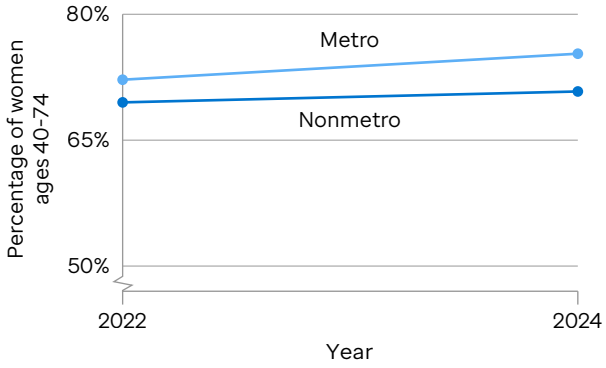
On the other hand, the percentage of adults who reported doing no physical activity or exercise other than their regular job decreased more in rural communities than among their metropolitan peers. The prevalence of physical inactivity among adults living in rural areas improved 10% (29.5% to 26.5%) between 2023 and 2024, compared with 7% among their metropolitan counterparts (23.6% to 21.9%). Additionally, physical inactivity remained 1.2 times higher among rural compared with metropolitan adults.

Colorectal Cancer Screening
By Metropolitan Status



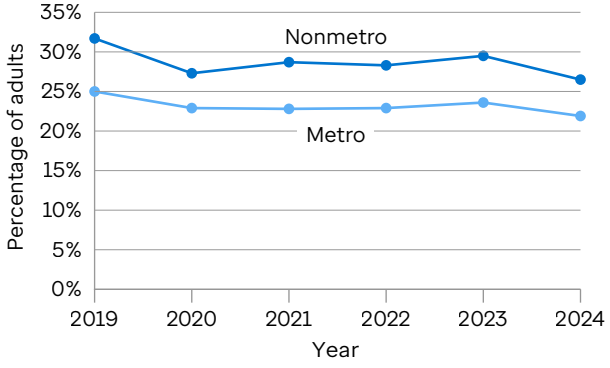
Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2022-2024.
Note: No data were available for Tennessee in 2024.

Breast Cancer Screening
By Metropolitan Status



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2022-2024.
Note: No data were available for Tennessee in 2024.

Physical Inactivity
By Metropolitan Status



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2019-2024.
Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Flu Vaccination

A flu vaccine is the best protection against seasonal influenza viruses.[64] Getting vaccinated can reduce the severity of symptoms, defend against catching the virus and protect those with chronic illnesses.[64] Hospitalizations for chronic conditions exacerbated by the flu, like diabetes and chronic lung disease, can also be reduced by vaccination.[64]

Changes over time. Nationally, the percentage of adults who reported receiving a seasonal flu vaccine in the past 12 months decreased 4% from 42.9% to 41.3% between 2023 and 2024. The current rate does not meet the Healthy People 2030 target to increase the proportion of people who get the flu vaccine every year to 70% of the population.[65]

Between 2023 and 2024, flu vaccinations significantly decreased:

- 8% among both adults who have difficulty with self-care (45.7% to 42.1%) and those who have independent living difficulty (42.8% to 39.4%), 5% among those without a disability (41.5% to 39.6%) and 4% among those who have difficulty with mobility (50.8% to 48.9%).
- 7% among adults ages 45-64 (42.3% to 39.4%) and 5% among those ages 18-44 (30.9% to 29.5%).
- 6% among Hispanic (33.5% to 31.5%) and 4% among white (45.9% to 43.9%) adults.
- 5% among men (38.7% to 36.7%) and 3% among women (45.4% to 44.0%).
- 5% among both high school graduates (36.2% to 34.5%) and college graduates (55.1% to 52.5%), and 4% among adults with some post-high school education (41.6% to 40.1%).
- 5% among adults with incomes of $25,000 to $49,999 (39.7% to 37.8%) and 4% among those with incomes of $50,000 to $74,999 (43.4% to 41.5%).
- 5% among straight adults (43.6% to 41.6%).
- 4% among adults living in metropolitan areas (43.2% to 41.3%).
- 4% among both adults who have not served in the U.S. armed forces (40.9% to 39.2%) and those who have served (53.6% to 51.5%).

During the same time, the percentage of adults who received flu vaccinations decreased in eight states. The largest decreases were 12% in Illinois (45.2% to 39.9%), 11% in Florida (37.6% to 33.5%), 8% in Ohio (42.9% to 39.6%) and 7% in Connecticut (50.8% to 47.3%).

Differences. Flu vaccinations significantly varied by age, educational attainment, geography, race/ethnicity, income, disability status, veteran status, gender and metropolitan status. The prevalence was:

- 2.1 times higher among adults age 65 and older (62.5%) compared with those ages 18-44 (29.5%).
- 1.7 times higher among college graduates (52.5%) compared with adults who have less than a high school education (31.4%).
- 1.6 times higher in Massachusetts (53.7%) than in Mississippi (33.0%).
- 1.5 times higher among Asian (48.1%) compared with Hawaiian/Pacific Islander (31.5%) adults.
- 1.4 times higher among adults with incomes of $150,000 or more (49.5%) compared with those with incomes less than $25,000 (35.2%).
- 1.3 times higher among adults who have difficulty hearing (49.9%) compared with those without a disability (39.6%).
- 1.3 times higher among adults who have served in the U.S. armed forces (51.5%) compared with those who have not served (39.2%).
- 1.2 times higher among women (44.0%) compared with men (36.7%).
- 1.2 times higher among adults living in metropolitan areas (41.3%) compared with adults in nonmetropolitan areas (35.8%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for Hawaiian/Pacific Islander (31.5%), Hispanic (31.5%), American Indian/Alaska Native (33.7%), multiracial (34.5%), other race (34.8%) and Black (35.9%) adults may not differ significantly based on overlapping 95% confidence intervals. The same is true for adults who have difficulty hearing (49.9%) and those who have difficulty with mobility (48.9%). Disability groups are not mutually exclusive.

Physical Inactivity

10% ▼

decrease from 24.2% to 21.8% of adults between 2023 and 2024.

Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2023-2024.

BEHAVIORS | NUTRITION AND PHYSICAL ACTIVITY

Physical Inactivity

Being physically active and reducing sedentary behavior improves health at all ages.[66] Regular physical activity (at least 150 minutes a week) is associated with reduced risk of cardiovascular diseases, hypertension, Type 2 diabetes, certain cancers, dementia, anxiety and depression.[66]

Changes over time. Nationally, the percentage of adults who reported doing no physical activity or exercise other than their regular job in the past 30 days decreased 10% from 24.2% to 21.8% between 2023 and 2024.

Between 2023 and 2024, the percentage of adults reporting physical inactivity decreased:

- 17% among multiracial (22.6% to 18.8%), 9% among Hispanic (32.9% to 30.1%), and 8% among both Black (28.2% to 26.0%) and white (21.9% to 20.2%) adults.
- 10% among men (22.1% to 20.0%) and 7% among women (27.3% to 25.4%).
- 10% among adults with less than a high school education (47.0% to 42.4%), 8% among high school graduates (33.5% to 30.8%), 7% among adults with some post-high school education (24.8% to 23.0%) and 6% among college graduates (13.7% to 12.9%).
- 10% among adults living in nonmetropolitan areas (29.5% to 26.5%) and 7% among those in metropolitan areas (23.6% to 21.9%).
- 10% among adults with difficulty hearing (36.7% to 33.1%), 9% among those without a disability (18.6% to 16.9%), 8% among those who have difficulty with cognition (35.3% to 32.5%) and 4% among those who have difficulty with mobility (52.4% to 50.1%).
- 9% among adults age 65 and older (32.0% to 29.1%), 8% among those ages 45-64 (26.0% to 23.9%) and 7% among those ages 18-44 (20.2% to 18.7%).
- 9% among adults with incomes less than $25,000 (43.7% to 39.6%) and 8% among those with incomes of $50,000 to $74,999 (24.0% to 22.2%).
- 7% among straight adults (24.2% to 22.5%).
- 8% among both adults who have served in the U.S. armed forces (23.5% to 21.7%) and those who have not served (24.9% to 22.8%).

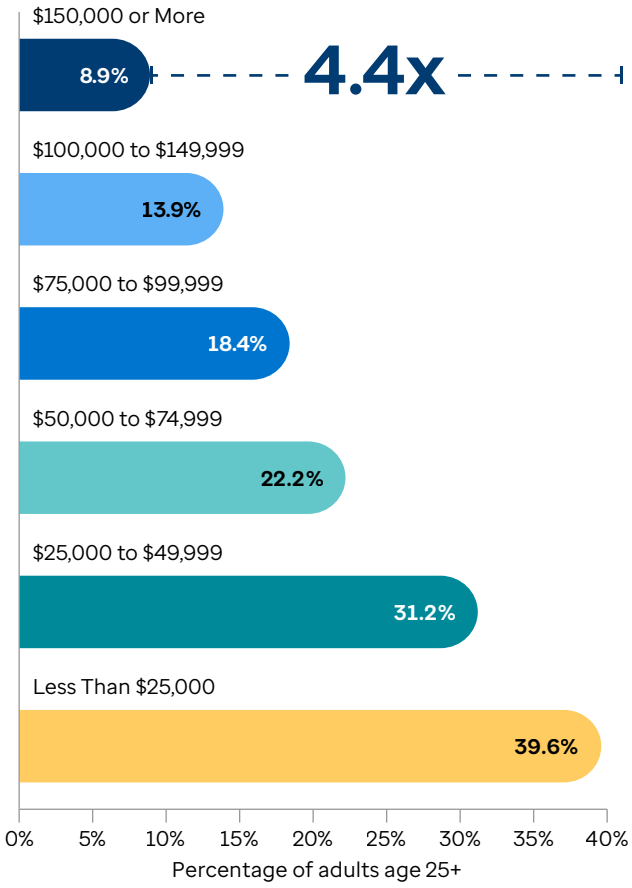
During this time frame, the prevalence of physical inactivity decreased in 19 states, led by: 23% in Minnesota (22.8% to 17.5%), 21% in Vermont (20.3% to 16.0%) and 20% in Wyoming (26.2% to 21.0%).

Differences. The prevalence of physical inactivity varied significantly by income, disability status, educational attainment, geography, race/ethnicity, age, gender, metropolitan status and sexual orientation in 2024. The prevalence was:

- 4.4 times higher among adults with incomes less than $25,000 (39.6%) compared with those with incomes of $150,000 or more (8.9%).
- 3.4 times higher among adults who have difficulty with self-care (57.5%) compared with those without a disability (16.9%).
- 3.3 times higher among adults with less than a high school education (42.4%) compared with college graduates (12.9%).
- 2.0 times higher in Mississippi (30.6%) than in Colorado (15.6%).
- 1.7 times higher among Hispanic (30.1%) compared with Asian (18.0%) adults.
- 1.6 times higher among adults age 65 and older (29.1%) compared with those ages 18-44 (18.7%).
- 1.3 times higher among women (25.4%) compared with men (20.0%).
- 1.2 times higher among adults living in nonmetropolitan areas (26.5%) compared with adults in metropolitan areas (21.9%).
- 1.1 times higher among straight (22.5%) compared with LGBQ+ (20.5%) adults.

Physical Inactivity

By Income Group in 2024



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2024.
Note: No data were available for Tennessee in 2024.

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for Asian (18.0%) and multiracial (18.8%) adults may not differ significantly based on overlapping 95% confidence intervals.

E-Cigarette Use

Electronic cigarettes, also called e-cigarettes or vape pens, are electronic devices that use heat to make an aerosol that is inhaled by the user.[67] The aerosol made by e-cigarettes contains toxic substances that can cause cancer and serious lung disease.[67] Use of e-cigarettes is associated with increased odds of developing respiratory symptoms or wheezing and respiratory disease.[68,69]

Changes over time. Nationally, the percentage of adults who reported using e-cigarettes or other electronic vaping products at least once in their lifetime and now use daily or some days increased 4% from 7.7% to 8.0% between 2023 and 2024. E-cigarette use significantly increased 41% in Wyoming (7.6% to 10.7%) and 26% in Wisconsin (6.6% to 8.3%).

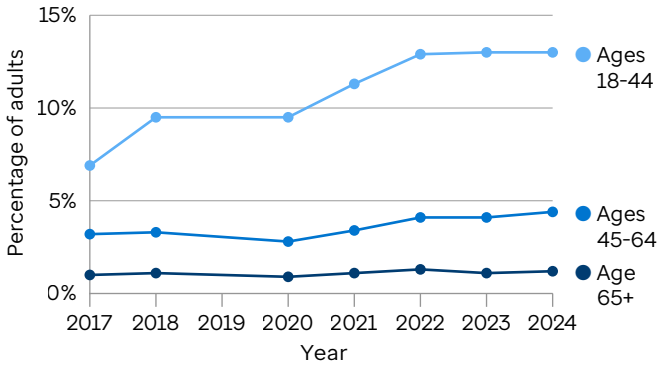
Differences. E-cigarette use varied significantly by age, disability status, race/ethnicity, educational attainment, geography, income, gender and metropolitan status in 2024. The prevalence was:

- 10.8 times higher among adults ages 18-44 (13.0%) compared with those age 65 and older (1.2%).
- 2.9 times higher among adults who have difficulty with cognition (16.3%) compared with those who have difficulty with mobility (5.7%).
- 2.4 times higher among multiracial (12.4%) compared with Black (5.2%) adults.
- 2.4 times higher among high school graduates (8.4%) compared with college graduates (3.5%).
- 2.1 times higher in Oklahoma (10.8%) than in Maryland (5.1%).
- 1.6 times higher among adults with an annual household income less than $25,000 (7.5%) compared with those who have incomes of $150,000 or more (4.6%).
- 1.2 times higher among men (8.3%) compared with women (6.9%).
- 1.2 times higher among adults living in nonmetropolitan areas (9.1%) than in metropolitan areas (7.4%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for adults who have difficulty with mobility (5.7%) and those with difficulty hearing (6.0%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for adults without a disability (6.4%), adults with difficulty hearing (6.0%) and adults with difficulty with self-care (7.5%); multiracial (12.4%), Hawaiian/Pacific Islander and American Indian/Alaska Native (both 11.4%) adults; as well as Black (5.2%) and Asian (6.2%) adults; high school graduates (8.4%) and adults with some post-high school education (7.7%); and adults with incomes less than $25,000 (7.5%), those with incomes of $25,000 to $49,999 (7.4%), those with incomes of $50,000 to $74,999 (7.3%) and those with incomes of $75,000 to $99,999 (6.9%). Disability groups are not mutually exclusive.

E-Cigarette Use

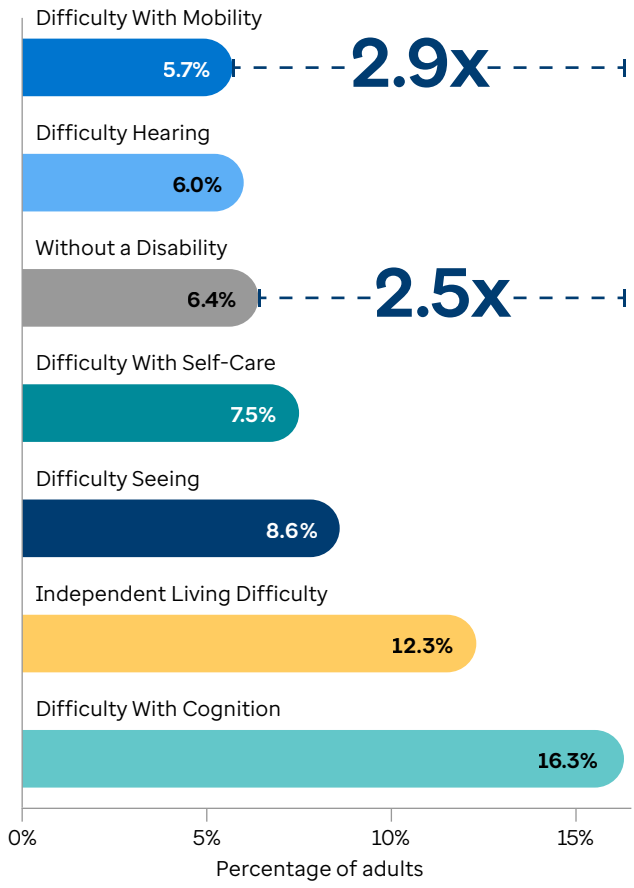
By Age Group



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2017-2024.
Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

E-Cigarette Use

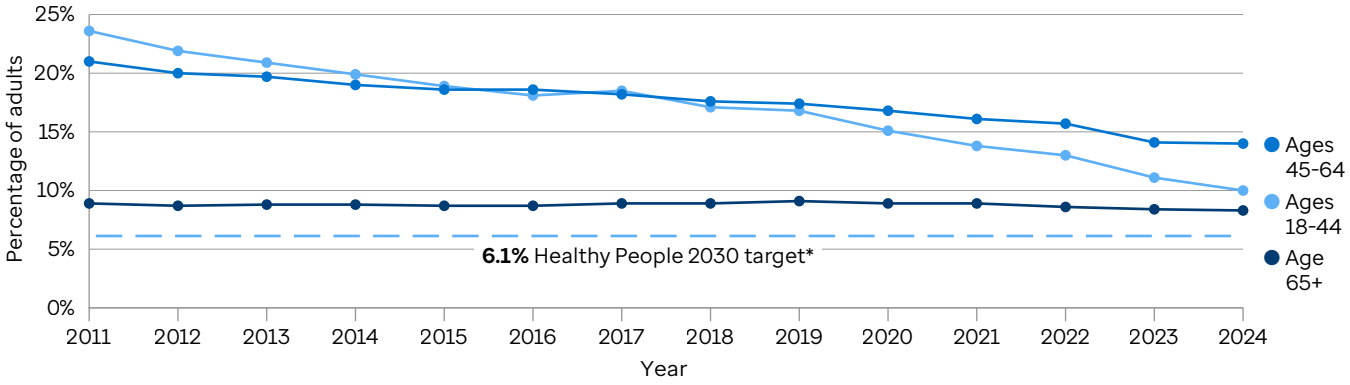
By Disability Status in 2024



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2024.
Note: No data were available for Tennessee in 2024. The values for adults who have difficulty with mobility (5.7%) and those with difficulty hearing (6.0%) may not differ significantly based on overlapping 95% confidence intervals. The same is true for adults without a disability (6.4%), adults with difficulty hearing (6.0%) and adults with difficulty with self-care (7.5%). Disability groups are not mutually exclusive.

Cigarette Smoking

By Age Group



Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2011-2024.
*Source: Healthy People 2030.
Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023.

Smoking

Smoking is the leading cause of preventable death in the U.S., accounting for more than 480,000 deaths every year.[70] Smoking damages nearly every organ and can cause heart disease, stroke, diabetes, multiple types of cancer and respiratory conditions such as emphysema and chronic bronchitis.[70]

Changes over time. Nationally, the percentage of adults who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days decreased 4% from 12.1% to 11.6% between 2023 and 2024, continuing a longer-term decrease of 45% from 21.2% in 2011. Despite progress, the prevalence remains higher than the Healthy People 2030 target to reduce current cigarette smoking to 6.1% of adults.[71]

Between 2023 and 2024, cigarette smoking decreased:

- 13% among adults with independent living difficulty (22.8% to 19.9%).
- 10% among adults ages 18-44 (11.1% to 10.0%).
- 7% among men (13.0% to 12.1%).
- 6% among white adults (12.0% to 11.3%).
- 4% among adults who have not served in the U.S. armed forces (11.2% to 10.7%).

During this time frame, cigarette smoking decreased 16% in Minnesota (12.2% to 10.2%) and 12% in Washington (9.0% to 7.9%).

Differences. Cigarette smoking varied significantly by income, race/ethnicity, educational attainment, geography, disability status, age, metropolitan status, gender, sexual orientation and veteran status in 2024. The prevalence was:

- 4.8 times higher among adults with an annual household income less than $25,000 (22.1%) compared with those who have incomes of $150,000 or more (4.6%).
- 4.4 times higher among American Indian/Alaska Native (21.3%) than Asian (4.8%) adults.
- 4.3 times higher among adults with less than a high school education (20.1%) than college graduates (4.7%).
- 3.6 times higher in West Virginia (20.8%) than in Utah (5.7%).
- 2.6 times higher among adults who have difficulty with self-care (22.0%) compared with those without a disability (8.4%).
- 1.7 times higher among adults ages 45-64 (14.0%) compared with those age 65 and older (8.3%).
- 1.5 times higher among adults living in nonmetropolitan areas (15.5%) than in metropolitan areas (10.1%).
- 1.3 times higher among men (12.1%) than women (9.6%).
- 1.1 times higher among LGBQ+ (12.3%) compared with straight (11.0%) adults.
- 1.1 times higher among adults who have served in the U.S. armed forces (12.3%) than those who have not served (10.7%).

Note: No data were available for Tennessee in 2024 or for Kentucky and Pennsylvania in 2023. The values for adults who have difficulty with self-care (22.0%) and adults with independent living difficulty (19.9%) may not differ significantly based on overlapping 95% confidence intervals. Disability groups are not mutually exclusive.

"The data contained in this report provide a clear roadmap, helping public health leaders identify what's working, where progress is needed and how to transform insight into measurable and meaningful improvement."

From Data to Action: How States Can Use *America's Health Rankings* to Drive and Measure Progress

Joseph Kanter, MD, MPH
CEO, Association of State and Territorial Health Officials

Promoting and protecting America's health is a shared mission that unites public health professionals, policymakers and community leaders across the country. We strive for a public health agenda that is evidence-based, measurable and rooted in the issues that matter most to American families. For more than three decades, *America's Health Rankings* has served as a vital resource for states and other stakeholders, providing an impartial, authoritative and standardized foundation for improving health outcomes.

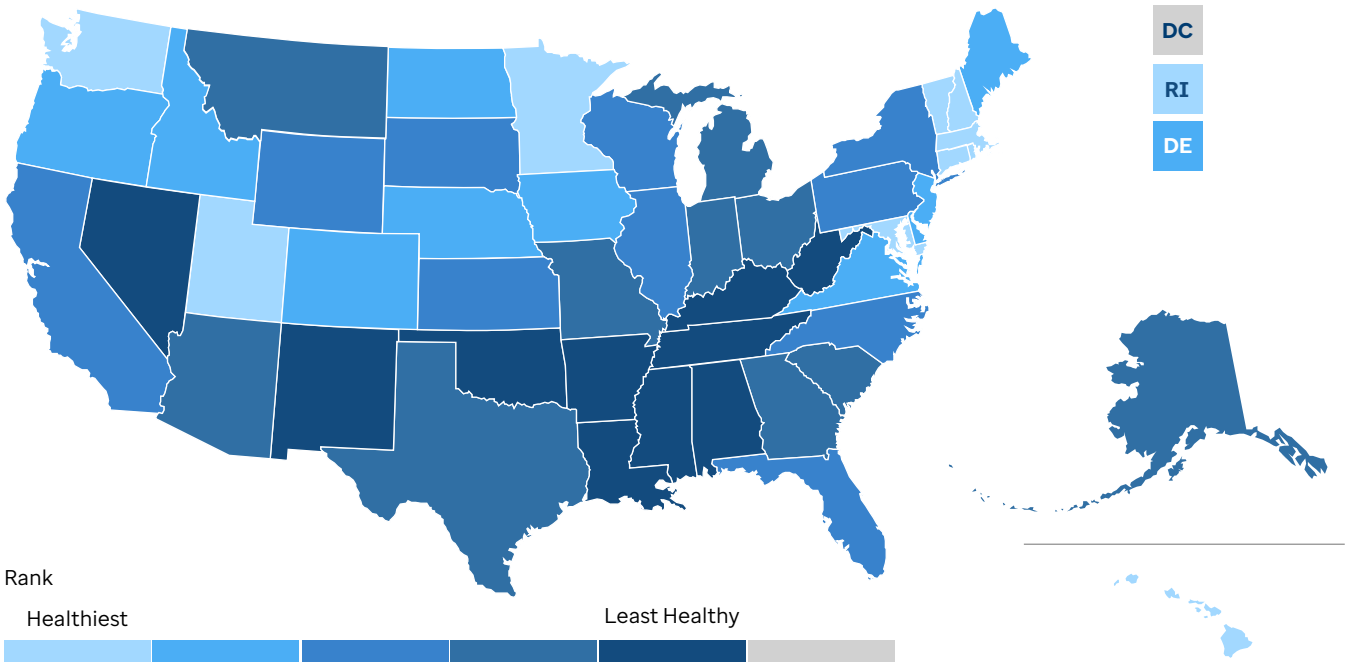
The data contained in this report provide a clear roadmap, helping public health leaders identify what's working, where progress is needed and how to transform insight into measurable and meaningful improvement. By offering a comprehensive view of the factors that shape health — from clinical care and individual behaviors to social, economic and environmental conditions — the platform empowers decision-makers to focus on what matters most for the communities they serve.

When we ground our decisions in data, we can direct our efforts where they will have the greatest impact and drive meaningful progress in the health of our communities. Reliable large-scale data like the findings in this report give leaders the context and information they need to act with purpose — equipping decision-makers to build on strengths, address persistent challenges and target resources to where they will make the biggest difference.

Ultimately, data are most powerful when they drive action — and every state has the opportunity to use these insights to make measurable, lasting improvements in health and well-being.

State Rankings

2025 Annual Report State Rankings



Source: *America's Health Rankings* composite measure, 2025.

State Rankings

The overall state rankings are based on 50 measures across five categories of health: Social and Economic Factors, Physical Environment, Behaviors, Clinical Care and Health Outcomes. The Methodology section (page 51) of the Appendix describes how overall ranks were calculated. Additional information can be found on the *America's Health Rankings* Methodology page.

New Hampshire No. 1

New Hampshire was the healthiest state in this year's report for the fourth consecutive year. It ranked among the top five states in Social and Economic Factors (No. 1), Behaviors (No. 2), Clinical Care (No. 3) and Health Outcomes (No. 2). New Hampshire ranked No. 9 in Physical Environment.

Strengths: Low prevalence of non-medical drug use, high prevalence of high school completion and low prevalence of adults using e-cigarettes.

Challenges: High prevalence of excessive drinking, high Black/white residential segregation and low per capita public health funding.

Massachusetts (No. 2), Vermont (No. 3), Connecticut (No. 4) and Utah (No. 5) completed the top five healthiest states.

Louisiana No. 50

Louisiana was the least healthy state in this year's report for the fourth consecutive year. The state ranked in the bottom five in Social and Economic Factors (No. 50), Physical Environment (No. 48), Behaviors (No. 50) and Health Outcomes (No. 50). Louisiana was No. 38 in Clinical Care.

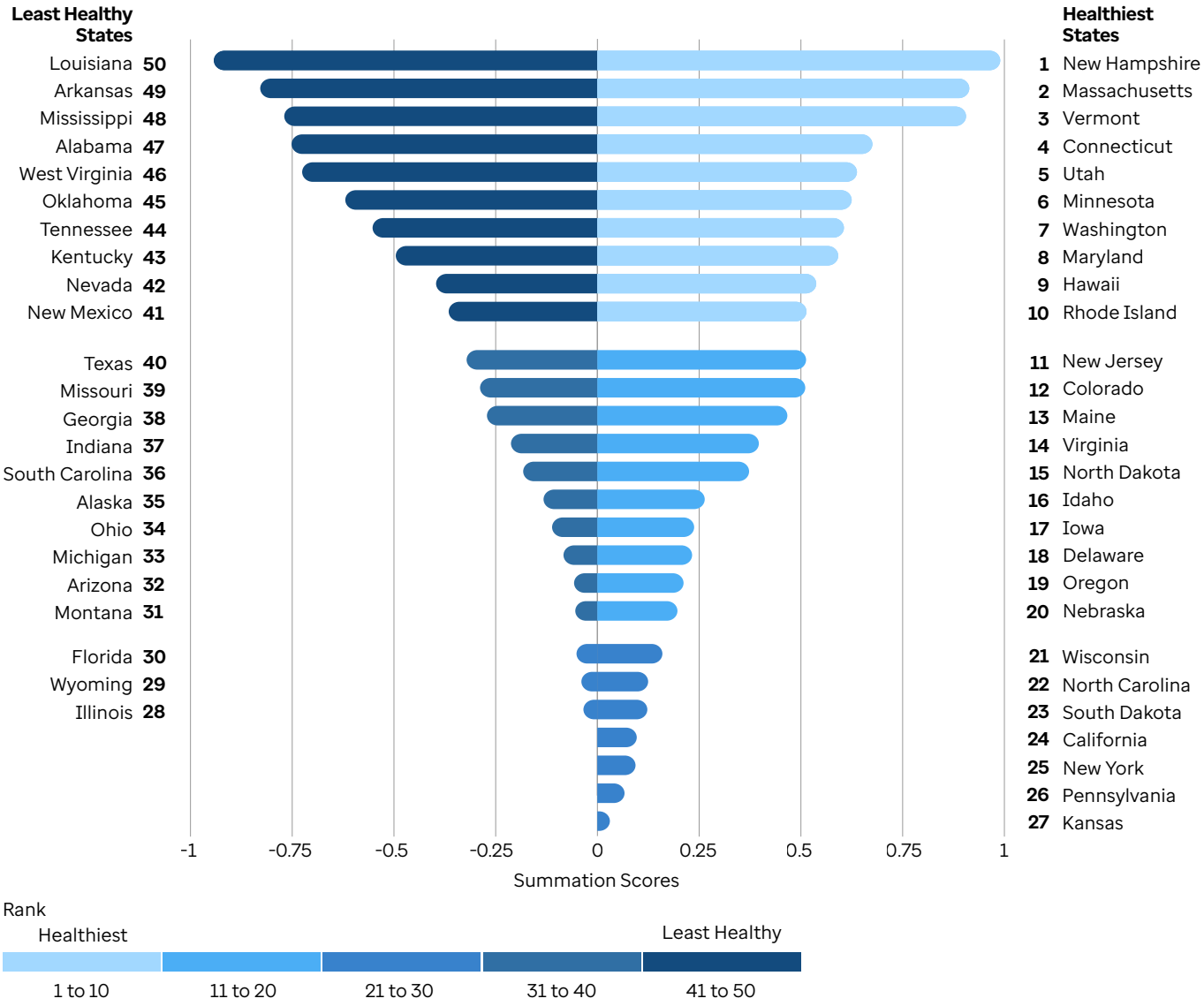
Strengths: High reading proficiency among fourth grade public school students, high prevalence of adults with a dedicated health care provider and high prevalence of cancer screenings.

Challenges: High economic hardship index score, high homicide rate and high incidence of chlamydia.

Arkansas (No. 49), Mississippi (No. 48), Alabama (No. 47) and West Virginia (No. 46) completed the five least healthy states.

Overall State Rankings and Scores*

2025 Annual Report



Source: *America's Health Rankings* composite measure, 2025.
*Sum of weighted z-scores of all ranked measures.

The graph above displays state scores and ranks, with the least healthy states on the left and the healthiest on the right. The distance between bars shows the difference between state scores. For example, Vermont (No. 3) and Connecticut (No. 4), while close in ranking, had a sizable difference in score, meaning Connecticut would need to make improvements in several measures to improve its rank. There was also a large gap in scores between Louisiana (No. 50) and Arkansas (No. 49).

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, key findings and rankings for individual measures, allowing users to identify which measures positively or negatively influenced each state's overall rank. This can be visualized by selecting a state in the Explore Data section. Disparity ratios, which show the relative difference between two groups within a demographic, are available for select measures in the website's State Summaries. The website also features an Adjust My Rank tool that allows users to explore how progress and challenges across key measures can impact a state's overall rank.

International Comparison

Comparing the health of the U.S. to that of other countries can help indicate areas of progress and areas for improvement. The following analysis used data from the Organization for Economic Co-operation and Development (OECD), which comprises 38 countries, including the U.S. The OECD collects and analyzes data from each member country on various social, economic and health-related topics, with the mission of promoting economic development and social well-being worldwide.

The following analysis compared U.S. data with data from other OECD countries for three health measures: infant mortality, life expectancy at birth and total health spending. Data presented are from 2023 unless otherwise specified. Infant mortality rates for the top- and bottom-ranked states from the *2025 Health of Women and Children Report* were included for comparison.

Despite having the highest total health spending of all OECD countries, the U.S. ranked poorly in measures of infant mortality and life expectancy compared with other member countries.

Infant Mortality

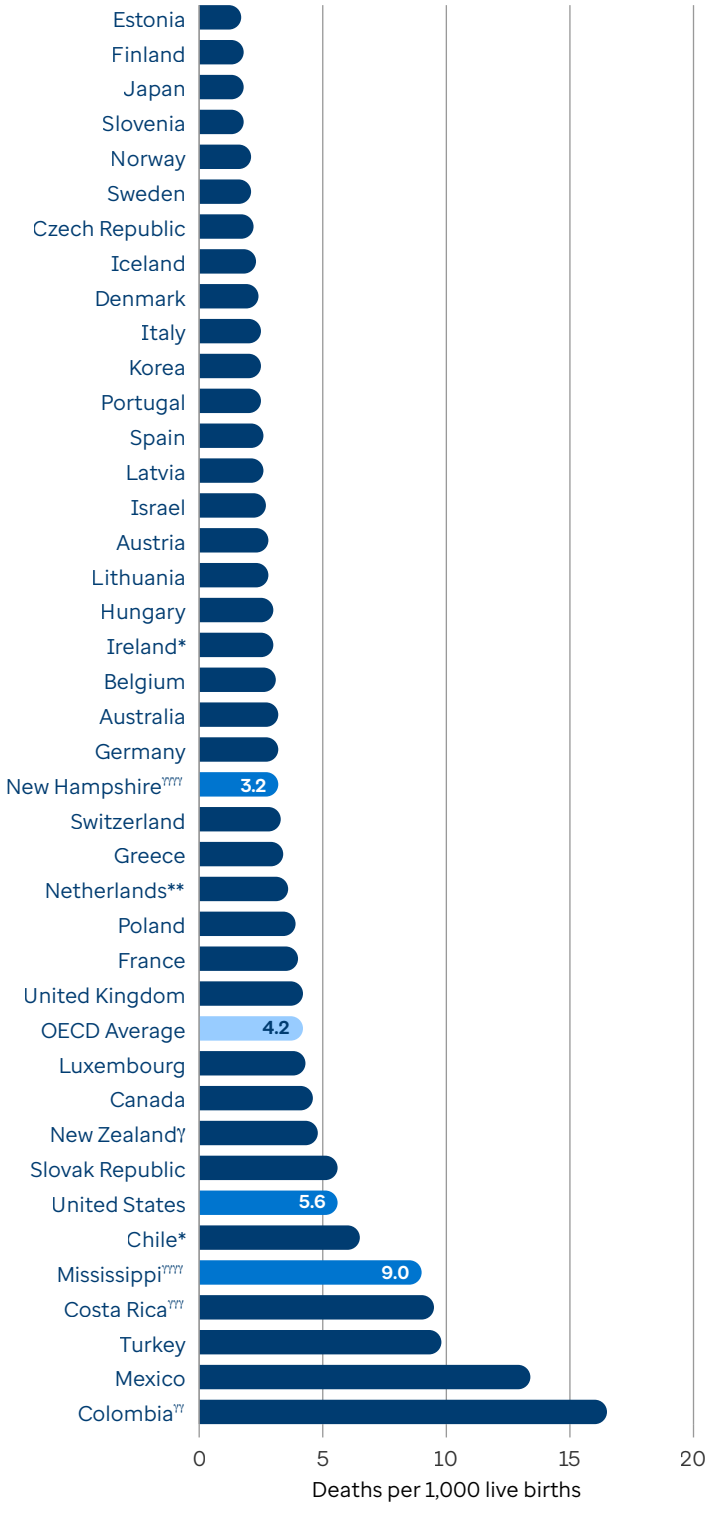
Infant mortality includes all deaths among children younger than 1 year of age and contributes to the nation's premature death rate.[72] Factors contributing to the high infant mortality rate in the U.S. include a high rate of cesarean deliveries, inadequate prenatal care and socioeconomic inequalities that are associated with maternal risk factors.[73]

The average infant mortality rate among OECD countries in 2023 was 4.2 deaths per 1,000 live births. At 5.6, the U.S. ranked No. 32 among the 38 OECD countries, tied with the Slovak Republic (also 5.6, No. 32) and falling between New Zealand (4.8, No. 31) and Chile* (6.5, No. 34). Estonia (1.7, No. 1) had the lowest infant mortality rate. Mexico (No. 37) and Colombia[YY] (No. 38) had the highest infant mortality rates at 13.4 and 16.5, respectively.

According to the *2025 Health of Women and Children Report*, New Hampshire[YYYY] had the lowest infant mortality rate in the U.S. at 3.2 deaths per 1,000 live births in 2022-2023, placing it on par with Australia and Germany (both also 3.2, No. 21). The state with the highest rate, Mississippi,[YYYY] had an infant mortality rate of 9.0, more than twice the OECD average.

There are large racial/ethnic disparities in U.S. infant mortality rates. In 2022-2023, the U.S. infant mortality rate was 3.1 times higher among Black (10.9 deaths per 1,000 live births) compared with Asian (3.5) infants.

The U.S. Ranked No. 32 out of 38 OECD Countries in Infant Mortality



Sources: Organization for Economic Co-operation and Development, 2023 or most recent year available; CDC WONDER, Linked Birth/Infant Death Files, 2022-2023.

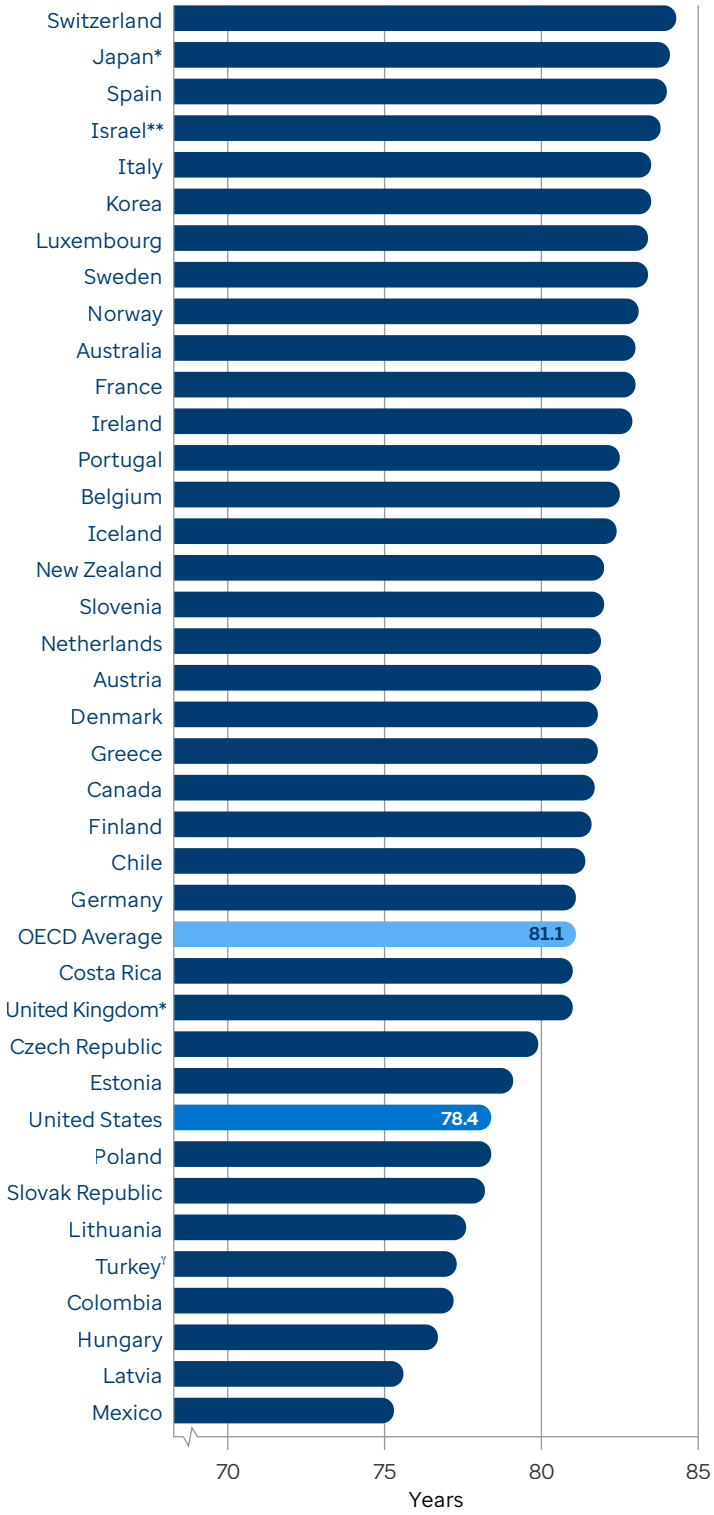
* Provisional Data. ** Estimated. [Y] 2020 data. [YY] 2021 data. [YYY] 2022 data. [YYYY] 2022-2023 data.

Life Expectancy

Life expectancy at birth describes how long a newborn is expected to live on average, assuming current death rates remain the same.[74] Life expectancy increased over the past 50 years across all OECD countries, but progress stalled before the COVID-19 pandemic.[75] The COVID-19 pandemic then led to a significant global decline in life expectancy in many countries.[76]

The average life expectancy at birth in OECD countries was 81.1 years in 2023. The U.S. life expectancy at birth was 78.4 years, ranking No. 30 out of the 38 OECD countries, placing it on par with Poland (also 78.4, No. 30) and between Estonia (79.1 years, No. 29) and the Slovak Republic (78.2 years, No. 32).

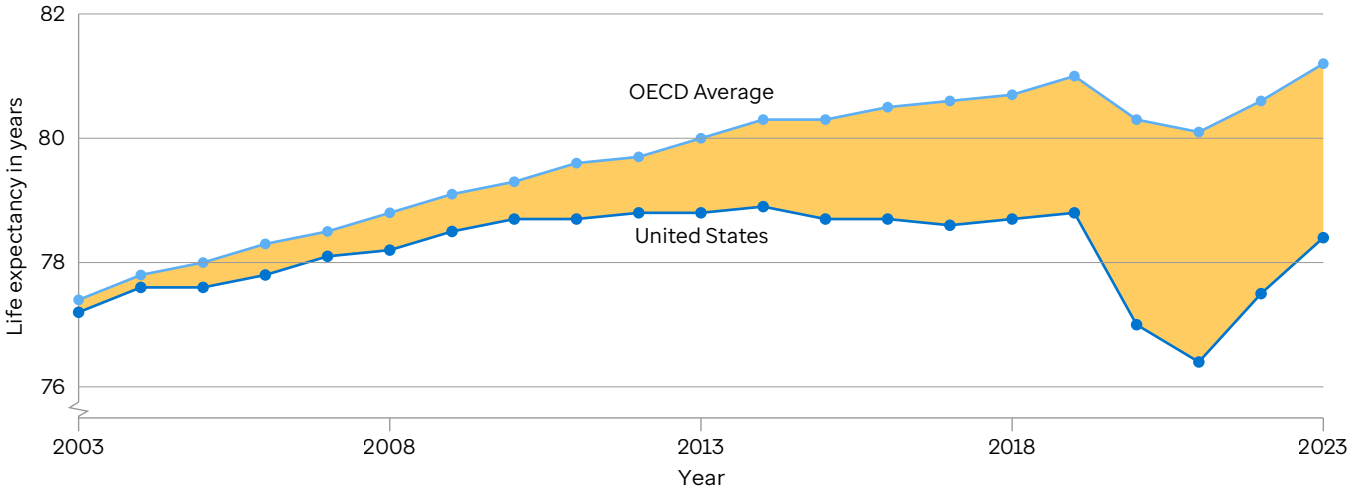
The U.S. Ranked No. 30 out of 38 OECD Countries in Life Expectancy at Birth



Source: Organization for Economic Co-operation and Development, 2023 or most recent year available.

* Estimated. ** Time series break. [Y] 2022 data.

The Gap in Life Expectancy Between the OECD Average and the U.S. Has Increased Since 2003



Source: Organization for Economic Co-operation and Development, 2003-2023.

Between 2003 and 2023, the gap in life expectancy between the U.S. and the OECD average grew considerably. In 2003, life expectancy in the U.S. was 77.2 years, compared with the OECD average of 77.4 years. By 2019, that 0.2-year gap had widened to 2.2 years (78.8 years in the U.S. compared with the OECD average of 81.0 years).

The gap in life expectancy was widest at the height of the COVID-19 pandemic in 2021, with U.S. life expectancy (76.4 years) falling to 3.7 years below the OECD average (80.1 years). In 2023, the U.S. life expectancy of 78.4 years was still 2.7 years less than the OECD average of 81.1 years.

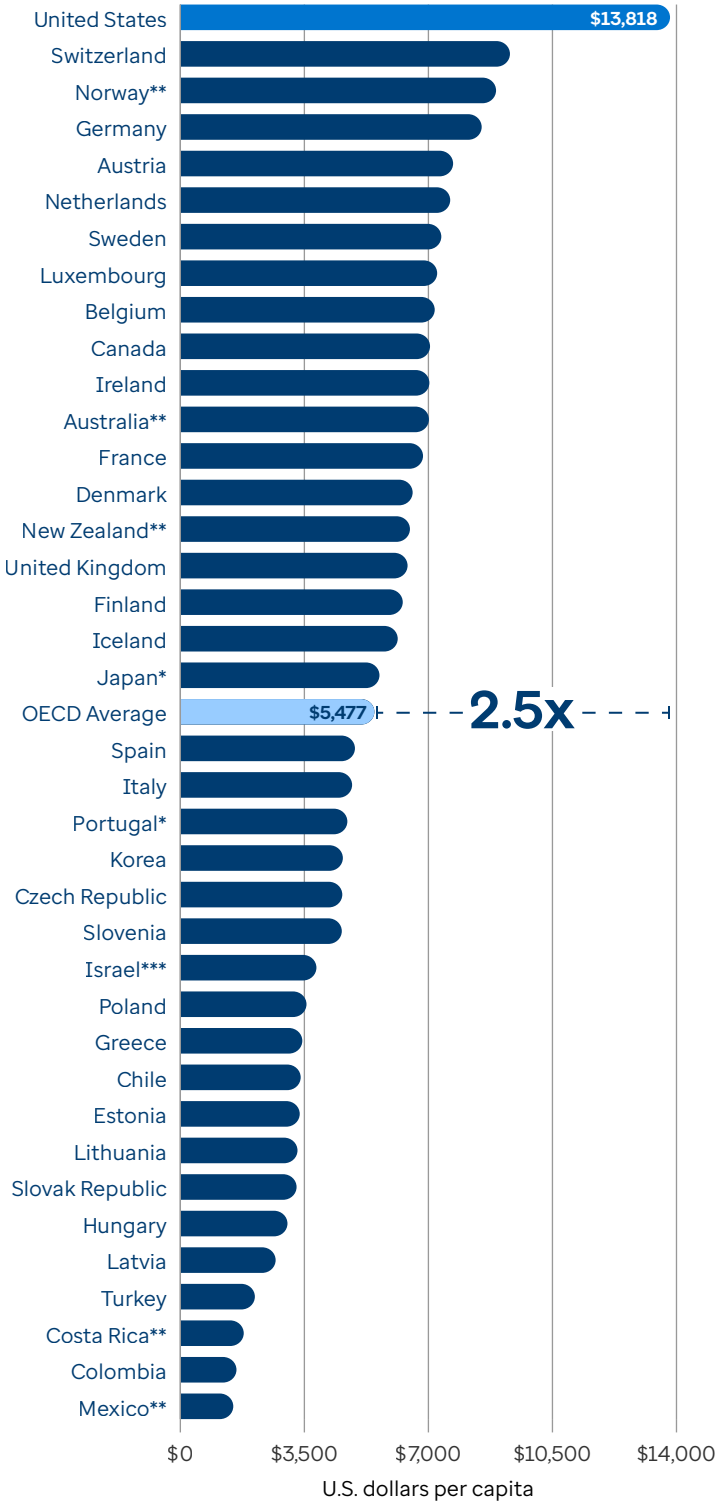
Total Health Spending

Total health spending comprises all expenses for the consumption of health-related goods and services, including personal health care, prevention and public health services.[77]

The average total health spending per capita in OECD countries was $5,477 in 2023. The U.S. spent 2.5 times that amount – $13,818 per capita – and remained the top spender among OECD countries. Switzerland, which ranked No. 2 in health spending among OECD countries ($9,301), 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 (61.5% vs. 45.6%).[78] Inpatient and outpatient care accounted for a larger share of health spending in 2021 than in 2013. However, roughly 56% of total health spending in the U.S. came from public funds in 2021, well below the OECD average of 73%.[75]

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



Source: Organization for Economic Co-operation and Development, 2022.

* Provisional data. ** Estimated. *** Definition differs.

Appendix

United States

Health Department Website: hhs.gov

Summary

Key Findings

Volunteerism
22% ▲
from 23.2% to 28.3% of people age 16 and older between 2021 and 2023.

Homelessness
16% ▲
from 19.4 to 22.6 people per 10,000 population between 2023 and 2024.

Cancer Screenings
15% ▲
from 56.0% to 64.5% of adults ages 40-75 between 2022 and 2024.

Air Pollution
13% ▲
from 7.8 to 8.8 micrograms of fine particulate per cubic meter between 2019-2021 and 2022-2024.

Premature Death
8% ▼
from 8,522 to 7,862 years lost before age 75 per 100,000 population between 2022 and 2023.

Unemployment
7% ▲
from 4.3% to 4.6% of civilian workers age 16 and older between 2023 and 2024.

Multiple Chronic Conditions
6% ▲
from 10.7% to 11.3% of adults between 2023 and 2024.

Mental Health Providers
5% ▲
from 344.9 to 362.6 per 100,000 population between September 2024 and September 2025.

E-Cigarette Use
4% ▲
from 7.7% to 8.0% of adults between 2023 and 2024.

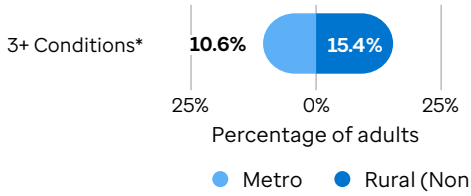
Drug Deaths
3% ▼
from 32.4 to 31.4 deaths per 100,000 population between 2022 and 2023.

Spotlight
Rural Health in the United States

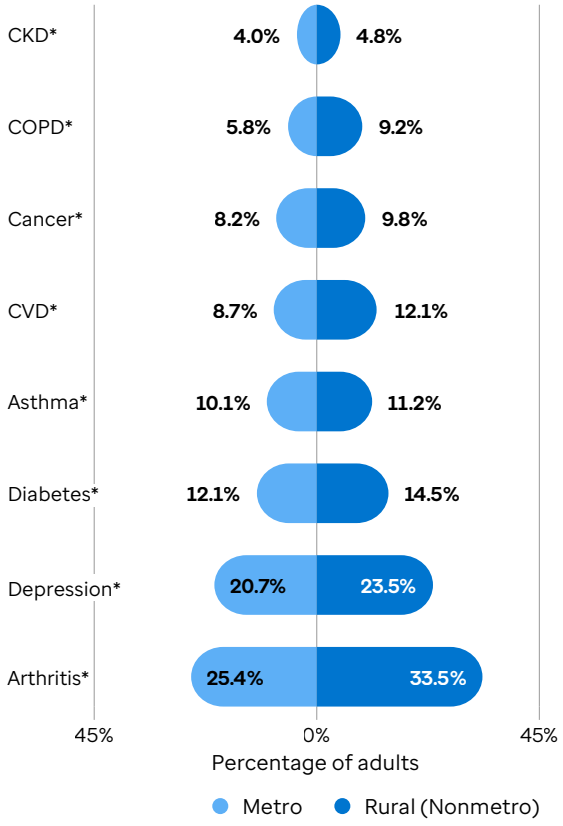
Rural Population in 2023
20.4%

Source: U.S. Census Bureau, American Community Survey, 1-Year Dataset, 2023.

Multiple Chronic Conditions
Prevalence by Metropolitan Status in 2024



Components



*Significant based on 95% confidence intervals.
Source: U.S. HHS, CDC, Behavioral Risk Factor Surveillance System, 2024.
Notes: Order of conditions based on U.S. prevalence. CKD=chronic kidney disease, COPD=chronic obstructive pulmonary disease, CVD=cardiovascular diseases.

Measures | United States

		U.S. Value
Social & Economic Factors		
Community and Family Safety	Firearm Deaths (Deaths per 100,000 population)*	14.0
	Homicide (Deaths per 100,000 population)	6.7
	Occupational Fatalities (Deaths per 100,000 workers)	4.2
	Public Health Funding (Dollars per person)	$124
Economic Resources	Economic Hardship Index (Index from 1-100)	–
	Food Insecurity (% of households)	12.2%
	Income Inequality (80:20 ratio)	4.85
Education	Fourth Grade Reading Proficiency (% of public school students)	30.5%
	High School Completion (% of adults age 25+)	89.9%
Social Support and Engagement	Adverse Childhood Experiences (% of children ages 0-17)	14.1%
	High-Speed Internet (% of households)	94.6%
	Residential Segregation - Black/White (Index from 0-100)	–
	Volunteerism (% of population age 16+)	28.3%
	Voter Participation (% of U.S. citizens age 18+)	58.8%
Physical Environment		
Air and Water Quality	Air Pollution (Micrograms of fine particles per cubic meter)	8.8
	Drinking Water Violations (Average violations per community water system)	2.5
	Water Fluoridation (% of population served by community water systems)	72.3%
Climate and Health	Climate Policies (Number out of four policies)	–
	Renewable Energy (% of total electricity generated)*	21.9%
Housing and Transit	Homelessness (People per 10,000 population)*	22.6
	Housing Cost Burden (% of households)*	32.0%
	Housing With Lead Risk (% of housing stock)	16.1%
	Severe Housing Problems (% of occupied housing units)	16.8%
Clinical Care		
Access to Care	Avoided Care Due to Cost (% of adults)	11.5%
	Dental Care Providers (Providers per 100,000 population)	66.3
	Mental Health Providers (Providers per 100,000 population)	362.6
	Primary Care Providers (Providers per 100,000 population)	291.4
	Uninsured (% of total population)	8.2%
Preventive Clinical Services	Cancer Screenings (% of adults ages 40-75)	64.5%
	Childhood Immunizations (% of 3-year birth cohort)	66.9%
	Dental Visit (% of adults)	67.5%
	Flu Vaccination (% of adults)	41.3%
	HPV Vaccination (% of adolescents ages 13-17)	62.9%
Quality of Care	Dedicated Health Care Provider (% of adults)	83.9%
	Preventable Hospitalizations (Discharges per 100,000 Medicare beneficiaries age 18+)	2,768
Behaviors		
Nutrition and Physical Activity	Exercise (% of adults)	30.4%
	Fruit and Vegetable Consumption (% of adults)	7.4%
	Physical Inactivity (% of adults)	21.8%
Sexual Health	Chlamydia (Cases per 100,000 population)	492.2
	High-Risk HIV Behaviors (% of adults)	5.6%
	Teen Births (Births per 1,000 females ages 15-19)	13.1
Sleep Health	Insufficient Sleep (% of adults)	35.5%
Smoking and Tobacco Use	E-Cigarette Use (% of adults)	8.0%
	Smoking (% of adults)	11.6%
Health Outcomes		
Behavioral Health	Drug Deaths (Deaths per 100,000 population)*	31.4
	Excessive Drinking (% of adults)	17.0%
	Frequent Mental Distress (% of adults)	15.6%
	Non-Medical Drug Use (% of adults)	16.8%
Mortality	Premature Death (Years lost before age 75 per 100,000 population)	7,862
	Premature Death Racial Disparity (Ratio of highest rate to white rate)	1.9
Physical Health	Frequent Physical Distress (% of adults)	13.0%
	Low Birth Weight (% of live births)	8.6%
	Low Birth Weight Racial Disparity (Ratio of highest rate to white rate)	2.1
	Multiple Chronic Conditions (% of adults)	11.3%
	Obesity (% of adults)	34.2%

Visit **AmericasHealthRankings.org** for the full list of measures, source details and methodologies.

* Unweighted measure that does not contribute to a state's Overall Rank.
– Data are not available, missing or suppressed.

Measures Table

Social and Economic Factors

Measure	Description	Source(s)	Data Year(s)
Community and Family Safety			
Firearm Deaths*^	Number of deaths due to firearm injury of any intent (unintentional, suicide, homicide or undetermined) per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023
Homicide^	Number of deaths due to injuries inflicted by another person with intent to injure or kill per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2022-2023
Occupational Fatalities	Number of fatal occupational injuries in construction, manufacturing, trade, transportation and utility industries as well as professional and business services per 100,000 workers	U.S. DOL, Bureau of Labor Statistics, Census of Fatal Occupational Injuries	2020-2022†
Public Health Funding	State dollars dedicated to public health per person (including federal grants directed to states from the CDC and the Health Resources and Services Administration)	Trust for America's Health, *The Impact of Chronic Underfunding on America's Public Health System Report Series;* U.S. HHS, CDC Grant Funding Profiles and HRSA Awarded Grants	2022-2023†
Economic Resources			
Economic Hardship Index	Index of state economic conditions based on crowded housing, dependency, education, income, poverty and unemployment; normalized values are 1 to 100, with a higher value indicating worse economic conditions	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Crowded Housing*	Percentage of occupied housing units with more than one person per room	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Dependency (Ages <18 or >64)*	Percentage of the population ages 0-17 or 65 and older	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Less Than High School Education*	Percentage of the population age 25 and older without a high school diploma	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Per Capita Income*	Per capita income in the past 12 months, in inflation-adjusted dollars to data year	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Poverty*	Percentage of households living below the federal poverty level	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Unemployment*	Percentage of the civilian workforce ages 16-64 that is unemployed	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Food Insecurity	Percentage of households unable to provide adequate food for one or more household members due to lack of resources	USDA, *Household Food Security in the United States* Report Series	2021-2023†
Homeownership*	Percentage of housing units owned by the occupant	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Homeownership Racial Disparity*	Difference between the homeownership rates of the white population and the racial/ethnic population with the lowest rate (varies by state)	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Income Inequality	Ratio of median household income at the 80th percentile to median household income at the 20th percentile	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Education			
Fourth Grade Reading Proficiency	Percentage of fourth grade public school students who scored proficient or above on the National Assessment of Educational Progress in reading comprehension	U.S. ED, National Center for Education Statistics, National Assessment of Educational Progress	2024
High School Completion	Percentage of adults age 25 and older with at least a high school diploma or equivalent	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
High School Graduation*	Percentage of high school students graduating with a regular high school diploma within four years of starting ninth grade	U.S. ED, National Center for Education Statistics, ED*Facts*	2021-2022 School Year†

Social Support and Engagement			
Adverse Childhood Experiences^	Percentage of children ages 0-17 who have ever experienced two or more of the following adverse experiences: parental divorce or separation; household with an alcohol or drug problem; household with mental illness; neighborhood violence victim or witness; domestic violence witness; parent served jail time; treated or judged unfairly due to race/ethnicity; treated or judged unfairly due to a health condition or disability; or death of a parent	U.S. HHS, Maternal and Child Health Bureau, National Survey of Children's Health	2023-2024
High-Speed Internet	Percentage of households with a broadband internet subscription and a computer, smartphone or tablet	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Neighborhood Racial/Ethnic Segregation	Index of segregation ranging from zero (all racial/ethnic census groups are distributed equally across all census tracts at the state level) to 100 (all groups reside in separate tracts)	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2019-2023
Residential Segregation – Black/White	Index of segregation between Black and non-Hispanic white households measured by the proportion of a state's population that would need to move in order to achieve complete integration, ranging from zero (the proportion of each racial/ethnic group in each census tract is the same as their proportion to the population as a whole) to 100 (each tract contains only one racial/ethnic group)	U.S. Census Bureau, American Community Survey, 5-Year Dataset	2019-2023
Volunteerism	Percentage of population age 16 and older who reported volunteering in the past 12 months	U.S. Census Bureau, Current Population Survey, Volunteering and Civic Life Supplement	2023
Voter Participation (Average)	Average of the percentage of U.S. citizens age 18 and older who voted in the last presidential and the last midterm national elections	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2022/2024
Voter Participation (Presidential)*	Percentage of U.S. citizens age 18 and older who voted in the last presidential election	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2024
Voter Participation (Midterm)*	Percentage of U.S. citizens age 18 and older who voted in the last midterm national election	U.S. Census Bureau, Current Population Survey, Voting and Registration Supplement	2022†

Physical Environment

Measure	Description	Source(s)	Data Year(s)
Air and Water Quality			
Air Pollution	Average exposure of the general public to particulate matter of 2.5 microns or less, measured in micrograms per cubic meter	U.S. EPA	2022-2024
Drinking Water Violations	Average number of health-based drinking water violations per community water system in a state	U.S. EPA, Safe Drinking Water Information System via ECHO	2024
Smoke-Free Policies*	Percentage of the population covered by 100% smoke-free laws for restaurants, bars and nonhospitality workplaces	American Nonsmokers' Rights Foundation	2025
Water Fluoridation	Percentage of the population served by community water systems that has fluoridated water	U.S. HHS, CDC, Water Fluoridation Reporting System	2022†

Climate and Health			
Climate Policies	Number of the four following state policies in place: legally binding electricity portfolio standards; carbon pricing policies; climate change action plans; and economy-wide greenhouse gas emission targets	Center for Climate and Energy Solutions	2024
Climate Risks*	Percentage of the population living in census tracts at or above the 90th percentile for projected flood risk, projected wildfire risk, fatalities and injuries from natural hazards, agricultural value losses from natural hazards, or building value losses from natural hazards	CEQ, Climate and Economic Justice Screening Tool	2022†
Heat and Worker Health*	Rate of nonfatal heat-related illness cases causing days away from work per 10,000 full-time workers	U.S. DOL, Bureau of Labor Statistics, Survey of Occupational Injuries and Illnesses via CDC National Environmental Public Health Tracking Network	2020†
Heat-Coded Emergency Department Visits*	Age-adjusted rate of emergency department visits for heat-related illness per 100,000 population	U.S. HHS, CDC, National Environmental Public Health Tracking Network	2023
Renewable Energy*^	Percentage of electricity generated from renewable sources (wind, solar rays, hydroelectric energy, biomass or geothermal heat)	U.S. EIA, State Energy Data System	2024
Transportation Energy Use*	Amount of energy in trillion British thermal units (BTUs) consumed by the transportation of people and goods per 100,000 population	U.S. EIA, State Energy Data System	2023
Housing and Transit			
Drive Alone to Work	Percentage of workers age 16 and older who drive alone to work	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Homelessness*^	Number of people experiencing homelessness per 10,000 population	U.S. HUD, *Annual Homelessness Assessment Reports to Congress*	2024
Housing Cost Burden*	Percentage of households for which housing costs are 30% or more of household income	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Housing With Lead Risk	Percentage of housing stock with potential elevated lead risk due to age of housing	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024
Severe Housing Problems	Percentage of occupied housing units with at least one of the following problems: lack of complete kitchen facilities, lack of plumbing facilities, overcrowding, or severely cost-burdened occupants	U.S. HUD, Comprehensive Housing Affordability Strategy	2017-2021†
Transportation Health Risks*	Percentage of the population living in census tracts at or above the 90th percentile in diesel particulate matter exposure, transportation barriers, or traffic proximity and volume	CEQ, Climate and Economic Justice Screening Tool	2022†

Clinical Care

Measure	Description	Source(s)	Data Year(s)
Access to Care			
Avoided Care Due to Cost	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	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Providers			
Dental Care Providers	Number of general dentists and advanced practice dental therapists per 100,000 population	U.S. HHS, CMS, National Plan and Provider Enumeration System	September 2025
Mental Health Providers	Number of psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care per 100,000 population	U.S. HHS, CMS, National Plan and Provider Enumeration System	September 2025
Primary Care Providers	Number of active primary care providers (including general practice, family practice, obstetrics and gynecology, pediatrics, geriatrics and internal medicine physicians, as well as physician assistants and nurse practitioners) per 100,000 population	U.S. HHS, CMS, National Plan and Provider Enumeration System	September 2025
Uninsured	Percentage of the population not covered by private or public health insurance	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2024

Preventive Clinical Services			
Cancer Screenings	Percentage of women ages 40-74 who reported receiving a mammogram in the past two years and percentage of adults ages 45-75 who reported receiving colorectal cancer screening within the recommended time period	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Breast Cancer Screening*	Percentage of women ages 40-74 who reported receiving a mammogram in the past two years	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Colorectal Cancer Screening*	Percentage of adults ages 45-75 who reported receiving one or more of the recommended colorectal cancer screening tests within the recommended time interval: blood stool test within the past year; sigmoidoscopy within the past five years; colonoscopy within the past 10 years; stool DNA test within the past three years; virtual colonoscopy within the past five years or sigmoidoscopy within the past 10 years and blood stool test in the past year	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Dental Visit	Percentage of adults who reported visiting a dentist or dental clinic within the past year	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Immunizations			
Childhood Immunizations	Percentage of children who received by age 24 months all recommended doses of the combined seven-vaccine series: diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine; measles, mumps and rubella (MMR) vaccine; poliovirus vaccine; *Haemophilus influenzae* type b (Hib) vaccine; hepatitis B (HepB) vaccine; varicella vaccine; and pneumococcal conjugate vaccine (PCV)	U.S. HHS, CDC, NIS-Child	2020-2021 Birth Cohort†
Flu Vaccination	Percentage of adults who reported receiving a seasonal flu vaccine in the past 12 months	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
HPV Vaccination	Percentage of adolescents ages 13-17 who received all recommended doses of the human papillomavirus (HPV) vaccine	U.S. HHS, CDC, NIS-Teen	2024
Quality of Care			
Dedicated Health Care Provider	Percentage of adults who reported having a personal doctor or health care provider	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Preventable Hospitalizations	Discharges following hospitalization for ambulatory care sensitive conditions (PQI 90) per 100,000 Medicare beneficiaries age 18 and older enrolled in the fee-for-service program	U.S. HHS, CMS, Mapping Medicare Disparities Tool	2023

Behaviors

Measure	Description	Source(s)	Data Year(s)
Nutrition and Physical Activity			
Exercise	Percentage of adults who met the federal physical activity guidelines (150 minutes of moderate or 75 minutes of vigorous aerobic activity and two days of muscle strengthening per week) in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023†
Fruit and Vegetable Consumption	Percentage of adults who reported consuming two or more fruits and three or more vegetables daily	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2021†
Physical Inactivity	Percentage of adults who reported doing no physical activity or exercise other than their regular job in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Sexual Health			
Chlamydia	Number of new cases of chlamydia per 100,000 population	U.S. HHS, CDC, NCHHSTP AtlasPlus	2023
High-Risk HIV Behaviors	Percentage of adults who reported having done any of the following in the past year: injecting any drug other than those prescribed for them; being treated for a sexually transmitted disease; or giving or receiving money or drugs in exchange for sex	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Teen Births	Births per 1,000 females ages 15-19	U.S. HHS, Natality Public Use Files via CDC WONDER	2023
Sleep Health			
Insufficient Sleep	Percentage of adults who reported sleeping, on average, less than seven hours in a 24-hour period	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2022†

Smoking and Tobacco Use			
E-Cigarette Use	Percentage of adults who reported using e-cigarettes or other electronic vaping products at least once in their lifetime and now use daily or some days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Smoking	Percentage of adults who reported smoking at least 100 cigarettes in their lifetime and currently smoke daily or some days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024

Health Outcomes

Measure	Description	Source(s)	Data Year(s)
Behavioral Health			
Drug Deaths*	Number of deaths due to drug injury (unintentional, suicide, homicide or undetermined) per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023
Excessive Drinking^	Percentage of adults who reported binge drinking (four or more drinks on one occasion in the past 30 days for females or five or more for males) or heavy drinking (eight or more drinks per week for females or 15 or more for males)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Frequent Mental Distress	Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Non-Medical Drug Use - Past Year	Percentage of adults who reported using prescription drugs non-medically (including pain relievers, stimulants and sedatives) or illicit drugs (excluding cannabis) in the last 12 months	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Cannabis Use*	Percentage of adults who reported using cannabis (including THC or both THC and CBD) in the last 12 months	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Illicit Drug Use (Excluding Opioids and Cannabis)*	Percentage of adults who reported using illicit drugs other than opioids and cannabis in the last 12 months	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Illicit Opioid Use*	Percentage of adults who reported using illicit opioids in the last 12 months	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Non-Medical Prescription Drug Use (Excluding Opioids and Cannabis)*	Percentage of adults who reported using prescription drugs other than opioids and cannabis non-medically in the last 12 months	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Non-Medical Prescription Opioid Use*	Percentage of adults who reported using prescription opioids non-medically in the last 12 months	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Non-Medical Drug Use - Past Month*	Percentage of adults who reported using prescription drugs non-medically (including pain relievers, stimulants, sedatives) or illicit drugs (excluding cannabis) in the last 30 days	RADARS® System Survey of Non-Medical Use of Prescription Drugs Program	2025
Suicide*	Number of deaths due to intentional self-harm per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023
Mortality			
Premature Death	Years of potential life lost before age 75 per 100,000 population	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2023
Premature Death Racial Disparity	Ratio of the premature death rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate	U.S. HHS, Multiple Cause of Death Files via CDC WONDER	2021-2023
Physical Health			
Frequent Physical Distress	Percentage of adults who reported their physical health was not good 14 or more days in the past 30 days	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
High Health Status*	Percentage of adults who reported their health was very good or excellent	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024

Low Birth Weight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth	U.S. HHS, Natality Public Use Files via CDC WONDER	2023
Low Birth Weight Racial Disparity	Ratio of the low birth weight rate of the racial/ethnic group with the highest rate (varies by state) to the non-Hispanic white rate	U.S. HHS, Natality Public Use Files via CDC WONDER	2021-2023
Multiple Chronic Conditions	Percentage of adults who have three or more of the following chronic health conditions: arthritis, asthma, chronic kidney disease, chronic obstructive pulmonary disease, cardiovascular disease (heart disease, heart attack or stroke), cancer (excluding non-melanoma skin cancer), depression or diabetes	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Arthritis*	Percentage of adults who reported ever being told by a health professional that they had some form of arthritis	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Asthma*	Percentage of adults who reported ever being told by a health professional that they have asthma	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Cancer*	Percentage of adults who reported ever being told by a health professional that they had any form of cancer other than non-melanoma skin cancer	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Cardiovascular Diseases*	Percentage of adults who reported ever being told by a health professional that they had angina or coronary heart disease, a heart attack or myocardial infarction, or a stroke	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Chronic Kidney Disease*	Percentage of adults who reported ever being told by a health professional that they had kidney disease (excluding kidney stones, bladder infection and incontinence)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Chronic Obstructive Pulmonary Disease*	Percentage of adults who reported ever being told by a health professional that they had chronic obstructive pulmonary disease, emphysema or chronic bronchitis	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Depression*	Percentage of adults who reported ever being told by a health professional that they had a depressive disorder, including depression, major depression, minor depression or dysthymia	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Diabetes*	Percentage of adults who reported ever being told by a health professional that they had diabetes (excluding prediabetes and gestational diabetes)	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2024
Risk Factors			
High Blood Pressure*	Percentage of adults who reported being told by a health professional that they had high blood pressure	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023†
High Cholesterol*	Percentage of adults who reported having their cholesterol checked and being told by a health professional that it was high	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023†
Obesity	Percentage of adults who have a body mass index of 30.0 or higher based on reported height and weight	U.S. HHS, CDC, Behavioral Risk Factor Surveillance System	2023
Demographics			
Total Population*	Number of estimated residents	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
Population – Age <18*	Percentage of the population that is younger than age 18	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
Population – Ages 18-64*	Percentage of the population that is ages 18-64	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
Population – Age 65+*	Percentage of the population that is age 65 and older	U.S. Census Bureau, Single-Race Population Estimates via CDC WONDER	2024
Rural Population*^	Percentage of a state's total population estimated to live in a rural area	U.S. Census Bureau, American Community Survey, 1-Year Dataset	2023†

* Unweighted measure, excluded from the Overall and category composite measures.
^ Data for each of the components are available in the Explore Data section.
† Data in this edition were repeated from the last edition.

Data Source Descriptions

The **American Community Survey** is an ongoing statistical survey coordinated by the United States Census Bureau that provides detailed information on national population demographics. Data are derived from the bureau directly via its 1-year and 5-year datasets or from using the public use microdata sample (PUMS) file.

The **American Nonsmokers' Rights Foundation** is a nonprofit organization dedicated to educating the public about the adverse health effects of smoking and secondhand smoke exposure, as well as the benefits of smoke-free environments. The foundation produces lists and maps covering laws regarding clean air, e-cigarettes, marijuana and tobacco sales in pharmacies. Data are accessed via the Lists & Maps webpage.

Annual Homelessness Assessment Reports are shared with Congress by the U.S. Department of Housing and Urban Development. The reports provide national estimates of homelessness and capacity and use of homeless services based on data from the Homeless Management Information System. Data are accessed via the HUD User Data Portal.

The **Behavioral Risk Factor Surveillance System (BRFSS)** is the nation's largest phone-based population survey. The survey, coordinated by the Centers for Disease Control and Prevention (CDC) in collaboration with state, territory and federal agencies, provides information about health-related risk behaviors, chronic health conditions and use of preventive services. Data are accessed via the CDC's BRFSS web page.

CDC WONDER is a query system for analyzing public-use data from the CDC's National Center for Health Statistics on births and deaths, as well as other topics. Data are obtained from the Multiple Cause of Death, Linked Birth/Infant Death, Natality and Single-Race Population Estimates files.

The **Census of Fatal Occupational Injuries** is conducted by the Bureau of Labor Statistics, which collects and analyzes data on employment, wages and other workplace statistics for the U.S. Department of Labor. Census data are obtained from the Bureau of Labor Statistics' Injuries, Illnesses, and Fatalities (IIF) program and combined with employment data from the U.S. Department of Commerce's Bureau of Economic Analysis.

The **Center for Climate and Energy Solutions (C2ES)** is a nonprofit environmental policy think tank that produces data and reports on climate basics, solutions and policies. Data are obtained from the C2ES website.

The **Climate and Economic Justice Screening Tool**, developed by the White House's Council on Environmental Quality, used data from multiple high-quality sources to identify disadvantaged communities in categories of burdens that included climate change, energy, health, housing, legacy pollution, transportation, water and wastewater, as well as workforce development. With regard to climate change, the tool helped federal agencies identify where to invest in climate and clean energy before being discontinued in January of 2025. Data in this edition were repeated from the last edition.

Comprehensive Housing Affordability Strategy (CHAS) data are produced by the Department of Housing and Urban Development's Office of Policy Development and Research, which manages specific housing data from the American Community Survey. These data demonstrate the extent of housing problems and needs, particularly for low-income households. Data are accessed via the Consolidated Planning/CHAS Data web portal.

EDFacts collects, analyzes and centralizes data from state education agencies and other data sources on district and school demographics, performance and participation for the U.S. Department of Education. Data are obtained using the ED Data Express tool.

The **Environmental Protection Agency** performs various federal research, monitoring, standard-setting and enforcement activities to ensure environmental protection. National Safe Drinking Water Act data are reported by states, compiled from the Safe Drinking Water Information System database for public water systems and downloaded from the Enforcement and Compliance History Online website. State-level air pollution data are obtained via a special request to the agency.

The ***Household Food Security in the United States*** report provides national statistics on food security, household food spending and use of federal food and nutrition assistance by food-insecure households. The report is produced annually by the Economic Research Service of the U.S. Department of Agriculture (USDA) using data from the Census Bureau's Current Population Survey Food Security Supplements.

The **Mapping Medicare Disparities (MMD) Tool** is a comprehensive source of information from the Centers for Medicare & Medicaid Services' Office of Minority Health, offering data on eliminating health disparities and improving the health of minority populations. This tool features health outcome measures of disease prevalence, costs, hospitalizations for 60 chronic conditions, emergency department use, readmissions rates, mortality, preventable hospitalizations and preventive services. Data are obtained from the MMD by Population website.

The **National Assessment of Educational Progress** is the largest continuing and nationally representative assessment of student academic achievement and learning experiences in the U.S., administered by the Department of Education's National Center for Education Statistics. Results from the assessment, including reading proficiency data, are published in the Nation's Report Card.

The **National Center for HIV/AIDS, Viral Hepatitis, STD and Tuberculosis Prevention (NCHHSTP) Atlas** allows users to create customized tables, maps and charts using more than 15 years of surveillance data on HIV/AIDS, viral hepatitis, sexually transmitted diseases, tuberculosis and social determinants of health. Data are obtained from the NCHHSTP AtlasPlus interactive website.

The **National Environmental Public Health Tracking Network (NEPHTN)** brings together health data and environmental data from national, state and city sources and provides supporting information to make the data easier to understand. Data from state and local health departments are compiled by the tracking network and accessed via their data explorer.

The **National Immunization Surveys (NIS)** are ongoing phone surveys conducted by the CDC that collect information on vaccinations among children ages 6 months to 17 years. NIS-Child and NIS-Teen data are obtained from the VaxView websites.

The **National Plan and Provider Enumeration System (NPPES)** is a registry developed by the Centers for Medicare & Medicaid Services to improve the efficiency of electronic health information transmission. NPPES assigns a unique National Provider Identifier (NPI) number to covered health care providers and health plans to conduct all administrative and financial transactions under HIPAA, the Health Insurance Portability and Accountability Act. Data are accessed via the NPI files website.

The **National Survey of Children's Health** collects annual data on children's health and access to health care based on responses from a parent or guardian who knows about the child's health and health care needs. Data for this report are obtained from the Maternal and Child Health Bureau, which funds and directs the survey. Survey data are also published annually on the U.S. Census Bureau's website.

The **State Energy Data System (SEDS)**, maintained by the U.S. Energy Information Administration, produces comprehensive statistics on state energy consumption, prices and expenditures over time. Data are obtained from the SEDS website.

The **Survey of Non-Medical Use of Prescription Drugs (NMURx) Program** is a data source from the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS®) System that collects product- and geographically-specific data on abuse, misuse and diversion of prescription drugs. The RADARS System is part of Denver Health and Hospital Authority's Rocky Mountain Poison & Drug Safety. Data are obtained via a direct request to the organization.

The **Survey of Occupational Injuries and Illnesses** provides annual information on the incidence rate and number of work-related injuries, illnesses and fatal injuries, and how these statistics vary by incident, industry, geography, occupation and other characteristics. Data are collected by the Bureau of Labor Statistics' IIF program and accessed via the CDC's NEPHTN data explorer.

Trust for America's Health is a public health policy, research and advocacy organization. State public health funding data are obtained via direct request to the organization.

Volunteering and Civic Life Supplement data are collected by the Current Population Survey, an ongoing statistical survey sponsored jointly by the U.S. Census Bureau and the Bureau of Labor Statistics. Data are released biennially in odd years and obtained from the Census Bureau's website.

Voting and Registration Supplement data from the Current Population Survey are released by the Census Bureau every two years following national elections.

The **Water Fluoridation Reporting System** monitors community water systems receiving optimally fluoridated drinking water across the U.S. National and state-level data are obtained from the CDC's Fluoridation Statistics website.

Methodology

How State Rankings Were Generated

This year, 99 measures (including 50 weighted and 49 unweighted measures) were analyzed for the *America's Health Rankings 2025 Annual Report*, using the most recent data available as of October 17, 2025, with the exception of National Survey of Children's Health data, which were released on December 2, 2025. Data years varied by measure because of the variety of data sources. Multiple data years were combined for some measures to ensure reliable state-level estimates. Measure definitions, sources and data years are available in the Measures Table (page 43). Measure changes were based on input from the *Annual Report* Advisory Committee and are detailed on the *2025 Annual Report* Measures Selection and Changes webpage.

Each state was ranked according to its value for each measure, with a rank of No. 1 assigned to the state with the healthiest value. Ties in value were assigned equal ranks. If a state value was unavailable for a measure in this edition, it was noted as missing, unavailable or suppressed. Composite scores were generated overall and by model category. The rankings show how a state compares with other states across all weighted measures.

Overall state rankings were based on 50 weighted measures that:

- Represented current population health issues.
- Had state-level data available.
- Maintained consistent measurement across all 50 states.
- Were current and regularly updated.
- Allowed for improvement over time.

The state value for each measure was normalized into a z-score, hereafter referred to as "score," using the following formula:

$$\text{Z-score} = \frac{\text{State value - National value}}{\text{Standard deviation of all state values}}$$

The score indicates the number of standard deviations a state value was above or below the U.S. value. Scores were capped at +/- 2.00 to prevent an extreme score from excessively influencing a state's Overall score. If a U.S. value was unavailable from the original data source for a measure, the mean of all states and the District of Columbia was used. If a value was unavailable for a state, its value from the most recent available data year was used to generate a score.

Composite scores were calculated by adding the products of the score for each measure multiplied by that measure's assigned model weight and association with health. Measures positively associated with population health, such as volunteerism and flu vaccination, were multiplied by 1. In contrast, measures with a negative association, such as smoking and premature death, were multiplied by -1. A state that ranked No. 1 will have a higher composite score (e.g., 2.00), reflecting better health, whereas a state that ranked No. 50 will have a lower composite score (e.g., -2.00). The overall state ranks were calculated by ranking the Overall score, which included all weighted measures in the model (see Measures, Weights and Direction for model and measure weights).

Scores and ranks were not calculated for the District of Columbia because of its unique status as an entirely urban population with different governing and funding mechanisms than states. While the District of Columbia was not included in the overall state rankings, its data are available in this report and on the *America's Health Rankings* website.

For additional methodology information, submit an inquiry.

Report

Findings. Data for all measures were analyzed and considered for inclusion in the report. Measures with updated data, measures with statistically significant changes (based on nonoverlapping 95% confidence intervals, when available) and new measures on emerging topics were prioritized for selection.

Health Disparities. Health disparities highlight significant differences within measures based on age, disability status, education, gender, income, metropolitan status, race/ethnicity, sexual orientation, special health care needs status among children and veteran status where data were available. Health disparities are presented as a ratio calculated by dividing the value of the group with the highest value by the value of the group with the lowest value. Only measures with significant differences, determined by nonoverlapping 95% confidence intervals, were considered. The groups with the largest health disparities, considering relevant risk factors, were prioritized for inclusion, along with health disparities by metropolitan status, the subject of this year's report spotlight. Not all statistically significant differences are detailed in the report. Full demographic data are published on the *America's Health Rankings* website. For more information, see Disparity Measures Methodology.

State Summaries

Strengths and Challenges represent measures with the greatest impact on a state's overall ranking (from the 50 weighted measures). Measures with newly available data that span model categories and topic areas were given priority during selection. Unweighted measures were excluded from the ranking calculations, and the District of Columbia was assessed separately by comparing its values to those of the healthiest and least healthy states. The U.S. summary is a reference for calculating z-scores and overall rankings, so it does not include strengths and challenges.

Key Findings highlight notable trends, presented as percent changes between two time periods of interest, often capturing inflection points or describing short- or long-term trends. Only statistically significant changes, as determined by nonoverlapping 95% confidence intervals, were considered for measures with confidence intervals. Measures without confidence intervals were considered if the change between the two time periods was 5% or more. Findings were selected to include a mix of improving and worsening measures across model categories and topic areas. Measures that did not lend themselves to changes over time were excluded from the analysis.

Demographic Group Definitions

Analyses were performed to illuminate health disparities by age, disability status, education, gender, income, metropolitan status, race/ethnicity, sexual orientation, special health care needs status among children and veteran status where data were available. Individual estimates were suppressed if they did not meet the reliability criteria set by the data source or internally established criteria. Some values had wide 95% confidence intervals, meaning the true value may be far from the estimate presented.

Age. Age data in this report were available for measures from the Centers for Disease Control and Prevention's (CDC's) Behavioral Risk Factor Surveillance System (BRFSS), CDC WONDER and the Voting and Registration Supplement of the Current Population Survey. BRFSS groupings included the following self-reported 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+. Voting and Registration Supplement groupings included the following age ranges: 18-24, 25-34, 35-44, 45-64 and 65+.

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. Responses of yes to the question, "Are you deaf or do you have serious difficulty hearing?" were coded as difficulty hearing. Responses of yes to the question, "Are you blind or do you have serious difficulty seeing, even when wearing glasses?" were coded as difficulty seeing. Responses of yes to the question, "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" were coded as difficulty with cognition. Responses of yes to the question, "Do you have serious difficulty walking or climbing stairs?" were coded as difficulty with mobility. Responses of yes to the question, "Do you have difficulty dressing or bathing?" were coded as difficulty with self-care. Responses of yes to the question, "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" were coded as independent living difficulty. Responses of no or missing to all questions, with at least one response being no, were coded as without a disability. Disability groups are not mutually exclusive.

Education. Education data in this report were available for measures from BRFSS, the National Survey of Children's Health (NSCH), the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS) System and the Volunteering and Civic Life Supplement of the Current Population Survey. BRFSS groupings were limited to adults age 25 and older and based on responses to the question, "What is the highest grade or year of school you completed?" Responses of grades nine through 11 were classified as less than high school. Responses of grade 12 or GED were classified as high school graduate/GED. Responses of college or technical school (one to three years) were classified as some post-high school. Responses of college (four years or more) were classified as college graduate. NSCH groupings were based on the highest level of education completed by an adult caregiver in the child's household, grouped into four categories: Less than high school education was classified as caregiver less than high school, high school or GED was classified as caregiver high school graduate/GED, some college or technical school was classified as caregiver some post-high school, and college degree or higher was classified as caregiver college graduate. RADARS groupings were limited to adults age 18 and older and were based on responses to the question, "What is the highest degree or level of school you have completed? Select one." A response of less than a high school diploma was classified as less than high school. A response of regular high school diploma, GED or alternative credential was classified as high school/GED. Responses of some college credit but no degree, trade school or associate degree were classified as some post-high school. Responses of bachelor's degree, master's degree, doctorate or professional degree were classified as college graduate. Volunteering and Civic Life Supplement groupings were based on responses to the question, "What is the highest level of school you have completed or the highest degree you have received?" Responses of grades below 12 or 12th grade with no diploma were summed and classified as less than high school. Responses of high school diploma or equivalent (GED) were classified as high school graduate/GED. Responses of some college but no degree were classified as some post-high school. Responses of associate degree, bachelor's degree, master's degree, professional school degree or doctoral school degree were classified as college graduate.

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 some national surveys limit the ability to describe the health of transgender and 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 — that is, not gay — were summed and classified as straight.

Income. Income data in this report were available for measures from BRFSS, RADARS and the Volunteering and Civic Life Supplement. BRFSS groupings were limited to adults age 25 and older and based on responses to the question, "[What] is your annual household income from all sources?" Responses were classified as less than $25,000, $25,000 to $49,999, $50,000 to $74,999, $75,000 to $99,999, $100,000 to $149,999 and $150,000 or more. RADARS groupings were limited to adults age 18 and older and were based on responses to the question, "What was your combined household income during the last 12 months? Select one." Responses were classified as less than $25,000, $25,000 to $74,999 and $75,000 or more. Volunteering and Civic Life Supplement groupings were based on responses to the question, "Which category represents your total combined income during the past 12 months (or the total combined income of all members of your family living in the household)? This includes money from jobs, net income from business, farm or rent, pensions, dividends, interest, social security payments and any other money income received by you (or by members of your family living in the household who are 15 years of age or older)." Responses were classified as less than $25,000, $25,000 to $49,999, $50,000 to $74,999, $75,000 to $99,999, $100,000 to $149,999 and $150,000 or more.

Metropolitan Status. Metropolitan status data in this report were available for measures from BRFSS and the Volunteering and Civic Life Supplement. 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 nonmetropolitan. Volunteering and Civic Life Supplement groupings were based on the 2010 definitions of metropolitan statistical area as determined by the Census Bureau.

Race/Ethnicity. Data were provided where available for the following racial and ethnic groups: American Indian/Alaska Native, Asian, Black, Hispanic, Hawaiian/Pacific Islander, white, multiracial, and those who identify as other race. Hispanic ethnicity includes members of all racial groups. Racial/ethnic groups were named and defined differently across data sources (details below). In summary, while American Community Survey data were collected and calculated as Hispanic-inclusive (except for white, which was non-Hispanic), all other sources collected race data as non-Hispanic. Those include: BRFSS; the CDC National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP); CDC WONDER; the U.S. Department of Housing and Urban Development (HUD); the National Center for Education Statistics (NCES); the National Survey of Children's Health (NSCH); RADARS; and the Volunteering and Civic Life and Voting and Registration Supplements.

Race and ethnicity categories by source:

- American Community Survey: American Indian and Alaska Native; Asian; Black or African American; Hispanic or Latino Origin (any race); Native Hawaiian or Other Pacific Islander; white (non-Hispanic); two or more races; and some other race.
- BRFSS: American Indian/Alaskan Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic, Latino/a or Spanish origin (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and multiracial (non-Hispanic).
- CDC NCHHSTP: American Indian or Alaska Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic or Latino/a (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and more than one race (non-Hispanic).
- CDC WONDER: American Indian or Alaska Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and more than one race (non-Hispanic).
- HUD: American Indian or Alaska Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic (any race); Pacific Islander (non-Hispanic); white (non-Hispanic); and other race, including multiple races (non-Hispanic).
- NCES: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hispanic (any race); Native Hawaiian/Pacific Islander (non-Hispanic); white (non-Hispanic); and multiracial (non-Hispanic).
- NSCH: American Indian/Alaskan Native (non-Hispanic); Asian (non-Hispanic); Black or African American (non-Hispanic); Hispanic (any race); Native Hawaiian or Other Pacific Islander (non-Hispanic); white (non-Hispanic); and multiple race (non-Hispanic).
- RADARS: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hispanic (any race); Hawaiian/ Pacific Islander (non-Hispanic); white (non-Hispanic); and other race (non-Hispanic).
- Volunteering and Civic Life Supplement: American Indian/Alaska Native (non-Hispanic); Asian (non-Hispanic); Black (non-Hispanic); Hawaiian/Pacific Islander (non-Hispanic); Hispanic (any race); multiracial (non-Hispanic); and white (non-Hispanic).
- Voting and Registration Supplement: Asian (non-Hispanic); Black (non-Hispanic); Hispanic (any race); and white (non-Hispanic).

Special Health Care Needs Status Among Children. Children with special health care needs (CSHCN) status data in this report were available for measures from NSCH. CSHCN are grouped into two categories and classified as children with special health care needs and children without special health care needs. Children were considered children with special health care needs if they either:

- Met the criteria from the Maternal and Child Health Bureau's CSHCN Screener, a five-item screening tool that identifies special health care needs based on the health consequences a child experiences due to an ongoing health condition, regardless of diagnosis.

The screening criteria are categorized as: 1) need or use of prescription medications, 2) need or use of services, 3) need or use of specialized therapies, 4) functional difficulties and 5) emotional, developmental, or behavioral problems for which treatment or counseling is needed.

- Or had at least one qualifying health condition and one qualifying functional difficulty. Conditions include autoimmune diseases, allergies, arthritis, asthma, blood disorders, cerebral palsy, cystic fibrosis, diabetes, Down syndrome, epilepsy, genetic or inherited conditions, heart conditions, frequent or severe headaches, Tourette syndrome, anxiety, depression, behavior problems, developmental delays, intellectual disabilities, speech disorders, learning disabilities, autism spectrum disorders, attention-deficit/hyperactivity disorder and fetal alcohol spectrum disorder. Functional difficulties include difficulty breathing, swallowing, and digesting food; difficulty with coordination, walking, using one's hands, climbing stairs, dressing and bathing, and doing errands alone; deafness or difficulty hearing; blindness or difficulty seeing; physical pain; and serious difficulty concentrating, remembering, or making decisions because of a physical, mental or emotional condition.

Veteran Status. Veteran status data in this report were available for measures from BRFSS and the Volunteering and Civic Life Supplement. 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?" Volunteering and Civic Life Supplement groupings were based on responses to the question, "Did you ever serve on active duty in the U.S. Armed Forces?" Responses of yes were classified as served. Responses of no were classified as not served.

Limitations

Rankings are a relative measure of health. Not all changes in rank translate into actual declines or improvements in health. 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. Values and ranks from prior years have been updated on the *America's Health Rankings* website to reflect known errors and updates from the reporting source.

Use caution when interpreting data, as many measures are self-reported and rely on an individual's perception of health and behaviors. Additionally, some health outcome measures are based on respondents being told by a health care professional that they have a disease and may exclude those who have not received a diagnosis or sought or obtained treatment.

This report provides health disparity data on various demographic group characteristics alongside socioeconomic factors and environmental influences. Relying solely on health disparity data may lead to misinterpretations of health outcomes, as they do not account for the social drivers that significantly impact individuals' access to care, quality of life and overall well-being.[79]

Inclusivity in data collection is essential to documenting, analyzing and addressing the health disparities people experience. Equitable systems must accurately represent diverse populations throughout the data life cycle, from data collection through analysis to interpretation.[80]

Inadequate representation of populations may hinder the identification of trends and patterns within different demographic groups and limit the ability to tailor public health interventions and personalize care that empowers people to make better health choices.

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

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