

Health, United States, 2020–2021

Annual Perspective



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics



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Overview of Health, United States

The *Health, United States* program provides a wide array of trends in health statistics to policymakers, public health professionals, and the public. As part of the program's legislative mandate, *Health, United States* is charged with presenting a comprehensive set of health topics, and examining trends in health status and determinants, healthcare utilization, healthcare resources, and health expenditures and payers. *Health, United States* provides a detailed look at these topics within specific demographic and socioeconomic groups, including age, sex, race and ethnicity, disability status, education, poverty level, and geographic area.

Monitoring the health of the American people informs evidence-based health policy decisions and research and program priorities. Important topics for the *Health, United States* series are selected based on the availability of comparable national data over a period of several years.

Since the start of the program in 1974, *Health, United States* products have been reevaluated and redesigned continually to reflect the ways that readers search for, access, and use health statistics. To better meet

the needs of today's readers and users, *Health, United States* materials are published online, with the goal of more timely release of updates. This allows the program to incorporate data more quickly from more than 40 data sources, including the National Center for Health Statistics (NCHS), the Centers for Disease Control and Prevention, other federal agencies, as well as private and global sources.

Starting with *Health, United States, 2020–2021* (<https://www.cdc.gov/nchs/hus/index.htm>), new online features are added to enhance accessibility and timeliness. Newly designed web pages bring together key findings, featured figures, and trend analyses on specific topics. Detailed Trend Tables, which provide the data that support these analyses, are available both through the main web page and the searchable Data Finder (<https://www.cdc.gov/nchs/hus/data-finder.htm>). The new website organization makes it simpler to find information on related Topics (<https://www.cdc.gov/nchs/hus/topics.htm>). Additionally, analyses directly link to detailed technical information in a new Sources and Definitions section (<https://www.cdc.gov/nchs/hus/sources-definitions.htm>).

Table AsthCh. Asthma in children under age 18, by selected characteristics: United States, selected years 1997-2019
Estimates (with more data years and standard errors when available) <https://www.cdc.gov/nchs/data/tables/2020-2021/asthch-asthch>
Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Characteristic	Current asthma ^a								
	1997	2000	2005	2009	2013	2016	2017	2018	2019
Total, under 18 years ^b	8.9	8.6	8.4	8.4	8.3	8.4	7.5	7.0	7.0
Percent of children									
Age group									
0-4 years	6.8	6.5	6.7	6.8	6.8	6.8	5.8	5.6	5.6
5-17 years	9.7	11.0	9.8	10.0	9.9	9.9	8.9	8.6	8.6
0-9 years	9.7	10.2	9.8	9.9	9.8	9.8	8.8	8.4	8.4
10-17 years	9.8	11.4	10.3	10.3	10.3	10.3	9.9	9.1	9.1
Sex									
Male	10.0	11.3	9.9	9.2	9.5	9.5	8.3	8.4	8.4
Female	7.8	7.9	6.9	7.4	7.3	7.3	6.7	5.5	5.5
Race ^c									
White only	8.0	8.2	7.5	6.8	7.0	6.1	5.9	5.9	5.9
Black or African American only	13.2	16.8	13.5	15.1	12.8	14.1	13.5	13.5	13.5
American Indian or Alaska Native only	-	-	13.4	15.1	-	-	-	-	-
Asian only	6.5	7.2	5.8	4.8	3.8	3.9	4.2	4.2	4.2
Native Hawaiian or Other Pacific Islander only	-	-	-	-	-	-	-	-	-
2 or more races	12.6	13.8	10.2	13.8	12.8	12.8	13.2	10.0	10.0
Hispanic origin and race ^d									
Hispanic or Latino	8.6	7.7	8.0	6.7	7.7	8.0	6.7	6.7	6.7
Not Hispanic or Latino	9.0	10.2	8.6	8.9	8.7	7.4	7.1	7.1	7.1
White only	7.9	8.5	7.4	7.1	7.2	5.6	5.7	5.7	5.7
Black or African American only	13.1	17.0	13.4	15.7	12.6	14.3	13.5	13.5	13.5
Percent of poverty level ^e									
Below 100%	10.6	13.5	10.7	10.5	11.0	10.2	10.5	10.5	10.5
100-199%	8.0	9.4	8.4	9.9	9.1	9.1	9.0	9.2	9.2
200%-399%	8.0	7.3	7.4	7.4	6.1	6.1	7.0	6.8	6.8
400% or more	8.2	9.3	7.0	6.9	6.7	5.5	4.9	4.9	4.9
Health insurance status at time of interview ^f									
Insured	9.2	9.9	8.5	8.4	8.5	7.7	7.2	7.2	7.2
Private	8.1	8.5	7.3	7.2	7.5	6.8	5.2	5.2	5.2
Medicaid	13.9	13.9	10.3	10.1	10.5	9.4	10.2	10.2	10.2
Uninsured	6.5	7.0	6.8	8.3	5.6	5.1	2.3	2.3	2.3

Asthma attack in past 12 months^g

Special Notice on COVID-19

In early 2020, the World Health Organization and the Secretary of the U.S. Department of Health and Human Services (HHS) declared the novel coronavirus disease 2019 (COVID-19) outbreak a pandemic and public health emergency (1,2). Since then, COVID-19 has widely impacted the health of Americans, including birth rates (3), mental health (4), healthcare utilization (4), hospitalizations (5), and deaths (6,7).

The pandemic response has been a priority for HHS. Progress reporting on the HHS Action Plan highlighted a worsening of factors associated with health disparities caused by the COVID-19 pandemic (8).

Health, United States, 2020–2021 draws from data sources that were collected through the end of 2019—before the start of the COVID-19 pandemic. The information presented in *Health, United States, 2020–2021* provides national baselines for understanding the health impacts of COVID-19—particularly for people of racial and ethnic minority groups—for many relevant topics including cancer and heart disease, deaths from suicide and drug overdose, and healthcare utilization and insurance.

Overview of the *Annual Perspective*

The *Annual Perspective* is a new publication from the *Health, United States* program. The *Health, United States, 2020–2021: Annual Perspective* is the 44th edition of the congressionally mandated annual report on health statistics. The report is submitted on behalf of the HHS Secretary to the President and Congress in compliance with Section 308 of the Public Health Service Act (9).

This brief annual report integrates selected analyses from the *Health, United States* topics presented online. Each *Annual Perspective* will explore a theme across multiple topics and data sources. This edition's theme is **health disparities**.

Health disparities are differences in health outcomes that are closely linked with sociodemographic, economic, or environmental disadvantage (10). These factors, also called social determinants of health (SDOH), are conditions in the environments in which people are born, live, learn, work, play, worship, and age that impact health and quality of life (11). Measuring the impacts of SDOH and the resulting health disparities is key to eliminating those disparities. Achieving health equity—the opportunity for all people to reach their full health potential—requires focused efforts to address inequalities, as well as unique social, historical, economic, and cultural circumstances (12–14).

Realizing these goals through evidenced-based action has been a consistent focus for HHS. The Report of the Secretary's Task Force on Black and Minority Health, released in 1985 by then-HHS Secretary Margaret Heckler, documented significant disparities across racial and ethnic populations in health and health care (15). In addition to introducing dedicated Offices of Minority Health across government, calling for increased diversity in healthcare providers, and expanding health promotion activities, the report also discussed the improvements that would be needed to collect high-quality data on race and ethnicity.

Longstanding health inequalities have contributed to a greater risk of poor health and disease for some racial and ethnic minority groups (16,17). Low education and income limit access to healthy foods and safe neighborhoods (18) and are related to poorer health (19). Neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks negatively impact health (18). Racial and ethnic minorities and people with low incomes are more likely to live in places with these risks (20).

The COVID-19 pandemic has emphasized how these factors increase health risks for some racial and ethnic and other minority groups (21–23). Other communities, often invisible in the data, have also been disproportionately affected by COVID-19, including people with disabilities and people experiencing homelessness (22). Individuals may belong to several groups that have experienced historical and contemporary injustices and may be affected by layered health and social inequities. Examining such

intersections can increase understanding of how to promote health equity and improve health outcomes (24).

Data are essential for identifying where disparities exist, directing efforts and resources to address disparities as they are identified, measuring progress toward achieving greater equity, and establishing accountability for achieving progress (25). Improving the collection, creation, and management of disaggregated data on race and ethnicity and other characteristics is central to the pursuit of health equity, not only related to COVID-19, but in health and health care more broadly (26,27).

The *Health, United States, 2020–2021: Annual Perspective* brings together data from a variety of sources on health and health care, examining disparities not only by race and ethnicity, but also by sex, education, poverty level, health insurance coverage, and geography. For many of the health topics examined in this report, trends show improvements in outcomes over time, both for the population overall and for specific groups. However, almost all analyses reveal that disparities remain by each of these SDOH.

This reporting is not meant to be comprehensive but aims to provide the reader with a starting point from which to explore the wide array of topics covered by the *Health, United States* program and the comparisons available by demographic and socioeconomic groups. Additional analyses and data can be found on the topic-specific web pages (<https://www.cdc.gov/nchs/hus/topics.htm>) and in the detailed trend tables (<https://www.cdc.gov/nchs/hus/data-finder.htm>).

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Summary of Trend Tables

Summary of changes over the last decade for measures in *Health, United States'* Trend Tables. See Data Finder, available from: <https://www.cdc.gov/nchs/hus/data-finder.htm>.

Key health indicators	Value (year)			Trend table	Data source
Health status and determinants					
Natality and mortality					
Live births per 1,000 women	13.5 (2009)	11.6 (2018)	11.4 (2019)	Brth	CDC, NCHS, National Vital Statistics System, Births
Life expectancy at birth (years)	78.5 (2009)	78.7 (2018)	78.8 (2019)	LExpMort	CDC, NCHS, National Vital Statistics System, Mortality
Infant deaths per 1,000 live births	6.4 (2009)	5.7 (2018)	5.6 (2019)	IMMort	CDC, NCHS, National Vital Statistics System, Mortality and Births
All-cause deaths per 100,000 population (age adjusted)	749.6 (2009)	723.6 (2018)	715.2 (2019)	SlctMort	CDC, NCHS, National Vital Statistics System, Mortality
Heart disease deaths per 100,000 population (age adjusted)	182.8 (2009)	163.6 (2018)	161.5 (2019)	SlctMort	CDC, NCHS, National Vital Statistics System, Mortality
Cancer deaths per 100,000 population (age adjusted)	173.5 (2009)	149.1 (2018)	146.2 (2019)	SlctMort	CDC, NCHS, National Vital Statistics System, Mortality
Drug overdose deaths per 100,000 population (age adjusted) ¹	11.9 (2009)	20.7 (2018)	21.6 (2019)	ODMort	CDC, NCHS, National Vital Statistics System, Mortality
Suicides per 100,000 population (age adjusted)	11.8 (2009)	14.2 (2018)	13.9 (2019)	SuicMort	CDC, NCHS, National Vital Statistics System, Mortality
Morbidity and risk factors					
Chlamydia new cases per 100,000 population ²	405.26 (2009)	537.54 (2018)	552.84 (2019)	IDNotif	CDC, Sexually Transmitted Disease Surveillance
HIV diagnoses per 100,000 resident population, people aged 13 years and over	14.8 (2015)	13.6 (2018)	13.2 (2019)	HIV	CDC, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Current asthma percent, children under 18 years ³	9.6 (2009)	7.5 (2018)	7.0 (2019)	AsthCh	CDC, NCHS, National Health Interview Survey
Heart disease prevalence percent, adults aged 18 and over (age adjusted) ³	6.2 (2009)	5.5 (2018)	5.5 (2019)	HDPrv	CDC, NCHS, National Health Interview Survey
History of cancer percent, adults aged 18 and over (age adjusted) ^{3,4}	5.8 (2009)	6.1 (2018)	6.6 (2019)	CanHst	CDC, NCHS, National Health Interview Survey
Disability percent, adults aged 18 and over (age adjusted) ^{3,5}	8.6 (2010)	9.5 (2018)	8.2 (2019)	FxLimit	CDC, NCHS, National Health Interview Survey
Fair or poor health status percent, all ages (age adjusted) ³	9.4 (2009)	9.0 (2018)	11.2 (2019)	HStat	CDC, NCHS, National Health Interview Survey
Current cigarette smoking percent, adults aged 18 and over (age adjusted) ^{3,6}	20.6 (2009)	13.9 (2018)	14.2 (2019)	SmokSex	CDC, NCHS, National Health Interview Survey
Past month illicit drug use percent, people aged 12 years and over ⁷	10.1 (2015)	11.7 (2018)	13.0 (2019)	SubUse	Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health
Past month nicotine vaping percent, all 12th graders	11.0 (2017)	20.9 (2018)	25.5 (2019)	SubUseTn	Monitoring the Future
Percent kcal from carbohydrates mean, adults aged 20 and over (age adjusted)	50.7 (1999–2002)	48.6 (2011–2014)	46.7 (2015–2018)	McrNutr	CDC, NCHS, National Health and Nutrition Examination Survey

See footnotes at end of table.

Summary of Trend Tables—Con.

Key health indicators	Value (year)			Trend table	Data source
Healthcare utilization					
Delay or nonreceipt of needed medical care due to cost percent, all ages ^{3,8}	11.4 (2009)	8.3 (2018)	8.5 (2019)	UnmtNd	CDC, NCHS, National Health Interview Survey
Combined 7-vaccine series percent, children vaccinated by age 24 months ⁹	65.9 (2010)	68.3 (2015)	69.7 (2016)	VaxCh	CDC, National Center for Immunization and Respiratory Diseases, National Immunization Survey–Child
HPV vaccination percent (up-to-date), female adolescents aged 13–17 years ¹⁰	49.5 (2016)	53.7 (2018)	56.8 (2019)	VaxTn	CDC, National Center for Immunization and Respiratory Diseases, National Immunization Survey–Teen
HPV vaccination percent (up-to-date), male adolescents aged 13–17 years ¹⁰	37.5 (2016)	48.7 (2018)	51.8 (2019)	VaxTn	CDC, National Center for Immunization and Respiratory Diseases, National Immunization Survey–Teen
Mammogram use in past 2 years percent, women aged 40 and over (age adjusted) ³	67.1 (2008)	65.6 (2018)	67.5 (2019)	CanBrTest	CDC, NCHS, National Health Interview Survey
Emergency department visit percent, children under 18 years ^{3,8}	20.8 (2009)	19.6 (2018)	18.0 (2019)	EDCh	CDC, NCHS, National Health Interview Survey
Emergency department visit percent, adults aged 18 and over ^{3,8}	21.2 (2009)	21.3 (2018)	21.8 (2019)	EDAd	CDC, NCHS, National Health Interview Survey
Initial injury-related visits to emergency departments per 10,000 people, all ages (age adjusted)	960.9 (2007–2008)	1,047.8 (2013–2014)	1,035.6 (2017–2018)	InjEDVis	CDC, NCHS, National Hospital Ambulatory Medical Care Survey
Hospital stays percent, people aged 1 year and over (age adjusted) ^{3,8}	7.3 (2009)	6.7 (2018)	7.3 (2019)	HospStay	CDC, NCHS, National Health Interview Survey
Visits to physician offices per 100 people, all ages (age adjusted)	315 (2008)	267 (2016)	250 (2018)	HCareVis	CDC, NCHS, National Ambulatory Medical Care Survey
Dental visits percent, children aged 2–17 years ^{3,8}	78.4 (2009)	85.9 (2018)	86.9 (2019)	DentCh	CDC, NCHS, National Health Interview Survey
Dental visits percent, adults aged 18–64 ^{3,8}	62.0 (2009)	65.9 (2018)	65.5 (2019)	DentAd	CDC, NCHS, National Health Interview Survey
Healthcare resources					
Physicians per 10,000 resident population	27.3 (2009)	29.5 (2018)	29.9 (2019)	DocSt	Health Resources and Services Administration, National Center for Health Workforce Analysis, American Medical Association Physician Masterfile
Dentists per 100,000 resident population	59.34 (2010)	61.04 (2019)	61.04 (2020)	DentSt	American Dental Association, Health Policy Institute
Community hospital beds per 1,000 resident population	2.6 (2009)	2.4 (2018)	2.4 (2019)	BedComSt	American Hospital Association, Annual Survey of Hospitals
Average length of stay (days), all hospitals	6.2 (2009)	6.1 (2018)	6.2 (2019)	HospAdmis	American Hospital Association, Annual Survey of Hospitals
Physician assistants mean hourly wage (dollars)	40.78 (2009)	49.08 (2016)	55.81 (2020)	HCEmpl	Department of Labor, Bureau of Labor Statistics, Occupational Employment and Wage Statistics

See footnotes at end of table.

Summary of Trend Tables—Con.

Key health indicators	Value (year)			Trend table	Data source
Health expenditures and payers					
Personal healthcare expenditures (billions), 2012 constant dollars ¹¹	2,248.7 (2009)	2,832.7 (2018)	2,937.2 (2019)	HExpPers	Centers for Medicare & Medicaid Services, National Health Expenditure Accounts
Private health insurance coverage percent, people aged 65 and under ³	63.3 (2009)	65.3 (2018)	64.3 (2019)	HIPriv	CDC, NCHS, National Health Interview Survey
Medicaid coverage percent, people aged 65 and under ^{3,12}	16.1 (2009)	20.2 (2018)	20.5 (2019)	HIMcaid	CDC, NCHS, National Health Interview Survey
No health insurance coverage percent, people aged 65 and under ^{3,13}	17.5 (2009)	11.0 (2018)	12.0 (2019)	HINone	CDC, NCHS, National Health Interview Survey

¹Drug overdose deaths include all manners and intents, including unintentional, suicide, homicide, and undetermined intent. See Sources and Definitions, Cause of death; *International Classification of Diseases* (ICD).

²Due to the coronavirus disease 2019 (COVID-19) pandemic, 2019 data from some jurisdictions may be incomplete. See Sources and Definitions, National Notifiable Diseases Surveillance System (NNDSS); Sexually Transmitted Disease (STD) Surveillance.

³In 2019, the National Health Interview Survey (NHIS) questionnaire was redesigned, and other changes were made to weighting and design methodology. Data for 2019 have not been fully evaluated for comparability with earlier years; therefore, trends through 2019 are not shown. For more information on the 2019 NHIS redesign and evaluation of the redesign on selected indicators, see: https://www.cdc.gov/nchs/nhis/2019_quest_redesign.htm.

⁴Excludes squamous cell and basal cell carcinomas. See Sources and Definitions, Cancer.

⁵Defined by the reported level of difficulty in six domains of functioning: seeing, hearing, mobility, communication, cognition, and self-care. Adults reporting a lot of difficulty or cannot do at all to at least one functioning domain are considered to have a disability. See Sources and Definitions, Functional limitation.

⁶Defined as ever smoking 100 cigarettes in their lifetime and smoking now every day or some days. See Sources and Definitions, Tobacco use.

⁷Includes marijuana, cocaine (including crack), heroin, hallucinogens (including LSD, PCP, peyote, mescaline, psilocybin mushrooms, Ecstasy [MDMA or Molly], ketamine, DMT/AMT/Foxy, and Salvia divinorum), and prescription psychotherapeutic drugs (including pain relievers, tranquilizers, stimulants, and sedatives). See Sources and Definitions, Illicit drug use.

⁸Within the past 12 months.

⁹Data are for birth year and are based on the 3 subsequent survey years. For example, 2010 birth year data are based on 2011, 2012, and 2013 survey data. See Sources and Definitions, Vaccination.

¹⁰Includes those who are fully vaccinated against HPV (also called up-to-date). Fully vaccinated against HPV is defined as three doses or more, or two doses when the first HPV vaccine dose was initiated before age 15 years and with at least 5 months minus 4 days between the first and second dose. See Sources and Definitions, Vaccination.

¹¹To account for inflation to compare expenditures over time, nominal (or current) dollar values are adjusted to constant (or real) dollars, using the chain-weighted personal healthcare deflator. See Sources and Definitions, Inflation-adjusted expenditures.

¹²Includes people who had any of the following at the time of interview: Medicaid, state-sponsored health plan, or Children's Health Insurance Program. It also includes those who had another type of coverage in addition to one of these. See Sources and Definitions, Health insurance coverage; Medicaid.

¹³People with only Indian Health Service coverage are considered to have no health insurance coverage. See Sources and Definitions, Health insurance coverage; Uninsured.

NOTES: CDC is the Centers for Disease Control and Prevention. NCHS is the National Center for Health Statistics.

Heart Disease by Race and Ethnicity

Non-Hispanic Black people have similar prevalence, but higher heart disease mortality than other groups

Heart disease mortality

Non-Hispanic Black people are more likely than people in other racial and ethnic groups to die of heart disease.

- **Heart disease mortality** in all racial and ethnic groups was lower in 2019 than in 2009 (Figure 1). Throughout the period, heart disease mortality was highest for non-Hispanic Black people and lowest for non-Hispanic Asian people (age-adjusted estimates).
- In 2019, heart disease was the **leading cause of death** in non-Hispanic Black, non-Hispanic Native Hawaiian or Other Pacific Islander, non-Hispanic White, and non-Hispanic American Indian or Alaska Native people, and the second leading cause of death in Hispanic and non-Hispanic Asian people (Table LCOdRace [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-LCOdRace>]).

AT A GLANCE

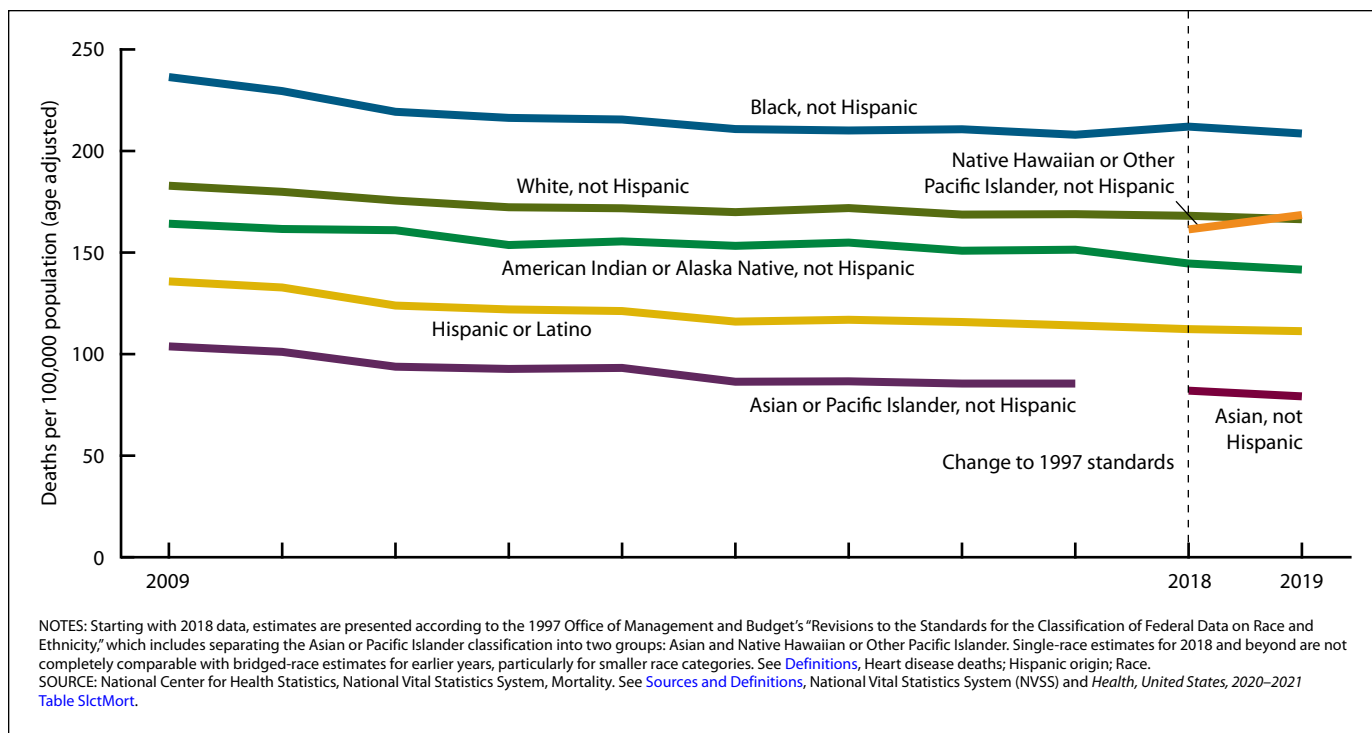
Background

Racial and ethnic disparities in heart disease mortality persist even as the total rate decreases (28). Non-Hispanic Black adults under age 65 experience higher rates of heart disease deaths than similarly aged adults in other racial and ethnic groups (29). Differences in risk factors by race and ethnicity may be due to socioeconomic disadvantage, including unequal access to prevention and treatment (28,30).

Select findings

Non-Hispanic Black adults have similar prevalence of heart disease as non-Hispanic White and Hispanic adults. However, non-Hispanic Black people die of heart disease at higher rates than people in other racial and ethnic groups.

Figure 1. Heart disease death rates, by race and Hispanic origin: United States, 2009–2019



Heart disease prevalence

Non-Hispanic Black, non-Hispanic White, and Hispanic adults had similar heart disease prevalence in 2019.

- From 2009 to 2018, the **prevalence of heart disease** decreased in non-Hispanic Black and non-Hispanic White adults but remained stable in non-Hispanic Asian and Hispanic adults (Table HDPrv [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HDPrv>], age-adjusted estimates).
- In 2019, heart disease was more prevalent in non-Hispanic Black (5.7%), non-Hispanic White (5.5%), and Hispanic (5.4%) adults than in non-Hispanic Asian adults (3.2%) (Table HDPrv [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HDPrv>], age-adjusted estimates).

Heart disease risk factors

Non-Hispanic White and non-Hispanic Black adults are more likely to be current smokers than Hispanic adults.

- **Cigarette smoking** among adults aged 18 and over decreased from 2009 (20.6%) to 2018 (13.9%). In 2019, 14.2% of adults smoked cigarettes (Table SmokSex [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SmokSex>], age-adjusted estimates).
- Current cigarette smoking was higher in non-Hispanic White (15.5%) and non-Hispanic Black (14.9%) adults than in Hispanic adults (8.8%) in 2019 (31).

Non-Hispanic Asian people are less likely to report binge drinking than people in other racial and ethnic groups.

- **Binge drinking** in the past 30 days by people aged 12 and over was higher for non-Hispanic White (25.0%), Hispanic (24.2%), non-Hispanic Native Hawaiian or Other Pacific Islander (23.8%), non-Hispanic Black (22.7%), and non-Hispanic American Indian or Alaska Native (20.9%) people than non-Hispanic Asian people (13.4%) in 2019 (Table SubUse [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SubUse>]).

Saturated fat consumption has increased over the last 2 decades.

- **Average saturated fat consumption** in adults aged 20 and over was higher in 2015–2018 (11.6% of total energy intake) than in 1999–2002 (10.7%) (Table McrNutr [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-McrNutr>], age-adjusted estimates). The recommended average saturated fat intake is 10% or less of total energy consumption (32).
- In 2017–2018, average saturated fat consumption as a percentage of total energy intake was 12% in non-Hispanic White, 11% in non-Hispanic Black, 11% in Hispanic, and 10% in non-Hispanic Asian adults aged 20 and over (33).

Cancer by Race and Ethnicity

Non-Hispanic Black people continue to have higher cancer mortality than other racial and ethnic groups

History of cancer

Non-Hispanic White adults reported a history of cancer more often than other groups.

- The history of cancer reflects both the number of people newly diagnosed and those surviving the disease (34). From 2009 to 2018, the percentage who reported a **history of cancer** increased in non-Hispanic White adults aged 18 and over but remained stable in non-Hispanic Black, Hispanic, and non-Hispanic Asian adults (Table CanHst [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-CanHst>], age-adjusted estimates).
- In 2019, 7.5% of non-Hispanic White, 4.9% of non-Hispanic Black, 4.6% of Hispanic, and 2.4% of non-Hispanic Asian adults aged 18 and over reported a history of cancer (Table CanHst [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-CanHst>], age-adjusted estimates).

AT A GLANCE

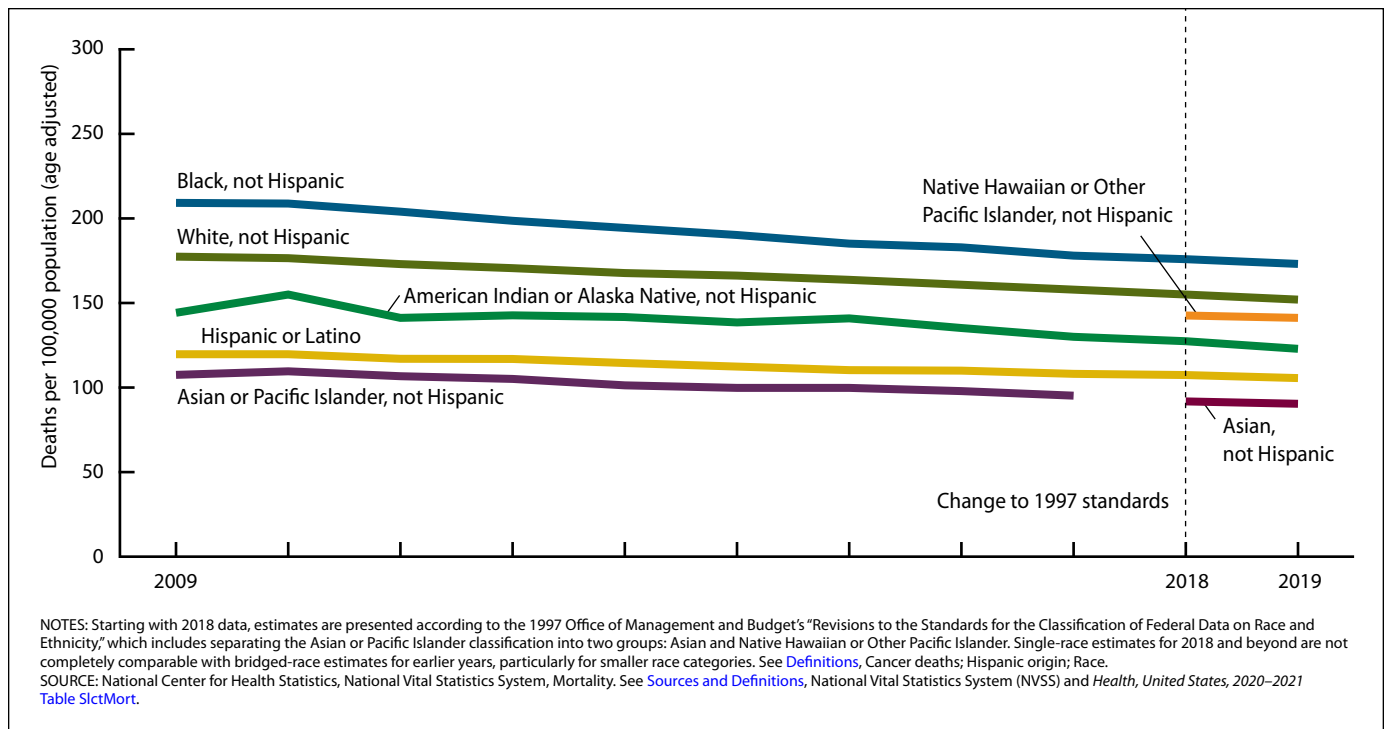
Background

Non-Hispanic Black people die of cancer more often than people in other racial and ethnic groups (35). This community also experiences a higher burden of other chronic health conditions, which can impact cancer survival (35). Disparities in cancer incidence, survival, and outcomes may reflect unequal access to health insurance, early detection, and cancer treatment (36), as well as community factors, such as limited access to healthy foods (36,37).

Select findings

Black people have similar cancer incidence but lower survival than White people. Non-Hispanic Black people die of cancer at higher rates than non-Hispanic White people.

Figure 2. Cancer death rates, by race and Hispanic origin: United States, 2009–2019



Cancer screening

Cancer screening, including mammography, was most common in non-Hispanic White and non-Hispanic Black adults.

- In 2019, having a **mammogram** within the past 2 years in women aged 40 and over was more common in non-Hispanic White (69.4%) and non-Hispanic Black (70.8%) women than in non-Hispanic Asian (64.0%) and non-Hispanic American Indian or Alaska Native (54.2%) women ([Table CanBrTest \[https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-CanBrTest\]](https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-CanBrTest)).
- Non-Hispanic White adults aged 50–75 reported the highest adherence to colorectal cancer screening recommendations, followed by non-Hispanic Black, non-Hispanic Asian, and Hispanic adults in 2018 (38).

Cancer mortality

Non-Hispanic Black people die of cancer at higher rates than other racial and ethnic groups.

- From 2009 to 2019, **cancer mortality** rates decreased across all racial and ethnic groups for which trend testing is possible; however, they remained highest in non-Hispanic Black people throughout the period ([Figure 2](#)).
- Cancer was the **leading cause of death** for Hispanic and non-Hispanic Asian people in 2019. It was the second leading cause of death for non-Hispanic Black, non-Hispanic White, non-Hispanic Native Hawaiian or Other Pacific Islander, and non-Hispanic American Indian or Alaska Native people ([Table LCODRace \[https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-LCODRace\]](https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-LCODRace)).
- From 2009 to 2018, White and Black people (including those of Hispanic origin) had the highest cancer incidence rates (35). However, Black people had the shortest survival time of any race group following diagnosis for most cancer types (35,39).

HIV and Sexually Transmitted Diseases (STDs) by Race and Ethnicity

HIV outcomes improved overall, but non-Hispanic Black people are most affected by HIV and STDs

HIV

Non-Hispanic Black people died of HIV at rates four times as high as people in other racial and ethnic groups.

- **HIV death rates** decreased for most racial and ethnic groups from 2009 to 2019 (Table SlctMort [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SlctMort>], age-adjusted estimates).
- In 2019, HIV death rates were highest in non-Hispanic Black people (5.9 per 100,000 population), followed by Hispanic (1.4), non-Hispanic American Indian or Alaska Native (1.2), non-Hispanic White (0.6), and non-Hispanic Asian (0.3) people (Table SlctMort [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SlctMort>], age-adjusted estimates).

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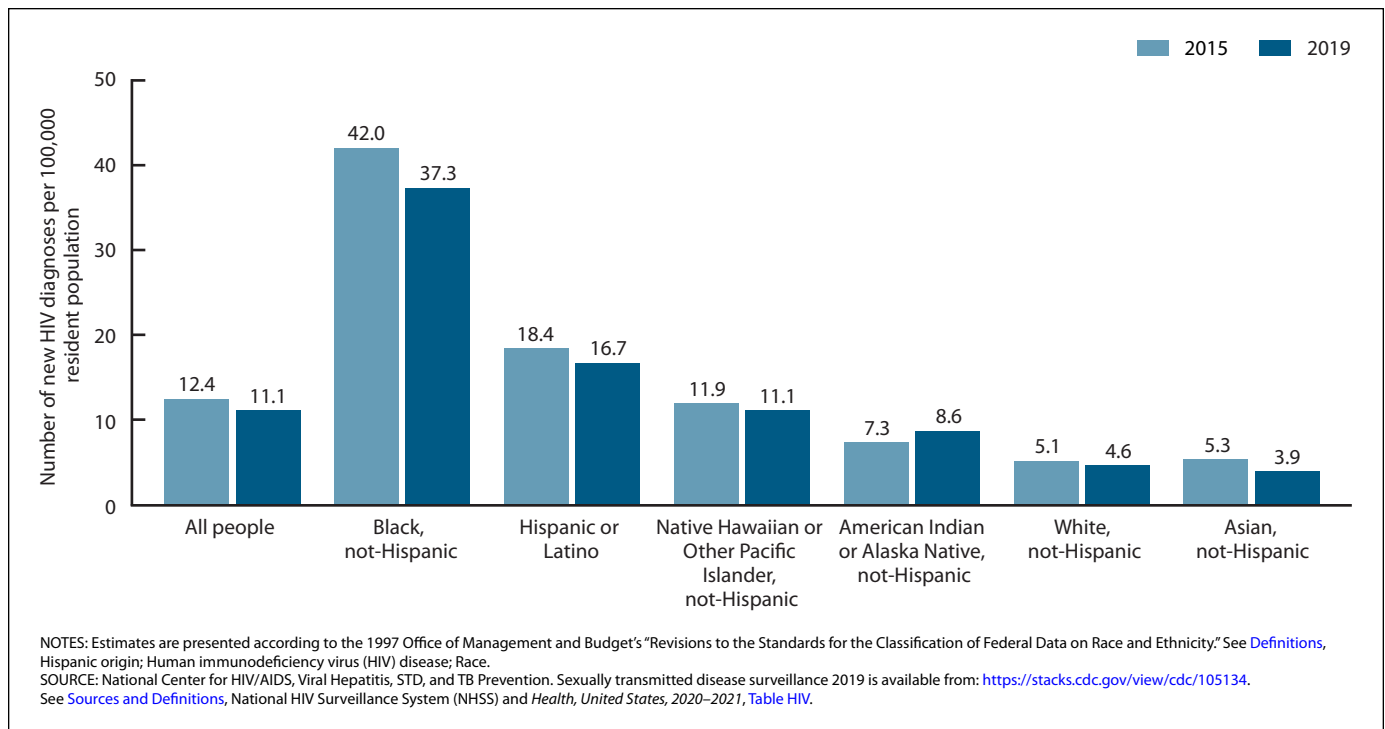
Background

Non-Hispanic Black people are disproportionately impacted by HIV and STDs (40,41). Early detection and intervention can prevent or improve the outcomes of HIV and STDs (40,42). Disparities in HIV and STDs reflect access to quality sexual health care, including access to pre- and post-exposure prophylaxis (41,43,44). Barriers to health care, racism, stigma, homophobia, and poverty also contribute to these disparities (41).

Select findings

STD cases increased, while HIV diagnoses and deaths decreased. Despite this decrease, non-Hispanic Black people are diagnosed with and die of HIV more often than people in other racial and ethnic groups.

Figure 3. New diagnoses of Human Immunodeficiency Virus (HIV) infection, by race and Hispanic origin: United States, 2015 and 2019



Non-Hispanic Black people were diagnosed with HIV at least twice as often as people in other racial and ethnic groups.

- The rate of **new HIV diagnoses** was 11% lower in 2019 than in 2015. Non-Hispanic American Indian or Alaska Native people had higher rates of new HIV diagnoses in 2019 (8.6 per 100,000 population) than in 2015 (7.3), while all other racial and ethnic groups had lower rates of new diagnoses (Figure 3).
- In 2019, 36,398 people were newly diagnosed with HIV. Approximately 40% of new diagnoses were in non-Hispanic Black people (Table HIV [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HIV>]).
- Approximately 70% of new HIV diagnoses in people aged 13 years and over were in men who have sex with men (MSM) in 2019 (Table HIV [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HIV>]).
- In 2019, non-Hispanic Black MSM accounted for one quarter of HIV diagnoses and nearly 40% of diagnoses attributed to MSM (44).
- New HIV diagnoses were highest in non-Hispanic Black people (37.3 per 100,000), followed by Hispanic (16.7), non-Hispanic Native Hawaiian or Other Pacific Islander (11.1), non-Hispanic American Indian or Alaska Native (8.6), non-Hispanic White (4.6), and non-Hispanic Asian (3.9) people in 2019 (Figure 3).

STDs

STD rates have increased, some to their highest levels ever.

- New cases of **chlamydia** were 16% higher in 2019 (552.8 per 100,000 people) than in 2015 (475.0). New cases of **gonorrhea** were 53% higher (188.4 compared with 123.0), and new cases of **syphilis** were 71% higher (39.7 compared with 23.2) in 2019 than in 2015 (Table IDNotif [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-IDNotif>]).
- About 30% of all cases of chlamydia, gonorrhea, and primary and secondary syphilis were in non-Hispanic Black people in 2019. In 2019, MSM accounted for more than one-half of primary and secondary syphilis infections in males (43).

Health Insurance and Access by Race and Ethnicity

Racial and ethnic disparities in receipt of needed medical care persist despite improvements in health insurance coverage

Health insurance coverage

Hispanic people were at least twice as likely as other racial and ethnic groups to lack health insurance in 2019.

- The percentage of people under age 65 who were **uninsured** decreased from 17.5% in 2009 to 11.0% in 2018 (Figure 4). In 2019, 12.0% of people under age 65 were uninsured.
- The percentage of people under age 65 who were uninsured decreased for all racial and ethnic groups from 2009 to 2018. However, in 2019, Hispanic people continued to be more likely to be uninsured (22.5%) than non-Hispanic Black (11.2%), non-Hispanic White (8.8%), and non-Hispanic Asian (6.2%) people (Figure 4).

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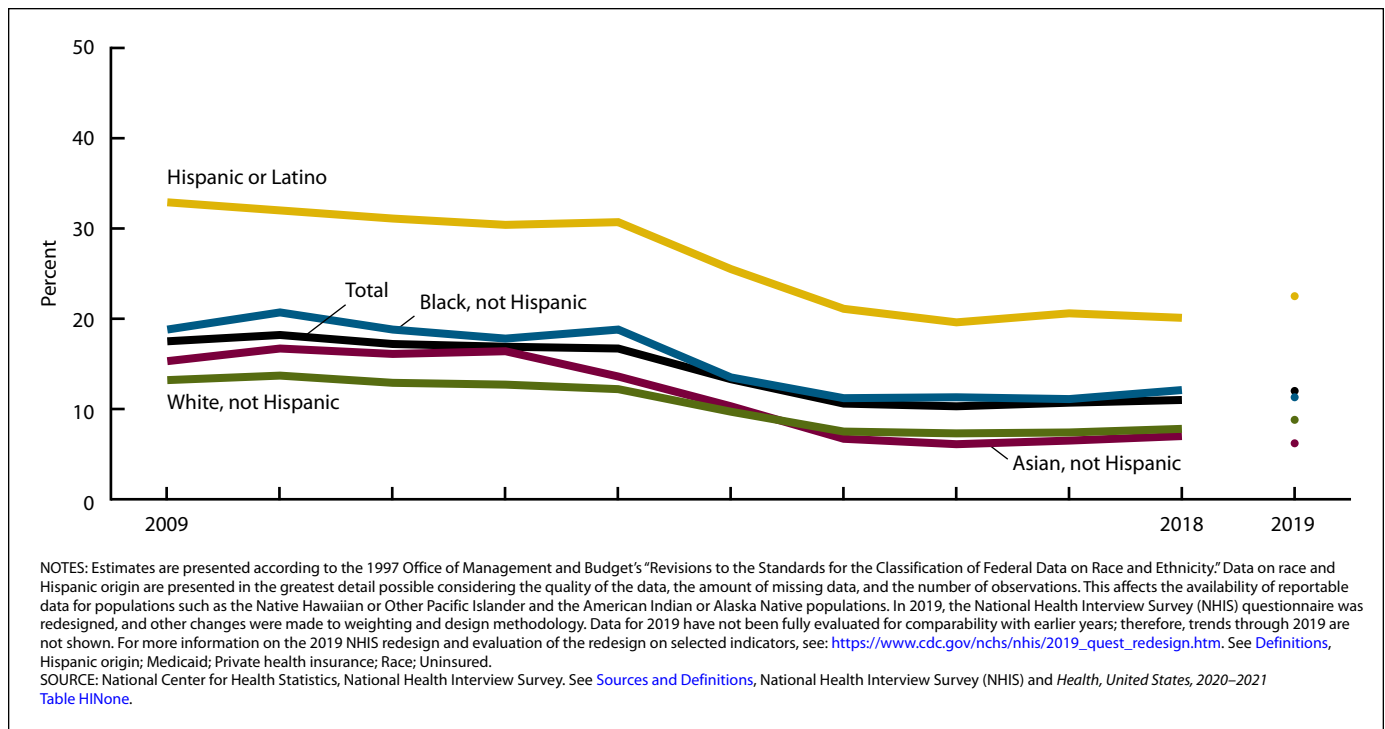
Background

Some racial and ethnic minority groups may have more difficulty finding affordable health care than non-Hispanic White people (45–47). Health insurance improves access but does not guarantee affordability or receipt of needed medical care. Experiences with discrimination, lack of culturally and linguistically appropriate services, and limited provider availability may affect access to care (47–52).

Select findings

From 2009 to 2018, unmet need for medical care due to cost generally decreased for all racial and ethnic groups, while health insurance coverage increased. In 2019, Hispanic adults were the most likely to lack insurance and have unmet need for medical care.

Figure 4. Lack of health insurance coverage among people under age 65, by race and Hispanic origin: United States, 2009–2019



Unmet need for health care

Adults without insurance were more likely to have unmet need for medical care and prescription drugs due to cost in 2019.

- In 2019, adults aged 18–64 without insurance (36.3%) were more than three times as likely as those with Medicaid (10.3%) and five times as likely as those with private health insurance (7.3%) to **delay or not receive needed medical care due to cost** (Table UnmtNd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-UnmtNd>]).
- Adults aged 18–64 without insurance (18.3%) were twice as likely as those with Medicaid (9.3%) and more than three times as likely as those with private health insurance (4.9%) to **not receive needed prescription drugs due to cost** in 2019 (Table UnmtNd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-UnmtNd>]).

Hispanic and non-Hispanic Black adults experienced higher unmet need for medical care due to cost than non-Hispanic White adults in 2019.

- Hispanic (15.6%) and non-Hispanic Black (14.4%) adults aged 18–64 delayed or did not receive needed medical care due to cost more often than non-Hispanic White adults (11.2%) in 2019 (Table UnmtNd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-UnmtNd>]).
- Nonreceipt of needed prescription drugs due to cost was higher in non-Hispanic Black adults aged 18–64 (10.3%) than in Hispanic (8.2%) and non-Hispanic White (7.4%) adults in 2019 (Table UnmtNd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-UnmtNd>]).

Hospital Use by Health Insurance Coverage

People with Medicaid are hospitalized more than privately insured or uninsured people

Hospitalization

People with Medicaid were twice as likely as those who were privately insured or uninsured to have a hospital stay in the previous year.

- In 2019, over 34 million **admissions to community hospitals** were recorded, 4.1% lower than in 2009 ([Table HospAdmis](https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HospAdmis) [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HospAdmis>]).
- Among people aged 1–64 who are privately insured, having a **hospital stay** in the past year decreased from 4.9% in 2009 to 4.2% in 2014, and then was stable through 2018. Among those with Medicaid, the percentage hospitalized decreased from 14.5% in 2009 to 9.3% in 2016, and then was stable through 2018. For those who were uninsured, the percentage was stable from 2009 to 2018 (3.7%) ([Figure 5](#), age-adjusted estimates).
- In 2019, having a hospital stay in the past year among people aged 1–64 was twice as likely for those with Medicaid (10.8%) as those who were privately insured

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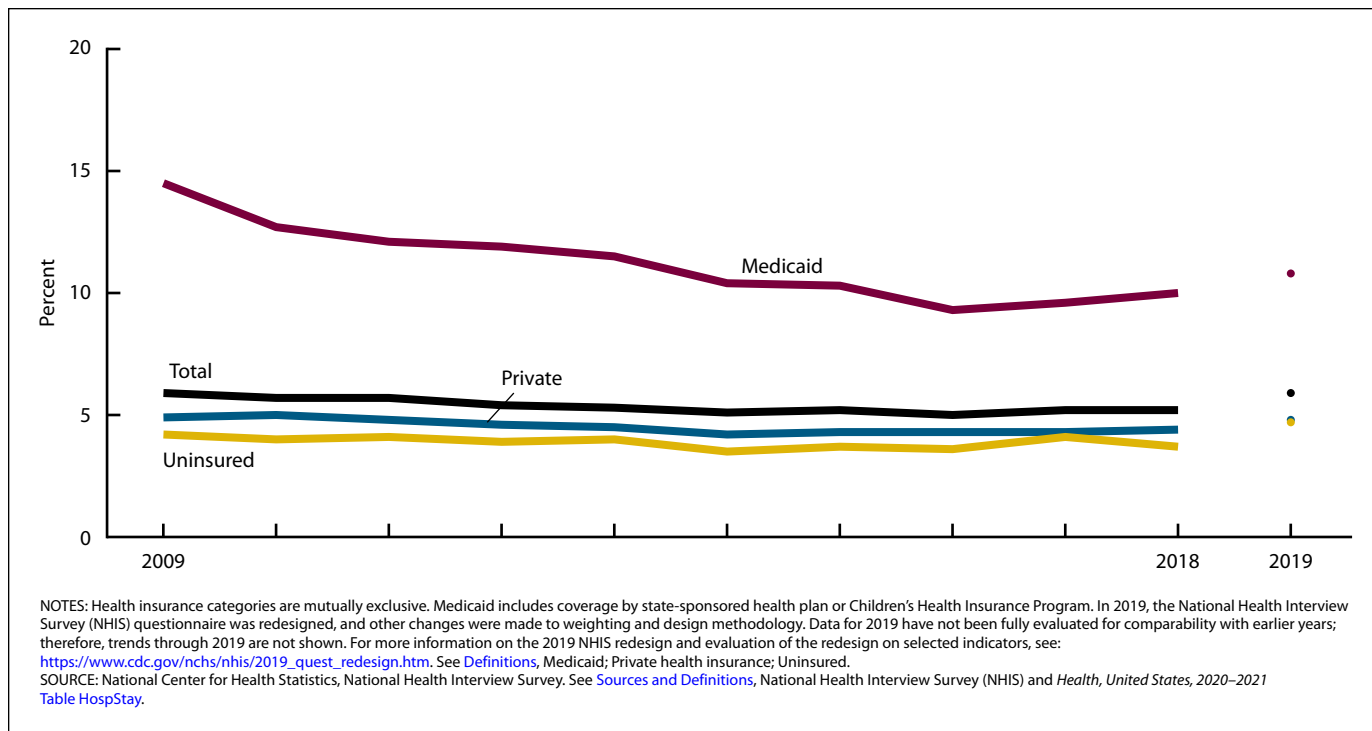
Background

Hospital use differs by health insurance coverage (53). Inpatient hospitalization is one of the most expensive settings for clinical care (54). People with inadequate insurance and high out-of-pocket healthcare costs may be less likely to obtain needed care. Foregoing care can lead to more serious health problems, emergency care, and hospital admission (55). Difficulty finding providers with convenient locations and hours and family obligations also impact healthcare utilization (47,48,56).

Select findings

People with Medicaid continue to be more likely than those with private or no insurance to have a hospital stay or emergency department visit in the past year.

Figure 5. People aged 1–64 with at least one hospital stay in the past year, by health insurance status: United States, 2009–2019



(4.8%) or uninsured (4.7%) (Figure 5, age-adjusted estimates).

- **Hospital care expenditures** were higher in 2019 (\$1,192 billion, current dollars) than in 2009 (\$771 billion, current dollars). In 2019, 36.8% of hospital care expenditures were paid by private health insurance, 26.5% by Medicare, and 17.3% by Medicaid (Table HExpPers [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HExpPers>]).

Emergency department visits

Emergency department use among adults with Medicaid decreased from 2009 to 2018.

- Adults aged 18–64 with Medicaid who had at least one **emergency department visit within the past 12 months** decreased from 2009 (41.5%) to 2018 (37.0%). In privately insured and uninsured adults, visiting an emergency department decreased through 2013 and 2014, respectively, and then increased through 2018 (Table EdAd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-EDAd>], age-adjusted estimates).
- In 2019, adults aged 18–64 with Medicaid (37.7%) were most likely to have visited an emergency department within the past 12 months, followed by uninsured (22.1%) and privately insured (16.5%) adults (Table EdAd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-EDAd>], age-adjusted estimates).
- In 2019, children under age 18 years with Medicaid (25.0%) were more likely to have visited an emergency department within the past 12 months than uninsured (15.4%) or privately insured (13.5%) children (Table EdCh [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-EDCh>]).
- The total annual number of **emergency department visits** was about 130 million in 2018 (Table HCareVis [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HCareVis>]).

Oral Health by Poverty Level

Dental care use and dentist supply increased, but adults with lower incomes least likely to get needed dental care

Dentists and dental expenditures

The proportion of out-of-pocket spending is five times as large for dental care as physician and clinical care.

- In 2019, out-of-pocket spending accounted for 41.9% of **dental services expenditures** compared with 7.9% of physician and clinical expenditures ([Table HExpPers](https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HExpPers) [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HExpPers>]).
- The national supply of **dentists** was higher in 2020 (61.04 per 100,000 residents) than in 2010 (59.34) ([Table DentSt](https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-DentSt) [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-DentSt>]). However, the supply of dentists was not evenly distributed, with the lowest in Arkansas (40.85), Alabama (41.27), and Mississippi (42.84) and the highest in Washington, D.C. (103.95), Massachusetts (84.22), and Alaska (80.01).

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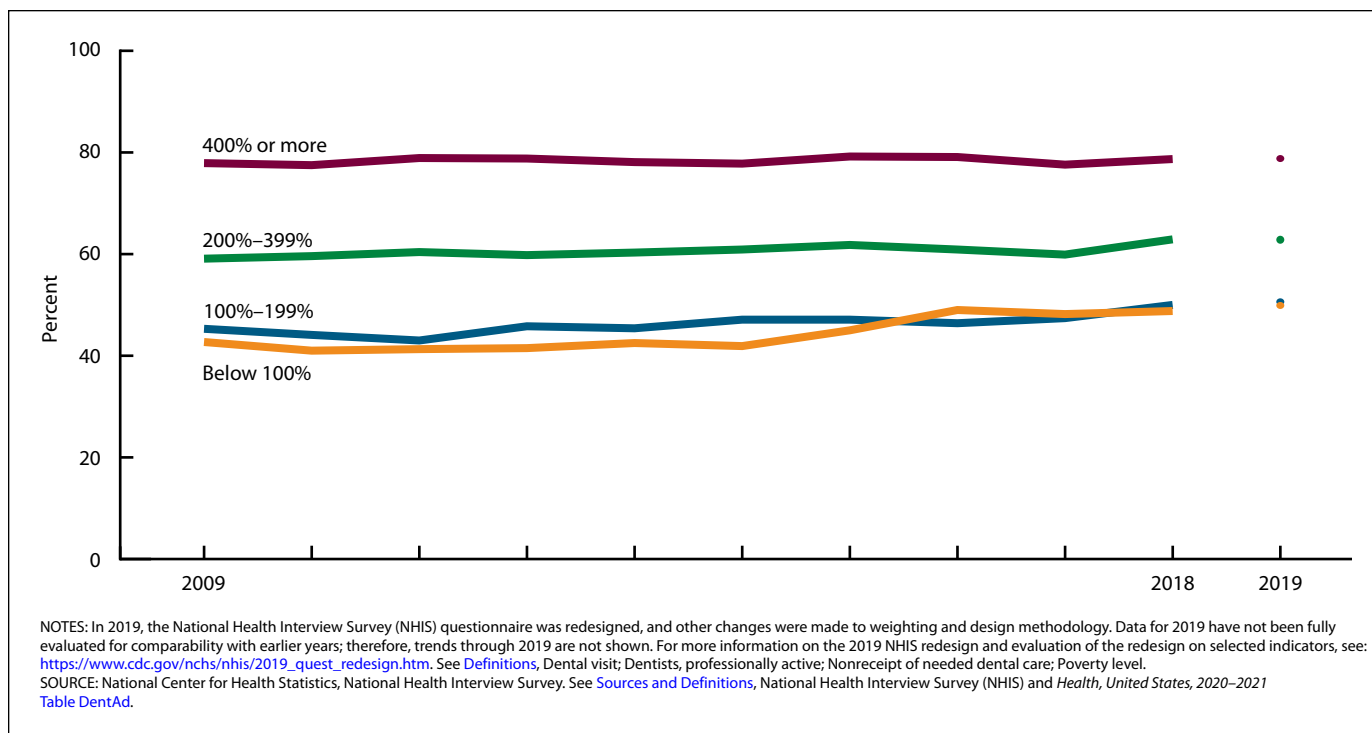
Background

People with lower incomes are less likely to receive needed dental care (57,58). Many oral diseases are preventable or treatable, but disparities persist in access to oral health care and outcomes (57). Cost is the primary barrier to obtaining dental care, even for people with dental insurance coverage (58). Insufficient supply of dentists and provider participation in public insurance programs may affect the availability of dental care services (57,58).

Select findings

Despite increases in the supply of dentists, adults living below 200% of the federal poverty level (FPL) were least likely to have seen a dentist in the past year in 2019.

Figure 6. Dental visits in the past year among adults aged 18–64, by percentage of federal poverty level: United States, 2009–2019



Use of dental care

Adults living below 200% of FPL were least likely to have a recent dental visit in 2019.

- The percentage of adults aged 18–64 living below 100% of FPL who had a **dental visit** in the past year was stable from 2009 to 2013 and then increased from 2013 (42.5%) to 2018 (48.8%) (Figure 6).
- From 2009 to 2018, the percentage of adults aged 18–64 with a dental visit in the past year increased for those living at 100%–199% of FPL (from 45.3% to 50.0%) and at 200%–399% of FPL (from 59.1% to 62.9%). During the period, the percentage was stable for adults living at 400% or more of FPL (78.7% in 2018) (Figure 6).
- In 2019, adults living at 400% or more of FPL were most likely to have visited a dentist in the past year (78.8%), followed by adults living at 200%–399% of FPL (62.8%). Adults living at 100%–199% of FPL (50.6%) and below 100% of FPL (49.8%) were the least likely to have visited a dentist in the past year (Figure 6).

Adults living below 200% of FPL were most likely to have unmet need for dental care due to cost in 2019.

- Adults aged 18–64 who **did not receive needed dental care due to cost** decreased from 2009 (16.8%) to 2016 (11.0%) and then increased through 2018 (12.2%) (Table UnmtNd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-UnmtNd>]).
- In 2019, the percentage of adults who did not receive needed dental care due to cost was highest in adults living below 100% of FPL (30.7%) and at 100%–199% of FPL (30.6%) and lowest in adults at 400% or more of FPL (8.2%) (Table UnmtNd [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-UnmtNd>]).

Substance Use by Education Level

Cigarette smoking is highest in adults with lower education levels; vapes are the most popular tobacco product in adolescents

Tobacco use

Adults with no high school diploma or high school equivalency diploma (GED) were over four times as likely to smoke cigarettes as those with a bachelor's degree or higher in 2019.

- From 2009 to 2018, **cigarette smoking** in adults aged 25 and over decreased from 20.4% to 14.8% overall and decreased in all education levels (Figure 7). Throughout the period, people with more education were less likely to smoke.
- In 2019, the prevalence of smoking in adults aged 25 and over was 15.1% (Figure 7).
- In 2019, adults with lower levels of education (23.9% of adults with no high school diploma or GED; 22.0% of adults with a high school diploma or GED) were more likely to smoke than those with higher levels of education (16.3% of adults with some college; 5.8% of adults with a bachelor's degree or higher) (Figure 7).

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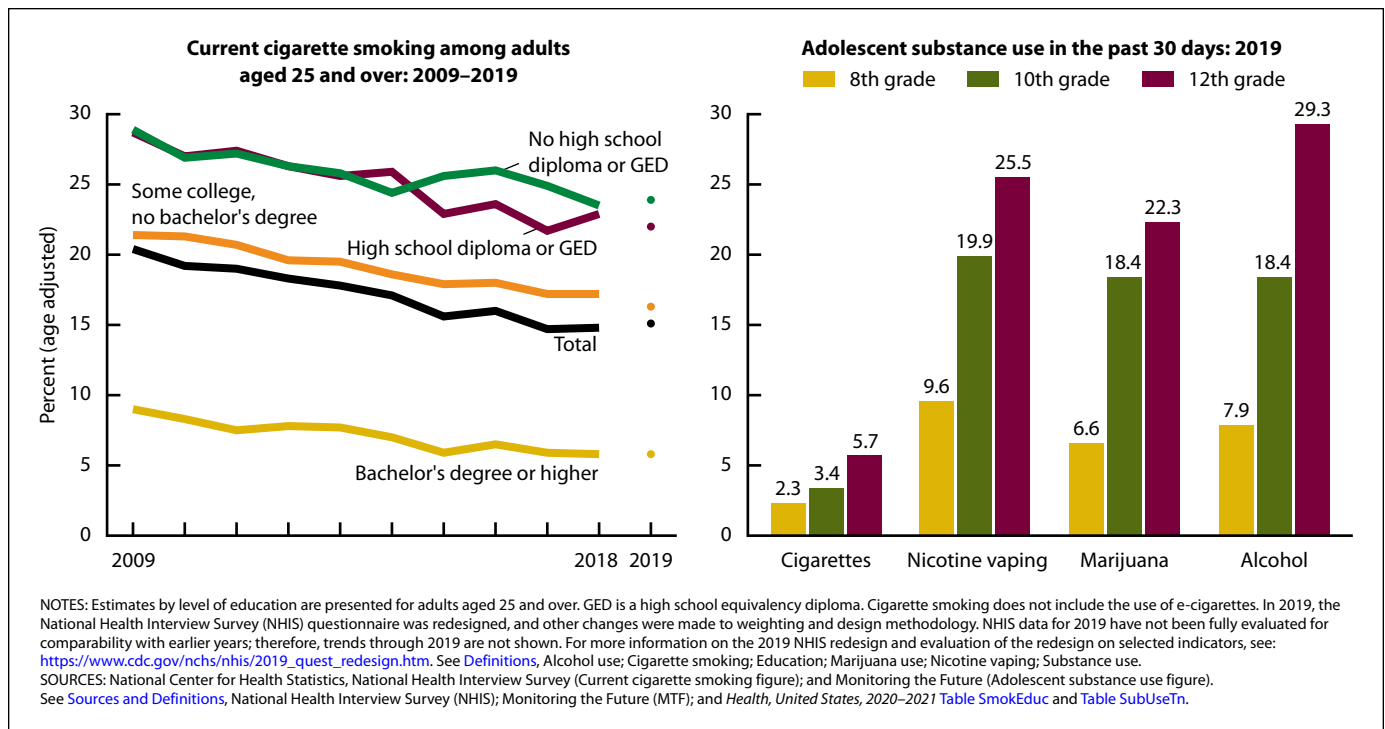
Background

Use of tobacco and other substances can vary by age and education level (31,59–61). Tobacco use—the leading cause of preventable disease, disability, and death (62,63)—is higher in adults with a lower socioeconomic status (31,59,60). While the percentage of adolescents who have ever smoked cigarettes decreased by one-half in the past 2 decades, the use of electronic cigarettes (or vapes) has increased sharply (64,65).

Select findings

In adults, cigarette smoking was highest in those with the lowest education levels. In adolescents, recent use of cigarettes, nicotine vapes, marijuana, and alcohol was higher among 12th graders compared with 8th and 10th graders.

Figure 7. Cigarette smoking among adults aged 25 and over, by education level and use of selected substances in the past 30 days among 8th, 10th, and 12th graders: United States, 2009–2019



- In 2019, **nicotine vapes** were the most used tobacco product in the past 30 days by 8th, 10th, and 12th graders. Prevalence of nicotine vape use increased with grade level (Figure 7).
- Compared with cigarette smoking in the past 30 days, 8th graders were four times as likely to vape nicotine (9.6% compared with 2.3%); 10th graders were nearly six times as likely to vape nicotine (19.9% compared with 3.4%); and 12th graders were four and one-half times as likely to vape nicotine (25.5% compared with 5.7%) (Figure 7).

Marijuana and alcohol use

Recent marijuana use doubled in adults aged 26 and over from 2009 to 2019.

- Marijuana use in the past 30 days was higher in 2019 than in 2009 for adults aged 18–25 (23.0% compared with 18.2%), 26–34 (19.0% compared with 9.6%), and 35 and over (8.2% compared with 3.4%) (Table SubUse [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SubUse>]).

Recent marijuana and alcohol use was more than three times as high in 12th graders as in 8th graders in 2019.

- In 2019, 6.6% of 8th graders, 18.4% of 10th graders, and 22.3% of 12th graders used marijuana in the past 30 days (Figure 7).
- In 2019, **alcohol use** in the past 30 days was 7.9% for 8th graders, 18.4% for 10th graders, and 29.3% for 12th graders. Alcohol was the most used substance in the past 30 days by 12th graders (Figure 7).

Risk Factors and Mortality by Sex

Males die younger, have higher substance use, and fewer healthcare visits

Mortality

Males were more likely than females to die from all causes and the five leading causes of death.

- While **all-cause mortality** decreased from 2009 to 2019, it remained one and four-tenths times as high in males as females (846.7 per 100,000 in males compared with 602.7 in females in 2019) (Table SlctMort [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SlctMort>], age-adjusted estimates). In 2019, this difference was largest in those aged 15–24 (two and six-tenths times as high) and 25–34 (two and two-tenths times as high) (66,67).
- For the **five leading causes of death**—heart disease, cancer, unintentional injuries, chronic lower respiratory diseases, and cerebrovascular diseases—death rates were higher in males than females in 2019 (Table LCOdRace [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-LCOdRace>]; Table SlctMort [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SlctMort>]).

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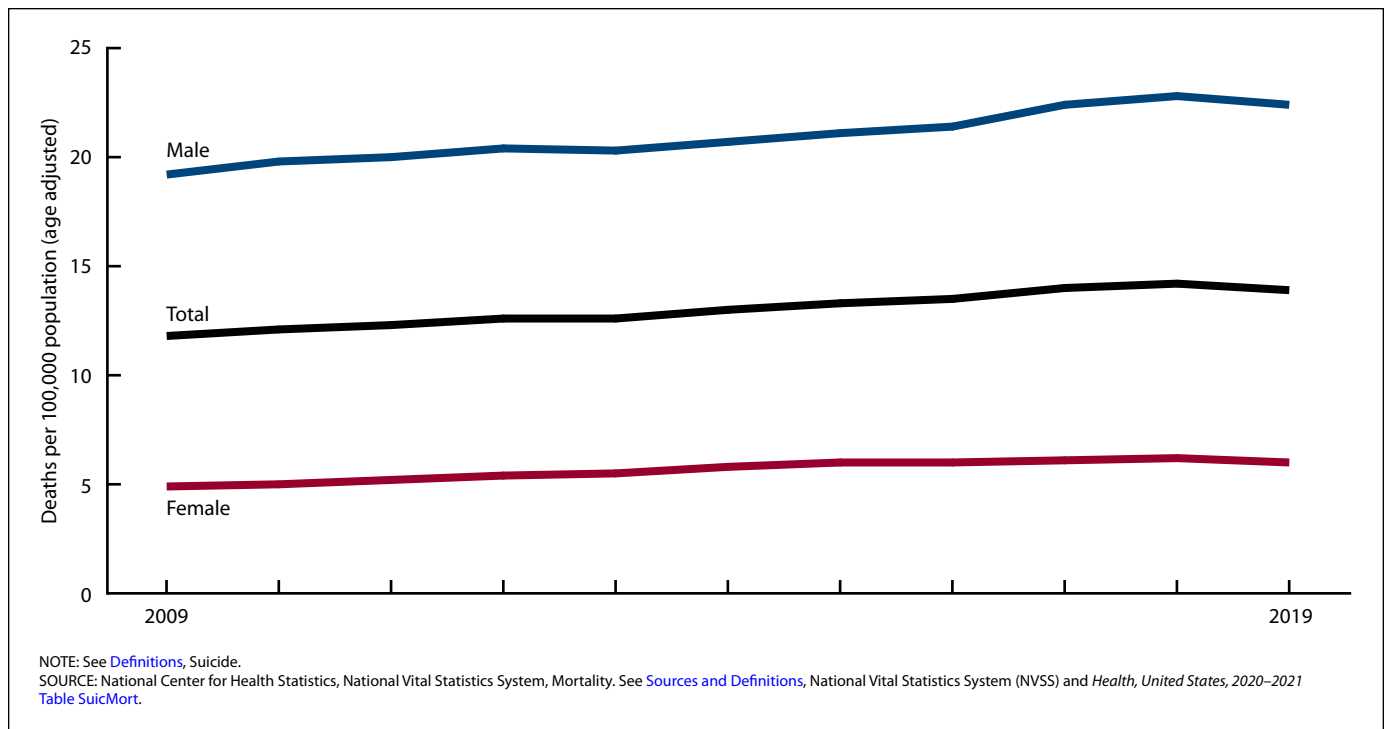
Background

Males have higher mortality and lower life expectancy than females (6). Males are more likely to engage in risky behavior, such as substance use (59), and less likely to take preventive health measures, such as wearing seatbelts (68). Substance use is related to injury deaths (69–72). Men are less likely to use healthcare services (73,74), which may affect their receipt of preventive and curative care.

Select findings

Males have higher substance use and lower use of health care than females. Despite a decrease in deaths for males and females, males continue to die at younger ages than females.

Figure 8. Suicide rates, by sex: United States, 2009–2019



Compared with females, males died three times as often from suicide and four times as often from homicide.

- The age-adjusted **suicide** rate increased from 2009 (11.8 per 100,000) to 2019 (13.9); however, the rate in 2019 was lower than the rate in 2018 (14.2). During this time, males remained three to four times as likely as females to die from suicide (22.4 per 100,000 compared with 6.0 in females in 2019) (Figure 8).
- Males (9.6 per 100,000) were four times as likely to die from **homicide** as females (2.4) in 2019 (Table SlctMort [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SlctMort>], age-adjusted estimates).
- In 2019, males (29.6 per 100,000) were more than two times as likely as females (13.7) to **die from a drug overdose**—a leading cause of injury death. This difference was greatest in those aged 25–34 (49.7 in males compared with 21.1 in females) (Table ODMort [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-ODMort>], age-adjusted estimates).

Substance use

More males than females reported current use of tobacco, drugs, and alcohol.

- In 2019, fewer adults **smoked cigarettes** than in the past several decades, but prevalence remained higher among men (15.5%) than women (13.0%) (Table SmokSex [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SmokSex>], age-adjusted estimates).
- Among 12th graders, cigarette smoking in the past 30 days was higher among males (6.9%) than females (4.0%) in 2019 (Table SubUseTn [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SubUseTn>]).
- **Nicotine vaping** has increased in recent years (75). In 2019, nicotine vaping in the past 30 days was more common among 12th grade males (28.1%) than females (22.9%) (Table SubUseTn [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SubUseTn>]).
- **Illicit drug use** in the past 30 days among people aged 12 and over was about one and one-half times as high among males as females from 2015 to 2019 (15.5% for males compared with 10.7% of females in 2019) (Table SubUse [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SubUse>]).
- From 2015 to 2019, males were twice as likely as females to engage in **heavy alcohol use** in the past 30 days (7.6% of males compared with 4.2% of females in 2019) (Table SubUse [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-SubUse>]).

Healthcare utilization

Fewer trips to physicians and emergency departments were made by young men than young women.

- In 2019, men (73.6%) were less likely than women (83.9%) to have had a wellness visit in the past 12 months (76).
- Fewer **visits to physicians** were made by males (224 visits per 100 males) than females (308 visits per 100 females) in 2018. This difference was largest in adults aged 18–44 (103 visits per 100 men compared with 243 visits per 100 women) (Table HCareVis [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HCareVis>]).
- Fewer **visits to hospital emergency departments** were made by men (33 visits per 100 men) than women (49 visits per 100 women) in adults aged 18–44 in 2018 (Table HCareVis [<https://www.cdc.gov/nchs/hus/contents2020-2021.htm#Table-HCareVis>]).

Definitions

Alcohol use—Based on whether respondents consumed alcohol ("more than just a few sips") in the past 30 days. See Sources and Definitions, Alcohol consumption (<https://www.cdc.gov/nchs/hus/sources-definitions/alcohol-consumption.htm>).

Average saturated fat consumption—Average saturated fat intake as a percentage of total energy intake (kilocalories) from all foods and beverages consumed during the previous 24-hour period.

Binge drinking—Defined as drinking five or more drinks for men or four or more drinks for women on the same occasion at least 1 day in the past 30 days. Occasion is defined as at the same time or within a couple of hours of each other. See Sources and Definitions, Alcohol consumption (<https://www.cdc.gov/nchs/hus/sources-definitions/alcohol-consumption.htm>); Binge alcohol use (<https://www.cdc.gov/nchs/hus/sources-definitions/binge-alcohol-use.htm>); Heavy alcohol use (<https://www.cdc.gov/nchs/hus/sources-definitions/heavy-alcohol-use.htm>).

Cancer deaths—Identified using *International Classification of Diseases, 10th Revision* (ICD-10) underlying cause-of-death codes C00–C97. See Sources and Definitions, Cause of death (<https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death.htm>); *International Classification of Diseases* (ICD) (<https://www.cdc.gov/nchs/hus/sources-definitions/icd.htm>).

Cigarette smoking—For adults, defined as ever smoking 100 cigarettes in one's lifetime and smoking now every day or some days. For adolescents, defined as having smoked cigarettes in the past 30 days. Cigarette smoking does not include the use of e-cigarettes. See Sources and Definitions, Cigarette smoking (<https://www.cdc.gov/nchs/hus/sources-definitions/cigarette-smoking.htm>); Tobacco use (<https://www.cdc.gov/nchs/hus/sources-definitions/tobacco-use.htm>).

Dental visit—For 2019 data, respondents were asked how long it had been since they or their child last had a dental examination or cleaning. For data before 2019, respondents were asked how long it had been since they or their child last saw or talked to a dentist. See Sources and Definitions, Dental visit (<https://www.cdc.gov/nchs/hus/sources-definitions/dental-visit.htm>).

Dentists, professionally active—Data are presented for dentists in private practice; dental school (student, faculty, or staff member); armed forces or other federal services; state or local government; hospital; graduate school (student, intern, or resident); or other health or dental organization. Dentists who are not licensed or are retired are excluded. See Sources and Definitions, American Dental Association (ADA) (<https://www.cdc.gov/nchs/hus/sources-definitions/ada.htm>).

Drug overdose death—Identified using *International Classification of Diseases, 10th Revision* (ICD-10) underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths include all manners and intents, including unintentional, suicide, homicide, and undetermined intent. See Sources and Definitions, Cause of death (<https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death.htm>); *International Classification of Diseases* (ICD) (<https://www.cdc.gov/nchs/hus/sources-definitions/icd.htm>).

Education—Defined by the highest level of school a person has completed or the highest degree received. Estimates by level of education are presented for adults aged 25 and over. See Sources and Definitions, Education (<https://www.cdc.gov/nchs/hus/sources-definitions/education.htm>).

Heart disease deaths—Identified using *International Classification of Diseases, 10th Revision* (ICD-10) underlying cause-of-death codes I00–I09, I11, I13, and I20–I51. See Sources and Definitions, Cause of death (<https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death.htm>); *International Classification of Diseases* (ICD) (<https://www.cdc.gov/nchs/hus/sources-definitions/icd.htm>).

Heart disease prevalence—Based on questions about whether respondents had ever been told by a doctor or other health professional that they had coronary heart disease, angina (angina pectoris), or a heart attack (myocardial infarction). See Sources and Definitions, Heart disease (<https://www.cdc.gov/nchs/hus/sources-definitions/heart-disease.htm>).

Heavy alcohol use—Defined as binge drinking (drinking five or more drinks on the same occasion for men or four or more drinks for women) on 5 or more days in the past 30 days. See Sources and Definitions, Alcohol consumption (<https://www.cdc.gov/nchs/hus/sources-definitions/alcohol-consumption.htm>); Binge alcohol use (<https://www.cdc.gov/nchs/hus/sources-definitions/binge-alcohol-use.htm>); Heavy alcohol use (<https://www.cdc.gov/nchs/hus/sources-definitions/heavy-alcohol-use.htm>).

Hispanic origin—Hispanic or Latino origin includes people of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, and other or unknown Latin American or Spanish origin. People of Hispanic origin may be of any race. See Sources and Definitions, Hispanic origin (<https://www.cdc.gov/nchs/hus/sources-definitions/hispanic-origin.htm>).

History of cancer—Based on a question about whether respondents had ever been told by a doctor or other health professional that they had cancer or a malignancy of any kind. Data exclude squamous cell and basal cell carcinomas. See Sources and Definitions, Cancer (<https://www.cdc.gov/nchs/hus/sources-definitions/cancer.htm>).

Homicide—Identified using *International Classification of Diseases, 10th Revision* (ICD–10) underlying cause-of-death codes *U01–*U02, X85–Y09, Y87.1. See Sources and Definitions, Cause of death (<https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death.htm>); *International Classification of Diseases* (ICD) (<https://www.cdc.gov/nchs/hus/sources-definitions/icd.htm>).

Hospital stays—Based on a question about whether respondents had any overnight hospital stays in the past year, excluding overnight stays in the emergency room. See Sources and Definitions, Hospital utilization (<https://www.cdc.gov/nchs/hus/sources-definitions/hospital-utilization.htm>).

Human immunodeficiency virus (HIV) infection—A virus that attacks the body’s immune system. A surveillance case for HIV requires two positive tests. See Sources and Definitions, Human immunodeficiency virus (HIV) disease (<https://www.cdc.gov/nchs/hus/sources-definitions/hiv-disease.htm>).

Illicit drug use—Includes marijuana, cocaine (including crack), heroin, hallucinogens (including LSD, PCP, peyote, mescaline, psilocybin mushrooms, Ecstasy [MDMA or Molly], ketamine, DMT/AMT/Foxy, and Salvia divinorum), and misuse of prescription psychotherapeutic drugs (including pain relievers, tranquilizers, stimulants, and sedatives). See Sources and Definitions, Illicit drug use (<https://www.cdc.gov/nchs/hus/sources-definitions/illicit-drug-use.htm>); Substance use (<https://www.cdc.gov/nchs/hus/sources-definitions/substance-use.htm>).

Leading causes of death—Ranked according to the number of deaths assigned to selected causes of death of public health and medical importance. See Sources and Definitions, Cause-of-death ranking (<https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death-ranking.htm>).

Mammogram—Defined as the percentage of women aged 40 and over who had a mammogram within the past 2 years. Survey questions have changed over time. See Sources and Definitions, Mammography (<https://www.cdc.gov/nchs/hus/sources-definitions/mammography.htm>).

Marijuana use—Based on whether respondents reported using marijuana in the past 30 days. See Sources and Definitions, Illicit drug use (<https://www.cdc.gov/nchs/hus/sources-definitions/illicit-drug-use.htm>).

Medicaid—Includes people with Medicaid, a state-sponsored health plan, or the Children’s Health Insurance Program. See Sources and Definitions, Health insurance coverage (<https://www.cdc.gov/nchs/hus/sources-definitions/health-insurance-coverage.htm>); Medicaid (<https://www.cdc.gov/nchs/hus/sources-definitions/medicaid.htm>).

Nicotine vaping—Defined as ever using a device such as a JUUL, vape-pen, e-cigarette, e-hookah, or e-vaporizer to inhale an aerosol containing nicotine into the lungs at least once in the past 30 days. See Sources and Definitions,

Tobacco use (<https://www.cdc.gov/nchs/hus/sources-definitions/tobacco-use.htm>).

Nonreceipt of needed dental care—Based on questions about whether there was any time during the past 12 months when the respondent needed dental care but did not get it because of the cost. Estimates are for people aged 2 years and over. See Sources and Definitions, Unmet need (<https://www.cdc.gov/nchs/hus/sources-definitions/unmet-need.htm>).

Nonreceipt or delay of needed medical care—Based on questions about whether there was any time during the past 12 months when the respondent needed medical care but delayed or did not get it because of the cost. See Sources and Definitions, Unmet need (<https://www.cdc.gov/nchs/hus/sources-definitions/unmet-need.htm>).

Nonreceipt or delay of needed prescription drugs—Based on questions about whether there was any time during the past 12 months when the respondent needed prescription drugs but did not get them because of the cost. See Sources and Definitions, Unmet need (<https://www.cdc.gov/nchs/hus/sources-definitions/unmet-need.htm>).

Personal healthcare expenditures—Outlays for goods and services relating directly to patient care. See Sources and Definitions, Health expenditures, national (<https://www.cdc.gov/nchs/hus/sources-definitions/health-expenditures.htm>).

Physician visits—Defined as visit with a physician or healthcare provider in a physician’s ambulatory practice (office). Offices in health maintenance organizations and private offices in hospitals are included. Offices in hospitals, nursing homes, other extended-care facilities, patients’ homes, industrial clinics, college clinics, or family planning clinics are excluded. See Sources and Definitions, Office visit (<https://www.cdc.gov/nchs/hus/sources-definitions/office-visit.htm>).

Poverty level—Based on family income, size, and composition using U.S. Census Bureau poverty thresholds. Missing family income data are imputed. See Sources and Definitions, Family income (<https://www.cdc.gov/nchs/hus/sources-definitions/family-income.htm>); Poverty (<https://www.cdc.gov/nchs/hus/sources-definitions/poverty.htm>).

Private health insurance—Includes insurance obtained through a workplace, union, professional association, or individual purchase. Also includes adult children covered by their parents’ private insurance. See Sources and Definitions, Health insurance coverage (<https://www.cdc.gov/nchs/hus/sources-definitions/health-insurance-coverage.htm>).

Race—Estimates are presented according to the 1997 Office of Management and Budget’s (OMB) “Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity,” which include the following race groups—American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander;

and White. These 1997 standards separated the Asian or Pacific Islander classification into two groups, Asian and Native Hawaiian or Other Pacific Islander. See Sources and Definitions, Hispanic origin (<https://www.cdc.gov/nchs/hus/sources-definitions/hispanic-origin.htm>); Race (<https://www.cdc.gov/nchs/hus/sources-definitions/race.htm>).

Substance use—Defined by the use of selected substances, including marijuana, inhalants, other illegal drugs, alcohol, and tobacco products, in the past 30 days. See Sources and Definitions, Alcohol consumption (<https://www.cdc.gov/nchs/hus/sources-definitions/alcohol-consumption.htm>); Illicit drug use (<https://www.cdc.gov/nchs/hus/sources-definitions/illicit-drug-use.htm>); Tobacco use (<https://www.cdc.gov/nchs/hus/sources-definitions/tobacco-use.htm>).

Suicide—Identified using *International Classification of Diseases, 10th Revision* (ICD–10) underlying cause-of-death codes *U03, X60–X84, and Y87.0. See Sources and Definitions, Cause of death (<https://www.cdc.gov/nchs/hus/sources-definitions/cause-of-death.htm>); *International Classification of Diseases* (ICD) (<https://www.cdc.gov/nchs/hus/sources-definitions/icd.htm>).

Uninsured—Excludes people covered by private health insurance, Medicaid, Children’s Health Insurance Program, state-sponsored or other government-sponsored health plans, Medicare, or military plans. People with only Indian Health Service coverage are considered to be uninsured. See Sources and Definitions, Health insurance coverage (<https://www.cdc.gov/nchs/hus/sources-definitions/health-insurance-coverage.htm>); Uninsured (<https://www.cdc.gov/nchs/hus/sources-definitions/uninsured.htm>).

Technical Notes

Data in the *Health, United States, 2020–2021: Annual Perspective* come from many surveys and data systems and cover a broad range of years. For topics of public health interest, some analyses present estimates for a recent data year, while others present trends over 10 years. Due to comparability issues in survey questions or definitions over time, shorter trends are presented for some measures. Estimates and standard errors (where applicable) for the data presented can be found in the Trend Tables (<https://www.cdc.gov/nchs/hus/data-finder.htm>).

The National Health Interview Survey (NHIS), used for several measures in this report, was redesigned in 2019. The comparability of 2019 data with earlier years has not been fully evaluated. Therefore, these data have been shown with a break in the trend between 2018 and 2019. See Sources and Definitions, National Health Interview Survey (NHIS) (<https://www.cdc.gov/nchs/hus/sources-definitions/nhis.htm>).

Age—Some measures are shown for people by age group because of the strong effect of age on most health outcomes. In other cases, age-adjusted measures are shown to account for the effect of differences in the age structure of the population over time or across groups (77). Adjustment of estimates and rates is noted in the text; see Trend Tables (<https://www.cdc.gov/nchs/hus/data-finder.htm>) for more adjustment information. See Sources and Definitions, Age adjustment (<https://www.cdc.gov/nchs/hus/sources-definitions/age-adjustment.htm>).

Race and ethnicity—In 1997, the Office of Management and Budget (OMB) issued “Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity,” which recommend six categories: non-Hispanic American Indian or Alaska Native; non-Hispanic Asian; non-Hispanic Black or African American; non-Hispanic Native Hawaiian or Other Pacific Islander; non-Hispanic White; and Hispanic or Latino. Data for most NCHS surveys and outside data sources by race and ethnicity are categorized based on the 1997 standards.

The National Vital Statistics System (NVSS) transitioned over time to the 2003 revisions of the U.S. Standard Certificates of Live Birth and Death, which contained the 1997 standards. The revisions were not adopted by all states until 2016 for births and 2018 for deaths. To allow for analysis of longer trends, selected figures using vital statistics data may include the combined non-Hispanic Asian or Pacific Islander group, which was the category in the prior OMB standards. See Sources and Definitions, National Vital Statistics System (NVSS) (<https://www.cdc.gov/nchs/hus/sources-definitions/nvss.htm>).

Data on race and ethnicity are presented in the greatest detail possible considering the quality of the data, the amount of missing data, and the number of observations. This affects the reportability of data for populations such as the Native Hawaiian or Other Pacific Islander and the American Indian or Alaska Native populations. Some

additional estimates by race and ethnicity that are not presented in this report may be found in the Trend Tables (<https://www.cdc.gov/nchs/hus/data-finder.htm>). See Sources and Definitions, Hispanic origin (<https://www.cdc.gov/nchs/hus/sources-definitions/hispanic-origin.htm>); Race (<https://www.cdc.gov/nchs/hus/sources-definitions/race.htm>).

Statistical testing, significance, and reliability—Statistical analyses in this report considered data source methodology, the type of dependent variable, and the number of data points. Analyses of trends were performed to detect an increase or decrease as well as a change in trend when sufficient data points were available. Trends were analyzed using the steps laid out in the NCHS Guidelines for Analysis of Trends (78).

Trends in NCHS survey data, including the National Health and Nutrition Examination Survey and NHIS, are based on record-level data. Trends in vital statistics data from NVSS use aggregated point estimates and their standard errors. The term “stable” indicates that the slope of the trend line was not significantly different from zero. Terms such as “increase” and “decrease” indicate a significant trend was found.

In addition to trend testing, comparisons are often made between estimates at two time points or for two populations. For data sources with standard errors, the difference between two data points was assessed for statistical significance using z tests at the 0.05 alpha level. For data sources with no standard errors, relative differences were assessed using the methods recommended by the data source. The terms “higher” or “highest” and “lower” or “lowest” indicate that the estimates were significantly different, while the terms “similar,” “no difference,” and “no change” indicate that the estimates were not significantly different.

Lack of comment does not necessarily indicate that trends or differences were tested and found to be not significant.

Data systems may have different standards for evaluating reliability. Generally, the reliability standards recommended by the data source are used. The NCHS reliability standards for proportions (79) are used for selected data sources and data years as noted in the text. See Sources and Definitions, Statistical reliability of estimates (<https://www.cdc.gov/nchs/hus/sources-definitions/statistical-reliability.htm>); Statistical significance (<https://www.cdc.gov/nchs/hus/sources-definitions/statistical-significance.htm>); Statistical testing (<https://www.cdc.gov/nchs/hus/sources-definitions/statistical-testing.htm>).

Detailed descriptions of the data sources, definitions, and methodology are provided in Sources and Definitions (<https://www.cdc.gov/nchs/hus/sources-definitions.htm>).

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