

Reaching America's Health Potential:
A State-by-State Look at Adult Health



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All State Profiles: www.commissiononhealth.org/statedata

Reaching America's Health Potential: *A State-by-State Look at Adult Health*

Everyone wants to be healthy. Yet too many Americans are not as healthy as they could be. In some states as many as half of all adults report that they are not in very good health. And as the data in this report show, there are dramatic gaps in health not only nationally but also within states.

Although reforming our nation's health system is urgently needed, there is far more to health than medical care. Access to affordable good-quality medical care is essential, but that alone will not make Americans healthy. Whether people get sick often has more to do with education, income and racial or ethnic group and with conditions in homes, schools, workplaces and neighborhoods where people spend their time.

For more than a year, the *Robert Wood Johnson Foundation Commission to Build a Healthier America* has explored how factors outside the medical care system influence health. Recognizing the fundamental role of conditions and experiences during childhood in shaping health throughout life, the Commission released a chartbook in October 2008, *Reaching America's Health Potential Starts with Healthy Children: A State-By-State Look*, which compares the health of children across social and economic groups nationally and in every state.

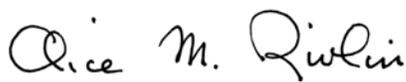
This companion chartbook, *Reaching America's Health Potential: A State-by-State Look at Adult Health*, follows a similar approach and illustrates similar conclusions: At every level of education and in every racial or ethnic group, Americans could be healthier. In almost every state, shortfalls in health are greatest among adults in the most disadvantaged groups, but even those typically considered middle class are less healthy than adults with greater advantages.

In April 2009, the Commission released recommendations urging policy-makers and stakeholders at all levels to take actions that would make it easier for Americans to choose health and be healthy. While each of us has responsibility to make healthy choices for ourselves and for our families, we don't all have the same resources and opportunities to make those choices. Income and education are two of the most critical resources that shape opportunities for improving health and reducing health disparities.

A nation's health is its most precious asset. And in these difficult economic times, it is more important than ever to ensure that all Americans are as healthy and productive as we can be. This chartbook documents the need for innovative and concerted efforts to reach our nation's health potential by addressing the conditions—where we live, learn, work and play—that are the foundation for building a healthier America.



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Executive Summary

Good health is essential for our well-being, for our ability to participate fully in society and for the economic productivity of our nation. Too many Americans, however, are not as healthy as they could be. Nationally and in almost every state, shortfalls in health are greatest among the most-disadvantaged adults, but even those considered middle class are less healthy than adults with greater social and economic advantages.

This chartbook—which is a companion piece to a chartbook on child health released in October 2008—provides state and national data on an important and widely-used measure of health: **self-reported adult health status**. These data illustrate a consistent and striking pattern of incremental improvements in health with increasing levels of educational attainment: As levels of education rise, health improves.

This report also compares the current state of adult health in the United States to a national benchmark—a level of good health that should be achievable for all Americans. This national adult health benchmark is set at the lowest rate of less than very good health observed in any state among the most-educated adults who also practiced healthy behaviors (i.e., college graduates who did not smoke and had recent leisure-time physical exercise). At the national level and across states, there are dramatic differences between this benchmark—a level of health that we know can be achieved—and levels of health among adults across education and racial or ethnic groups. Both nationally and in every state, even those in the most-advantaged groups could be healthier.

National health benchmark:

The level of good health that should be attainable for all adults in every state. For adult health status, the national benchmark used here—19.0 percent of adults who rated their own health as less than very good—was selected as the lowest (and best) statistically reliable rate of less than very good health observed in any state among the most-educated adults who practiced healthy behaviors (i.e., college graduates who did not smoke and had recent leisure-time physical exercise).

Nationally and in almost every state, shortfalls in health are greatest among the most-disadvantaged adults, but even those considered middle class are less healthy than adults with greater social and economic advantages.

Key Findings

America's adults are not as healthy as they could be. The findings presented here reveal substantial shortfalls in the health of American adults at the national level and in every state, providing new state-by-state evidence of the extent of health disparities among adults in the United States.

- In the United States overall during 2005-2007, 45.2 percent of adults ages 25 to 74 reported being in less than very good health. This percentage varied across states from 34.7 percent in Vermont to 52.9 percent in Mississippi.
- Nationally and in every state, the percent of adults in less than very good health varied by level of education. Compared with the most-educated adults (college graduates), the least-educated adults (those who had not graduated from high school) were more likely—more than three times as likely, in some states—to be in less than very good health. However, differences were not seen only when comparing the most- and least-educated groups. Even high-school graduates were more likely—more than twice as likely, in some states—than college graduates to be in less than very good health.
- While the gap in adult health status by education was evident in every state, the size of this gap (the difference between the overall percent of adults in less than very good health and the percent among college graduates) varied across states—from a difference of 9.0 percentage points in Delaware to 19.9 percentage points in California.
- Health status among adults also varied across racial or ethnic groups. Nationally and in nearly every state, the percent of adults in less than very good health was lower among non-Hispanic whites than in all other groups. Non-Hispanic black and Hispanic adults typically were most likely to be in less than very good health—more than twice as likely as white adults, in some states.
- In nearly every state, rates of less than very good health among adults at every education level and in every racial or ethnic group exceeded the national benchmark of 19.0 percent—a level of health that should be attainable for all adults nationally and in every state.

Introduction

Health is essential for well-being and full participation in society, and ill health can mean suffering, disability and premature loss of life. Measures of both child and adult health are important indicators of our nation's overall state of health, with implications for our nation's economic productivity. This chartbook examines the health of American adults to explore whether we are reaching our full health potential as a nation and in every state. Considering the differences between observed levels of adult health and the levels of health that would be achieved if all adults were as healthy as those in the most favorable social and economic conditions, the new state-by-state evidence presented here reveals dramatic health gaps in this country.

Purpose

This chartbook is intended to inform, raise awareness and stimulate discussion. Its purpose is to provide information that will be helpful to policy-makers, advocates and other leaders in their efforts to: (1) assess how far they are from reaching the full health potential of adults in their state; (2) raise awareness about the need to address social factors such as educational attainment in order to close gaps in adult health; and (3) stimulate discussion and debate within states and nationally about promising directions for closing those gaps. While analyzing the causes of these differences in health was not within the scope of this chartbook, a large body of research shows that the causes are complex and that medical care interventions are important but not sufficient. The information presented here should be used to help guide an ongoing process of inquiry—exploring the most promising national, state and local programs and policies to realize America's full health potential by shaping healthier conditions in which Americans live, learn, work and play.

This report was produced by research staff of the Robert Wood Johnson Foundation Commission to Build a Healthier America to aid Commissioners as they explored promising directions outside the medical care system that could improve the health of all Americans. Additional information about the Commission, along with the October 2008 child health chartbook, *America's Health Starts with Healthy Children: How Do States Compare?*, and individual national and state charts, are available at www.commissiononhealth.org.

Content

Findings from this report are presented in two forms: a print overview and a Web version that contains a wealth of state-by-state data. The print version includes three sets of charts. The first set describes how one well-established key indicator of adult health varies markedly at the national level by education and racial or ethnic group. The second set includes a table and map that describe differences at the state level in adult health status by educational attainment, with states ranked according to the size of the gap between the level of health seen for all adults and the level seen for adults in the most-educated group. The final set of charts provides an example of the information that is available on the Commission Web site for every state. Readers can download individual files for each state at www.commissiononhealth.org/statedata. The files provide state-specific data on adult health status, as well as information on key social factors (income, educational attainment and racial or ethnic group) linked with health.

Measures of Adult Health

- **Adult health status.** Self-reported assessment of one's own health was measured as excellent, very good, good, fair or poor. Because poor, fair or good health is considered by many to be less than optimal, we focused on the percentage of adults ages 25 to 74 who rated their health status as less than very good (poor, fair or good rather than very good or excellent). Rates of less than very good health were considered to be statistically reliable when the relative standard errors were 30 percent or less. Studies have shown that self-reported health status corresponds closely with objective clinical assessments of an individual's overall health made by health professionals. Among the adults studied here, for example, those who reported being in less than very good health had rates of diabetes and cardiovascular disease that were more than five times as high as the rates for adults who reported being in very good or excellent health.

Social Factors

- **Income.** Taking family size into account, an individual's household income was categorized in 100-200 percent increments of the Federal Poverty Level (FPL), which has been defined as the amount of income providing a bare minimum of food, clothing, transportation, shelter and other necessities. In 2007, the FPL for the 48 contiguous states and the District of Columbia was \$17,170 for a family of three and \$20,650 for a family of four. Adults were considered to be poor (with household incomes below 100% of FPL), near poor (100-199% of FPL), middle income (200-399% of FPL), or higher income (400% of FPL or higher).
- **Education.** An individual's educational attainment was measured as his or her highest level of completed schooling and grouped into one of four categories: less than high-school graduate, high-school graduate, some college, or college graduate and above.
- **Racial or ethnic group.** Racial or ethnic group was considered using slightly different categories, depending on the data source and size of the groups. At the national level, we considered: (a) all categories for which information was collected by the U.S. Census Bureau, to describe the racial or ethnic composition of all adults; and (b) all categories for which information was collected by the Behavioral Risk Factor Surveillance System (BRFSS), to describe differences in adult health status by racial or ethnic group. At the state level, we considered: (a) all categories for which information in the state was collected by the BRFSS, to describe the racial or ethnic composition of all adults; and (b) categories in the BRFSS that included at least 3 percent of surveyed adults in the state (smaller groups and individuals reporting more than one racial or ethnic group were included with "other"), to describe racial or ethnic differences in adult health status.

Data Sources

Two sources of data were used to produce this chartbook:

- The **2007 American Community Survey (ACS)**, conducted by the U.S. Census Bureau, was analyzed to obtain information, nationally and in each state, on household income and on educational attainment and racial or ethnic group.
- The **2005-2007 Behavioral Risk Factor Surveillance System Survey Data**, from the U.S. Centers for Disease Control and Prevention, were used to analyze information on adult health status: by educational attainment and racial or ethnic group, nationally and in each state; by educational attainment within racial or ethnic groups, nationally; and by health-related behaviors at each level of educational attainment, nationally.

Analyses

We examined differences in adult health status by education and racial or ethnic group at both the national and state levels. In addition, we examined differences in adult health status at the national level by educational attainment within racial or ethnic groups and by health-related behaviors within education groups. We estimated the size of the “health gaps” for each state and Washington, D.C., using a standard measure known as the Population Attributable Risk, or PAR. In this report, the PAR was calculated at the state level to quantify the improvement in overall adult health status that would occur if all adults in the state had the level of health experienced by those in the state’s most-educated group. States were ranked according to the size of this health gap; states with the same size gap (to one decimal point) were given the same ranking. For mapping purposes, states were grouped based on the size of the gaps into three approximately equal groups (i.e., as having small, medium or large gaps).

It is important to note that the highest education and income groups used here to reflect the most socially-advantaged groups were relatively large: Nationally, 29 percent of adults had graduated from college and 45 percent had household incomes at or above four times the FPL. If the data sources had permitted comparisons with adults with professional degrees, for example, the observed health differences could have been even larger. The health differences reported here thus likely understate the true magnitude and extent of the gaps in health in each state and in the nation overall.

A **national benchmark** was also calculated for adult health status. This additional reference point—intended to represent a level of good health that should be attainable for all adults in every state—is featured to emphasize two additional points:

- (1) Levels of adult health are better in some states than in others, even when only adults in the most-educated groups are considered.
- (2) Differences in health occur among adults even within the most-educated groups.

At every level of educational attainment, adult’s opportunities for good health are also shaped by other factors, including whether they practice good health-related habits like exercising regularly.

The national benchmark used here—19.0 percent of adults who rated their own health as less than very good—was selected as the lowest (and best) statistically reliable rate of less than very good health in any state among the most-educated adults who practiced healthy behaviors (i.e., college graduates who did not smoke and had recent leisure-time physical exercise).

For further information on data sources and analytic methods, see the Technical Notes for this document at www.commissiononhealth.org/PDF/AdultChartbookTechNotes.pdf.

What Shapes Health?

Access to affordable, high-quality medical care is clearly essential for health. For example, timely screenings and adequate treatment for conditions like diabetes and high blood pressure can make a big difference in a person's health. Genetic predisposition to certain diseases also plays a role in shaping health. But high-quality medical care and genes are not the only factors that determine health. Whether individuals live long and healthy lives is greatly influenced by powerful *social factors* such as education, income, racial or ethnic group and the quality of the environments where people live, learn, work and play.

The Links Between Social Factors and Health

Adults clearly have responsibility for making healthy choices for themselves and their families, and typically this responsibility begins with awareness of the benefits and risks of particular behaviors. But being able to make healthy choices also depends on physical and social conditions at home, in neighborhoods, at schools and at work. For example, a person's ability—and motivation—to be physically active, eat a healthy diet and avoid smoking and excessive drinking can be diminished by living in a neighborhood that lacks safe places for physical activity, where there are liquor stores but no grocery stores, and where intensive tobacco and alcohol advertising is prevalent. But living and working in neighborhoods that have sidewalks and safe places to exercise, after-school recreation programs and access to nutritious foods can promote good health by making it easier to adopt and maintain healthy behaviors.

Three Important Social Factors— Education, Income and Racial or Ethnic Group

This chartbook highlights three important social factors—educational attainment, income and racial or ethnic group—that can influence health and healthy choices in multiple ways. For example, people with more schooling may have a better understanding of the importance of health-related behaviors. Higher educational attainment can lead to higher-paying jobs with greater economic security, healthier working conditions and better benefits including health insurance. Higher income makes it easier to pay for necessary medical care, to purchase more nutritious foods, and to live in a neighborhood with good schools and recreational facilities. Conversely, limited income can make everyday life a struggle, leaving little or no resources, time or energy to adopt healthy behaviors.

Race and ethnicity matter in part because they continue to influence educational and employment opportunities. In addition, discrimination and its legacy in residential segregation mean that black and Hispanic families more often live in substandard housing and unsafe or deteriorating neighborhoods compared with whites who have similar incomes and education.

Social Factors and Health: The Role of Chronic Stress

Much has been learned recently about physiologic pathways that help explain the links between social factors and health. Coping with the constant challenges of daily living—balancing the demands of work and family, for example—can be particularly stressful for people with limited financial and social resources. Stress can trigger the body to release hormones and other substances that over time can damage immune defenses and vital organs. This physiologic chain of events can accelerate aging and lead to serious chronic illnesses including cardiovascular disease. This “toxic” chronic stress differs from the type of stress typically associated with jobs that are high-pressure but rewarding; that type of stress does not appear to harm health.

Achieving Better Health

Health is shaped by conditions and experiences throughout life—beginning in early childhood, when the foundations for health are laid. Adverse social and physical conditions during childhood can compromise healthy development, with lasting effects on health. Many of the important health outcomes that account for a major portion of preventable illness and premature death in the United States—including heart disease and stroke, high blood pressure, diabetes, obesity and depression—are strongly linked to deficits in early cognitive and behavioral development.

Although low-income and less-educated Americans face the greatest obstacles to healthy choices and greatest risks to health, even people considered “middle class”—in other words, the majority of people in this country—can be much healthier. We know that interventions such as improving access to high-quality child care, expanding opportunities for educational attainment and ensuring safe and health-promoting working conditions can make dramatic differences in adult health and well-being. By creating healthier social and physical environments, health-promoting policies at the local, state and national levels can lead to improved quality of life, reduced suffering and disability and increased economic productivity. These outcomes are not only desirable; they represent both ethical and pragmatic imperatives for our society.

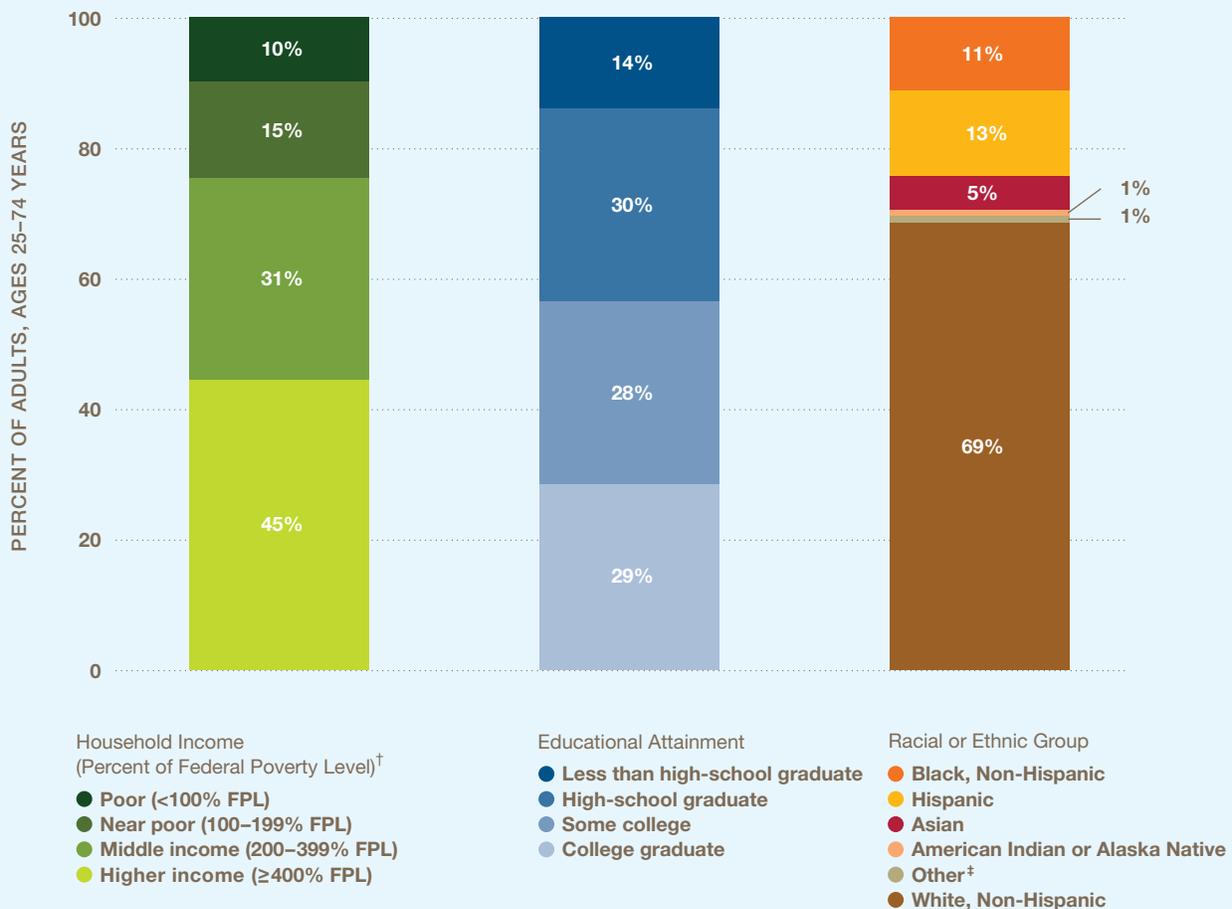
Charts and Data



UNITED STATES: Social Factors Affecting Adult Health

Health among adults is powerfully linked with social factors such as household income, educational attainment and racial or ethnic group. This national snapshot of adults ages 25 to 74 shows that:

- One quarter of adults nationwide live in poor or near-poor households, nearly one third live in middle-income households and nearly half live in higher-income households.
- Forty-four percent of adults have no schooling beyond high school, 28 percent have attended but not completed college and 29 percent are college graduates.
- Approximately two thirds of adults nationwide are non-Hispanic white, 13 percent are Hispanic, 11 percent are non-Hispanic black, 5 percent are Asian, 1 percent are American Indian or Alaska Native and 1 percent are in another or more than one racial or ethnic group.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2007 American Community Survey.

[†] Guidelines set by the U.S. government for the amount of income providing a bare minimum of food, clothing, transportation, shelter and other necessities. In 2007, the FPL for the 48 contiguous states and the District of Columbia was \$17,170 for a family of three and \$20,650 for a family of four.

[‡] “Other” includes adults in any other racial or ethnic group or in more than one group.

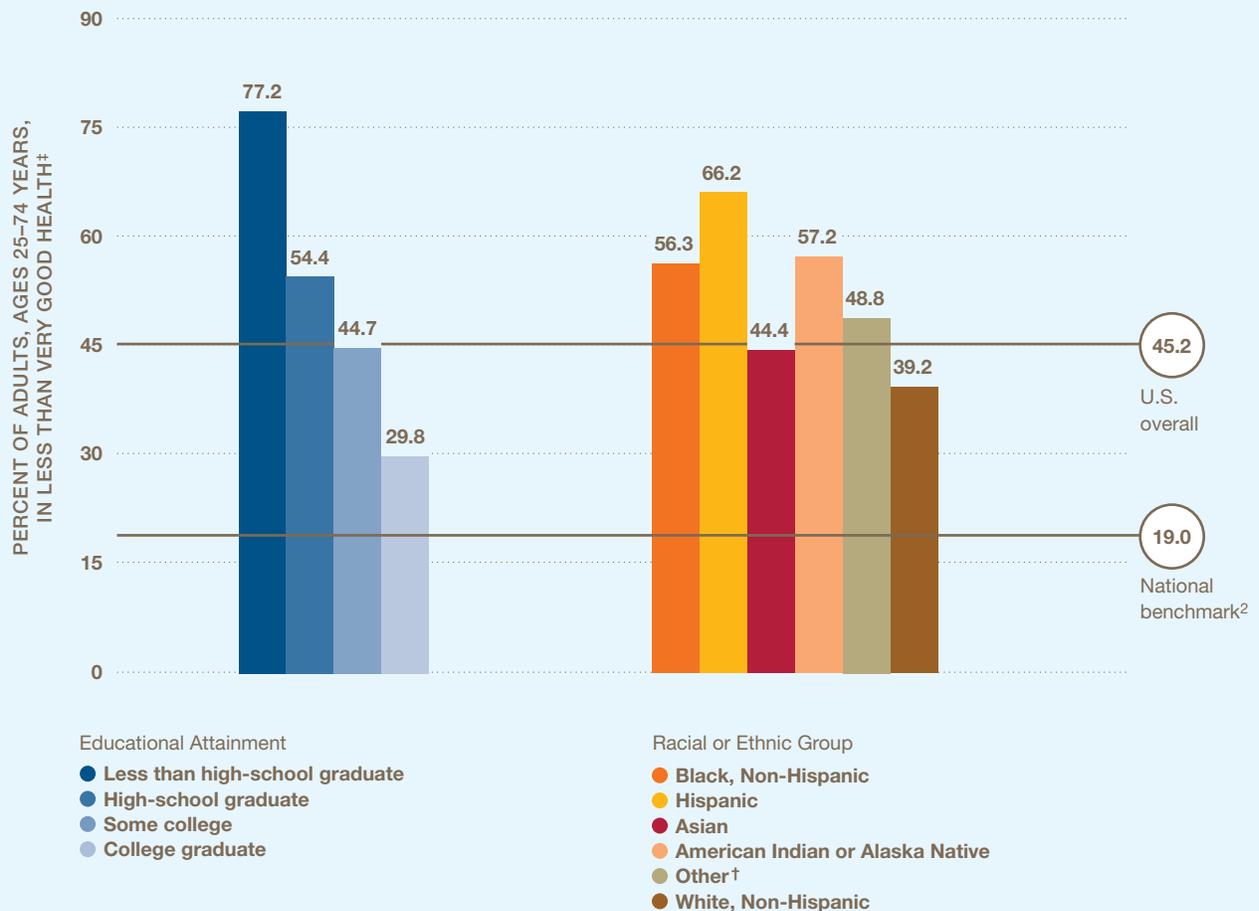
UNITED STATES: Gaps in Adult Health Status

In the United States overall, adult health status¹ varies by level of educational attainment and racial or ethnic group.

- Compared with college graduates, adults who have not graduated from high school are more than 2.5 times as likely—and those who have graduated from high school are nearly twice as likely—to be in less than very good health.

- Non-Hispanic white adults fare better than any other racial or ethnic group.

Comparing these rates against the national benchmark² for adult health status reveals that, at every education level and in every racial or ethnic group, adults in this country are not as healthy as they could be.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

¹ Based on self-report and measured as poor, fair, good, very good or excellent.

² The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with recent leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults nationally in 2005–2007.

‡ Age-adjusted.

Education Is Linked With Health Regardless of Racial or Ethnic Group

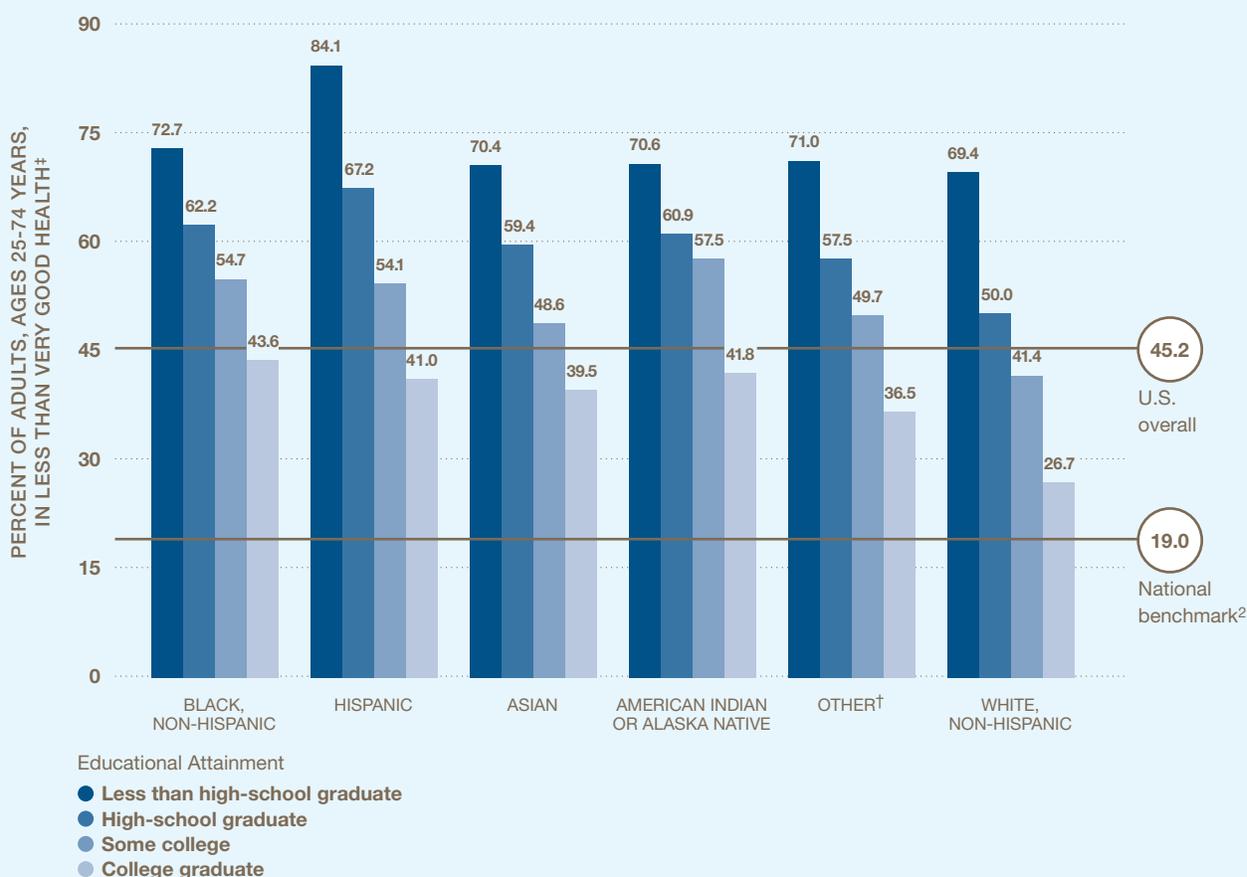
Differences in adult health status¹ by education do not simply reflect differences by racial or ethnic group; nor do they simply reflect differences between the least-educated and most-educated groups. Both educational attainment and racial or ethnic group matter for a person's health.

- Within each racial or ethnic group, a steep education gradient is evident. Adult health status improves as educational attainment increases. Among non-Hispanic whites, for example, adults who have not graduated from high school, those who have only

completed high school and those who have some college education are 2.6, 1.9 and 1.6 times as likely to be in less than very good health as college graduates.

- At nearly every level of education, non-Hispanic white adults fare better than adults in any other racial or ethnic group.

Health shortfalls are even more dramatic when considering the level of adult health that should be attainable. At every level of education in every racial or ethnic group, the percentage of adults in less than very good health exceeds the national benchmark.²



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 Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

¹ Based on self-report and measured as poor, fair, good, very good or excellent.

² The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with recent leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

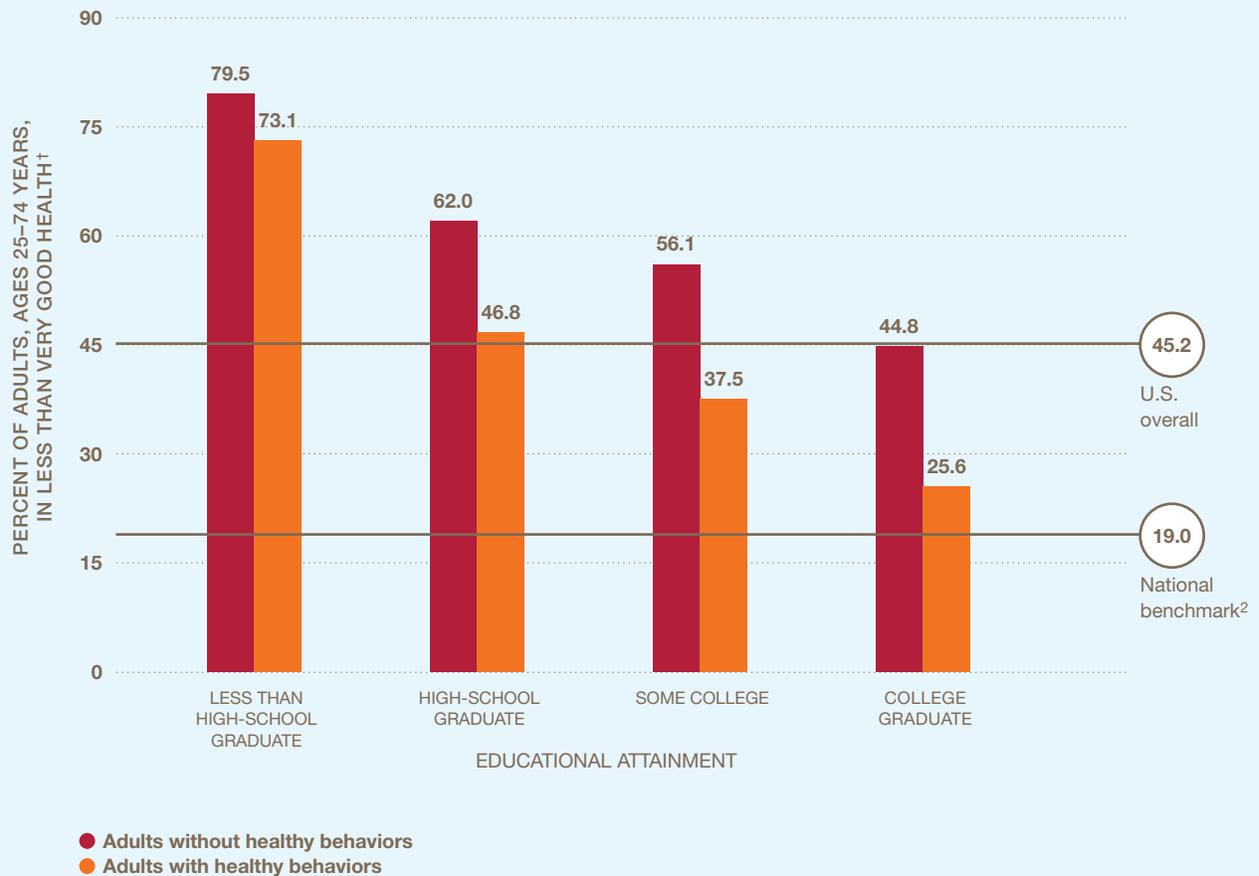
† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults nationally in 2005–2007.

‡ Age-adjusted.

Health-Related Behaviors and Education Both Affect Health

Differences in adult health status¹ are evident not only across racial or ethnic and education groups but also with respect to individuals' health-related behaviors. At every level of educational attainment, for example, adults who do not smoke and get leisure-time physical exercise are less likely to be in less than very good health than adults without these healthy behaviors.

The national benchmark² for adult health status reflects the best (in this case, lowest) statistically reliable rate of less than very good health observed in any state among adults who both had graduated from college and practiced healthy behaviors. This benchmark rate—19.0 percent of adults in less than very good health, seen in Vermont—reflects a level of good health that should be attainable for all adults nationally and in every state.



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Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

1 Based on self-report and measured as poor, fair, good, very good or excellent.

2 The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates with healthy behaviors (i.e., non-smokers with recent leisure-time physical exercise). Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

† Age-adjusted.

Gaps in Adult Health Status by Level of Education: How Do States Compare?

Differences in adult health status¹ by educational attainment are similar at the state level to those seen among adults nationally. In every state, differences in health are seen between the most-educated adults and those with less education. These differences occur along a gradient that includes not only adults with the most and least education, but those in the middle as well. Compared with adults who have graduated

from college, adults who have not completed high school experience particularly marked shortfalls, but even those who have attended some college are less healthy than college graduates. Comparing states based on the size of the gap² in adult health status by education tells us that Americans are not as healthy as they could be—both nationally and in every state.

	Number of Adults, Ages 25–74 Years ³	Overall Rate of Less Than Very Good Health (%)	Ranking on Overall Rate of Less Than Very Good Health	Less Than High-School Graduate	High-School Graduate	Some College	College Graduate	Percent of Population That Would Be Affected if Gap Were Eliminated ⁴	Size of Health Gap ²	Ranking on Size of Health Gap ⁵
Alabama	2,691,849	50.8	48	77.2	56.5	48.8	35.3	70.7	15.5	37
Alaska	380,174	43.1	25	65.5	52.9	45.0	29.8	63.7	13.3	19
Arizona	3,427,659	45.6	32	77.9	55.8	45.2	30.2	63.4	15.4	36
Arkansas	1,609,044	50.3	47	78.5	57.6	49.3	33.5	69.7	16.9	41
California	20,966,854	47.9	39	82.0	55.5	42.9	28.0	63.9	19.9	51
Colorado	2,782,543	38.0	6	79.1	49.3	39.4	23.9	56.1	14.1	26
Connecticut	2,091,367	36.3	4	71.1	48.5	40.3	25.1	50.8	11.2	7
Delaware	505,447	41.2	18	67.3	48.9	41.8	32.2	58.9	9.0	1
District of Columbia	351,075	38.3	7	70.1	59.2	47.5	23.6	43.4	14.7	32
Florida	10,664,932	44.0	28	71.9	52.1	43.9	30.6	64.6	13.4	20
Georgia	5,403,101	45.6	32	71.1	55.2	46.2	31.9	62.1	13.7	21
Hawaii	748,845	48.0	40	65.8	60.1	47.9	37.9	60.4	10.0	2
Idaho	806,110	43.3	27	71.4	51.6	44.1	28.2	67.9	15.1	35
Illinois	7,558,327	47.2	36	81.2	57.8	48.6	32.9	60.8	14.3	28
Indiana	3,629,639	47.8	37	76.5	54.8	47.0	32.1	69.7	15.7	38
Iowa	1,744,042	40.4	14	71.6	47.9	40.5	27.8	67.3	12.6	14
Kansas	1,565,541	41.3	19	73.0	51.3	42.2	28.7	61.0	12.6	14
Kentucky	2,579,348	52.8	50	74.4	60.0	50.3	33.6	74.4	19.2	49
Louisiana	2,491,883	49.4	43	68.8	56.2	49.4	34.7	68.8	14.6	31
Maine	808,867	39.5	10	68.8	48.6	41.8	25.7	63.3	13.8	22

Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

1 Based on self-report and measured as poor, fair, good, very good or excellent.

2 Defined as the difference between the state's overall rate and the rate among college graduates.

3 This number represents a yearly average for 2005-2007.

	Percent of Adults in Less Than Very Good Health by Level of Educational Attainment									
	Number of Adults, Ages 25-74 Years ³	Overall Rate of Less Than Very Good Health (%)	Ranking on Overall Rate of Less Than Very Good Health	Less Than High-School Graduate	High-School Graduate	Some College	College Graduate	Percent of Population That Would Be Affected if Gap Were Eliminated ⁴	Size of Health Gap ²	Ranking on Size of Health Gap ⁵
Maryland	3,347,365	38.4	8	66.5	49.8	40.2	28.4	52.5	10.1	3
Massachusetts	3,847,284	37.5	5	70.1	50.3	40.2	26.2	50.6	11.3	8
Michigan	5,900,297	44.3	29	70.4	55.0	45.7	29.8	65.6	14.5	29
Minnesota	3,054,284	35.7	2	66.4	46.5	38.9	24.8	58.1	10.9	6
Mississippi	1,652,848	52.9	51	73.6	60.2	49.5	36.5	72.7	16.5	40
Missouri	3,417,530	46.3	34	72.5	56.2	46.5	29.9	67.6	16.4	39
Montana	555,307	40.2	11	65.9	50.0	40.8	28.6	63.2	11.6	10
Nebraska	1,020,100	41.9	20	74.2	50.5	43.2	28.9	64.0	13.0	17
Nevada	1,460,181	49.1	41	81.3	57.0	45.0	32.1	68.6	17.1	43
New Hampshire	817,179	35.7	2	64.3	45.8	39.3	24.0	56.6	11.7	11
New Jersey	5,165,709	44.3	29	80.8	55.9	45.2	30.3	55.5	14.0	24
New Mexico	1,107,513	49.5	44	82.7	58.7	47.0	31.7	65.8	17.8	46
New York	11,404,275	45.4	31	78.0	54.1	46.4	30.9	60.0	14.5	29
North Carolina	5,178,716	47.8	37	77.6	57.5	45.4	29.3	67.2	18.5	48
North Dakota	361,807	41.1	17	65.9	49.3	42.6	30.9	64.2	10.2	4
Ohio	6,742,564	43.2	26	73.3	51.8	43.5	28.4	65.9	14.7	32
Oklahoma	2,093,456	50.1	45	79.5	56.1	48.9	32.7	72.3	17.5	44
Oregon	2,184,355	42.6	23	73.2	51.4	45.2	28.5	62.6	14.2	27
Pennsylvania	7,273,894	43.0	24	69.7	51.3	42.6	29.2	66.0	13.8	22
Rhode Island	627,588	40.2	11	73.5	48.4	42.5	27.5	58.3	12.8	16
South Carolina	2,599,644	46.9	35	75.0	56.5	45.2	29.9	68.0	17.0	42
South Dakota	434,190	39.0	9	65.0	45.6	40.2	28.6	64.5	10.4	5
Tennessee	3,708,411	49.3	42	77.4	57.8	46.0	31.2	73.1	18.1	47
Texas	13,158,177	50.1	45	78.3	59.5	47.2	32.3	65.8	17.7	45
Utah	1,287,862	40.4	14	74.7	49.1	40.7	28.7	63.5	11.7	11
Vermont	379,968	34.7	1	67.6	46.1	36.2	21.7	57.9	13.0	17
Virginia	4,539,053	40.2	11	73.1	50.2	43.2	28.5	54.4	11.7	11
Washington	3,768,213	42.0	22	74.8	54.2	44.8	28.1	59.0	14.0	24
West Virginia	1,116,118	52.6	49	75.8	58.3	49.4	33.1	76.5	19.5	50
Wisconsin	3,259,450	40.5	16	72.1	48.8	40.5	29.2	65.1	11.4	9
Wyoming	302,980	41.9	20	68.5	51.2	43.3	27.2	67.4	14.7	32
United States	174,572,966	45.2	—	77.2	54.4	44.7	29.8	63.5	15.4	—

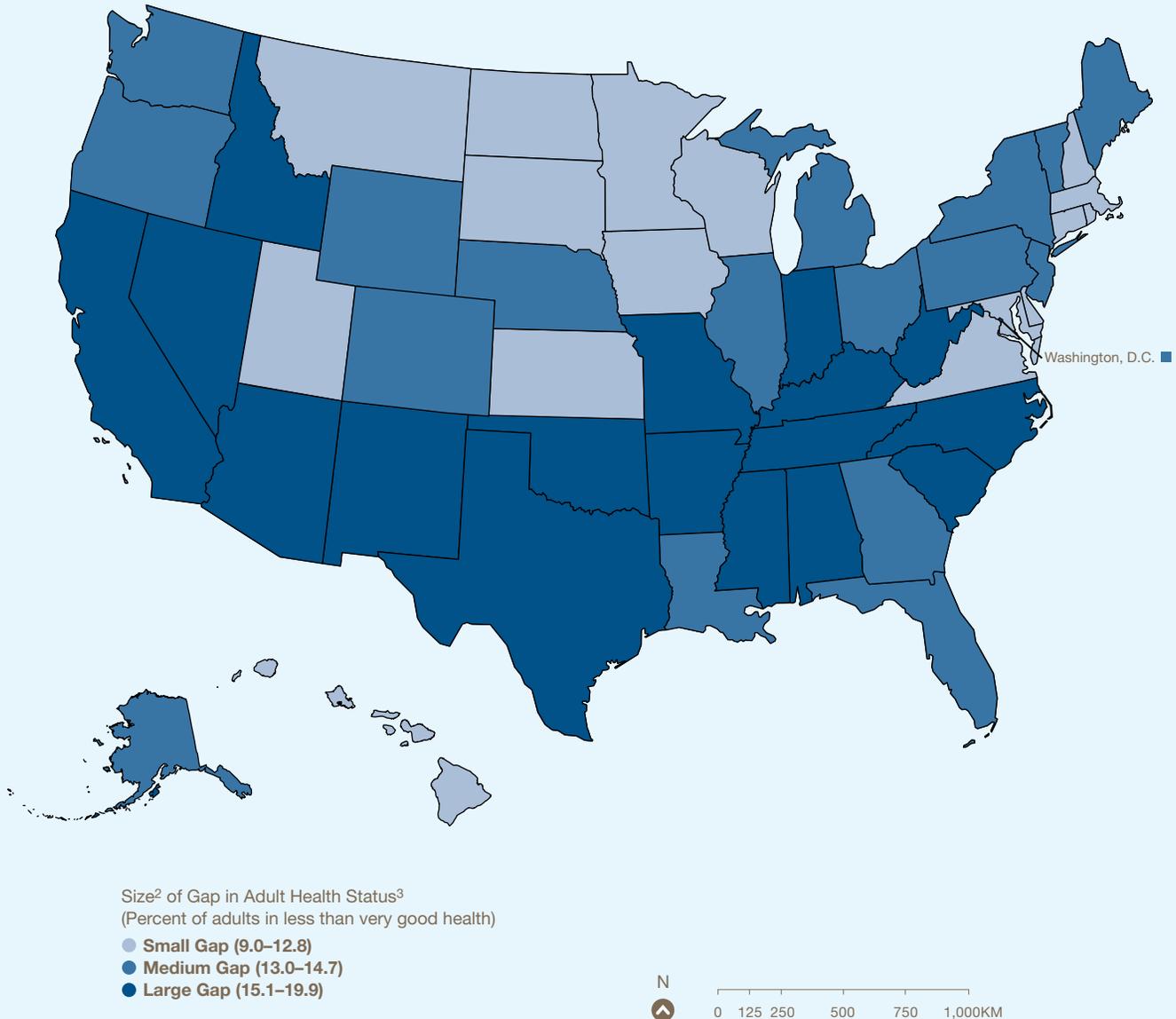
4 Defined as the percent of adults who have not graduated from college.

5 Ranked by size of gap, from smallest to largest; states with the same size gap were assigned the same ranking.

Gaps in Adult Health Status by Level of Education: How Do States Compare?

In every state, the percent of adults ages 25 to 74 in less than very good health was lowest among college graduates and increased as the level of educational attainment decreased. Although the size of the gap¹

between each state's overall rate of less than very good health and the rate among college graduates varies markedly, adults in every state could be healthier.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

1 Defined as the difference between the state's overall rate and the rate among college graduates.

2 States were categorized into three approximately equal groups based on the size of the gaps in adult health status by level of educational attainment.

3 Based on self-report and measured as poor, fair, good, very good or excellent.

Adult Health Status: A Snapshot of New York



Adults in New York are not as healthy as they could be. Based on self-reported health status, an important indicator of overall health, levels of health for most New York adults fall short of those for adults in the most-advantaged subgroups in the state and across the country. This snapshot describes these differences in health as well as the social factors that shape them.

ADULT HEALTH STATUS

New York ranks 31st among states based on the overall rate of 45.4 percent of adults in less than very good health.

At the same time, New York ranks 29th among states based on the size of the gap in adult health status by education—the difference between the overall rate of adults in less than very good health (45.4%)

and the lower rate of 30.9 percent seen among the state's most-educated adults. Even if New York achieved this lower rate overall, the state's rate would still exceed the *national benchmark* for adult health status—19.0 percent, the lowest (and best) rate of less than very good health seen in any state among college graduates who were non-smokers with recent leisure-time physical exercise. In New York, the health status of adults in every education and racial or ethnic group did not meet the national benchmark.

SOCIAL FACTORS AFFECT ADULT HEALTH

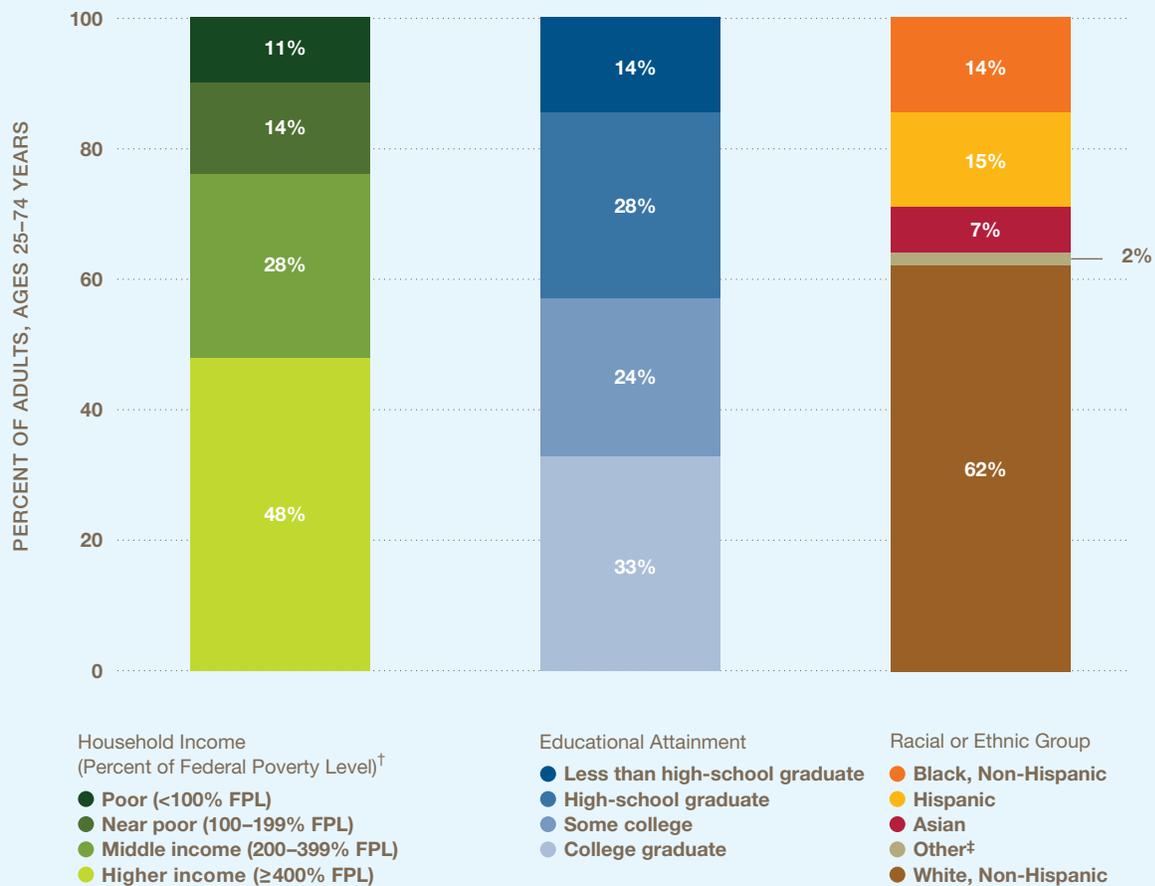
Social factors such as income, education and racial or ethnic group can greatly affect a person's health. This snapshot describes these factors and how they are linked with adult health status in the state.



NEW YORK: Social Factors Affecting Adult Health

Health among adults is powerfully linked with social factors such as household income, educational attainment and racial or ethnic group. This snapshot of adults ages 25 to 74 in New York shows that:

- One quarter of New York’s adults live in poor or near-poor households, more than one quarter live in middle-income households and nearly half live in higher-income households.
- Forty-two percent of adults in New York have no education beyond high school, 24 percent have attended but not completed college and 33 percent are college graduates.
- Nearly two thirds of New York’s adults are non-Hispanic white, 15 percent are Hispanic, 14 percent are non-Hispanic black and 7 percent are Asian.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: 2007 American Community Survey.

[†] Guidelines set by the U.S. government for the amount of income providing a bare minimum of food, clothing, transportation, shelter and other necessities. In 2007, the FPL for the 48 contiguous states and the District of Columbia was \$17,170 for a family of three and \$20,650 for a family of four.

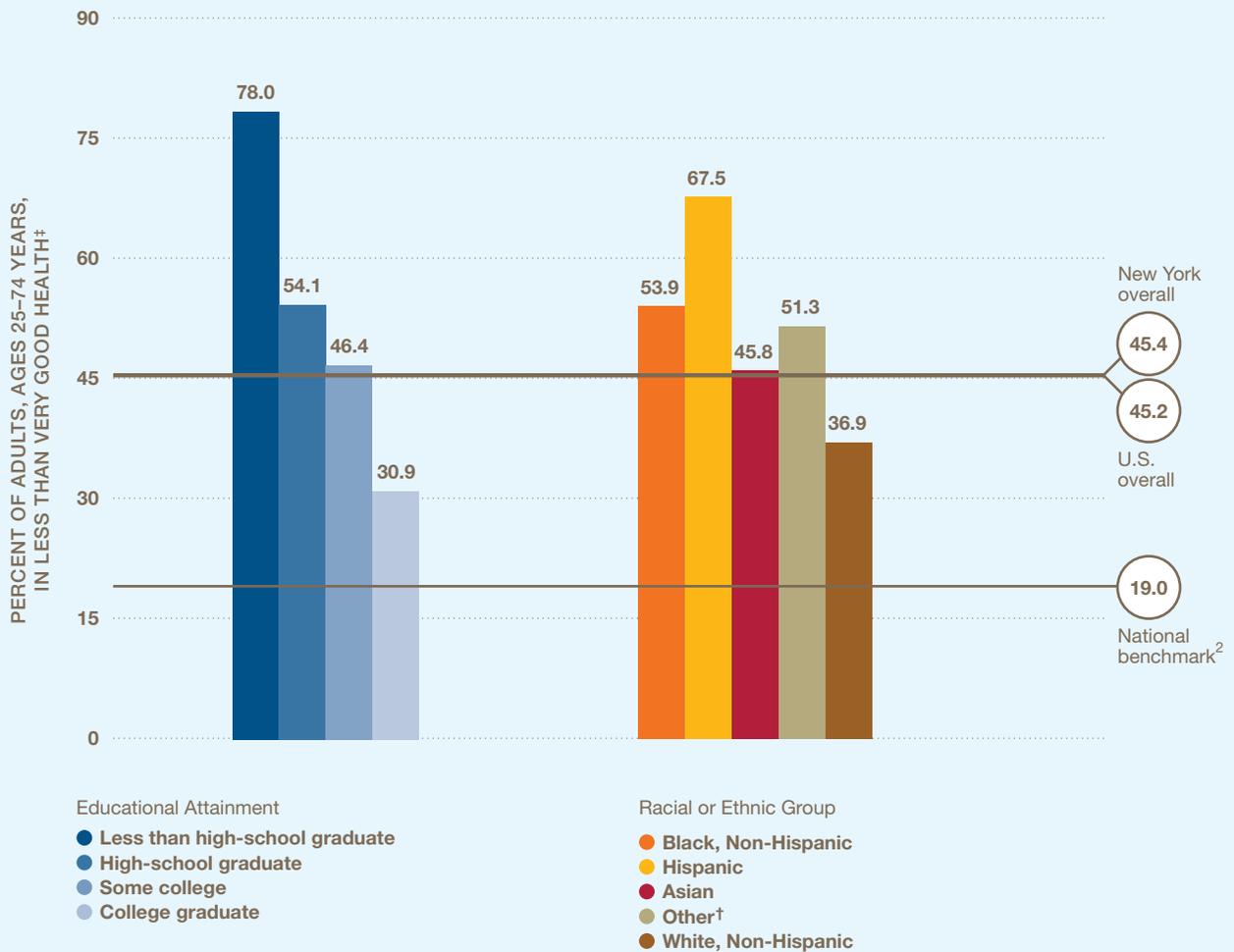
[‡] “Other” includes adults in any other racial or ethnic group or in more than one group.

NEW YORK: Gaps in Adult Health Status

In New York, adult health status¹ varies by level of educational attainment and by racial or ethnic group.

- Compared with college graduates, adults who have not graduated from high school are 2.5 times as likely—and those who have graduated from high school are nearly twice as likely—to be in less than very good health.
- Hispanic adults are 83 percent more likely and non-Hispanic black adults are 46 percent more likely than non-Hispanic white adults to be in less than very good health.

Comparing New York's experience against the national benchmark² for adult health status reveals that, at every education level and in every racial or ethnic group, adults in New York are not as healthy as they could be.



Prepared for the RWJF Commission to Build a Healthier America by the Center on Social Disparities in Health at the University of California, San Francisco.

Source: 2005-2007 Behavioral Risk Factor Surveillance System Survey Data.

1 Based on self-report and measured as poor, fair, good, very good or excellent.

2 The national benchmark for adult health status represents the level of health that should be attainable for all adults in every state. The benchmark used here—19.0 percent of adults in less than very good health, seen in Vermont—is the lowest statistically reliable rate observed in any state among college graduates who were non-smokers with leisure-time physical exercise. Rates with relative standard errors of 30 percent or less were considered to be statistically reliable.

† Defined as any other or more than one racial or ethnic group, including any group with fewer than 3 percent of surveyed adults in the state in 2005-2007.

‡ Age-adjusted.



ROBERT WOOD JOHNSON FOUNDATION
Commission to Build a Healthier America

The *Robert Wood Johnson Foundation Commission to Build a Healthier America* is a national, independent, non-partisan group of leaders tasked with seeking ways to improve the health of all Americans. Launched in February 2008, the Commission investigated how factors outside the health care system—such as income, education and environment—shape and affect opportunities to live healthy lives. The Commission, which is co-chaired by former senior White House advisors Mark McClellan and Alice Rivlin, issued a full set of recommendations in April 2009. For more information about the Commission and its activities, please visit:

www.commissiononhealth.org

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