



2008 Edition

A Call to Action for Individuals & Their Communities



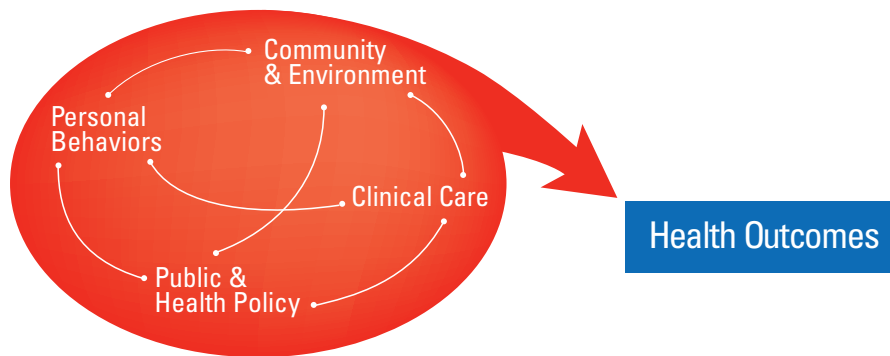
Components of Health

The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

In addition to the contributions of our individual genetic predispositions to disease, health is the result of:

- Our personal behaviors,
- The environment and the community in which we live,
- The public and health policies and practices of our government, and
- The clinical care we receive.

These four aspects interact with each other in a complex web of cause and effect, and much of this interaction is just beginning to be fully understood. Understanding these interactions is vital if we are to create the healthy outcomes we desire, including a long, disease-free, robust life for all individuals regardless of race, gender or socio-economic status. This report focuses on these determinants and on the overall health outcomes we desire.





A Call to Action for Individuals & Their Communities

2008 Edition

America's Health Rankings™— 2008 Edition is available in its entirety at www.americashealthrankings.org. Visit the site to request or download additional copies.

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We at the American Public Health Association, Partnership for Prevention and United Health Foundation, are pleased to again present *America's Health Rankings™: A Call to Action for Individuals and Their Communities*. For 19 years, *America's Health Rankings™* has provided an annual state-by-state analysis of our nation's health. The longest running report of its kind, the Rankings presents a unique historical and comprehensive view of the health of the nation and an annual ranking of the healthiest and least healthy states.

Unfortunately, as you will read, our nation's health is not improving. We continue to fall short of our potential and we fare poorly in comparison to many other nations. The consequences are tragic — for individuals, for communities and for our children. We have a fundamental responsibility to work together to help people live healthier lives. An urgent need exists for overall solutions and innovative actions to help individuals, communities, and our nation to become healthier.

As with previous Editions, we are pleased to include the insights of distinguished national health leaders. Their thoughts are intended to stimulate change as well as showcase innovative models. This year, contributors include:

- Dr. Risa Lavizzo-Mourey, President and CEO of the Robert Wood Johnson Foundation, provides a compelling case to connect what we know with what we do.
- Dr. Martin Sepulveda, Vice President for Integrated Health Services, IBM Corporation, outlines positive changes taken by a major employer to better serve employees' health and well-being needs while achieving remarkable cost savings.
- Medical officers Dr. Otis Brawley, American Cancer Society; Dr. Richard Kahn, American Diabetes Association; and Dr. Rose Marie Robertson, American Heart Association, come together to discuss the critical need to close the prevention gap.
- University of North Carolina public health graduate students Jennifer King and Elizabeth Walker present ideas for outcomes-based health care financing.
- Peter V. Lee, Executive Director of the Pacific Business Group on Health, discusses strategies to promote quality and value in health reform.

We continue to respect and greatly appreciate the efforts of our Scientific Advisory Committee, comprised of leading public health scholars charged with the responsibility of maintaining and strengthening the report's methodological framework. In particular, thanks to Thomas Ricketts, Ph.D., Chair of the Committee and Professor of Health Policy and Administration, University of North Carolina. We also extend our continued gratitude for the dedicated efforts of public health, clinical and health policy professionals who work tirelessly every day on behalf of the people of this country.

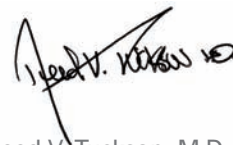
We invite you to share proven or innovative programs that have made a difference in your community by emailing info@unitedhealthfoundation.org. Let us learn from each other as we work to turn the tide on the health challenges facing the nation. There is no better time than the present.



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It's Time To Connect What We Know With What We Do

Risa Lavizzo-Mourey, M.D., M.B.A.
President and CEO
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Robert Wood Johnson
 Foundation

When it comes to health and health care, we are not all equal. The health and health care of Americans are impacted by the same gaps in fairness and conditions that we find in education, housing, employment, income, even in the health geographies of infant mortality, disease prevalence, and childhood obesity. Variations in medical treatment, provider performance and the quality of care are pervasive in every section of the country. Racial and ethnic disparities in individual and community health status, treatment and patient outcomes underscore the widening divide between haves and have-nots in our society.

In the past, we measured the differences and disparities by anecdote and intuition. Now, research, data aggregation and thorough analyses are feeding a steadily growing body of evidence that pinpoints the clinical and cultural symptoms, socio-economic causes and most likely cures.

Where I work, evidence is crucial in deciding how best to fulfill our foundation's mission to improve the health and health care of all Americans. This is why each year we eagerly await United Health Foundation's latest edition of *America's Health Rankings*[™]. It provides an updated perspective on the constantly evolving problems and their most doable solutions.

The *America's Health Rankings*[™] deliver a terrific value-added benefit. They confirm that there is much more to good health than good health care. Fair and full access to affordable, high quality health care is vital, but only part of the story. Our health, good or bad, is perhaps more definitively determined by our personal choices of lifestyle and behavior; how and where we live, work and play; our access to

reliable information and our understanding of what to do with it.

The U.S. spends more than \$2 trillion a year on health care — one-sixth of our economy — more per person than any other nation on earth. Yet our health is not what it should or could be. In fact, we rank far lower than many developed countries in key areas like infant mortality and life expectancy.

One big reason: Our equation for what makes good health has fallen out of calibration. While we focus on “sick care” to make the ill well, we ignore the often toxic truth that broad economic, social, political and environmental factors hold as much sway over our health as do the viral or genetic.

Taking responsibility for our own good health is a start, but it is not that simple. The world around us pounds us with the invitation and opportunity to do the unhealthy thing. Conditions of race, residence, income, education, or family conspire against us. In fact, when it comes to our own health and health care, sometimes we have little control over our own lives.

It can start at birth. Obstacles children encounter early in life can set off a negative chain of events so hard to break that they can transcend generations. Poor education leads to limited job options, which lead to lower income, living in poor neighborhoods with poor housing, higher crime, more violence, limited access to nutritious foods, safe places to exercise or medical care — all of which leads to poorer physical and mental health.

As a parent, physician and health care philanthropist— from whichever angle I look— I see how improving the health of our population begins by investing in early childhood development. This is a proven gateway to educational achievement, which is linked to lower rates of heart disease,

stroke, hypertension, diabetes, obesity, smoking, drug use and depression.

Take an idea like the Nurse-Family Partnership, which provides home visits to first time, low-income mothers and their families, beginning in pregnancy. Among its many beneficial effects: Children of these women are nearly 60 percent less likely to be arrested and almost 50 percent less likely to be abused, neglected or injured. There's a financial return here too. A study conducted by RAND estimated the return on investment at \$5.70 per dollar spent on the program. This means that for every dollar spent on the program, more than \$5 in other societal costs are averted or other value is gained. Just think of what we could accomplish if all women in poverty and their babies had access to a program like this.

As children grow older, social disparities in health can become matters of life and death. For example, we often see higher rates of death from heart disease in communities where fewer adults have a college education. In fact, the prevalence of heart disease is nearly 50 percent higher among poor adults than among adults in the highest income group.

Decades of reliable research tells us that education, economic development, housing, job security, geography, and income affect health just as much as personal behavior. For example, 19 years ago, when the first *America's Health Rankings*[™] came out, we didn't know that poverty helps kill American adults at about the same rate as smoking cigarettes.

There's a somewhat new health policy term of art that describes factors like these: “the social determinants of health.” I also know them by another name: “the social conditions of living.” In other words, the world around us

and the environment that enfolds us affect our health just as much as the genes within us or the health care system that treats us.

We now know that the major disease problems of our time cannot and will not be solved within the clinical care system alone. Health care's old school relied on "the rule of more" to make the sick well — more technology, more tests, more treatment, more pharmaceuticals. That school is about to be let out. By every evidence-based measure now available to us, more intensive health care is not the best medicine for what ails America's health. We also need less disease to begin with.

Right now, in the U.S. about 95 percent of everything we spend on health supports a "sick care" system of medical care and biomedical research. Less than five percent is for public health and disease prevention. Yet, all we are learning about population health tells us that behavior and environment cause more than 70 percent of avoidable deaths. My conclusion: The 95 to 5 solution is counter-intuitive, counter-productive and counter to the health of the public.

Not until fairly recently did we have sufficient evidence to make a persuasive case for investing in prevention. Reliable information streams like *America's Health Rankings*[™] are now the advocate's best friend. For example, a recent study from Trust for America's Health (TFAH), a Robert Wood Johnson Foundation grantee, shows that even a small investment in community prevention programs can return substantial savings in overall health care costs.

TFAH found that investing only \$10 per person in community programs to increase physical activity, improve

nutrition and prevent smoking could save the country more than \$16 billion within five years. This is a return of \$5.60 for every \$1 invested. Projected savings include \$9 billion for private payers, \$1.9 billion for Medicaid and \$5 billion for Medicare.

The larger ROI argument is that prevention works. We know, for example, that when people modify preventable behaviors such as smoking, they become healthier and live longer. California's tobacco control program began in the 1980s, about the same time as *America's Health Rankings*[™].

Since then, smoking among Californians has declined 25 percent, saving an estimated 50,000 lives by 2010. The financial ROI is huge: some \$86 billion in personal health care costs so far, a 50-to-1 return on the state's investment of \$1.8 billion. This is a great case study of how public health can transform the health trajectory of an entire population with a sound strategy and a willingness to stay the course.

Our foundation is investing half-a-billion dollars to achieve the same dramatic results by reversing the epidemic of childhood obesity by 2015. In four decades, obesity rates have quadrupled among children ages 6 to 11. Today, almost 32 percent of all children and adolescents in the U.S. are overweight or obese, more than 23 million kids and teenagers. America's teenagers are the fattest in the world. Medically, they are at much higher risk for debilitating chronic conditions, like type 2 diabetes, high blood pressure, cardiovascular disease; stroke; even colon, kidney and breast cancers. It is almost certain they will mature into obese adults, bringing the same severe health conditions with them.

The fiscal prospects are ominous. Federal officials estimate the cost of

obesity-related medical expenses and lost productivity to be at least \$117 billion per year and that is before the current crop of overweight and obese kids even reach adulthood. By then, researchers predict, one of every five dollars spent on elder care will be related to obesity. Medicaid and Medicare will collapse under the weight if the epidemic is not abated. Our goal is to alter unhealthy behaviors by stimulating more healthy choices among individuals, communities, the social and cultural environment and in public policies.

Our foundation's experience in bringing about needed change convinces me that America can develop common sense solutions to our nation's crisis of health and health care. Step one — improving the safety, quality and equality of care — shows encouraging progress. Step two — overcoming the obstacles to better health itself — is not far behind.

Though evidence drives everything, research and data on their own are not enough. To improve health care, we must speedily transfer the best science and best practices into the hands of practitioners and patients. Similarly, to improve health we must connect evidence-based public health and disease prevention strategies to a newly-fired political will to put them into practice at every level — local, state and federal.

America cannot afford to back-burner the country's health and health care any longer. The threats to our nation's economic, social and national security are too severe and their connection to the good health of our people too tight. If you have any doubt that the writing is on the wall, take another look at the latest chapter of *America's Health Rankings*[™]. How the story ends is up to us.

Introduction

Health is a result of our personal behaviors, our individual genetic predisposition to disease, the environment and the community in which we live, the clinical care we receive and the policies and practices of our health care and prevention systems. Each of us, individually, as a community, and as a society, strives to optimize these health determinants, so that all of us can have a long, disease-free and robust life regardless of race, gender or socio-economic status.

This report looks at the four groups of health determinants that can be affected:

1. **Personal behaviors** include the everyday activities we do that affect our personal health. It includes habits and practices we develop as individuals and families that have an effect on our personal health and on our utilization of health resources. These behaviors are modifiable with effort by the individual supported by community, policy and clinical interventions.
2. **Community & environment** reflects the reality that the daily conditions in which we live our lives have a

great effect on achieving optimal individual health.

3. **Public & health policies** are indicative of the availability of resources to encourage and maintain health and the extent that public and health programs reach into the general population.
4. **Clinical care** reflects the quality, appropriateness and cost of the care we receive at doctors' offices, clinics and hospitals.

All health determinants are intertwined and must work together to be effective. For example, an initiative that addresses tobacco cessation requires not only efforts on the part of the individual but also support from the community in the form of public and health policies that promote non-smoking and the availability of effective counseling and care at clinics. Similarly, sound prenatal care requires individual effort, access to and availability of prenatal care coupled with high quality of health care services.

America's Health Rankings™ combines individual measures of each of these determinants with the resultant health outcomes into one, comprehensive view of the health of a

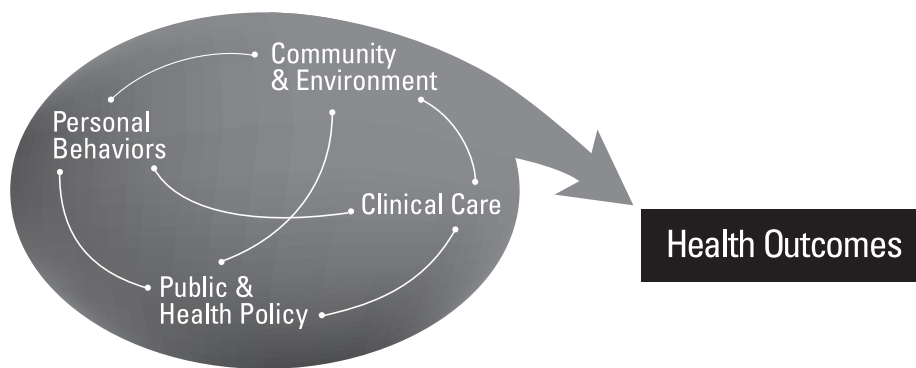
state. Additionally, it discusses health determinants separately from health outcomes.

America's Health Rankings™ employs a unique methodology, developed and periodically reviewed by a panel of leading public health scholars, which balances the contributions of various factors, such as smoking, binge drinking, high school graduation rates, children in poverty, access to care and incidence of preventable disease, to a state's health. The report is based on data from the U.S. Departments of Health and Human Services, Commerce, Education and Labor; U.S. Environmental Protection Agency; the American Medical Association; the Dartmouth Atlas Project; and the Trust for America's Health.

Purpose

The ultimate purpose of *America's Health Rankings™* is to stimulate action by individuals, communities, public health professionals, health industry employees and public administration and health officials to improve the health of the population of the United States. We do this by promoting public conversation concerning health in our states, as well as providing information to facilitate citizen participation. We encourage participation in all elements: personal behaviors, community, environment, clinical care, and public and health policies. Each person individually, and in their capacity as an employee, employer, voter, community volunteer, health official or elected official, can contribute to the advancement of the healthiness of their state. Proven, effective and innovative actions can improve the health of people in every state whether the state is first or 50th.

Figure 1
Components of Health



Scientific Advisory Committee

In 2002, United Health Foundation, in concert with the American Public Health Association (APHA) and Partnership for Prevention, commissioned the School of Public Health at the University of North Carolina at Chapel Hill to undertake an ongoing review of *America's Health Rankings*[™]. The Scientific Advisory Committee, led by Thomas Ricketts, Ph.D., M.P.H., was charged with conducting a thorough review of the current index and recommending improvements that would maintain the value of the comparative, longitudinal information; reflect the evolving role and science of public health; utilize new or improved measures of health as they become available and acceptable; and incorporate new methods as feasible. Minor issues with data are always addressed immediately and incorporated into the contents of the next edition of the report. However, more significant issues, such as new measurements of health conditions, require more in-depth study and analysis. Several changes in the methodology were made to the 2002, 2004, 2005, 2006 and 2007 Editions at the recommendation of the Committee. Previous Editions are available at www.americashealthrankings.org.

The Scientific Advisory Committee continues its review, and its input is reflected in this Edition. The Committee emphasizes the importance of this tool

as a vehicle to promote and improve the general discussion of public health and, also, to encourage balance among public health efforts to benefit the entire community.

The committee made several suggestions regarding the 2008 Edition. Its suggestions include:

- Integrating the effect of health disparities directly into the index. In prior years, health disparities were discussed in the commentaries and included through the race adjusted mortality rates in Health Outcomes. It was not included as an explicit measure in the index. Geographic Disparity was added as a measure this year.
- Incorporating the effect of air pollution directly into the index. Air Pollution was added this year and may serve as a proxy for the impact that the environment has on health.

In addition, the committee continues to work on issues concerning improved environmental health indicators, methods of expressing variability within the rankings, oral health indicators, mental health indicators, improved health disparities, improved cost measures, quality of care measures and international benchmarking. The committee also accents the importance of focusing on health determinants, as improving these measures can improve the healthiness of the states and the nation.

The methodology review group represents a variety of stakeholders, including representatives from state health departments and the Centers for Disease Control and Prevention, members of APHA, as well as experts from many academic disciplines.

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Findings

2008 Results

America's Health Rankings™— 2008 Edition shows Vermont at the top of the list of healthiest states. This is the second year that Vermont has been ranked number one. The state has had a steady climb in the rankings for the last eight years from a ranking of 8th in 2001. Hawaii is ranked second this year; it was third in the 2007 Edition. New Hampshire is number three, followed by Minnesota and Utah. Louisiana is 50th and the least healthy state, while Mississippi is 49th. South Carolina, Tennessee and Texas complete the bottom five states.

Vermont moved from 16th in 1990 to the top position in 2007 and 2008. Vermont's strengths include ranking in the top five states for a high rate of high school graduation, a low violent crime rate, a low percentage of children in poverty, high per capita public health funding, ready access to primary care, low geographic disparity of mortality rates within the state and a low premature death rate. It also ranks first overall in all health determinants combined and ranks in the top 20 states for all measures except two. Those two challenges are low immunization coverage with 79.8 percent of children ages 19 to 35 months receiving complete immunizations and a high prevalence of binge drinking at 17.3 percent of the population. For further details, see Vermont's state snapshot on page 79 or visit www.americashealthrankings.org/2008/glance.html.

Louisiana is 50th this year, down from 49th in the 2007 Edition. It has been in the bottom two states since the 1990 Edition. The state ranks well for ready access to prenatal care, a low prevalence of binge drinking, high per capita public health funding and few poor mental health days. It ranks in the bottom five states on 10 of the 22 measures including a high prevalence of obesity, a high percentage of children in poverty, a high rate of uninsured population, a high incidence of infectious disease, a low rate of high school graduation and many preventable hospitalizations. It ranks 50th for all health determinants combined, so its overall ranking is unlikely to change significantly in the near future. For further details, see Louisiana's state snapshot on page 52 or visit www.americashealthrankings.org/2008/glance.html.

Table 1 (page 8) lists the score and ranking for each of the 50 states.

Scores presented in the tables indicate the percentage a state is above or below the national norm. For example, Connecticut with a score of 17.5 is 17.5 percent above the national average for that measure. A negative score means the state is below the national average. When comparing states from year to year, differences in score are more important than changes in ranking.

Table 1
2008 Overall Rankings

ALPHABETICAL BY STATE			RANK ORDER		
RANK	STATE	SCORE*	RANK	STATE	SCORE*
40	Alabama	-7.0	1	Vermont	24.8
30	Alaska	1.3	2	Hawaii	21.6
33	Arizona	0.4	3	New Hampshire	19.9
43	Arkansas	-8.1	4	Minnesota	18.8
24	California	5.3	5	Utah	18.2
19	Colorado	9.7	6	Massachusetts	17.7
7	Connecticut	17.5	7	Connecticut	17.5
35	Delaware	-1.6	8	Idaho	16.1
45	Florida	-8.9	9	Maine	15.3
41	Georgia	-7.8	10	Washington	14.9
2	Hawaii	21.6	11	Rhode Island	14.0
8	Idaho	16.1	12	North Dakota	12.5
31	Illinois	0.8	13	Nebraska	12.0
34	Indiana	-0.6	14	Wyoming	11.8
15	Iowa	11.6	15	Iowa	11.6
22	Kansas	6.7	16	Oregon	11.3
37	Kentucky	-3.6	17	Wisconsin	10.3
50	Louisiana	-15.2	18	New Jersey	9.8
9	Maine	15.3	19	Colorado	9.7
26	Maryland	3.4	20	Virginia	9.0
6	Massachusetts	17.7	21	South Dakota	7.5
27	Michigan	2.0	22	Kansas	6.7
4	Minnesota	18.8	23	Montana	6.5
49	Mississippi	-15.0	24	California	5.3
38	Missouri	-4.9	25	New York	3.8
23	Montana	6.5	26	Maryland	3.4
13	Nebraska	12.0	27	Michigan	2.0
42	Nevada	-7.9	27	Pennsylvania	2.0
3	New Hampshire	19.9	29	New Mexico	1.7
18	New Jersey	9.8	30	Alaska	1.3
29	New Mexico	1.7	31	Illinois	0.8
25	New York	3.8	32	Ohio	0.7
36	North Carolina	-3.2	33	Arizona	0.4
12	North Dakota	12.5	34	Indiana	-0.6
32	Ohio	0.7	35	Delaware	-1.6
43	Oklahoma	-8.1	36	North Carolina	-3.2
16	Oregon	11.3	37	Kentucky	-3.6
27	Pennsylvania	2.0	38	Missouri	-4.9
11	Rhode Island	14.0	39	West Virginia	-5.0
48	South Carolina	-10.7	40	Alabama	-7.0
21	South Dakota	7.5	41	Georgia	-7.8
47	Tennessee	-9.7	42	Nevada	-7.9
46	Texas	-9.0	43	Arkansas	-8.1
5	Utah	18.2	43	Oklahoma	-8.1
1	Vermont	24.8	45	Florida	-8.9
20	Virginia	9.0	46	Texas	-9.0
10	Washington	14.9	47	Tennessee	-9.7
39	West Virginia	-5.0	48	South Carolina	-10.7
17	Wisconsin	10.3	49	Mississippi	-15.0
14	Wyoming	11.8	50	Louisiana	-15.2

*Scores presented in this table indicate the percentage a state is above or below the national norm.

Determinants and Outcomes

The 22 measures that comprise *America's Health Rankings™* are of two types — health determinants and health outcomes. Health determinants represent those actions that can affect the future health of the population, whereas health outcomes represent the result of what has already occurred, either through death or missed days due to illness.

For a state to improve the health of its population, efforts must focus on changing the determinants of health. If a state is significantly better in its ranking for health determinants than its ranking for health outcomes, it will be more likely to improve its overall health ranking in the future. Conversely, if a state is worse in its ranking for health determinants than its ranking for health outcomes, its overall health ranking will be more likely to worsen over time.

Table 2 (page 10) presents the rankings for the health determinants, the rankings for the health outcomes and implications for the future. If the current trend is positive, the future overall ranking is more likely to increase; if it is neutral, the future overall ranking will probably stay the same; or if it is negative, the future overall ranking is more likely to decrease.

The top ten states for strong determinants are, in order from the top ranked state: Vermont, Hawaii, New Hampshire, Utah, Minnesota, Maine, Massachusetts, Idaho, Connecticut and Rhode Island. The states with the weakest determinants, beginning with the lowest listed first, are: Louisiana, Mississippi, Texas, South Carolina, Florida, Tennessee, Georgia, Nevada, Arkansas and Oklahoma.

When compared to other states, South Dakota and Virginia have a much higher ranking for health determinants than for health outcomes, showing a stronger indication they will improve over time.

New York, Iowa and Texas show a stronger indication that they will decline over time compared to other states.

Health Disparities Within States

One of the primary goals of *Healthy People 2010* is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.¹

The statewide measures used in *America's Health Rankings™* reflect the condition of the "average" resident. However, when those measures are examined more closely, startling differences can exist within a state when race, gender, geographic location and/or economic status are considered.

The National Healthcare Disparities Report (<http://www.ahrq.gov/qual/nhdr07/nhdr07.pdf>), released each year by the Agency for Healthcare Research and Quality, highlights disparities at a national level. The report analyzes 47

¹ Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Rockville, Md., <http://www.healthypeople.gov/About/goals.htm>

measures and indicates that disparities exist for many groups, including women, children, the elderly, rural residents, and among racial and socioeconomic groups. The report also indicates that such disparities affect all aspects of health and health care delivery, including preventive care, acute care and chronic disease management, and affect many delivery locations including primary care, home health care, hospice, emergency care, hospitals and nursing homes.

Three themes emerge from this report:

- Access to quality health care varies widely among Americans.
- The disparities in access to quality health care are not decreasing, and gaps between groups have not been reduced.
- The problem of persistent uninsurance is a major barrier to reducing these health disparities.

While each state has unique issues that contribute to disparities, states that have been successful in reducing disparities in health indicators while retaining high overall health can serve as models for other states.

The 2008 Edition of *America's Health Rankings™* now contains an

Graph 1
Geographic Disparity for United States Since 2004

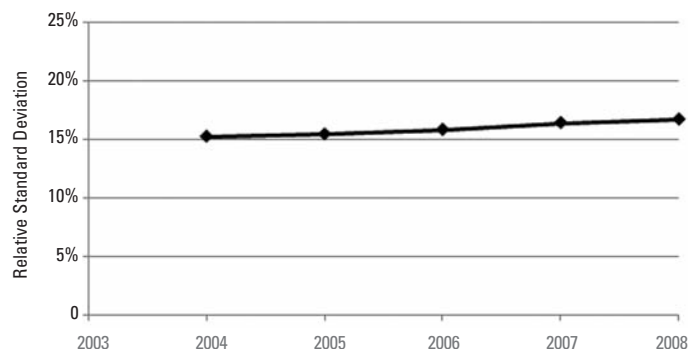


Table 2
Determinants and
Health Outcomes, 2008

STATE	RANK FOR ALL DETERMINANTS	RANK FOR ALL HEALTH OUTCOMES	INFLUENCE ON FUTURE OVERALL RANK
Alabama	39	49	Positive
Alaska	29	30	Neutral
Arizona	32	25	Negative
Arkansas	42	44	Neutral
California	24	21	Neutral
Colorado	16	23	Positive
Connecticut	7	4	Neutral
Delaware	35	34	Neutral
Florida	46	41	Negative
Georgia	44	38	Negative
Hawaii	2	4	Neutral
Idaho	7	12	Positive
Illinois	33	21	Negative
Indiana	34	28	Negative
Iowa	21	2	Negative
Kansas	23	17	Negative
Kentucky	36	39	Neutral
Louisiana	50	48	Neutral
Maine	6	17	Positive
Maryland	25	28	Neutral
Massachusetts	7	2	Negative
Michigan	26	27	Neutral
Minnesota	5	1	Neutral
Mississippi	49	50	Neutral
Missouri	40	37	Neutral
Montana	22	32	Positive
Nebraska	15	10	Negative
Nevada	43	40	Neutral
New Hampshire	3	7	Neutral
New Jersey	20	15	Negative
New Mexico	30	23	Negative
New York	31	8	Negative
North Carolina	37	36	Neutral
North Dakota	12	16	Neutral
Ohio	28	34	Positive
Oklahoma	41	45	Neutral
Oregon	18	13	Negative
Pennsylvania	27	25	Neutral
Rhode Island	10	19	Positive
South Carolina	47	42	Negative
South Dakota	13	43	Positive
Tennessee	45	47	Neutral
Texas	48	33	Negative
Utah	4	14	Positive
Vermont	1	6	Positive
Virginia	14	30	Positive
Washington	11	10	Neutral
West Virginia	38	46	Positive
Wisconsin	17	20	Neutral
Wyoming	19	8	Negative

explicit metric for disparities — Geographic Disparity. This indicator reflects the range of age-adjusted mortality rates that exist within a state at the county level. Graph 1 (page 9) shows the disparity increasing in the United States over the last five years. Disparity in mortality rates occur for many reasons, including differences in personal behaviors, genetics, community and environmental situations, health care policies and clinical interventions. State data is available at www.americashealthrankings.org/2008/geographic.html.

While this overall disparity metric provides a broad view of the challenges facing a state, specific measures shed more light on the sources of the disparity. Three examples are highlighted here: lack of health insurance, low birth weight infants and mortality from cardiovascular disease, with specific supporting information presented in each state's snapshot. Some of the greatest disparities exist in states where one population group has been especially successful in one determinant. For example, in Connecticut and Minnesota, the number of uninsured non-Hispanic whites is very low when compared to either the non-Hispanic black or the Hispanic populations.

Lack of health insurance, cited in the 2007 National Healthcare Disparities Report as one of the underlying causes of disparities, shows that at a national level uninsurance among Hispanics age 18 to 64 years is almost three times that of non-Hispanic whites, and non-Hispanic blacks are uninsured at a rate about 1.5 times that of non-Hispanic whites (Table 3). However, the uninsured rate for Hispanics is over four times higher than the uninsured rate among non-Hispanic whites in five states: Connecticut, Illinois, Iowa, New Jersey and North Carolina. This is in contrast to Ohio, Wyoming, Montana and Mississippi where the rate is only 1.5 times higher for Hispanics

compared to non-Hispanic whites. In Minnesota, the uninsured rate for non-Hispanic blacks is almost three times the uninsured rate for non-Hispanic whites which contrasts with Arizona and West Virginia, where the difference is only 1.2 times. There are also differences by gender across the states. These data illustrate that basic access to health care varies greatly by population group. See www.americashealthrankings.org/2008/disparity-insurance.html for details on the differences in uninsurance by race and gender for the states.

Strong disparities are also apparent in the percentage of babies born with low birth weight, measured as less than 2,500 grams (Table 4). Nationally, low birth weight infants are 1.9 times as common among non-Hispanic blacks as among non-Hispanic whites and twice as common among non-Hispanic blacks as among Hispanics. Within states, this disparity varies; from Michigan, where low birth weight infants are 2.1 times as common among non-Hispanic blacks as among non-Hispanic whites, to West Virginia, where it is only 1.5 times as common. State data is available at www.americashealthrankings.org/2008/disparity-lbw.html.

Cardiovascular death rates also vary considerably by race as shown in Table 5, which indicates the gap between blacks with a cardiovascular death rate of 395.7 deaths per 100,000 population and all other non-white races at 181.8 deaths per 100,000 population. While these disparities exist in all states, the gaps are largest in California, Michigan and Wyoming and smallest in West Virginia and Massachusetts. State data is available at www.americashealthrankings.org/2008/disparity-cvd.html.

All of these disparities in health outcomes highlight the need to identify specific areas that contribute to these gaps within each state and throughout our country and develop programs that address those needs, thus reducing health disparities.

Table 3
Uninsured Rates by Race/Ethnicity and by Gender in the United States

GROUP	UNINSURED PERCENT OF POPULATION AGE 18 TO 64
Non-Hispanic White	12.2%
Non-Hispanic Black	17.7%
Hispanic	34.2%
Males	18.2%
Females	15.1%

Source: 2004-2006 data, Centers for Disease Control and Prevention, BRFSS. See www.cdc.gov/nchs/health_data_for_all_ages.htm.

Table 4
Low Birth Weight Infants by Race/Ethnicity in the United States

GROUP	PERCENT OF BIRTHS
Non-Hispanic White	7.2%
Non-Hispanic Black	13.8%
Hispanic	6.8%

Source: 2003-2005 data, Centers for Disease Control and Prevention. See www.cdc.gov/nchs/health_data_for_all_ages.htm.

Table 5
Cardiovascular Death Rate by Race in the United States

GROUP	DEATHS PER 100,000 POPULATION (AGE-ADJUSTED)
White	291.2
Black	395.7
All Other Races	181.8

Source: 2005 data, Center for Disease Control and Prevention, National Center for Health Statistics

Healthy Environment

The environment in which we live, including the air we breathe, the water we drink and the environs with which we interact, affects our health. To date, numerous studies have linked the environment to health, and with each passing year, we learn of even greater impact.

In acknowledgement of these connections, for the first time, *America's Health Rankings™— 2008 Edition* includes an explicit factor, Air Pollution, as a Health Determinant for the environment. The impact of the environment is also reflected in many other measures, such as cancer deaths, cardiovascular deaths and poor physical health days, all currently included as measures in the Health Outcomes.

Air Pollution is a measure of the exposure of the general population to fine, microscopic solids or liquid droplets that are so minute that they are absorbed deep in the lungs. Such particles can include dust, smoke and chemicals; all of which are so fine that they appear as a haze in higher concentrations. Numerous scientific studies have linked particulate pollution exposure to a variety of problems, including:

- Increased respiratory symptoms, such as irritation of the airways, coughing, or difficulty breathing;
- Decreased lung function;
- Aggravated asthma;
- Development of chronic bronchitis;
- Irregular heartbeat;
- Nonfatal heart attacks; and
- Premature death in people with existing heart or lung disease.

It should be noted that people with heart or lung diseases, children and older adults are the most likely to be affected by particulate pollution exposure (<http://www.epa.gov/air/particlepollution/health.html>).

Air pollution information is gathered by the U.S. Environmental Protection Agency and reported online at www.epa.gov/air/data/. This data

is gathered through the state EPA departments, which place and monitor detectors throughout the United States, thus gathering data on the air quality at very specific locations. County estimates are determined by combining readings from all monitors in that county to provide an average of the exposure for the county. The measure used in this report is the population-weighted average exposure over all counties monitored within a state.

Nationally, air pollution has declined over the last seven years from 15.0 to 13.1 micrograms of fine particulate per cubic meter. California has experienced the greatest improvement in this measure during the last seven years, declining from 20.0 to 14.8 micrograms of fine particulate per cubic meter. Only five states have experienced no improvement during this interval: Utah, Texas, Wisconsin, Alaska and Iowa; these same states, with the exception of Texas, are already below the national average.

State data is available at www.americashealthrankings.org/2008/air.html.

Comparison to Other Nations

When health in the United States is compared to health in other countries, the picture is disappointing. The World Health Organization, in its annual *World Health Statistics 2008*, compares the United States to the nations of the world on a large variety of measures. While the U.S. does exceed many countries, it is far from the best in many of the common measures used to gauge our healthiness and lags behind its peers in other developed countries.

Healthy life expectancy (HALE) is a measure that indicates the number of years that a newborn can expect to live a healthy and productive life. Japan is the perennial leader in this measure with a HALE of 75 years on average for both genders. At 69 years, the United States has the same HALE as Portugal and Slovenia. There are 27 other

countries that exceed the United States in healthy life expectancy, including Australia, Greece, United Kingdom, Italy, Germany and France. The difference between Japan and the United States for females is 7 years; the difference for males is 5 years (Table 6).

One of the underlying causes for these differences is the gap in infant mortality rates between the United States and many other countries (Table 6). The infant mortality rate for the U.S. in 2006 was seven deaths per 1,000 live births; the infant mortality rates for Japan, Sweden, Finland, Singapore, Slovenia, Italy, Norway, Denmark, Portugal and the Czech Republic were three deaths per 1,000 live births. Other countries that had lower rates than the United States in this area include Canada, Australia, the United Kingdom, France and Germany. Of the over 150 countries rated, fully 38 countries had lower infant mortality rates than the United States.

Table 6 also shows the age-adjusted mortality rate for cancer and cardiovascular disease and the prevalence of obesity. Among the top nations, the U.S. is rated average to slightly below average when judged by cancer and cardiovascular death rates and is rated comparably in the prevalence of smoking. Citizens in the U.S. are clearly more obese than those of other countries, often at more than twice the rate of other countries.

Differences in healthy life expectancy are also affected by the effectiveness of treating disease, especially those that are amenable to care, including bacterial infections, treatable cancers, diabetes, cardiovascular and cerebrovascular disease, some ischemic heart disease and complications from common surgical procedures. The age-adjusted amenable mortality rate before age 75 for the United States was 109.7 deaths per 100,000 population in 2002, which meant it ranked last among the nineteen countries of the Organization for Economic Cooperation and

Table 6
International Comparisons

LOCATION	HEALTHY LIFE EXPECTANCY*	INFANT MORTALITY RATE*	CANCER DEATHS*	CARDIO-VASCULAR DEATHS*	PERCENT OF FEMALES WHO ARE OBESE*	PERCENT OF MALES WHO ARE OBESE*	PERCENT WHO USE TOBACCO*
Japan	75	3	119	106	3.3	2.9	29.4
Iceland	73	2	136	164	12.3	12.4	26.3
Italy	73	3	134	174	8.9	7.4	26.1
Monaco	73	3	120	115	—	—	—
San Marino	73	3	140	223	—	—	—
Spain	73	4	131	137	13.5	13	33.7
Sweden	73	3	116	176	9.5	10.4	22
Switzerland	73	4	116	142	7.5	7.9	26.5
Australia	73	5	127	140	—	—	24.8
Canada	72	5	138	141	13.9	15.9	21.6
Andorra	72	3	126	125	—	—	32.9
France	72	4	142	118	—	—	31.7
Germany	72	4	141	211	12.3	13.6	31.6
Luxembourg	72	3	134	177	—	—	34.7
Norway	72	3	137	181	5.9	6.4	32
Austria	71	4	127	204	—	—	43.3
Belgium	71	4	148	162	13.4	11.9	27.1
Finland	71	3	115	201	13.5	14.9	28.1
Greece	71	4	132	258	18.2	26	51.8
Israel	71	4	133	136	—	—	24.6
Malta	71	5	124	214	21.3	25	28.7
Netherlands	71	4	155	171	—	—	34.3
United Kingdom	71	5	143	182	23	22.3	35.7
New Zealand	71	5	139	175	23.2	21.9	28.6
Denmark	70	3	167	182	9.1	9.8	33.4
Ireland	70	4	151	214	12	14	26.3
Singapore	70	3	128	171	7.3	6.4	—
United States of America	69	7	134	188	33.2	31.1	23.9
Portugal	69	3	140	208	—	—	35.8
Slovenia	69	3	160	228	13.8	16.5	26.5
Czech Republic	68	3	177	315	16.3	13.7	31.0

— Data not available

Source: Various years of data, World Health Statistics, 2008, World Health Organization, Geneva, Switzerland.

*Definitions:

Healthy Life Expectancy (HALE): Years at birth, both genders.

Infant Mortality Rate (IMR): Deaths per 1,000 live births, both genders.

Cancer Deaths: Age-standardized mortality rate for cancer per 100,000 population.

Cardiovascular Deaths: Age-standardized mortality rate for cardiovascular diseases per 100,000 population.

Obesity-Females: Percent of female adults ≥ 15 years old who are obese.

Obesity-Males: Percent of male adults ≥ 15 years old who are obese.

Tobacco Use: Prevalence of current tobacco use among adults ≥ 15 years old, both genders (%).

Development (OECD) nations studied. The rate in the U.S. is 50 percent higher than the rate in France, Japan, Spain, Italy, Canada and Australia.

Additionally, the study indicated that despite spending more than any other country on health care, the United States continues to slip further behind other countries.

In 1997, the U.S. ranked 15th in this mortality rate. Since then, Finland, Portugal, United Kingdom and Ireland have reduced their mortality rate from disease amenable to care more rapidly than the United States. All now have better rates than the U.S.²

Equally discouraging are results from a UNICEF study of child well-being, in which the U.S. ranked second to last when compared to 21 comparably “rich” countries based on 40 different measures. When UNICEF looked specifically at child health aspects of well-being, the United States fared very poorly due to a high infant mortality rate, a high percentage of low birth weight infants and only an

average rate of immunization coverage.³

The Commonwealth Fund rates the U.S. last in health care system performance when compared to a group of six countries that include Australia, Canada, Germany, New Zealand and the United Kingdom. The U.S. spends twice as much as these six countries on a per-capita basis, yet it is last on dimensions of access, patient safety, efficiency and equity.⁴ So, while the U.S. is spending more on total health care when compared to other countries, the country is getting less access, patient safety, efficiency and equity.

The results of these studies are a wake-up call to everyone in the United States to strive to improve all aspects of our health system however possible, including education, prevention and clinical care. Other countries have improved their overall health by improving their health care system, indicating that we too can do the same.

2 Nolte, Ellen and McKee, C. Martin, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, 27, No 1 (2006): 58-71 <http://content.healthaffairs.org/cgi/content/abstract/27/1/58>

3 “UNICEF, Child poverty in perspective: An overview of child well-being in rich countries, Innocents Report Card 7” 2007, UNICEF Innocenti Research Centre, Florence, <http://www.unicef-irc.org>

4 Davis, K. et. al. Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care, The Commonwealth Fund, May 2007. www.commonwealthfund.org <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w457>

Changes from 1990

National

The 19-year perspective provided by this report allows us to view health over time. During the past 19 years, this report has tracked our nation's 18.4 percent improvement in overall health (Graph 2). This national success stems from improvements in the reduction of infant mortality, infectious disease, prevalence of smoking, cardiovascular deaths, violent crime, children in poverty and occupational fatalities, and an increase in immunization coverage and prenatal care (Table 7). However, success has eluded us in two very significant measures — the rapid increases in both the prevalence of obesity and the rate of uninsured population.

Graph 2 shows that the rate of improvement in the health of the United States' population experienced for the first fifteen years of this index has ceased. During the 1990s, health improved at an average annual rate of 1.5 percent per year. In the last four years, it has stagnated. The overall health of the population in the United States is no longer improving. Special concern surrounds the decline in health determinants, as those measures point to the future health of the population.

The United States has the potential to return to the rates of improvement typical of the 1990s. However, to do so, it must address the drivers of declining health more directly while focusing on reducing important risk factors. For example, while there has been an overall 33 percent decrease in the prevalence of smoking — from 29.5 percent of the population in 1990 to 19.8 percent of the population in 2008 — most of this decrease occurred in the early 1990s. Reductions in the rate of smoking have virtually stagnated in the last four years (Graph 3).

Unprecedented and unchecked growth in the prevalence of obesity has also dramatically affected the overall health of the United States. The prevalence of obesity has more than

Graph 2
Improvements Since 1990

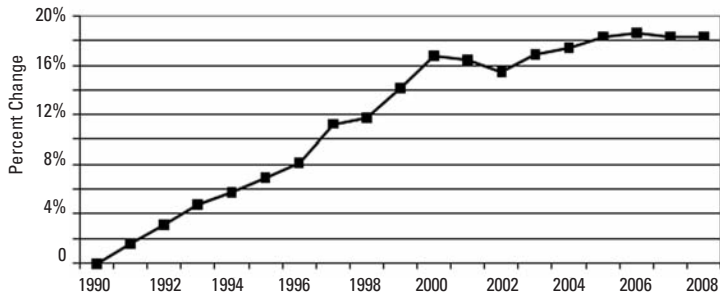


Table 7
National Measures of Successes and Challenges: Long Term

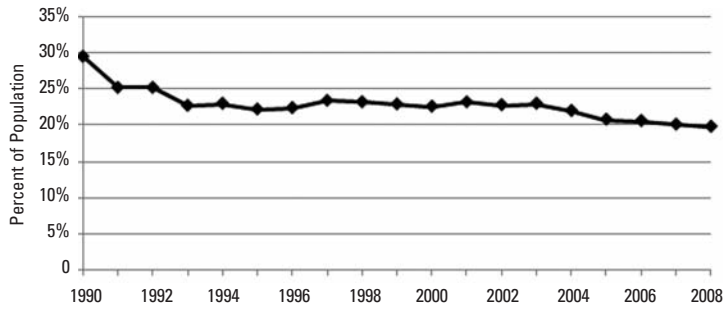
MEASURE	EDITION TO EDITION CHANGES
SUCCESSSES	
Infectious Disease	51 percent decrease in the incidence of infectious disease from 40.7 cases in 1990 to 20.1 cases per 100,000 population in 2008.
Infant Mortality	33 percent decrease in the infant mortality rate from 10.2 deaths in 1990 to 6.8 deaths per 1,000 live births in 2008.
Prevalence of Smoking	33 percent decline in the prevalence of smoking from 29.5 percent in 1990 to 19.8 percent of the population in 2008.
Violent Crime	23 percent decline in the violent crime rate from 609 offenses in 1990 to 467 offenses per 100,000 population in 2008.
Cardiovascular Deaths	26 percent decline in the rate of deaths from cardiovascular disease from 405.1 deaths in 1990 to 298.2 deaths per 100,000 population in 2008.
Children in Poverty	13 percent decline in the percentage of children in poverty from 20.6 percent in 1990 to 18.0 percent of persons under age 18 in 2008.
Occupational Fatalities	40 percent decline in the occupational fatalities rate from 8.7 deaths in 1990 to 5.2 deaths per 100,000 workers in 2008.
Immunization Coverage	45 percent increase in immunization coverage from 55.1 percent in 1996 to 80.1 percent of children ages 19 to 35 months receiving complete immunizations in 2008.
High School Graduation	Slight increase in the rate of high school graduation in the last few years; 74.7 percent of incoming ninth graders now graduate within four years.
Premature Death	14 percent decline from 8,716 years of potential life lost before age 75 per 100,000 population in 1990 to 7,490 years of potential life lost before age 75 per 100,000 population in 2008.
CHALLENGES	
Prevalence of Obesity	127 percent increase in the prevalence of obesity from 11.6 percent in 1990 to 26.3 percent of the population in 2008.
Lack of Health Insurance	16 percent increase in the rate of uninsured population from 13.4 percent in 1990 to 15.5 percent in 2008.
Poor Mental Health Days	In the last eight years, the number of poor mental health days per month increased from 3.0 to 3.4 days in the previous 30 days.
Poor Physical Health Days	In the last eight years, the number of poor physical health days per month increased from 3.2 to 3.6 days in the previous 30 days.

doubled from 11.6 percent of the population in 1990 to 26.3 percent of the population in 2008. Now, more than one in four people in the U.S. is considered obese — a category that the Centers for Disease Control and Prevention reserves for those who are significantly over the suggested body weight given their height. This alarming rate of increase shows no evidence of slowing or abating (Graph 4).

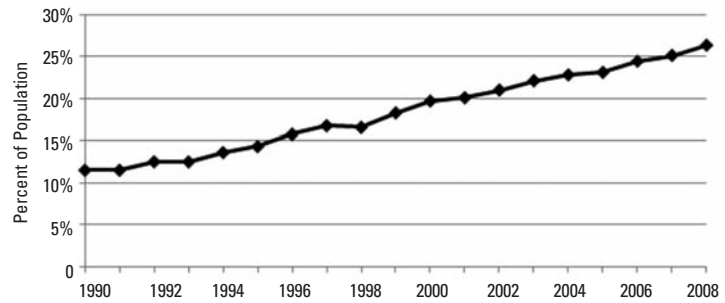
Lack of health insurance coverage increased from 13.9 percent in 2002 to 15.5 percent of the population in 2008 (Graph 5). Lack of health insurance not only inhibits people from getting the proper care when needed but also reduces access to necessary preventive care to curtail or minimize future illnesses.

While there have been improvements since 1990, these worsening influences have caused and will continue to cause slower rates of improvement than experienced in the 1990s.

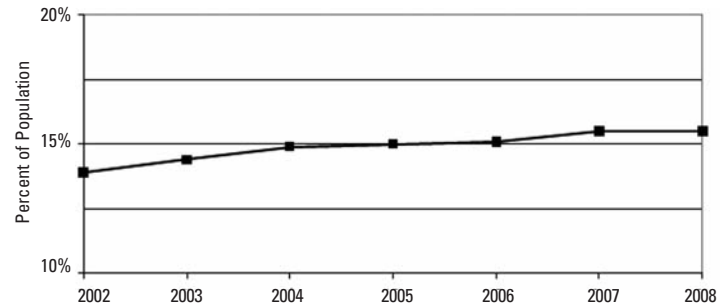
Graph 3
Prevalence of Smoking Since 1990



Graph 4
Prevalence of Obesity Since 1990



Graph 5
Lack of Health Insurance Since 2002



States

All states show a positive change in overall score between 1990 and 2008.

Vermont, Oregon, Idaho, Alaska and Washington have improved more than 28.4 percent overall since the 1990 Edition, or 10 percent more than the national average change in score of 18.4 percent (Table 8). Twenty-eight states in total have exceeded the national rate of improvement.

The principal reasons for the changes in these states from 1990 to 2008 are:

Vermont: The prevalence of smoking declined from 30.7 percent to 17.6 percent of the population, the percentage of children in poverty declined from 15.9 percent to 10.9 percent of persons under age 18, and the prevalence of obesity increased from 10.7 percent to 21.9 percent of the population, indicating a slower rise in obesity in this area than in the U.S. overall. Occupational fatalities, lack of health insurance and violent crime in Vermont remain very low. Vermont leads the nation in its ranking for health determinants, an indication that it will continue to have a position at the top of the rankings in future years. Health outcomes are also strong in the state as the infant mortality rate decreased from 9.2 to 5.8 deaths per 1,000 live births, and the rate of deaths from cardiovascular disease decreased from 401.7 to 255.7 deaths per 100,000 population. The premature death rate declined from 7,842 to 5,905 years of potential life lost before age 75 per 100,000 population. See Vermont's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Oregon: The incidence of infectious disease declined from 92.8 to 11.8 cases per 100,000 population, the prevalence of smoking declined from 27.1 percent to 16.9 percent of the population, and the violent crime rate declined from 540 to 288 offenses per 100,000 population. The percentage of children in poverty increased from 12.4 percent to 15.3 percent of persons

under age 18, and the prevalence of obesity increased from 10.9 percent to 26.3 percent of the population. Overall determinants improved from a ranking of 31st to a ranking of 18th, a fact that supports improvement in overall ranking in recent years. On measures of health outcomes, the infant mortality rate declined from 9.9 to 5.9 deaths per 1,000 live births, and the rate of deaths from cardiovascular disease decreased from 370.0 to 265.1 deaths per 100,000 population. See Oregon's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Idaho: The percentage of children in poverty decreased from 19.3 percent to 12.6 percent of persons under age 18, the occupational fatalities rate declined from 17.5 to 4.7 deaths per 100,000 workers, and the incidence of infectious disease decreased from 38.8 to 4.5 cases per 100,000 population. Overall determinants in the state improved from a ranking of 21st to a ranking of 7th, a fact that supports the state's improvement in overall ranking in recent years. On measures of health outcomes, the infant mortality rate decreased from 10.8 to 5.9 deaths per 1,000 births, and the premature death rate decreased from 7,831 to 6,444 years of potential life lost before age 75 per 100,000 population. See Idaho's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Alaska: The incidence of infectious disease decreased from 92.2 to 14.9 cases per 100,000 population, the percentage of children in poverty declined from 16.6 percent to 8.5 percent of persons under age 18 and the prevalence of obesity increased from 13.4 percent to 28.2 percent of the population, a rate of increase slightly less than the national average. The violent crime rate increased from 455 to 661 offenses per 100,000 population, despite a decline in crime rates nationally. In health outcomes, the infant mortality rate in Alaska decreased from 10.6 to 6.1 deaths per

Table 8

States with the Greatest Overall Health Score Improvement 1990 to 2008

STATE	CHANGE IN SCORE
Vermont	+34.6
Oregon	+34.5
Idaho	+30.4
Alaska	+29.2
Washington	+28.8

1,000 live births, the premature death rate decreased from 9,304 to 7,582 years of potential life lost before age 75 per 100,000 population, and deaths from cancer declined from 200.6 to 188.2 deaths per 100,000 population. See Alaska's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Washington: The prevalence of smoking decreased from 28.6 percent to 16.8 percent of the population, the incidence of infectious disease decreased from 84.1 to 12.4 cases per 100,000 population and the occupational fatalities rate decreased from 9.9 to 3.7 deaths per 100,000 workers. The prevalence of obesity in the state increased from 9.4 percent to 25.9 percent of the population, a rate faster than the national average. Health determinants and health outcomes rank equally in the state, indicating Washington will likely remain near its current ranking in future years. Strong health outcomes for the state are the declining infant mortality rate, which dropped from 9.7 to 4.8 deaths per 1,000 live births and a declining premature death rate, which decreased from 7,725 to 6,131 years of potential life lost before age 75 per 100,000 population. See Washington's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Twenty-two states are below the national rate of improvement and are slipping further behind in healthiness

when compared to the nation as a whole. Missouri improved the least since 1990 and has improved its overall score only by 9.9 percent compared to the national 18.4 percent rate of improvement. Wisconsin, Oklahoma, Ohio and North Dakota have increased by less than 12 percent (Table 9).

The principal reasons for changes in these states from 1990 to 2008 are:

Missouri: The prevalence of smoking declined a very small amount in Missouri from 27.7 percent in 1990 to 24.5 percent of the population in 2008; this is a much slower decline than the national average. The prevalence of obesity increased from 11.9 percent to 28.2 percent of the population and the percentage of children in poverty increased from 19.4 percent to 22.1 percent of persons under age 18. The state's infant mortality rate, while improving from 10.5 to 8.1 deaths per 1,000 live births, lags most other states in both the level and rate of improvement. Similarly, the rates of cardiovascular deaths, cancer deaths and premature death are improving, but very slowly. See Missouri's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Wisconsin: In 1990, Wisconsin was ranked 6th for a low prevalence of smoking; this year their rank is 24th, showing that the state is improving slower than other states. The violent crime rate increased from 250 to 291 offenses per 100,000 population from 1990 to 2008, counter to a national decline. The percentage of children in poverty increased from 12.6 percent to 15.7 percent of persons under age 18. The infant mortality rate declined from 8.9 deaths in 1990 to 6.5 deaths per 1,000 live births in 2008 in the state, a notable improvement but slower than the national rate of decline. Health determinants and health outcomes rank about equally, indicating Wisconsin will probably not change significantly in rankings in the next few

years. See Wisconsin's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Oklahoma: The prevalence of obesity increased from 11.6 percent to 28.8 percent of the population, the prevalence of smoking decreased from 33.0 percent to 25.8 percent of the population, the percentage of children in poverty increased from 17.7 percent to 19.0 percent of persons under age 18 and the violent crime rate increased from 419 to 500 offenses per 100,000 population. Health determinants and health outcomes rank about equally, indicating Oklahoma will probably not change significantly in rankings in the next few years. Changes in Oklahoma's health outcomes in the last 19 years include an increase in the rate of cancer deaths, which increased from 190.0 to 203.7 deaths per 100,000 population and a decline in the infant mortality rate, which decreased from 10.0 to 7.9 deaths per 1,000 live births but failed to match the rate of decline elsewhere in the U.S. See Oklahoma's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Ohio: The prevalence of obesity increased from 11.3 percent to 28.1 percent of the population and the percentage of children in poverty increased from 17.2 percent to 19.1 percent of persons under age 18. Health determinants rank just slightly higher than health outcomes, indicating Ohio may improve slightly in future rankings. Changes in Ohio's health outcomes in the last 19 years include a decline in the infant mortality rate, which decreased from 9.9 to 8.1 deaths per 1,000 live births but failed to match the rate of decline elsewhere in the U.S. The state's premature death rate also declined from 8,313 years lost in 1990 to 7,861 years of potential life lost before age 75 per 100,000 population, a rate slower than the national decline. See Ohio's complete state summary later in this report or

Table 9
States with the Least Overall Health Score Improvement 1990 to 2008

STATE	CHANGE IN SCORE
Missouri	+9.9
Wisconsin	+10.3
Oklahoma	+11.1
Ohio	+11.4
North Dakota	+11.7

visit www.americashealthrankings.org/2008/glance.html.

North Dakota: The prevalence of smoking decreased from 26.4 percent in 1990 to 20.9 percent of the population in 2008, slower than the decline in the national smoking rate. The violent crime rate increased from 57 to 142 offenses per 100,000 population and the prevalence of obesity increased from 12.1 percent to 27.0 percent of the population during this same time period. The state's premature death rate also declined from 7,005 years lost in 1990 to 6,447 years of potential life lost before age 75 per 100,000 population, a rate slower than the national decline. See North Dakota's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

The changes in scores and rankings for all 50 states since the 1990 Edition of *America's Health Rankings™* are at www.americashealthrankings.org/2008/changes-1990.html. States that have changed less than 18.4 percent are not improving as quickly as the nation as a whole.

Changes from 2007

National

Since the 2007 Edition, overall health in the United States has not changed and has remained essentially stagnant since the 2005 Edition.

Table 10 shows the national changes in the last year. There were two improvements — the incidence of infectious disease decreased from 22.5 to 20.1 cases per 100,000 population and cardiovascular deaths decreased from 309.0 to 298.2 deaths per 100,000 population. These improvements were offset by a deterioration in several measures, including an increase in the prevalence of obesity from 25.1 percent to 26.3 percent of the population and an increase in the percentage of children in poverty from 17.4 percent to 18.0 percent of persons under age 18.

States

Comparisons of state scores for these two years indicate that 35 states had positive changes in their overall scores on health and 14 experienced declines. The largest positive increases were in Arkansas, New Mexico and Kentucky, all of which increased by 7.0 points or more (Table 11).

The principal reasons for the changes in these states are:

Arkansas: In the last year, the prevalence of smoking declined from 23.7 percent to 22.4 percent of the population, the percentage of children in poverty decreased from 26.6 percent to 19.1 percent of persons under age 18 and the rate of uninsured population declined from 18.2 percent to 17.5 percent. These gains were offset by an increase in obesity from 26.9 percent to 29.3 percent of the population and a decrease in public health funding from \$83 to \$73 per person. The rate of cardiovascular deaths declined from 354.2 to 340.0 deaths per 100,000 population. See Arkansas' complete state summary later in this report or visit

Table 10

National Measures of Successes and Challenges: 2007 to 2008

MEASURE	EDITION TO EDITION CHANGES
SUCCESSSES	
Infectious Disease	Decreased from 22.5 to 20.1 cases per 100,000 population.
Cardiovascular Deaths	Decreased from 309.0 to 298.2 deaths per 100,000 population.
Public Health Funding	Increased from \$75 to \$88 dollars per person.
High School Graduation	Increased from 74.3 percent to 74.7 percent of incoming ninth graders who graduate in four years.
CHALLENGES	
Prevalence of Obesity	Increased from 25.1 percent to 26.3 percent of the population who are obese.
Children in Poverty	Increased from 17.4 percent to 18.0 percent of persons under age 18.
Immunization Coverage	Decreased from 80.6 percent to 80.1 percent of children ages 19 to 35 months receiving complete immunizations.

www.americashealthrankings.org/2008/glance.html.

New Mexico: In the last year, the percentage of children in poverty declined from 23.2 percent to 18.1 percent of persons under age 18, the occupational fatalities rate declined from 9.2 to 6.9 deaths per 100,000 workers and public health funding increased from \$120 to \$132 per person. However, the rate of uninsured population increased from 21.6 percent to 22.7 percent, and the prevalence of obesity increased from 22.9 percent to 25.1 percent of the population. See New Mexico's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Kentucky: In the last year, the prevalence of binge drinking decreased from 9.5 percent to 8.4 percent of the population, the incidence of infectious disease declined from 12.1 to 10.3 cases per 100,000 population, the percentage of children in poverty declined from 23.5 percent to 21.0 percent of persons under age 18 and public health funding increased from \$64 to \$71 per person. The violent crime rate increased from 263 to 295 offenses per 100,000 population. See Kentucky's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Table 11

States with the Greatest Overall Health Score Improvement: 2007 to 2008

STATE	CHANGE IN SCORE
Arkansas	+8.2
New Mexico	+7.6
Kentucky	+7.0

Table 12
States with the Greatest
Overall Health Score Decline:
2007 to 2008

STATE	CHANGE IN SCORE
Texas	-3.5
Montana	-3.0

The states with the largest decreases in their overall health score were Texas and Montana (Table 12). Other states' declines were less than 3.0 points.

The principal reasons for the changes in these states are:

Texas: In the last year, the prevalence of smoking increased from 17.9 percent to 19.3 percent of the population, the prevalence of obesity increased from 26.1 percent to 28.6 percent of the population and the percentage of children in poverty increased from 22.0 percent to 25.0 percent of persons under age 18. In addition, the number of poor mental health days and the number of poor physical health days in the previous 30 days both increased. See Texas' complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

Montana: In the last year, the prevalence of obesity increased from 21.2 percent to 22.6 percent of the population, the violent crime rate increased from 254 to 288 offenses per 100,000 population, the infant mortality rate increased from 5.5 to 6.1 deaths per 1,000 live births and the geographic disparity within the state increased from 15.5 percent to 17.8 percent. The percentage of children in poverty declined from 17.2 percent to 15.7 percent of persons under age 18. See Montana's complete state summary later in this report or visit www.americashealthrankings.org/2008/glance.html.

The comparisons of scores and rankings between 2007 and 2008 are shown at www.americashealthrankings.org/2008/changes-2007.html.

Methodology

The methodology underlying *America's Health Rankings™* reflects the evolving expectations and role of health in our society and our ability to measure various aspects of health. The methodology has evolved over the report's 19-year history to capture these changes; however, we have strived to maintain comparability among editions and to provide a useful resource for tracking and evaluating progress.

The tables that present each measure contain three columns: rank, data and score. They are calculated as follows:

The data is the raw data as obtained from the stated sources and adjusted for age as appropriate. All age-adjusted data utilizes the population profile for the middle year of data. For example, if the data is from 2003 to 2005, the standard population is set at 2004.

The score for each state is based on the following formula. The score is stated as a percentage.

$$\text{SCORE} = \frac{\text{ABSOLUTE VALUE}}{\text{NATIONAL MEAN}} - 1.0 \times 100$$

This calculation results in a score of 0.0 for a state with the same value as the national average. States that have a higher value than the national average will have a positive score while those with lower values will have a negative score.

To prevent an extreme value from excessively influencing a final score, the maximum score any state could receive for a measure is limited to the national norm plus or minus two standard deviations.

For several measures, such as Infant Mortality and Infectious Disease, the data from multiple years are combined to provide sufficient sample size to be meaningful.

Where a value for the United States overall is not available, the national average is set at the average value of the states measured.

The overall score was calculated by adding the scores of each measure multiplied by its weight or the percent of total overall ranking. (Note: Scores reported for individual measures may not add up to the overall scores due to the rounding of numbers.)

The ranking is the ordering of each state according to score. Ties in scores are assigned equal rankings.

All earlier results have been revised to correct any errors discovered since the release of prior editions.

Measures

Selection of Measures

Four primary considerations drove the design of *America's Health Rankings*[™] and the selection of the individual measures:

1. The overall rankings had to represent a broad range of issues that affect a population's health,
2. Individual measures needed to use common health measurement criteria,
3. Data had to be available at a state level, and
4. Data had to be current and updated periodically.

While not perfect, the measures selected are believed to be the best available indicators of the various aspects of healthiness at this time and are consistent with past reports.

The Scientific Advisory Committee (page 5) suggested that the measures be divided into two categories — determinants and outcomes. For further clarity, determinants are divided into four groups: Personal Behaviors, Community and Environment, Public and Health Policies, and Clinical Care. These four groups of measures influence the health outcomes of the population in a state, and improving these inputs will improve outcomes over time. Most measures are actually a combination of activities in all four groups. For example, the prevalence of smoking is a personal behavior that is strongly influenced by the community environment in which we live, by public policy, including taxation and restrictions on smoking in public places and by the care received to treat the chemical and behavioral addictions associated with tobacco. However, for simplicity, we placed each measure in a single category.

For *America's Health Rankings*[™] to continue to meet its objectives, it must evolve and incorporate new information as it becomes available. The Scientific Advisory Committee provides guidance for the evolution of the rankings, balancing the need to

change with the desire for longitudinal comparability. Over the last few years, change is being driven by: 1) the acknowledgement that health is more than years lived but includes the quality of those years; 2) data about the quality and cost of health care delivery are becoming available on a comparable basis; and 3) measurement of the additional determinants of health are being initiated and/or improved. The committee also emphasizes that the real impact on health will be made by addressing the health determinants, and making improvements on these items that affect the long-term health of the population. The determinants are the predictors of our future health.

This year, two new measures are introduced to the index: Air Pollution as a health determinant and Geographic Disparity as an outcome. As the source of data for Per Capita Public Health Spending is no longer available, a similar measure, Public Health Funding, which relies on Trust for America's Health data, was substituted. Other adjustments were made including eliminating the race adjustment for Cardiovascular Deaths and Cancer Deaths and reporting Lack of Health Insurance as a two-year instead of a one-year average.

Health outcomes are traditionally measured using mortality measures including premature death, infant mortality, cancer and cardiovascular mortality. While these measures overlap significantly, they do present different views of mortality outcomes of the population. Two measures of the quality of life — poor mental health days and poor physical health days — are also included and defined as the number of days in the previous 30 days when a person indicates their activities are limited due to mental or physical health difficulties. Disparity in health outcomes is now explicitly captured in the newly added Geographic Disparity measure.

As with all indices, the positive and negative aspects of each measure must be weighed when choosing and developing them. These aspects for consideration include: 1) the interdependence of the different measures; 2) the possibility of the overall ranking disguising the effects of individual measures; 3) an inability to adjust all data by age and race; 4) an over-reliance on mortality data; and 5) the use of indirect measures to estimate some effects on health. These concerns cannot be addressed directly by adjusting the methodology; however, assigning weights to the individual measures can mitigate their impact (Table 17).

Each measure is assigned a weight that determines its percentage of the overall score. Determinants account for 75 percent of the results, and outcomes account for 25 percent, a shift from the 50/50 balance in the original 1990 index to reflect the importance and growing measurement of determinants.

Description of Measures

Table 13 on page 22 is a summary of each of the measures in *America's Health Rankings*[™]. A short discussion of each measure immediately follows. The data for each year is the most current data available at the time the report was compiled.

The data tables are available at www.americashealthrankings.org/2008/tables.html.

Table 13
Summary Description of Measures

DETERMINANTS	DESCRIPTION
PERSONAL BEHAVIORS	
Prevalence of Smoking	Percentage of population over age 18 that smokes on a regular basis. This is an indication of known, addictive, health-adverse behaviors within the population. (www.americashealthrankings.org/2008/smoking.html)
Prevalence of Binge Drinking	Percentage of population over age 18 that has drunken excessively in the last 30 days. Binge drinking is defined as 5 drinks for a male and 4 for a female in one setting. It is a proxy indicator for excessive drug and alcohol use within a population. (www.americashealthrankings.org/2008/binge.html)
Prevalence of Obesity	Percentage of the population estimated to be obese, with a body mass index (BMI) of 30.0 or higher. Obesity is known to contribute to a variety of diseases, including heart disease, diabetes and general poor health. (www.americashealthrankings.org/2008/obesity.html)
COMMUNITY & ENVIRONMENT	
High School Graduation	Percentage of incoming ninth graders who graduate in four years from a high school with a regular degree, as reported by NCES in compliance with the No Child Left Behind initiative. It is an indication of the individual's ability to learn about, create and maintain a healthy lifestyle and to understand and access health care when required. (www.americashealthrankings.org/2008/graduation.html)
Violent Crime	The number of murders, rapes, robberies and aggravated assaults per 100,000 population. It reflects an aspect of overall lifestyle within a state and its associated health risks. (www.americashealthrankings.org/2008/crime.html)
Occupational Fatalities	Number of fatalities from occupational injuries per 100,000 workers. This measure reflects job safety as a part of public health. (www.americashealthrankings.org/2008/occupational.html)
Infectious Disease	Number of AIDS, tuberculosis and hepatitis (A and B) cases reported to the Centers for Disease Control and Prevention per 100,000 population. This is an indication of the toll that infectious disease is placing on the population. (www.americashealthrankings.org/2008/disease.html)
Children in Poverty	The percentage of persons under age 18 who live in households at or below the poverty threshold. Poverty is an indication of the lack of access to health care by this vulnerable population. (www.americashealthrankings.org/2008/poverty.html)
Air Pollution	The average exposure of the general public to particulate matter of 2.5 microns or less in size (PM2.5). Health studies have shown a significant association between exposure to fine particles and premature death from heart or lung disease. Fine particles can aggravate heart and lung diseases and have been linked to effects such as: cardiovascular symptoms; cardiac arrhythmias; heart attacks; respiratory symptoms; asthma attacks; and bronchitis. (www.americashealthrankings.org/2008/air.html)
PUBLIC & HEALTH POLICIES	
Lack of Health Insurance	Percentage of the population that does not have health insurance privately, through their employer or the government. This is an indicator of the ability to access care as needed, especially preventive care. (www.americashealthrankings.org/2008/insurance.html)
Public Health Funding	State funding dedicated to public health as well as federal funding directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration, expressed on a per capita basis. This represents the annual investment being made in public health programs to monitor and improve population health. (www.americashealthrankings.org/2008/funding.html)
Immunization Coverage	Percentage of children ages 19 to 35 months who have received four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any measles-containing vaccine, three or more doses of HiB, and three or more doses of HepB vaccine. (www.americashealthrankings.org/2008/immunization.html)

DETERMINANTS	DESCRIPTION
CLINICAL CARE	
Adequacy of Prenatal Care	Percentage of pregnant women receiving adequate prenatal care, as defined by Kotelchuck's Adequacy of Prenatal Care Utilization (APNCU) Index. This measures how well women are receiving the care they require for a healthy pregnancy and development of the fetus. (www.americashealthrankings.org/2008/prenatal.html)
Primary Care Physicians	Number of primary care physicians (including general practice, family practice, OB-GYN, pediatrics and internal medicine) per 100,000 population. This measure reflects the availability of physicians to assist the population with preventive and regular care. (www.americashealthrankings.org/2008/pcp.html)
Preventable Hospitalizations	Discharge rate among the Medicare population for diagnoses that are amenable to non-hospital based care. This reflects how well a population uses the various delivery sites for necessary care. (www.americashealthrankings.org/2008/hospitalizations.html)

OUTCOMES	DESCRIPTION
Poor Mental Health Days	Number of days in the previous 30 days when a person indicates their activities are limited due to mental health difficulties. This is a general indication of the population's ability to function on a day-to-day basis. (www.americashealthrankings.org/2008/mental.html)
Poor Physical Health Days	Number of days in the previous 30 days when a person indicates their activities are limited due to physical health difficulties. This is a general indication of the population's ability to function on a day-to-day basis. (www.americashealthrankings.org/2008/physical.html)
Geographic Disparity	The variation among the overall mortality rates among the counties within a state. Equality among counties would be expressed by low variation. This measure indicates how equal the outcomes are across a state. (www.americashealthrankings.org/2008/geographic.html)
Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births. This is an indication of the prenatal care, access and birth process for both child and mother. (www.americashealthrankings.org/2008/imr.html)
Cardiovascular Deaths	Number of deaths due to all cardiovascular diseases, including heart disease and strokes, per 100,000 population. This is an indication of the toll that these types of diseases place on the population. (www.americashealthrankings.org/2008/cvd/html)
Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population. This is an indication of the toll cancer places on the population. (www.americashealthrankings.org/2008/cancer.html)
Premature Death	Number of years of potential life lost prior to age 75 per 100,000 population. This is an indication of the number of useful years of life that are not available to a population due to early death. (www.americashealthrankings.org/2008/ypll.html)

Determinants

PERSONAL BEHAVIORS

Three measures reflect behaviors that are potentially modifiable through a combination of personal, community and clinical interventions: the prevalence of smoking, the percentage of the population that binge drinks and the prevalence of obesity. These items are determinants that measure negative behaviors and activities having an immediate or delayed effect on health and are prominently included in these rankings. However, the selection of these three does not imply that they are the only underlying behaviors that need to be addressed in a comprehensive public health effort. For example, the American Academy of Family Physicians suggests that to improve health, individuals should:

- Avoid any form of tobacco,
- Eat a healthy diet,
- Exercise regularly,
- Drink alcohol in moderation, if at all,
- Avoid use of illegal drugs,
- Practice safe sex,
- Use seat belts (and car seats for children) when riding in a car or truck,
- Avoid sunbathing and tanning booths,
- Keep immunizations up-to-date, and
- See a doctor regularly for preventive care.

Additional suggestions for individual initiatives are in *Healthy People in Healthy Communities, A Community Planning Guide Using Healthy People 2010*, published by the U.S. Department of Health and Human Services, Washington, D.C., available at <http://www.healthypeople.gov/Publications/HealthyCommunities2001/default.htm>.

The impact of changing behaviors is huge. CDC estimates that if tobacco use, poor diet and physical inactivity were eliminated, 80 percent of heart disease and stroke, 80 percent of Type 2 diabetes and 40 percent of cancer would be prevented.⁵

Prevalence of Smoking measures the percent of the population over age 18 that smokes tobacco products regularly. The information is obtained from the Behavioral Risk Factor Surveillance System (BRFSS) and measures the percentage of the population that has smoked at least 100 cigarettes and currently smokes regularly.

The prevalence of smoking in the population has an adverse impact on overall health by causing increased cases of respiratory diseases, heart disease, stroke, cancer and other illnesses (<http://www.cdc.gov/tobacco/>). It is a lifestyle behavior that an individual can directly influence with support from the community and, as required, clinical intervention.

The 2008 ranks, based on 2007 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), can be found at www.americashealthrankings.org/2008/smoking.html. The national average is 19.8 percent of the population, a decrease of 0.3 percent from the rate last year. This means that about 45 million American adults smoke on a regular basis. The proportion of the population that smokes varies from a low of 11.7 percent in Utah to more than 25 percent in Kentucky, West Virginia and Oklahoma. The prevalence of smoking decreased by 2.0 percent or more in Delaware, Rhode Island and Kansas. It increased by more than 2.0 percent in Idaho. If all states were to accomplish a smoking rate equal to the best state (Utah), there would be 18 million fewer adult smokers in the U.S.

Since the 1990 Edition, the prevalence of smoking decreased in the United States by 9.7 percent. Rhode Island, Nevada and Virginia each lowered the prevalence of smoking since 1990 by 14 percent or more. Every state experienced a decrease since the 1990 Edition. Utah had the smallest decrease in percentage of the population but still retains its position as the state with the

fewest smokers. Due to the limits of the BRFSS, caution must be used in comparing changes in prevalence of smoking in states with small populations.

Prevalence of Binge Drinking measures the percentage of the population who binge drink. Binge drinking is defined as males having five or more drinks and females having four or more drinks on one occasion. Binge drinking has an adverse effect on health due to increased injuries and deaths, increased aggression, damage to the fetus and liver diseases along with other health concerns (<http://www.cdc.gov/alcohol/>).

Prevalence of Binge Drinking is measured over a two year span to increase the reliability of the estimates and to allow better state to state comparisons. The measure reflects the impact of excessive alcohol on increased motor vehicle deaths, liver damage and unintentional injuries.

The 2008 ranks, based on 2006 and 2007 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention) are at www.americashealthrankings.org/2008/binge.html. The prevalence of binge drinking varies from less than 10 percent in Tennessee, Kentucky and Utah to more than 20 percent in Iowa, North Dakota and Wisconsin. The national average is 15.6 percent of the adult population who binge drinks and has varied from 14.8 percent to 16.3 percent of the population over the last seven years. The largest decrease in the last year was in Minnesota where prevalence of binge drinking decreased by 2.2 percent from 18.2 percent to 16.0 percent of the population. The largest increase in the last year was in North Dakota where prevalence of binge drinking increased by 2.1 percent from 20.0 percent to 22.1 percent of the population.

Prevalence of Obesity is the percentage of the population estimated to be obese, defined as having a body mass index (BMI) of 30.0 or higher. BMI is equal to your

5 Mensah, George A., Associate Director for Medical Affairs, CDC "Global and Domestic Health Priorities: Spotlight on Chronic Disease", National Business Group on Health Webinar, May 23, 2006.

weight in pounds divided by your height in inches squared and then multiplied by 703. NIH has a calculator for BMI at <http://www.nhlbi.support.com/bmi/>. Weight status is determined per Table 14. Obesity is known to contribute to a variety of diseases, including heart disease, diabetes and general poor health (<http://www.cdc.gov/nccdphp/dnpa/obesity/>). The data are collected by each state as part of the Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention.

The 2008 ranks, based on 2007 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/obesity.html. The average for the United States is 26.3 percent of the adult population, up from 25.1 percent of the population in 2007 and substantially more than double the rate of 11.6 percent of the population in 1990. In the United States, this means that more than one-in-four are obese — this is 56 million adults with a body mass index of 30.0 or higher. If the population of the United States could return to the weight status of 1990, there would be over 25 million fewer obese individuals — more than the entire population of the second largest state in the United States, Texas.

The prevalence of obesity ranges from 19.3 percent of the population in Colorado to over 30 percent of the population in Mississippi, Alabama, Tennessee, Louisiana and West Virginia. In the last year, Wisconsin experienced a decline of 1.3 percent in this measure. In Louisiana and Pennsylvania, the prevalence of obesity in their populations increased by three percent or more. Since 1990, the prevalence of obesity increased in all states. The smallest increases were in Connecticut, Florida, Rhode Island and Wyoming, where an additional one of 11 people is now considered obese. The largest increase was in Tennessee, where an additional one of six people is now considered obese.

Table 14
Body Mass Index (BMI)

BMI	WEIGHT STATUS	EXAMPLES (ADULTS)		
		5'6"	5'10"	6'2"
Below 18.5	Underweight	Under 115 lbs	Under 129 lbs	Under 144 lbs
18.5 to 24.9	Normal	115 to 154 lbs	129 to 174 lbs	144 to 194 lbs
25.0 to 29.9	Overweight	155 to 185 lbs	175 to 208 lbs	195 to 233 lbs
30.0 and above	Obese	Over 186 lbs	Over 208 lbs	Over 233 lbs

COMMUNITY & ENVIRONMENT

Six measures are used to represent the community and the environment: the high school graduation rate, the violent crime rate, the occupational fatalities rate, the percentage of children in poverty, the incidence of infectious disease and the exposure to air pollution. Measures of community and environment reflect the reality that the daily conditions in which we live our lives have a great effect on achieving optimal individual health. The presence of pollution, violence, illegal drugs, infectious disease and unsafe workplaces are detrimental. In addition, studies indicate that the general socio-economic conditions and the level of education have a significant relationship to the healthiness of a community's residents.

These determinants measure both positive and negative aspects of the community and the environment of each state and their effects on the population's health. Again, there are many additional efforts of communities that improve the overall health of a population but are not directly reflected in these six measures. Each community has its strengths, challenges and resources and should undertake a careful planning process to determine what action plans are best for them.

High School Graduation estimates the percentage of incoming ninth graders who graduate within four years and are considered regular graduates. The National Center for Education Statistics collects the enrollment and completion data and, now, as part of the No Child Left

Behind initiative, estimates the graduation rate for each state. The rate is the number of graduates divided by the estimated count of freshmen four years earlier. This average freshman enrollment count is the sum of the number of 8th graders five years earlier, the number of 9th graders four years earlier (because this is when current year seniors were freshmen) and the number of 10th graders three years earlier divided by three. Enrollment counts include a proportional distribution of students not enrolled in a specific grade.

Data are not adjusted for the presence or quality of basic health and consumer health education in the curriculum, for continuing education programs nor for other non-traditional learning programs. Also, individual states are increasingly altering graduation requirements, which may affect their reported number of regular graduates, their graduation rate and the comparability of these rates across time.

Education is a vital contributor to health as consumers must be able to learn about, create and maintain a healthy lifestyle and understand and participate in their options for care.

The 2008 ranks, based on 2004 to 2005 data (National Center for Education Statistics, Washington, D.C., U.S. Department of Education), are at www.americashealthrankings.org/2008/graduation.html. The rate varies from 87.8 percent of incoming ninth graders who graduate within four years in Nebraska to 55.8 percent in Nevada. The national average is 74.7 percent, up 0.4 percent from 74.3 percent in the 2007 Edition. Arizona reported the

largest change with an increase from 66.8 percent to 84.7 percent of incoming ninth graders who graduate within four years; this more than offsets the large reported decrease in the last Edition from 75.9 percent to 66.8 percent of incoming ninth graders who graduate within four years. Louisiana and Nevada indicated a drop of five percent or more in the last year.

Violent Crime measures the effect of criminal behavior on a population's health. It represents factors such as illegal drug use and various social ills. Violent crime measures the annual number of murders, rapes, robberies and aggravated assaults per 100,000 population. Violent crime reflects an aspect of current U.S. lifestyle and is an indicator of health risk and death.

The 2008 ranks, based on 2007 data (Crime in the United States: 2007. Washington, D.C., Federal Bureau of Investigation), are at www.americashealthrankings.org/2008/crime.html. The violent crime rate is dependent upon many factors, not just population; thus when taking action to combat crime, each state must consider its specific circumstances.

The violent crime rate varies from less than 150 offenses per 100,000 population in Maine, Vermont, New Hampshire and North Dakota to more than 750 offenses per 100,000 population in South Carolina, Tennessee and Nevada. The national average is 467 offenses per 100,000 population, down 7 offenses per 100,000 population from the prior year and down 142 offenses per 100,000 population from the 1990 Edition. Crime peaked in 1993 and 1994 at 758 offenses per 100,000 population.

The largest reported decrease in violent crime from the 2007 Edition occurred in Colorado where reported offenses decreased by 44 offenses per 100,000 population and in Missouri where reported offenses decreased by 41 offenses per 100,000 population. The largest reported increases occurred in Montana, from 254 to 288 offenses per 100,000 population; in Kentucky, from 263 to 295 offenses per

100,000 population; and in Louisiana, from 698 to 730 offenses per 100,000 population.

This is the ninth year that the national violent crime rate is lower than the 1990 Edition, and it has not changed appreciably in the last four years. However, several states experienced significant increases since 1990, led by Delaware, Tennessee and Alaska with increases of 257 offenses, 219 offenses and 206 offenses per 100,000 population, respectively. New York, California and Florida reduced violent crime the most since the 1990 Edition, decreasing from 1,007 to 414 offenses per 100,000 population, from 918 to 523 offenses per 100,000 population, and from 1,024 to 723 offenses per 100,000 population, respectively.

Occupational Fatalities represents the impact of hazardous jobs on the population. Occupational injuries would be a preferred measure; however, there is not a uniform reporting system used by all 50 states. Due to the different industry mixes in each state, occupational fatalities are adjusted to more accurately reflect the actual safety differences between the states.

Occupational fatalities are measured over a three-year span because of their low incidence rate. The industry adjustment is based on the ratio of workers in the following industries: construction, manufacturing, trade, transportation, utilities, professional and business services as defined by the North American Industry Classification System (NAICS).

The 2008 ranks, based on 2005 to preliminary 2007 data (Census of Fatal Occupational Injuries, Bureau of Labor Statistics, U.S. Department of Labor, Washington, D.C.), are at www.americashealthrankings.org/2008/occupational.html. Scores vary from 3.3 deaths per 100,000 workers in Massachusetts to over 10 deaths per 100,000 workers in Wyoming and Mississippi. The national norm is 5.2 deaths per 100,000 workers, down

from 5.3 deaths per 100,000 workers in the 2007 Edition. The occupational fatalities rate decreased the most in the last year in Alaska and New Mexico, by 2.6 deaths and 2.3 deaths per 100,000 workers, respectively. The rate increased in Rhode Island by 1.4 deaths per 100,000 workers in the last year.

Children in Poverty measures the percentage of related persons under age 18 living in a household that is below the poverty threshold. The poverty threshold established by the U.S. Census Bureau for a household of four people which includes two children is approximately \$21,736 in household income.

The 2008 ranks, based on 2007 data (March 2008 Current Population Survey, Washington, D.C., U.S. Census Bureau), are at www.americashealthrankings.org/2008/poverty.html. The percentage of children in poverty ranged from less than 10 percent of persons under age 18 in New Hampshire and Alaska to a high of 25 percent or more in Mississippi and Texas. The national average is 18.0 percent, up 0.6 percent from the 2007 Edition and up 2.2 percent from the low of 15.8 percent of persons under age 18 reported in the 2002 Edition. It is 2.6 percent below the 1990 Edition. In the past year, the percentage of children in poverty increased in 26 of 50 states. It increased by 5.4 percent in South Carolina and decreased by more than five percent in New Mexico and Arkansas. Since 1990, the percentage of children in poverty has increased in 14 of 50 states. Children in poverty increased by four percent or more in Rhode Island, Delaware and Connecticut, while during the same time period, it decreased by nine percent or more in Louisiana, Tennessee, Colorado, Hawaii and New Mexico.

Infectious Disease includes the occurrence of Acquired Immune Deficiency Syndrome (AIDS), tuberculosis and hepatitis (A and B) as representative of all major infectious diseases in a state. It is a running three-year average.

It should be noted that this measure is neither age nor race adjusted, and, as reporting comes from each individual state health department, the level of accuracy may differ from state to state. Despite these drawbacks, the data remains the best available.

The 2008 ranks, based on 2005 to 2007 data (Mortality and Morbidity Weekly Reports, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/disease.html. AIDS cases in 2007 were not available as the data collection system for this measure is being revised. For this year, 2007 AIDS cases were assumed equal to 2006 AIDS cases. The incidence of infectious disease per 100,000 population varies from a reported low of less than five cases in North Dakota, Wyoming, Montana and Idaho to a reported high of more than 30 cases in New York, Maryland and Florida. The national average is 20.1 cases per 100,000 population, down from 22.5 cases per 100,000 population in the 2007 Edition and down considerably from 40.7 cases per 100,000 population in the 1990 Edition.

Reported infectious disease decreased by five or more cases per 100,000 population in Delaware, New York, Massachusetts, Hawaii and New Jersey. No state had a considerable increase. Since the 1990 Edition, Oregon, Alaska, Arizona and Washington have seen the greatest decreases in reported cases with more than 70 fewer cases per 100,000 population. None of the states have experienced increases in the incidence of infectious disease since the 1990 Edition.

Air Pollution measures the fine particulates in the air we breathe. The fine particulates, too small to see individually but appearing as haze in the air, can enter the deepest portions of the lungs. Air pollution has been shown to have an adverse effect on health, including decreased lung function, aggravated asthma, development of chronic bronchitis,

irregular heartbeat, nonfatal heart attacks, and premature death in people with heart or lung disease. See www.epa.gov/air/particlepollution/health.html for more information.

Air Pollution is a new measure in the 2008 Edition. It is the population-weighted average exposure to particulates 2.5 micron and smaller for each county reporting within a state. Air pollution is monitored in many counties where population density is significant and/or where there have been pollution concerns in prior years. Population weighting of the county data adjusts the information to reflect the actual number of people potentially exposed to the particulate. The data is collected by the EPA and available at <http://www.epa.gov/air/data/>.

The 2008 ranks, based on 2005 to 2007 data (U.S. Environmental Protection Agency, Washington, D.C. and the U.S. Census Bureau, Washington, D.C.), are at www.americashealthrankings.org/2008/air.html. Air pollution varies from a low of 4.9 micrograms of fine particulate per cubic meter in Hawaii to more than 15 micrograms of fine particulate per cubic meter in Illinois, Indiana, Pennsylvania, Alabama, Ohio, West Virginia and Georgia. The average for reporting counties in the United States is 13.1 micrograms of fine particulate per cubic meter, down slightly from last year and down significantly from five years ago when it was 14.5 micrograms of fine particulate per cubic meter.

PUBLIC & HEALTH POLICIES

Three measures are used to represent public and health policies and programs: public health funding, immunization coverage and lack of health insurance. These measures are indicative of the availability of resources and the extent of the program's reach to the public.

Every state has many excellent and effective public health programs, too numerous and individualized to list, that contribute to the overall health of the population but are not explicitly

included in these rankings. Contact your state public health officials to obtain additional information about programs in your state that are enacted to optimize individual and community health. Each state summary lists the Web site for that state's health department. Individuals can also see the spectrum of options available to states and communities by visiting www.thecommunityguide.org, a Web site that provides a systemic review of programs and evidence-based recommendations for health and community officials.

Lack of Health Insurance measures the percentage of the population not covered by private or public health insurance. Individuals without health insurance have great difficulty accessing the health care system, frequently are not able to participate in preventive care programs and can add substantially to the cost of health care due to delayed care and emergency department treatment.

The 2008 ranks, based on 2007 data (March 2008 Current Population Survey, Washington, D.C., U.S. Census Bureau), are at www.americashealthrankings.org/2008/insurance.html. Starting with this Edition, the measure is the two-year average percentage of individuals without health insurance; prior Editions reported the one-year average. Direct comparison between years uses adjusted two-year average data.

The rate of uninsured population ranged from 7.9 percent in Massachusetts to over 20 percent in Texas, New Mexico and Florida. The national average is 15.5 percent (45.7 million people) uninsured, which is the same as last year. If the United States as a whole could emulate the best state, the number of uninsured would decrease by about 22 million people or about the population of Texas, the second largest state in the United States.

In the last year, the two-year average rate of uninsured population decreased in 22 states, led by Massachusetts with a decline of 1.9

percent. The rate of uninsured population increased in 26 states, including an increase of 1.0 percent or more in Nebraska, Kansas, New Mexico and Mississippi.

Public Health Funding measures the dollars per person that are spent on public or population health through funding from Centers for Disease Control and Prevention, Health Resources Services Administration and the state. High spending on these health programs are indicative of states that are proactively implementing preventive and education programs targeted at improving the health of at-risk populations within a state. Recent research has shown that an investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years. This is a return of \$5.60 for every \$1 invested (<http://healthyamericans.org/reports/prevention08/>).

The 2008 ranks, based on 2005 and 2006 data (Trust for America's Health, Washington, D.C.) are at www.americashealthrankings.org/2008/funding.html. It ranges from more than \$150 per person in Alaska and Hawaii to less than \$40 per person in Kansas, Ohio, Nevada, Wisconsin and Indiana. The average funding in the United States is \$88 per person, up from \$75 per person last year.

Immunization Coverage is the percentage of children ages 19 to 35 months who have received the suggested early childhood immunizations listed in Table 15. Early childhood immunization has been shown to be a safe and cost-effective manner of controlling diseases within the population.

The 2008 ranks, based on 2007 data (National Immunization Program, Centers for Disease Control and Prevention) are at www.americashealthrankings.org/2008/immunization.html. It ranges from immunization

Table 15
Immunization Coverage

IMMUNIZATION	DOSES
DTP	4 or more
Poliovirus	3 or more
MCV	1 or more
HiB	3 or more
HepB	3 or more

coverage of greater than 90 percent in Maryland and New Hampshire to less than 70 percent in Nevada. Compared to coverage in the prior year, coverage for the complete series of immunizations in the United States has decreased slightly from 80.6 percent to 80.1 percent of children ages 19 to 35 months. In the last year, immunization coverage has decreased in 27 states and increased in 21 states. Reported coverage in Maryland and New Hampshire jumped by more than 10 percent in the last year. In Iowa, Oregon, Wisconsin and Missouri, immunization coverage decreased by more than five percent of children ages 19 to 35 months receiving complete immunizations. In the last 13 years, coverage in the United States increased from 55.1 percent to 80.1 percent of children ages 19 to 35 months who received the complete set of immunizations; however, the rate of improvement has leveled off in the last five years, remaining at approximately 80 percent of children receiving a full set of immunizations.

The Guide to Community Preventive Services has numerous proven methods to increase the rate of vaccinations in a community that include ways to increase the demand in the community, improving access and system-based or provider-based innovations. See their suggestions at <http://www.thecommunityguide.org/vaccine/default.htm>.

CLINICAL CARE

Preventive and curative care must be delivered in an effective, appropriate and timely manner. In the 2008 Edition,

three measures are included in this section: Adequacy of Prenatal Care, Primary Care Physicians and Preventable Hospitalizations. Adequacy of Prenatal Care has been included since the 1990 Edition and Primary Care Physicians and Preventable Hospitalizations were added in the 2007 Edition.

Adequacy of Prenatal Care is a measure of both access to and frequency of prenatal care based on the Adequacy of Prenatal Care Utilization (APNCU) Index developed by Kotelchuck. This index considers two aspects of prenatal care: the month it was initiated and the number of visits occurring after initiation. The 1990 through 2004 Editions of the report defined Adequacy of Prenatal Care using the Kessner Index, a measure highly correlated to Kotelchuck; however, it does not consider both initiation and frequency of visits. The introduction of a new birth certificate, the information of record from which the APNCU is derived, is an additional complication to the data. The adoption of the new birth certificate is gradual across the system and directly comparing the APNCU from the different certificates is not valid. Therefore, starting with this Edition, the APNCU index only compares a state to another state using the same birth certificate. While this does allow a score to be calculated among peer states, it doesn't allow for ranking the states for this measure.

Adequacy of prenatal care is not adjusted for age or race.

2007 data and scores are based on 2005 data (National Center for Health Statistics. Adequacy of Care by State, United States, Hyattsville, Md.) and are at www.americashealthrankings.org/2008/prenatal.html.

Maine, Louisiana, Massachusetts, Kentucky, Idaho, Iowa, New Hampshire and Kansas were all 10 percent or more above their peer group. Pennsylvania, Hawaii, New Jersey, Arkansas, Nevada, Washington, Alaska and New Mexico were all 10 percent or more below their peer group for access to adequate prenatal care.

Primary Care Physicians is a measure of access to primary care for the general population as measured by number of primary care physicians per 100,000 population. Primary care physicians provide a combination of direct care to the patient and, as necessary, counsel the patient in the appropriate use of specialists and advance treatment locations.

The 2008 ranks, based on 2006 data (American Medical Association, *Physician Characteristics and Distribution in the United States*, 2008 Edition, Chicago, Ill. Data used with permission), are at www.americashealthrankings.org/2008/PCP.html. Primary care physicians include all those who identify themselves as Family Practice physicians, General Practitioners, Internists, Pediatricians, Obstetricians or Gynecologists.

The number of Primary Care Physicians per 100,000 population will change because of changing state population, physician retirements, new physicians, and physicians moving between states and specialties. Since the 2007 Edition, the largest increase occurred in Louisiana where the number of primary care physicians increased from 113.5 to 119.4 physicians per 100,000 population. The largest decrease was in Vermont where the number of physicians dropped from 167.6 to 165.1 physicians per 100,000 population, the lowest number in four years. Nationally, the number of physicians per 100,000 population was unchanged from 2007 to 2008.

Preventable Hospitalizations is a measure of the discharge rate from hospitals for ambulatory care-sensitive conditions. Ambulatory care-sensitive conditions are those "for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease." These hospitalizations can often be reduced by strong outpatient care systems and include conditions such as adult asthma, bacterial pneumonia, congestive heart failure, chronic obstructive pulmonary disease,

diabetes, low birth weight, urinary tract infection and other conditions. It is not adjusted by characteristics of the population served, such as age or health status.

These discharges are also highly correlated with general admissions and reflect the tendency for a population to overuse the hospital setting as a site for care.

The 2008 ranks, based on 2005 data (The Dartmouth Atlas of Health Care, The Dartmouth Institute for Health Policy and Clinic Practice, Lebanon, N.H.), are at www.americashealthrankings.org/2008/hospitalizations.html. The data in this Edition is identical to the data presented in the 2007 Edition as no updates were available at the time of publication. The rate of preventable hospitalizations ranges from a low of under 50 discharges per 1,000 Medicare enrollees in Hawaii and Utah to over 100 discharges per 1,000 Medicare enrollees in West Virginia, Kentucky, Louisiana and Mississippi. The national average is 78.4 discharges per 1,000 Medicare enrollees. In the last seven years, the national discharge rate declined from 82.5 to 78.4 discharges per 1,000 Medicare enrollees.

HEALTH OUTCOMES

Health outcomes include the length of life, the disparity among outcomes in a state and the quality of life. These seven measures represent the burden placed on the overall health of a population by death, disparity and depressed quality of life. Measures range from counting days in which people feel their normal activities are limited due to poor health to disease-specific mortality and years of potential life lost.

Poor Mental Health Days is the average number of days in the previous 30 days that a person could not perform work or household tasks due to mental illness. The data is collected by the Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention and rely on the accuracy of each

respondent's estimate of the number of limited activity days lost in the previous 30 days.

The 2008 ranks, based on 2007 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/mental.html. The number of poor mental health days in the previous 30 days ranges from an average of 2.4 days in South Dakota and North Dakota to 4.0 or more days in West Virginia and Mississippi. The average number of poor mental health days in the previous 30 days for the United States is 3.4 days, the same as the 2007 Edition. Kentucky had the largest decrease (0.7 days in the last 30 days), and New Hampshire and Texas had the largest increase (0.5 days in the previous 30 days) since the 2007 Edition.

Poor mental health days highlight the fact that good health outcomes preclude days in which mental health prohibits an individual from accomplishing everyday activities.

Poor Physical Health Days is the average number of days in the previous 30 days that a person could not perform work or household tasks due to physical illness. The data are collected by the Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention and rely on the accuracy of each respondent's estimate of the number of limited activity days lost in the previous 30 days.

The 2008 ranks, based on 2007 data (Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/physical.html. The number of poor physical health days in the previous 30 days ranges from an average of 2.7 days in North Dakota and 2.8 days in Nebraska and South Dakota to 4.8 days in Kentucky and 5.1 days in West Virginia. The average number of poor physical health days in the previous 30 days for the United States is 3.6 days, and it has remained the same as in 2006 and 2007.

Poor physical health days highlight that good health outcomes preclude days in which physical health prohibits an individual from accomplishing everyday activities.

Geographic Disparity measures the variation in the age-adjusted mortality rate among counties within a state. Ideally, health and mortality should be equal among the populations of every county within a state and not vary based upon the physical location where a person lives. Many things may differ among counties, including natural features such as altitude, latitude, moisture and temperature and man-made features such as land use, population density, roads and communications. But even with all these variations, health should still be equal.

Geographic Disparity is a new measure in the 2008 Edition. It indicates the amount of variation among the counties of a state. It is the standard deviation of the 3-year average, age-adjusted all-cause mortality rate for all counties within a state divided by the 3-year age-adjusted all-cause mortality rate for the state. The lower the percent, the closer each county is to the state average and the more uniform the mortality rate is across the state.

The 2008 ranks, based on 2003 to 2005 data (Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/geographic.html. It varies from a low geographic disparity of less than 6 percent in

Vermont, New Hampshire and Delaware to a high geographic disparity of more than 20 percent in Florida and South Dakota. For the United States as a whole, the geographic disparity among all counties is 16.8 percent.

To better illustrate this indicator, Table 16 shows examples of the top and bottom states and the mortality rates for the counties with the highest and lowest mortality within that state.

Infant Mortality represents many factors surrounding birth, including but not limited to: the health of the mother, prenatal care, quality of the health services delivered to the mother and child and infant care. In addition, high infant mortality rates are often considered preventable and, thus, can be influenced by various educational and care programs.

The 2008 ranks, based on a two-year average using 2005 and 2006 data (National Center for Health Statistics, Washington, D.C. Some data is provisional), are at www.americashealthrankings.org/2008/IMR.html. Infant mortality varies greatly among states, from less than 5.0 deaths per 1,000 live births in Washington to more than 10.0 deaths per 1,000 live births in Mississippi and Louisiana. The national average is 6.8 deaths per 1,000 live births, unchanged from the 2007 Edition. The rate has not changed appreciably since the 2003 Edition.

In the last year, infant mortality decreased by 0.5 deaths per 1,000 live

births or more in Wyoming, Nebraska and Washington. It increased by 0.5 deaths per 1,000 live births or more in Vermont and Montana. Since 1990, all states have lowered their infant mortality rates, led by Wyoming and New York which each have 5.0 fewer deaths per 1,000 births. Louisiana has experienced the least improvement with a decline of only 1.5 fewer deaths per 1,000 live births.

States with a low number of births will experience more fluctuations in the two-year average infant mortality rate than states with a higher number of births.

Cardiovascular Deaths is measured using a three-year average, age-adjusted death rate due to heart disease, strokes and other cardiovascular disease. The effect of cardiovascular disease on health was measured using mortality data due to the improved accuracy of the data and the ability to adjust for age and race. In prior editions, this measure was race adjusted to compensate for disparity in outcomes by race — however with the introduction of the Geographic Disparity measure, it is not race adjusted, and the new measure indicates disparity more directly.

The use of mortality data may not reflect the full impact of cardiovascular disease. Data used also do not reflect new procedures to treat heart disease and prolong the useful lives of patients.

The 2008 ranks, based on 2003 to 2005 data (Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/CVD.html. This measure varies from a low of 219.4 deaths from cardiovascular disease per 100,000 population in Minnesota to over 350 deaths per 100,000 population in West Virginia, Tennessee, Alabama, Oklahoma and Mississippi. The national average is 298.2 deaths per 100,000 population, down from 309.0 deaths per 100,000 population last year and 405.1 deaths per 100,000 population in 1990.

Table 16
Geographic Disparity – Examples

GEOGRAPHIC AREA	GEOGRAPHIC DISPARITY	COUNTY WITH LOWEST MORTALITY RATE (DEATHS PER 100,000 POPULATION)	COUNTY WITH HIGHEST MORTALITY RATE (DEATHS PER 100,000 POPULATION)
Vermont	5.2%	683.1	831.5
New Hampshire	5.6%	733.6	873.0
Delaware	4.2%	813.1	883.1
Florida	20.5%	536.4	1,652.2
South Dakota	26.5%	486.6	1808.2
United States	16.8%	332.7	1808.2

In the last year, the rate of deaths from cardiovascular disease decreased in Texas by 15.0 deaths per 100,000 population. No state experienced an increase. Since 1990, the rate of deaths from cardiovascular disease declined by more than 125 deaths per 100,000 population in eight states and by more than 100 deaths per 100,000 population in another 24 states. Mississippi experienced the least improvement in the rate of deaths from cardiovascular disease, declining by only 45.8 deaths per 100,000 population.

Cancer Deaths is measured using a three-year average, age-adjusted death rate due to cancer. The effect of cancer on health was measured using mortality data due to the improved accuracy of the data and the ability to adjust for age. In prior editions, this measure was race adjusted to compensate for disparity in outcomes by race; however, with the introduction of the Geographic Measure measure, it is not race adjusted, thus the new measure indicates disparity more directly.

The 2008 ranks, based on 2003 to 2005 data (Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/cancer.html. The rate varies from less than 150 cancer deaths per 100,000 population in Utah to over 220 deaths per 100,000 population in Louisiana and Kentucky. The national average is 193.4 deaths per 100,000 population, a decrease of 1.8 deaths per 100,000 population from the 2007 Edition and a decrease of only 4.1 deaths per 100,000 population from the 1990 Edition. Cancer deaths peaked in 1996 when the national rate was 205.5 deaths per 100,000 population.

Since the 2007 Edition, the rate of cancer deaths decreased by more than four deaths per 100,000 population in Minnesota and Alaska. Cancer deaths increased in six states with increases of 2.7 deaths per 100,000 population in Delaware, Hawaii and South Dakota. Since the 1990 Edition, it declined by

more than 20 deaths per 100,000 population in Maryland and New York and increased by 18.7 deaths per 100,000 population in Kentucky.

Premature Death measures the loss of years of productive life due to death before age 75 as defined by Centers for Disease Control and Prevention's Years of Potential Life Lost (YPLL-75). Thus, the death of a 25-year-old would account for 50 years of lost life, while the death of a 60-year-old would account for 15 years.

The 2008 ranks, based on 2005 data (Centers for Disease Control and Prevention), are at www.americashealthrankings.org/2008/YPLL.html. The age-adjusted data vary from less than 6,000 years lost per 100,000 population in Minnesota, Massachusetts, New Hampshire, Vermont and Connecticut to more than 10,000 years lost per 100,000 population in Mississippi, Louisiana and Alabama. The national average is 7,490 years lost before age 75 per 100,000 population, which is 79 years more than the 2007 Edition and 1,226 years less per 100,000 population than the 1990 Edition.

In the last year, the years of potential life lost in Alaska, Maryland and Utah decreased by over 200 years per 100,000 population whereas the years of potential life lost in Montana, Mississippi and North Dakota increased by over 500 years per 100,000 population. Since the 1990 Edition, the years of potential life lost decreased in 42 of the 50 states. New York has shown the greatest decline, with a decrease of 3,526 years from 9,754 to 6,228 years of potential life lost before age 75 per 100,000 population. Oklahoma experienced the greatest increase of 1,073 years from 8,551 to 9,624 years of potential life lost before age 75 per 100,000 population.

Weighting of Measures

Three criteria were considered when assigning weights to measures.

1. What effect does a measure have on overall health?

2. Is the effect measured solely by this measure or is it included in other measures?

3. How reliable is the data supporting a measure?

The final weights, presented in Table 17, are based on input from the experts in 1990 and 1991 and from input from the Scientific Advisory Committee and its continuing methodological review (Page 5). The weights of the measures total 100 percent. The column labeled “% of Total” indicates the weight of each measure in determining the overall ranking. For example, prevalence of smoking is ten percent of the *America’s Health Rankings*[™]. The column labeled “Effect on Score” presents how each measure positively or negatively relates to the overall ranking. For example, a high prevalence of smoking has a negative effect on score and will lower the ranking of a state. An increase in the percent of high school graduates has a positive effect on score and will increase the overall ranking of a state.

Table 17
Weight of Individual Measures

NAME OF MEASURE	% OF TOTAL	EFFECT ON SCORE
DETERMINANTS		
PERSONAL BEHAVIORS		
Prevalence of Smoking	10.0	Negative
Prevalence of Binge Drinking	5.0	Negative
Prevalence of Obesity	5.0	Negative
COMMUNITY & ENVIRONMENT		
High School Graduation	5.0	Positive
Violent Crime	5.0	Negative
Occupational Fatalities	2.5	Negative
Infectious Disease	5.0	Negative
Children in Poverty	5.0	Negative
Air Pollution	5.0	Negative
PUBLIC & HEALTH POLICIES		
Lack of Health Insurance	5.0	Negative
Public Health Funding	2.5	Positive
Immunization Coverage	5.0	Positive
CLINICAL CARE		
Adequacy of Prenatal Care	5.0	Positive
Primary Care Physicians	5.0	Positive
Preventable Hospitalizations	5.0	Negative
HEALTH OUTCOMES		
Poor Mental Health Days	2.5	Negative
Poor Physical Health Days	2.5	Negative
Geographic Disparity	5.0	Negative
Infant Mortality	5.0	Negative
Cardiovascular Deaths	2.5	Negative
Cancer Deaths	2.5	Negative
Premature Death	5.0	Negative
OVERALL HEALTH RANKING	100.0	—

State-By-State Snapshots

The following pages describe the overall ranking, strengths, challenges and significant changes for each state. The state-by-state snapshot also displays data from the 2007, 2003 and 1990 Editions to permit year-to-year comparisons and comparisons over time.

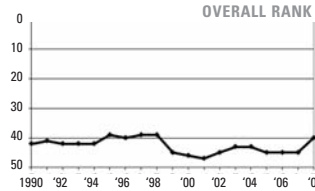
On each state's snapshot, there is a separate paragraph that describes aspects of the health disparities within that state and included variations in premature death by race or gender for:

- Cardiovascular deaths
(www.americashealthrankings.org/2008/Disparity-CVD.html),
- Lack of health insurance
(www.americashealthrankings.org/2008/Disparity-Insurance.html) and
- Low birth weight infants
(www.americashealthrankings.org/2008/Disparity-LBW.html).

Further information about health disparities appears on page 9, and the complete data tables are available at the Web site links shown above.

Ranking: Alabama is 40th this year; it was 45th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 11.0 percent of the population, moderate immunization coverage with 81.6 percent of children ages 19 to 35 months receiving complete immunizations, low geographic disparity within the state at 7.7 percent and strong public health funding at \$94 per person. Alabama ranks higher for health determinants than for health outcomes, indicating that overall healthiness may improve over time.



Challenges: Challenges include a high prevalence of obesity at 30.9 percent of the population, high levels of air pollution at 15.4 micrograms of fine particulate per cubic meter, a high percentage of children in poverty at 22.5 percent of persons under age 18, a high premature death rate with 10,261 years of potential life lost before age 75 per 100,000 population, a high rate of deaths from cardiovascular disease at 366.2 deaths per 100,000 population and a high infant mortality rate at 9.2 deaths per 1,000 live births.

Significant Changes:

- ▼ In the past year, the rate of uninsured population decreased from 14.9 percent to 13.6 percent.
- ▲ In the past year, the percentage of children in poverty increased from 18.8 percent to 22.5 percent of persons under age 18.
- ▲ Since 1990, the prevalence of obesity increased from 12.3 percent to 30.9 percent of the population.
- ▼ Since 1990, the rate of uninsured population declined from 16.9 percent to 13.6 percent.

Health Disparities: In Alabama, low birth weight babies are more common among non-Hispanic blacks at 15.0 percent than Hispanics at 6.9 percent. Access to health care varies significantly by race and ethnicity in Alabama; 36.9 percent of Hispanics lack health insurance compared to 16.6 percent of non-Hispanic whites.

State Health Department Web Site: www.adph.org

Overall Rank: 40
Change: ▲5

Strengths:

- Low prevalence of binge drinking
- Moderate immunization coverage
- Low geographic disparity within the state

Challenges:

- High prevalence of obesity
- High levels of air pollution
- High percentage of children in poverty

Significant Changes:

- In the past year, the rate of uninsured population decreased by 9%
- In the past year, the percentage of children in poverty increased by 20%
- Since 1990, the prevalence of obesity increased by 151%
- Since 1990, the rate of uninsured population decreased by 19%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	22.5	40	23.2	41	24.4	34	30.6	29
Prevalence of Binge Drinking (Percent of population)	11.0	6	10.7	6	13.1*	13	—	—
Prevalence of Obesity (Percent of population)	30.9	49	30.5	48	25.7	47	12.3	33
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	65.9	41	65.0	46	58.2*	44*	69.5*	39
Violent Crime (Offenses per 100,000 population)	448	30	425	27	439	29	559	36
Occupational Fatalities (Deaths per 100,000 workers)	7.0	37	8.0	37	6.2	33	7.7*	13
Infectious Disease (Cases per 100,000 population)	17.7	34	18.7	31	19.1	23	31.3	25
Children in Poverty (Percent of persons under age 18)	22.5↑	46	18.8	35	23.2	47	26.2	45
Air Pollution (Micrograms of fine particles per cubic meter)	15.4	47	15.3	46	16.3	44.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	13.6↓	22	14.9	29	12.3	25	16.9	39
Public Health Funding (Dollars per person)	\$ 94	16	\$98	11	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	81.6	15	80.6	24	76.8	23	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	76.4**	—	78.0	21	76.91*	23	67.6*	33
Primary Care Physicians (Number per 100,000 population)	99.7	40	100.1	40	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	94.8	44	94.8	44	101.4	46	—	—
ALL DETERMINANTS								
	-4.3	39	-5.1	37	-1.5	34	-4.3	42
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.9	47	4.1	46	4.2	48	—	—
Poor Physical Health Days (Days in previous 30 days)	4.3	48	4.3	46	4.2	47	—	—
Geographic Disparity (Relative standard deviation)	7.7	1	7.7%	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	9.2	47	9.1	46	9.4	47	12.7	48
Cardiovascular Deaths (Deaths per 100,000 population)	366.2	48	372.3	48	386.6	0	431.1	40
Cancer Deaths (Deaths per 100,000 population)	211.4	43	211.5	43	214.3	42	204.0	34
Premature Death (Years lost per 100,000 population)	10,261↑	48	10,106	48	9,844	48	9,997	46
ALL HEALTH OUTCOMES								
	-2.7	49	-6.7	49	-7.2	49	-3.0	39
OVERALL								
	-7.0	40	-11.9	45	-11.1	43	-7.4	42

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 30 Change: no change

Strengths:

- Low percentage of children in poverty
- Low levels of air pollution
- Strong per capita public health funding

Challenges:

- Low high school graduation rate
- High geographic disparity within the state
- High violent crime rate

Significant Changes:

- In the past year, the prevalence of smoking decreased by 8%
- In the past year, the percentage of children in poverty decreased by 27%
- In the past five years, the rate of preventable hospitalizations declined by 24%
- Since 1990, the incidence of infectious disease decreased by 84%

Ranking: Alaska is 30th this year, unchanged from 2007.

Strengths: Strengths include a low percentage of children in poverty at 8.5 percent of persons under age 18, low levels of air pollution at 7.6 micrograms of fine particulate per cubic meter, strong public health funding at \$175 per person, a low rate of deaths from cardiovascular disease at 248.5 deaths per 100,000 population and a low rate of preventable hospitalizations with 58.2 discharges per 1,000 Medicare enrollees.

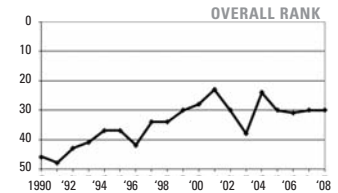
Challenges: Challenges include a low high school graduation rate with 64.1 percent of incoming ninth graders who graduate within four years, high geographic disparity within the state at 17.1 percent, a high violent crime rate at 661 offenses per 100,000 population and a high occupational fatalities rate at 9.9 deaths per 100,000 workers.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 24.0 percent to 22.2 percent of the population.
- ▼ In the past year, the percentage of children in poverty declined from 11.6 percent to 8.5 percent of persons under age 18.
- ▼ In the past five years, the rate of preventable hospitalizations decreased from 76.8 to 58.2 discharges per 1,000 Medicare enrollees.
- ▼ Since 1990, the incidence of infectious disease declined from 92.2 to 14.9 cases per 100,000 population.

Health Disparities: In Alaska, low birth weight babies are more common among non-Hispanic blacks at 11.7 percent than all races overall in the state at 6.0 percent.

State Health Department Web Site: health.hss.state.ak.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	22.2↓	38	24.0	45	29.3	49	34.3	47
Prevalence of Binge Drinking (Percent of population)	18.0	41	17.1	41	18.2*	42	—	—
Prevalence of Obesity (Percent of population)	28.2↑	35	26.2	33	23.4	34	13.4	42
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	64.1	45	67.2	40	63.8*	38*	73.6*	33
Violent Crime (Offenses per 100,000 population)	661	43	688	45	588	41	455	29
Occupational Fatalities (Deaths per 100,000 workers)	9.9↓	46	12.5	47	14.4	46	22.3*	48
Infectious Disease (Cases per 100,000 population)	14.9↓	27	16.2	26	18.4	20	92.2	47
Children in Poverty (Percent of persons under age 18)	8.5↓	1	11.6	8	12.5	19	16.6	18
Air Pollution (Micrograms of fine particles per cubic meter)	7.6	1	8.1	5	7.6	1.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	17.4	39	16.8	36	16.9	42	17.6	40
Public Health Funding (Dollars per person)	\$175↑	2	\$138	2	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	78.6	35	73.5	48	75.3	30	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	59.1**	—	63.9	47	69.22*	42	66.5*	36
Primary Care Physicians (Number per 100,000 population)	114.1	26	115.5	23	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	58.2	8	58.2	8	76.8	25	—	—
ALL DETERMINANTS	0.1	29	-1.8	34	-5.8	42	-3.0	38
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.1	14	3.2	18	2.5	2	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.4	25	2.5	2	—	—
Geographic Disparity (Relative standard deviation)	17.1	43	18.7%	47	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.1	17	6.2	19	7.5	34	10.6	33
Cardiovascular Deaths (Deaths per 100,000 population)	248.5	6	249.8	2	281.2	0	350.6	7
Cancer Deaths (Deaths per 100,000 population)	188.2	16	192.9	23	199.6	20	200.6	30
Premature Death (Years lost per 100,000 population)	7,582	26	7,969	34	8,144	36	9,304	41
ALL HEALTH OUTCOMES	1.1	30	1.9	22	0.2	29	-6.5	50
OVERALL	1.3	30	0.1	30	-5.5	38	-9.5	46

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Arizona is 33rd this year, unchanged from 2007.

Strengths: Strengths include a high rate of high school graduation with 84.7 percent of incoming ninth graders who graduate within four years, a low rate of preventable hospitalizations with 61.5 discharges per 1,000 Medicare enrollees, and low rates of deaths from cancer and cardiovascular disease, at 173.6 deaths and 250.2 deaths per 100,000 population, respectively.

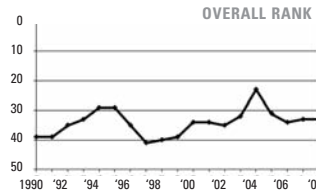
Challenges: Challenges include a high rate of uninsured population at 19.6 percent, limited access to primary care with 90.9 primary care physicians per 100,000 population, low public health funding at \$50 per person and high geographic disparity within the state at 14.2 percent. Arizona ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▲ In the past year, the high school graduation rate increased from 66.8 percent to 84.7 percent of incoming ninth graders who graduate within four years.
- ▲ In the past year, immunization coverage increased from 74.8 percent to 80.2 percent of children ages 19 to 35 months receiving complete immunizations.
- ▲ In the past year, the prevalence of smoking increased from 18.2 percent to 19.8 percent of the population.
- ▼ Since 1990, the incidence of infectious disease decreased from 91.0 to 17.2 cases per 100,000 population.

Health Disparities: In Arizona, low birth weight babies are more common among non-Hispanic blacks at 12.4 percent than Hispanics at 6.7 percent. Access to health care varies significantly by race and ethnicity in Arizona; 46.1 percent of Hispanics lack health insurance compared to 13.6 percent of non-Hispanic whites.

State Health Department Web Site: www.azdhs.gov



Overall Rank: 33 Change: no change

Strengths:

- High rate of high school graduation
- Low rate of preventable hospitalizations
- Low rates of cancer deaths and cardiovascular deaths

Challenges:

- High rate of uninsured population
- Limited access to primary care
- Low per capita public health funding

Significant Changes:

- In the past year, the high school graduation rate increased by 27%
- In the past year, immunization coverage increased by 7%
- In the past year, the prevalence of smoking increased by 9%
- Since 1990, the incidence of infectious disease decreased by 82%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.8↑	25	18.2	13	23.4	29	29.5	24
Prevalence of Binge Drinking (Percent of population)	15.1	23	14.9	25	16.9*	36	—	—
Prevalence of Obesity (Percent of population)	25.8↑	22	22.9	11	19.6	15	10.8	15
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	84.7↑	8	66.8	43	70.5*	28*	70*	38
Violent Crime (Offenses per 100,000 population)	483	33	501	35	540	36	612	39
Occupational Fatalities (Deaths per 100,000 workers)	4.9	17	4.8	15	4	9	7.4*	10
Infectious Disease (Cases per 100,000 population)	17.2↓	32	20.4	34	26.4	37	91.0	47
Children in Poverty (Percent of persons under age 18)	20.0	38	20.0	39	22.3	44	19.8	28
Air Pollution (Micrograms of fine particles per cubic meter)	11.2↑	22	10.8	20	11.0	17.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	19.6	45	20.3	47	16.9	42	17.8	41
Public Health Funding (Dollars per person)	\$50	40	\$44	42	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.2↑	24	74.8	46	67.9	43	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	68**	—	67.6	44	69.14*	43	62.8*	42
Primary Care Physicians (Number per 100,000 population)	90.9	43	92.4	43	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	61.5	9	61.5	9	55.8	5	—	—
ALL DETERMINANTS								
	-1.1	32	-3.3	36	-4.2	40	-4.7	43
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.4	28	3.2	18	3.3	31	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.3	17	3.9	44	—	—
Geographic Disparity (Relative standard deviation)	14.2	39	12.8%	34	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.5	24	6.8	29	6.8	23	9.4	19
Cardiovascular Deaths (Deaths per 100,000 population)	250.2	7	258.9	7	287.3	0	332.5	3
Cancer Deaths (Deaths per 100,000 population)	173.6	5	175.4	5	177.2	5	181.0	12
Premature Death (Years lost per 100,000 population)	7,867	32	7,699	31	7,855	30	8,861	32
ALL HEALTH OUTCOMES								
	1.5	25	1.6	24	0.9	26	-1.9	35
OVERALL								
	0.4	33	-1.7	33	-2.1	32	6.7	39

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 43 Change: ▲5

Strengths:

- Low prevalence of binge drinking
- Moderate per capita public health funding

Challenges:

- High prevalence of obesity
- Low immunization coverage
- High premature death rate
- High rate of cancer deaths

Significant Changes:

- In the past year, the prevalence of smoking decreased by 6%
- In the past year, the prevalence of obesity increased by 9%
- In the past five years, the percentage of children in poverty declined by 33%
- Since 1990, the incidence of infectious disease decreased by 57%

Ranking: Arkansas is 43rd this year; it was 48th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 11.4 percent of the population, moderate public health funding at \$73 per person and moderate geographic disparity within the state at 10.5 percent.

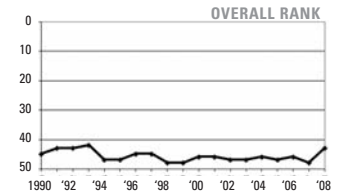
Challenges: Challenges include a high prevalence of obesity at 29.3 percent of the population, a high occupational fatalities rate at 9.6 deaths per 100,000 workers, low immunization coverage with 75.0 percent of children ages 19 to 35 months receiving complete immunizations, a high premature death rate with 9,694 years of potential life lost before age 75 per 100,000 population and a high rate of cancer deaths at 213.4 deaths per 100,000 population.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 23.7 percent to 22.4 percent of the population.
- ▲ In the past year, the prevalence of obesity increased from 26.9 percent to 29.3 percent of the population.
- ▼ In the past five years, the percentage of children in poverty declined from 28.3 percent to 19.1 percent of persons under age 18.
- ▼ Since 1990, the incidence of infectious disease decreased from 37.0 to 16.0 cases per 100,000 population.

Health Disparities: In Arkansas, low birth weight babies are more common among non-Hispanic blacks at 14.9 percent than non-Hispanic whites at 7.8 percent. Access to health care varies significantly by race and ethnicity in Arkansas; 55.5 percent of Hispanics lack health insurance compared to 20.7 percent of non-Hispanic whites.

State Health Department Web Site: www.healthyarkansas.com

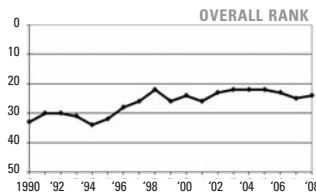


DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	22.4↓	39	23.7	44	26.3	39	31.3	35
Prevalence of Binge Drinking (Percent of population)	11.4	7	11.4	8	12*	7	—	—
Prevalence of Obesity (Percent of population)	29.3↑	45	26.9	36	23.7	38	13.2	41
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	75.7	30	76.8	26	73.2*	21*	78.6*	18
Violent Crime (Offenses per 100,000 population)	529	39	552	40	453	30	413	23
Occupational Fatalities (Deaths per 100,000 workers)	9.6	45	10.1	45	7	40	14*	41
Infectious Disease (Cases per 100,000 population)	16.0	31	16.4	27	21.3	28	37.0	35
Children in Poverty (Percent of persons under age 18)	19.1↓	36	26.6	49	28.3	50	25.2	43
Air Pollution (Micrograms of fine particles per cubic meter)	13.3↑	32	13.0	30	13.7	30.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	17.5	40	18.2	41	15.9	38	19.1	45
Public Health Funding (Dollars per person)	\$73↓	25	\$83	19	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	75.0	46	75.0	45	71.0	39	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	62.7**	—	69.0	41	71.64*	40	61.4*	46
Primary Care Physicians (Number per 100,000 population)	98.5	41	98.7	41	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	92.7	43	92.7	43	96.9	43	—	—
ALL DETERMINANTS	-6.5	42	-11.4	48	-6.1	45	-5.4	44
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.5	32	3.8	43	3.7	46	—	—
Poor Physical Health Days (Days in previous 30 days)	4.1	45	4.1	45	4.4	48	—	—
Geographic Disparity (Relative standard deviation)	10.5	24	10.5	26	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	8.1	41	7.9	38	8.4	41	10.3	30
Cardiovascular Deaths (Deaths per 100,000 population)	340.0↓	43	354.2	43	380.4	0	426.0	36
Cancer Deaths (Deaths per 100,000 population)	213.4	45	213.8	45	210.8	38	196.9	24
Premature Death (Years lost per 100,000 population)	9,694	47	9,763	47	9,466	45	9,523	44
ALL HEALTH OUTCOMES	-1.6	44	-4.9	44	-5.7	46	-3.9	45
OVERALL	-8.1	43	-16.3	48	-14.2	47	-9.3	45

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: California is 24th this year; it was 25th in 2007.

Strengths: Strengths include a low prevalence of smoking at 14.3 percent of the population, a low prevalence of obesity at 23.3 percent of the population, a low occupational fatalities rate at 3.4 deaths per 100,000 workers, a low infant mortality rate at 5.3 deaths per 1,000 live births, a low rate of cancer deaths at 175.4 deaths per 100,000 population and a low rate of preventable hospitalizations with 63.1 discharges per 1,000 Medicare enrollees.



Challenges: Challenges include high levels of air pollution at 14.8 micrograms of fine particulate per cubic meter, a high rate of uninsured population at 18.5 percent, high geographic disparity within the state at 17.3 percent and a high incidence of infectious disease at 21.4 cases per 100,000 population.

Significant Changes:

- ▼ In the past year, the incidence of infectious disease declined from 23.7 to 21.4 cases per 100,000 population.
- ▲ In the past year, the prevalence of binge drinking increased from 14.7 percent to 16.2 percent of the population.
- ▼ Since 1990, the violent crime rate decreased from 918 to 523 offenses per 100,000 population.
- ▼ Since 1990, the infant mortality rate declined from 9.0 to 5.3 deaths per 1,000 live births.

Health Disparities: In California, low birth weight babies are more common among non-Hispanic blacks at 12.5 percent than all other races in the state at 6.7 percent. Access to health care varies significantly by race and ethnicity in California; 34.4 percent of Hispanics lack health insurance compared to 9.7 percent of non-Hispanic whites.

State Health Department Web Site: www.dhs.ca.gov

Overall Rank: 24

Change: ▲ 1

Strengths:

- Low prevalence of smoking
- Low prevalence of obesity
- Low rate of cancer deaths

Challenges:

- High levels of air pollution
- High rate of uninsured population
- High geographic disparity within the state

Significant Changes:

- In the past year, the incidence of infectious disease declined by 10%
- In the past year, the prevalence of binge drinking increased by 10%
- Since 1990, the violent crime rate decreased by 43%
- Since 1990, the premature death rate declined by 25%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	14.3	2	14.9	2	16.4	2	25.6	4
Prevalence of Binge Drinking (Percent of population)	16.2↑	30	14.7	24	15.2*	23	—	—
Prevalence of Obesity (Percent of population)	23.3	9	23.3	16	19.2	11	9.8	6
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	74.6	33	73.9	32	68.7*	31*	68.5*	41
Violent Crime (Offenses per 100,000 population)	523	38	533	37	617	43	918	48
Occupational Fatalities (Deaths per 100,000 workers)	3.4	2	3.5	3	3.6	7	8.4*	16
Infectious Disease (Cases per 100,000 population)	21.4↓	41	23.7	40	29.8	42	70.6	46
Children in Poverty (Percent of persons under age 18)	17.9	31	18.1	33	16.4	32	22.0	36
Air Pollution (Micrograms of fine particles per cubic meter)	14.8↓	42	15.5	49	19.4	50.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	18.5	44	18.8	44	18.4	48	17.9	43
Public Health Funding (Dollars per person)	\$104	12	\$94	15	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	79.4	31	80.3	27	73.2	35	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	77.5**	—	78.7	18	79.87*	16	—*	31
Primary Care Physicians (Number per 100,000 population)	117.2	22	116.8	21	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.1	10	63.1	10	69.3	17	—	—
ALL DETERMINANTS								
	3.1	24	2.3	25	2.1	27	-1.6	34
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.5	32	3.8	43	3.6	40	—	—
Poor Physical Health Days (Days in previous 30 days)	3.3	15	3.7	38	3.6	40	—	—
Geographic Disparity (Relative standard deviation)	17.3	44	15.3	42	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.3	9	5.4	9	5.4	4	9.0	12
Cardiovascular Deaths (Deaths per 100,000 population)	289.2↓	26	299.7	27	328.1	0	378.0	20
Cancer Deaths (Deaths per 100,000 population)	175.4	6	177.0	6	182.3	6	193.8	22
Premature Death (Years lost per 100,000 population)	6,356	14	6,323	14	6,506	15	8,453	25
ALL HEALTH OUTCOMES								
	2.2	21	1.3	26	3.5	9	-1.8	34
OVERALL								
	5.3	24	3.6	25	5.7	22	-3.4	33

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 19 Change: ▼3

Strengths:

- Low prevalence of obesity
- Low levels of air pollution
- Low rate of preventable hospitalizations
- Low rates of cancer deaths and cardiovascular deaths

Challenges:

- High geographic disparity within the state
- High rate of uninsured population

Significant Changes:

- In the past year, the violent crime rate decreased by 11%
- In the past year, per capita public health funding increased by 34%
- In the past five years, immunization coverage increased by 25%
- Since 1990, the percentage of children in poverty declined by 42%

Ranking: Colorado is 19th this year; it was 16th in 2007.

Strengths: Strengths include a low prevalence of obesity at 19.3 percent of the population, low levels of air pollution at 8.5 micrograms of fine particulate per cubic meter, few poor physical health days per month at 2.9 days in the previous 30 days, low rates of deaths from cancer and cardiovascular disease at 168.3 deaths and 247.0 deaths per 100,000 population, respectively, and a low rate of preventable hospitalizations with 56.2 discharges per 1,000 Medicare enrollees. Colorado ranks higher for health determinants than for health outcomes, indicating that overall healthiness may improve over time.

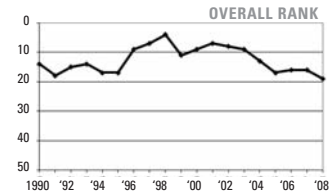
Challenges: Challenges include a high prevalence of binge drinking at 16.8 percent of the population, a high rate of uninsured population at 16.8 percent and high geographic disparity within the state at 18 percent.

Significant Changes:

- ▼ In the past year, the violent crime rate decreased from 392 to 348 offenses per 100,000 population.
- ▲ In the last year, public health funding increased from \$55 to \$74 per person.
- ▲ In the past five years, immunization coverage increased from 62.7 percent to 78.6 percent of children ages 19 to 35 months receiving complete immunizations.
- ▼ Since 1990, the percentage of children in poverty decreased from 21.8 percent to 12.6 percent of persons under age 18.

Health Disparities: In Colorado, cardiovascular death rates vary by race, with all races experiencing 247.0 deaths per 100,000 population in contrast to blacks who experience 316.4 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in Colorado; 42.5 percent of Hispanics lack health insurance compared to 12.8 percent of non-Hispanic whites.

State Health Department Web Site: www.cdphe.state.co.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	18.7	15	17.9	9	20.4	6	28.6	16
Prevalence of Binge Drinking (Percent of population)	16.8	37	16.3	33	17.7*	41	—	—
Prevalence of Obesity (Percent of population)	19.3↑	1	18.2	1	16.5	1	6.9	1
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	76.7↓	27	78.7	20	69.3*	30*	76*	28
Violent Crime (Offenses per 100,000 population)	348↓	26	392	26	351	21	468	30
Occupational Fatalities (Deaths per 100,000 workers)	6.3	29	6.2	27	4.9	18	11.6*	33
Infectious Disease (Cases per 100,000 population)	10.6↓	20	12.3	20	14.3	18	32.0	27
Children in Poverty (Percent of persons under age 18)	12.6	9	13.4	17	10.6	11	21.8	35
Air Pollution (Micrograms of fine particles per cubic meter)	8.5	6	8.4	6	9.2	7.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	16.8	36	16.9	38	15.0	34	12.8	28
Public Health Funding (Dollars per person)	\$74↑	23	\$55	36	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	78.6↓	35	80.3	27	62.7	50	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	65.7**	—	68.6	42	68.24*	45	71.2*	23
Primary Care Physicians (Number per 100,000 population)	115.4	23	116.6	22	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	56.2	6	56.2	6	58.7	7	—	—
ALL DETERMINANTS								
	7.6	16	5.7	20	5.7	17	3.2	23
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	2.8	7	3.5	38	—	—
Poor Physical Health Days (Days in previous 30 days)	2.9	4	2.9	3	3.3	30	—	—
Geographic Disparity (Relative standard deviation)	18	48	16.8	46	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.3	22	6.7	27	6.0	11	9.2	14
Cardiovascular Deaths (Deaths per 100,000 population)	247.0	4	256.8	6	276.5	0	332.4	3
Cancer Deaths (Deaths per 100,000 population)	168.3	3	171.5	3	171.7	3	164.0	3
Premature Death (Years lost per 100,000 population)	6,407	15	6,424	16	6,448	10	7,353	11
ALL HEALTH OUTCOMES								
	2.1	23	4.0	9	4.1	6	6.6	8
OVERALL								
	9.7	19	9.7	16	13.7	9	9.8	14

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Connecticut is 7th this year; it was 5th in 2007.

Strengths: Strengths include a low prevalence of smoking at 15.4 percent of the population, a low prevalence of obesity at 21.7 percent of the population, a low rate of uninsured population at 9.4 percent, high immunization coverage with 89.3 percent of children ages 19 to 35 months receiving complete immunizations, ready access to primary care with 159.6 primary care physicians per 100,000 population and low geographic disparity within the state at 6.3 percent.

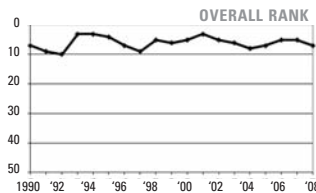
Challenges: Challenges include a high incidence of infectious disease at 20.4 cases per 100,000 population and moderate public health funding at \$60 per person.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 17.0 percent to 15.4 percent of the population.
- ▲ In the past year, the percentage of children in poverty increased from 10.3 percent to 13.8 percent of persons under age 18.
- ▼ Since 1990, the prevalence of smoking decreased from 29.6 percent to 15.4 percent of the population.
- ▲ Since 1990, the rate of uninsured population increased from 6.4 percent to 9.4 percent.

Health Disparities: In Connecticut, low birth weight babies are more common among non-Hispanic blacks at 12.9 percent than non-Hispanic whites at 6.6 percent. Access to health care varies significantly by race and ethnicity in Connecticut; 36.2 percent of Hispanics lack health insurance compared to 7.8 percent of non-Hispanic whites.

State Health Department Web Site: www.ct.gov/dph/



Overall Rank: 7
Change: ▼ 2

Strengths:

- Low prevalence of smoking
- Low prevalence of obesity
- High immunization coverage
- Low geographic disparity within the state

Challenges:

- High incidence of infectious disease
- Moderate public health funding

Significant Changes:

- In the past year, the prevalence of smoking decreased by 9%
- In the past year, the percentage of children in poverty increased by 34%
- Since 1990, the prevalence of smoking decreased by 48%
- Since 1990, the rate of uninsured population increased by 47%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	15.4↓	3	17.0	4	19.4	5	29.6	25
Prevalence of Binge Drinking (Percent of population)	16.1↑	28	14.6	23	15.1*	21	—	—
Prevalence of Obesity (Percent of population)	21.7↑	2	20.6	3	18.0	5	11.7	25
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	80.9	14	80.7	13	72.9*	22*	78.2*	19
Violent Crime (Offenses per 100,000 population)	256	10	281	14	336	19	419	24
Occupational Fatalities (Deaths per 100,000 workers)	4.1	7	4.2	8	4.1	10	8.7*	17
Infectious Disease (Cases per 100,000 population)	20.4↓	39	25.2	41	26.7	38	32.9	31
Children in Poverty (Percent of persons under age 18)	13.8↑	18	10.3	3	9.3	8	9.2	3
Air Pollution (Micrograms of fine particles per cubic meter)	12.4	26	12.9	28	14.4	35.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	9.4	6	10.2	9	9.6	11	6.4	1
Public Health Funding (Dollars per person)	\$ 60	33	\$57	35	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	89.3	3	86.3	3	81.9	5	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	78.5**	—	80.4	14	85.32*	3	78.3*	5
Primary Care Physicians (Number per 100,000 population)	159.6	6	159.1	6	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	67.3	17	67.3	17	64.6	10	—	—
ALL DETERMINANTS	12.0	7	12.1	6	10.2	9	11.6	1
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.0	8	2.8	7	3.2	25	—	—
Poor Physical Health Days (Days in previous 30 days)	2.9	4	3.1	10	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	6.3	1	7.4	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.9	14	5.5	10	6.3	15	8.9	8
Cardiovascular Deaths (Deaths per 100,000 population)	258.9	11	272.0	11	305.8	0	372.0	17
Cancer Deaths (Deaths per 100,000 population)	190.1	19	191.2	19	191.5	14	200.1	27
Premature Death (Years lost per 100,000 population)	5,925	5	5,993	7	6,499	14	7,446	13
ALL HEALTH OUTCOMES	5.5	4	4.5	5	3.3	12	4.9	14
OVERALL	17.5	7	16.6	5	14.7	6	16.5	7

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 35 Change: ▼ 1

Strengths:

- High immunization coverage
- Low percentage of children in poverty
- Low geographic disparity within the state

Challenges:

- High prevalence of binge drinking
- High violent crime rate
- High infant mortality rate

Significant Changes:

- In the past year, the prevalence of smoking decreased by 13%
- In the past year, the prevalence of obesity increased by 9%
- Since 1990, the violent crime rate increased by 60%
- Since 1990, the percentage of children in poverty increased by 52%

Ranking: Delaware is 35th this year; it was 34th in 2007.

Strengths: Strengths include high immunization coverage with 81.8 percent of children ages 19 to 35 months receiving complete immunizations, a low percentage of children in poverty at 13.1 percent of persons under age 18, a low prevalence of smoking at 18.9 percent of the population and low geographic disparity within the state at 4.2 percent.

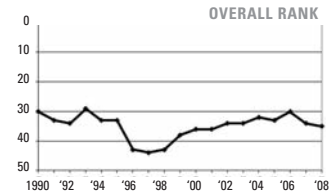
Challenges: Challenges include a high prevalence of binge drinking at 18.8 percent of the population, a high violent crime rate at 689 offenses per 100,000 population, a high incidence of infectious disease at 24.6 cases per 100,000 population, a high infant mortality rate at 9.0 deaths per 1,000 live births and a high rate of cancer deaths at 209.8 deaths per 100,000 population.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 21.7 percent to 18.9 percent of the population.
- ▲ In the past year, the prevalence of obesity increased from 26.0 percent to 28.2 percent of the population.
- ▲ Since 1990, the violent crime rate increased from 432 to 689 offenses per 100,000 population.
- ▲ Since 1990, the percentage of children in poverty increased from 8.6 percent to 13.1 percent of persons under age 18.

Health Disparities: In Delaware, low birth weight babies are more common among non-Hispanic blacks at 14.3 percent than Hispanics at 7.0 percent. Access to health care varies by race and ethnicity in Delaware; 19.7 percent of Hispanics lack health insurance compared to 9.2 percent of non-Hispanic whites.

State Health Department Web Site: www.dhss.delaware.gov/dhss



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	18.9↓	16	21.7	34	24.7	37	31.8	39
Prevalence of Binge Drinking (Percent of population)	18.8↑	46	17.3	43	17*	37	—	—
Prevalence of Obesity (Percent of population)	28.2↑	35	26.0	31	22.4	27	14.4	47
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	73.1	37	72.9	35	64.5*	36*	71*	36
Violent Crime (Offenses per 100,000 population)	689	45	682	44	611	42	432	27
Occupational Fatalities (Deaths per 100,000 workers)	4.8	15	4.3	12	4.3	14	8.7*	17
Infectious Disease (Cases per 100,000 population)	24.6↓	45	31.7	46	35.1	45	48.9	42
Children in Poverty (Percent of persons under age 18)	13.1	13	12.4	9	9.3	8	8.6	1
Air Pollution (Micrograms of fine particles per cubic meter)	14.6	40	14.7	42	15.8	39.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	11.7	18	12.2	18	9.2	7	9.1	13
Public Health Funding (Dollars per person)	\$89	18	\$88	17	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	81.8↓	12	84.3	9	78.7	13	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	74**	—	80.3	15	81.56*	10	69.9*	25
Primary Care Physicians (Number per 100,000 population)	113.8	27	111.7	29	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	72.1	23	72.1	23	73.3	22	—	—
ALL DETERMINANTS								
	-2.0	35	-0.3	32	1.6	28	3.0	25
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.6	38	3.6	39	3.2	25	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.4	25	3.3	30	—	—
Geographic Disparity (Relative standard deviation)	4.2	1	4.0	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	9.0	46	9.4	47	10.0	49	11.6	41
Cardiovascular Deaths (Deaths per 100,000 population)	305.6	32	309.2	29	328.5	0	422.4	33
Cancer Deaths (Deaths per 100,000 population)	209.8	42	207.1	39	214.2	41	222.1	50
Premature Death (Years lost per 100,000 population)	7,886↓	34	8,067	35	8,232	38	8,916	33
ALL HEALTH OUTCOMES								
	0.4	34	-2.4	39	-4.2	42	-3.8	44
OVERALL								
	-1.6	35	-2.8	34	-3.4	34	-0.7	30

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Florida is 45th this year; it was 41st in 2007.

Strengths: Strengths include a low prevalence of obesity at 24.1 percent of the population, high immunization coverage with 82.4 percent of children ages 19 to 35 months receiving complete immunizations, low levels of air pollution at 9.6 micrograms of fine particulate per cubic meter and a low rate of cancer deaths at 185.4 deaths per 100,000 population.

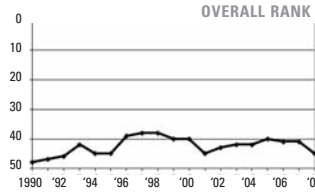
Challenges: Challenges include a high incidence of infectious disease at 36.3 cases per 100,000 population, a high rate of uninsured population at 20.7 percent, a high violent crime rate at 723 offenses per 100,000 population and high geographic disparity within the state at 20.5 percent. Florida ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 21.0 percent to 19.3 percent of the population.
- ▲ In the past year, the percentage of children in poverty increased from 14.6 percent to 17.9 percent of persons under age 18.
- ▼ Since 1990, the infant mortality rate decreased from 10.8 to 7.2 deaths per 1,000 live births.
- ▼ Since 1990, the violent crime rate declined from 1,024 to 723 offenses per 100,000 population.

Health Disparities: In Florida, low birth weight babies are more common among non-Hispanic blacks at 13.3 percent than non-Hispanic whites at 7.4 percent. Access to health care varies significantly by race and ethnicity in Florida; 43.8 percent of Hispanics lack health insurance compared to 17.9 percent of non-Hispanic whites.

State Health Department Web Site: www.doh.state.fl.us



Overall Rank: 45 Change: ▼ 4

Strengths:

- Low prevalence of obesity
- High immunization coverage
- Low levels of air pollution

Challenges:

- High incidence of infectious disease
- High rate of uninsured population
- High geographic disparity within the state

Significant Changes:

- In the past year, the prevalence of smoking decreased by 8%
- In the past year, the percentage of children in poverty increased by 23%
- Since 1990, the infant mortality rate decreased by 33%
- Since 1990, the violent crime rate decreased by 29%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.3↓	19	21.0	30	22.0	16	31.7	37
Prevalence of Binge Drinking (Percent of population)	14.0	16	13.9	17	12.9*	12	—	—
Prevalence of Obesity (Percent of population)	24.1	10	23.1	14	19.4	12	13.6	43
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	64.6↓	44	66.4	44	54.6*	48*	63.5*	49
Violent Crime (Offenses per 100,000 population)	723	46	712	47	797	50	1024	50
Occupational Fatalities (Deaths per 100,000 workers)	6.9	34	7.2	35	5.2	23	10.7*	30
Infectious Disease (Cases per 100,000 population)	36.3↓	48	41.0	49	45.7	48	47.0	40
Children in Poverty (Percent of persons under age 18)	17.9↑	31	14.6	23	18.8	36	25.4	44
Air Pollution (Micrograms of fine particles per cubic meter)	9.6	13	9.7	14	10.2	13.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	20.7	48	20.7	48	16.9	42	17.8	41
Public Health Funding (Dollars per person)	\$64	30	\$66	28	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	82.4	10	82.2	16	74.5	33	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	66.5*	—	77.0	25	78.83*	19	62.8*	42
Primary Care Physicians (Number per 100,000 population)	105.9	33	106.2	32	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	70.1	20	70.1	20	70.3	18	—	—
ALL DETERMINANTS								
	-7.7	46	-9.1	47	-9.7	49	-10.5	50
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.3	30	3.0	17	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.4	25	3.4	33	—	—
Geographic Disparity (Relative standard deviation)	20.5	49	19.1	49	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.2	32	7.2	30	7.1	27	10.8	37
Cardiovascular Deaths (Deaths per 100,000 population)	264.4↓	15	275.4	17	308.2	0	360.8	13
Cancer Deaths (Deaths per 100,000 population)	185.4	14	186.0	12	190.7	12	190.0	18
Premature Death (Years lost per 100,000 population)	8,094	36	8,076	36	8,121	34	9,190	39
ALL HEALTH OUTCOMES								
	-1.2	41	0.3	32	0.3	28	-1.0	32
OVERALL								
	-8.9	45	-8.8	41	-10.8	42	-11.6	48

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 41 Change: ▼ 1

Strengths:

- Low prevalence of binge drinking
- High immunization coverage

Challenges:

- Low high school graduation rate
- High incidence of infectious disease
- High levels of air pollution
- High rate of uninsured population

Significant Changes:

- In the past year, per capita public health funding decreased by 22%
- In the past year, immunization coverage declined by 3%
- Since 1990, the prevalence of smoking decreased by 39%
- Since 1990, the prevalence of obesity increased by 166%

Ranking: Georgia is 41st this year; it was 40th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 12.3 percent of the population and high immunization coverage with 80.8 percent of children ages 19 to 35 months receiving complete immunizations.

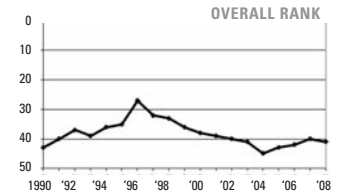
Challenges: Challenges include a low high school graduation rate with 61.7 percent of incoming ninth graders who graduate within four years, a high incidence of infectious disease at 29.4 cases per 100,000 population, high levels of air pollution at 15.9 micrograms of fine particulate per cubic meter and a high rate of uninsured population at 17.6 percent. Georgia ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▼ In the past year, public health funding decreased from \$96 to \$75 per person.
- ▼ In the past year, immunization coverage declined from 83.3 percent to 80.8 percent of children ages 19 to 35 months receiving complete immunizations.
- ▼ Since 1990, the prevalence of smoking decreased from 31.8 percent to 19.4 percent of the population.
- ▲ Since 1990, the prevalence of obesity increased from 10.8 percent to 28.7 percent of the population.

Health Disparities: In Georgia, low birth weight babies are more common among non-Hispanic blacks at 13.8 percent than non-Hispanic whites at 7.4 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 325.9 deaths per 100,000 population in contrast to blacks who experience 394.7 deaths per 100,000 population.

State Health Department Web Site: www.health.state.ga.us

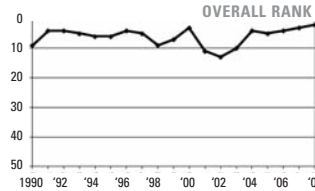


DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.4	22	19.9	23	23.2	25	31.8	39
Prevalence of Binge Drinking (Percent of population)	12.3	9	12.1	10	12.4*	10	—	—
Prevalence of Obesity (Percent of population)	28.7↑	40	27.1	38	23.5	36	10.8	15
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	61.7	48	61.2	48	51.4*	49*	65*	48
Violent Crime (Offenses per 100,000 population)	493	34	471	32	497	33	576	38
Occupational Fatalities (Deaths per 100,000 workers)	6.0	25	6.8	33	5.3	25	14.1*	42
Infectious Disease (Cases per 100,000 population)	29.4↓	47	31.7	46	36.0	46	39.7	37
Children in Poverty (Percent of persons under age 18)	20.6	41	20.4	40	19.5	37	25.1	42
Air Pollution (Micrograms of fine particles per cubic meter)	15.9	50	16.0	50	17.0	47.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	17.6	41	18.0	40	15.8	37	16.0	38
Public Health Funding (Dollars per person)	\$75↓	22	\$96	14	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.8↓	19	83.3	13	80.4	9	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	68.3**	—	73.6	31	79.43*	18	66.8*	35
Primary Care Physicians (Number per 100,000 population)	101.8	38	103.0	36	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	82.0	35	82.0	35	87.9	38	—	—
ALL DETERMINANTS	-7.1	44	-6.6	42	-3.6	38	-1.8	35
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.6	38	3.4	34	3.6	40	—	—
Poor Physical Health Days (Days in previous 30 days)	3.6	30	3.3	17	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	12.8	35	13.6	38	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	8.0	40	8.3	43	8.5	43	12.6	47
Cardiovascular Deaths (Deaths per 100,000 population)	325.9↓	40	339.3	41	375.3	0	442.2	44
Cancer Deaths (Deaths per 100,000 population)	196.6	26	199.5	25	204.1	23	200.6	30
Premature Death (Years lost per 100,000 population)	8,417↓	39	8,609	41	8,924	42	10,202	48
ALL HEALTH OUTCOMES	-0.7	38	-1.9	36	-3.6	40	-5.9	48
OVERALL	-7.8	41	-8.5	40	-7.6	41	-7.7	43

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Hawaii is 2nd this year; it was 3rd in 2007.

Strengths: Strengths include a low prevalence of obesity at 21.7 percent of the population, low levels of air pollution at 4.9 micrograms of fine particulate per cubic meter, a low rate of uninsured population at 8.2 percent, strong public health funding at \$198 per person, a low rate of preventable hospitalizations with 32.2 discharges per 1,000 Medicare enrollees and low rates of death from cancer and cardiovascular disease at 159.0 deaths and 241.1 deaths per 100,000 population, respectively.



Challenges: Challenges include a high prevalence of binge drinking at 18.1 percent of the population.

Significant Changes:

- ▼ In the past year, the incidence of infectious disease decreased from 21.5 to 15.6 cases per 100,000 population.
- ▲ In the past year, immunization coverage increased from 80.1 percent to 87.8 percent of children ages 19 to 35 months receiving complete immunizations.
- ▼ Since 1990, the prevalence of smoking decreased from 27.6 percent to 17.0 percent of the population.
- ▼ Since 1990, the percentage of children in poverty declined from 20.7 percent to 11.6 percent of persons under age 18.

Health Disparities: In Hawaii, low birth weight babies are more common among non-Hispanic blacks at 11.4 percent than non-Hispanic whites at 6.4 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 241.1 deaths per 100,000 population in contrast to blacks who experience 169.3 deaths per 100,000 population.

State Health Department Web Site: www.hawaii.gov/health

Overall Rank: 2 Change: ▲ 1

Strengths:

- Low rate of uninsured population
- Low rate of preventable hospitalizations
- Low levels of air pollution
- Strong per capita public health funding
- Low rates of cancer deaths and cardiovascular deaths

Challenges:

- High prevalence of binge drinking

Significant Changes:

- In the past year, the incidence of infectious disease decreased by 27%
- In the past year, immunization coverage increased by 10%
- Since 1990, the prevalence of smoking decreased by 38%
- Since 1990, the percentage of children in poverty declined by 44%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	17.0	8	17.5	6	21.0	8	27.6	10
Prevalence of Binge Drinking (Percent of population)	18.1↑	44	17.0	40	11.2*	6	—	—
Prevalence of Obesity (Percent of population)	21.7↑	2	20.6	3	17.1	2	9.1	3
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	75.1	31	72.6	36	61*	41*	84.5*	6
Violent Crime (Offenses per 100,000 population)	273	12	281	15	255	9	263	13
Occupational Fatalities (Deaths per 100,000 workers)	5.5	22	5.4	21	6.1	31	9.5*	27
Infectious Disease (Cases per 100,000 population)	15.6↓	30	21.5	37	23.1	33	32.7	30
Children in Poverty (Percent of persons under age 18)	11.6↑	5	10.5	4	15.9	29	20.7	29
Air Pollution (Micrograms of fine particles per cubic meter)	4.9	2	4.9	1	5.1	1.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	8.2	2	8.7	2	9.5	10	10.0	16
Public Health Funding (Dollars per person)	\$198↑	1	\$176	1	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	87.8↑	4	80.1	29	78.7	13	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	63.7**	—	66.1	46	75.48*	26	65.8*	37
Primary Care Physicians (Number per 100,000 population)	146.9	7	147.7	7	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	32.2	1	32.2	1	34.8	1	—	—
ALL DETERMINANTS								
	16.0	2	14.0	2	5.6	19	7.1	11
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.8	7	2.6	5	2.1	1	—	—
Poor Physical Health Days (Days in previous 30 days)	2.9	4	2.9	3	2.1	1	—	—
Geographic Disparity (Relative standard deviation)	8.8	13	9.6	19	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.1	17	6.3	21	7.2	29	9.1	13
Cardiovascular Deaths (Deaths per 100,000 population)	241.1	2	254.6	4	273.7	0	295.6	1
Cancer Deaths (Deaths per 100,000 population)	159.0	1	156.3	1	158.4	2	160.3	1
Premature Death (Years lost per 100,000 population)	6,255	12	6,130	8	6,321	8	6,818	2
ALL HEALTH OUTCOMES								
	5.5	4	5.5	2	4.7	4	8.0	3
OVERALL								
	21.6	2	19.5	3	13.4	10	15.1	9

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 8 Change: ▲7

Strengths:

- Low incidence of infectious disease
- Low rate of preventable hospitalizations
- Low levels of air pollution
- Low percentage of children in poverty

Challenges:

- Limited access to primary care
- Low immunization coverage

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 5%
- In the past year, the prevalence of smoking increased by 14%
- Since 1990, the incidence of infectious disease declined by 88%
- Since 1990, the infant mortality rate decreased by 45%

Ranking: Idaho is 8th this year; it was 15th in 2007.

Strengths: Strengths include a low incidence of infectious disease at 4.5 cases per 100,000 population, low levels of air pollution at 8.8 micrograms of fine particulate per cubic meter, a low percentage of children in poverty at 12.6 percent of persons under age 18, a low violent crime rate at 239 offenses per 100,000 population, strong public health funding at \$113 per person, a low rate of preventable hospitalizations with 55.8 discharges per 1,000 Medicare enrollees and a low rate of cancer deaths at 180.2 deaths per 100,000 population. Idaho ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time as was the case this year.

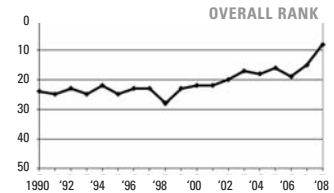
Challenges: Challenges include limited access to primary care with 78.9 primary care physicians per 100,000 population and low immunization coverage with 75.8 percent of children ages 19 to 35 months receiving complete immunizations.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 13.2 percent to 12.6 percent of persons under age 18.
- ▲ In the past year, the prevalence of smoking increased from 16.8 percent to 19.1 percent of the population.
- ▼ Since 1990, the incidence of infectious disease declined from 38.8 to 4.5 cases per 100,000 population.
- ▼ Since 1990, the infant mortality rate decreased from 10.8 to 5.9 deaths per 1,000 live births.

Health Disparities: In Idaho, disparities in the percentage of low birth weight babies are fairly equal, however, access to health care varies significantly by race and ethnicity in the state; 54.6 percent of Hispanics lack health insurance compared to 17.9 percent of non-Hispanic whites.

State Health Department Web Site: www.healthandwelfare.idaho.gov



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.1↑	18	16.8	3	20.6	7	24.1	2
Prevalence of Binge Drinking (Percent of population)	14.7	17	14.0	19	14.3*	17	—	—
Prevalence of Obesity (Percent of population)	25.1	14	24.1	19	20.2	17	11.9	27
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	81.0	13	81.5	11	78*	8*	79.6*	15
Violent Crime (Offenses per 100,000 population)	239	8	247	9	243	8	214	8
Occupational Fatalities (Deaths per 100,000 workers)	4.7↓	14	6.2	27	7.1	42	17.5*	47
Infectious Disease (Cases per 100,000 population)	4.5	4	5.1	5	6.8	6	38.8	36
Children in Poverty (Percent of persons under age 18)	12.6	9	13.2	14	15.9	29	19.3	25
Air Pollution (Micrograms of fine particles per cubic meter)	8.8	7	9.0	8	10.1	11.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	14.7	31	15.1	31	16.4	41	15.2	36
Public Health Funding (Dollars per person)	\$113	8	\$111	7	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	75.8↓	45	77.8	39	69.4	41	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	70.9*	—	73.9*	26	72.79*	36	68.5*	32
Primary Care Physicians (Number per 100,000 population)	78.9	50	79.9	49	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	55.8	5	55.8	5	57.7	6	—	—
ALL DETERMINANTS	12.0	7	7.7	14	5.0	21	3.4	21
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.5	37	3.2	25	—	—
Poor Physical Health Days (Days in previous 30 days)	3.3	15	3.3	17	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	10.4	23	10.4	24	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.9	14	5.7	12	6.9	25	10.8	37
Cardiovascular Deaths (Deaths per 100,000 population)	267.0	21	275.3	17	293.6	0	354.9	11
Cancer Deaths (Deaths per 100,000 population)	180.2	8	178.3	7	183.0	7	168.7	6
Premature Death (Years lost per 100,000 population)	6,444↓	16	6,596	19	6,537	16	7,831	17
ALL HEALTH OUTCOMES	4.1	12	2.6	17	2.3	16	0.8	24
OVERALL	16.1	8	10.3	15	9.0	17	4.1	24

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Illinois is 31st this year; it was 27th in 2007.

Strengths: Strengths include a low occupational fatalities rate at 4.2 deaths per 100,000 workers, ready access to primary care with 128.9 primary care physicians per 100,000 population and few poor mental and physical health days per month at 3.1 days and 3.4 days, respectively, in the previous 30 days.

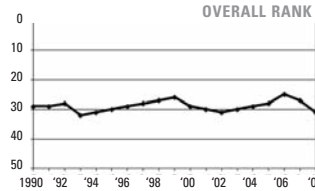
Challenges: Challenges include a high prevalence of binge drinking at 19.4 percent of the population, low immunization coverage with 76.9 percent of children ages 19 to 35 months receiving complete immunizations, a high rate of preventable hospitalizations with 89.4 discharges per 1,000 Medicare enrollees and a high violent crime rate at 533 offenses per 100,000 population.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 14.9 percent to 14.3 percent of persons under age 18.
- ▼ In the past year, immunization coverage declined from 79.8 percent to 76.9 percent of children ages 19 to 35 months receiving complete immunizations.
- ▼ Since 1990, the infant mortality rate decreased from 11.9 to 7.2 deaths per 1,000 live births.
- ▼ Since 1990, the percentage of children in poverty decreased from 21.8 percent to 14.3 percent of persons under age 18.

Health Disparities: In Illinois, low birth weight babies are more common among non-Hispanic blacks at 14.7 percent than Hispanics at 6.6 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 303.2 deaths per 100,000 population in contrast to blacks who experience 417.7 deaths per 100,000 population.

State Health Department Web Site: www.idph.state.il.us/



Overall Rank: 31 Change: ▼ 4

Strengths:

- Low occupational fatalities rate
- Ready access to primary care
- Few poor mental and physical health days

Challenges:

- High prevalence of binge drinking
- Low immunization coverage
- High rate of preventable hospitalizations

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 4%
- In the past year, immunization coverage decreased by 4%
- Since 1990, the infant mortality rate declined by 40%
- Since 1990, the percentage of children in poverty decreased by 34%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	20.1	29	20.5	27	22.8	23	28.7	19
Prevalence of Binge Drinking (Percent of population)	19.4↑	47	18.0	45	17.6*	40	—	—
Prevalence of Obesity (Percent of population)	25.6	21	25.1	25	22.0	25	10.9	17
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	79.4	19	80.3	16	70.9*	27*	77.8*	21
Violent Crime (Offenses per 100,000 population)	533	40	542	38	637	44	795	47
Occupational Fatalities (Deaths per 100,000 workers)	4.2	8	4.2	8	4.2	11	8.3*	15
Infectious Disease (Cases per 100,000 population)	19.1↓	38	20.6	35	24.6	35	27.2	19
Children in Poverty (Percent of persons under age 18)	14.3	20	14.9	24	15.8	28	21.8	34
Air Pollution (Micrograms of fine particles per cubic meter)	15.2	44	15.1	45	17.3	48.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	13.7	24	13.9	26	13.3	28	10.1	18
Public Health Funding (Dollars per person)	\$57	35	\$59	33	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	76.9↓	42	79.8	32	78.6	17	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	73.4**	—	77.5	23	77.31*	22	68.8*	30
Primary Care Physicians (Number per 100,000 population)	128.9	10	127.8	10	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	89.4	42	89.4	42	88.0	39	—	—
ALL DETERMINANTS	-1.4	33	1.9	27	1.3	30	0.4	30
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.1	14	3.0	13	3.0	17	—	—
Poor Physical Health Days (Days in previous 30 days)	3.4	18	3.3	17	3.0	16	—	—
Geographic Disparity (Relative standard deviation)	9.9	20	9.8	20	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.2	32	7.3	31	8.1	39	11.9	46
Cardiovascular Deaths (Deaths per 100,000 population)	303.2↓	31	314.0	31	348.8	0	431.7	41
Cancer Deaths (Deaths per 100,000 population)	201.2	35	203.6	35	210.3	35	203.9	33
Premature Death (Years lost per 100,000 population)	7,145	22	7,221	23	7,777	29	8,791	31
ALL HEALTH OUTCOMES	2.2	21	0.6	31	-1.4	34	-0.1	30
OVERALL	0.8	31	2.5	27	0.4	30	0.3	29

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 34 Change: ▼2

Strengths:

- Low rate of uninsured population
- Low incidence of infectious disease
- Low geographic disparity within the state

Challenges:

- High prevalence of smoking
- High levels of air pollution
- Low per capita public health funding

Significant Changes:

- In the past year, the percentage of children in poverty increased by 32%
- In the past year, the rate of uninsured population declined by 9%
- In the past five years, the percentage of children in poverty increased by 66%
- Since 1990, the incidence of infectious disease decreased by 50%

Ranking: Indiana is 34th this year; it was 32nd in 2007.

Strengths: Strengths include a low rate of uninsured population at 11.6 percent, a low incidence of infectious disease at 9.0 cases per 100,000 population and a low geographic disparity within the state at 8.6 percent.

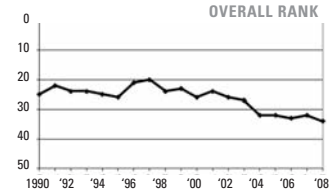
Challenges: Challenges include a high prevalence of smoking at 24.1 percent of the population, high levels of air pollution at 15.3 micrograms of fine particulate per cubic meter, low public health funding at \$33 per person, a high rate of preventable hospitalizations with 83.2 discharges per 1,000 Medicare enrollees and low immunization coverage with 76.8 percent of children ages 19 to 35 months receiving complete immunizations. Indiana ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 14.3 percent to 18.8 percent of persons under age 18.
- ▼ In the past year, the rate of uninsured population decreased from 12.7 percent to 11.6 percent.
- ▲ In the past five years, the percentage of children in poverty increased from 11.3 percent to 18.8 percent of persons under age 18.
- ▼ Since 1990, the incidence of infectious disease decreased from 18.0 to 9.0 cases per 100,000 population.

Health Disparities: In Indiana, low birth weight babies are more common among non-Hispanic blacks at 13.5 percent than Hispanics at 6.3 percent. Access to health care varies significantly by race and ethnicity in the state; 46.7 percent of Hispanics lack health insurance compared to 15.3 percent of non-Hispanic whites.

State Health Department Web Site: www.in.gov/isdh



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	24.1	45	24.1	46	27.6	46	32.8	43
Prevalence of Binge Drinking (Percent of population)	15.8	26	15.1	27	14.9*	18	—	—
Prevalence of Obesity (Percent of population)	27.4	30	27.8	41	24.1	41	14.5	48
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	73.2	36	73.5	33	67.9*	33*	75.9*	30
Violent Crime (Offenses per 100,000 population)	334	24	315	22	372	25	329	18
Occupational Fatalities (Deaths per 100,000 workers)	6.7	32	6.8	33	6.4	37	10.8*	31
Infectious Disease (Cases per 100,000 population)	9.0↓	14	10.6	17	11.6	14	18.0	11
Children in Poverty (Percent of persons under age 18)	18.8↑	34	14.3	21	11.3	14	20.8	30
Air Pollution (Micrograms of fine particles per cubic meter)	15.3	45	15.0	43	16.4	45.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	11.6	16	12.7	21	11.7	22	10.9	22
Public Health Funding (Dollars per person)	\$33	50	\$33	49	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	76.8↓	43	79.5	34	76.0	27	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	70.1**	—	73.2	32	73.56*	31	72*	19
Primary Care Physicians (Number per 100,000 population)	101.9	37	101.1	39	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	83.2	36	83.2	36	85.0	36	—	—
ALL DETERMINANTS	-1.9	34	1.2	28	4.9	22	2.1	28
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.4	28	3.6	39	3.6	40	—	—
Poor Physical Health Days (Days in previous 30 days)	3.4	18	3.5	31	3.4	33	—	—
Geographic Disparity (Relative standard deviation)	8.6	12	9.5	18	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.7	37	7.8	36	7.7	36	10.7	35
Cardiovascular Deaths (Deaths per 100,000 population)	317.9	37	327.0	37	362.7	0	425.0	35
Cancer Deaths (Deaths per 100,000 population)	209.0	40	210.7	41	215.2	43	204.1	34
Premature Death (Years lost per 100,000 population)	7,972	35	7,890	32	7,964	32	8,242	21
ALL HEALTH OUTCOMES	1.2	28	-1.9	36	-2.2	37	1.8	20
OVERALL	-0.6	34	-0.7	32	1.9	27	3.9	25

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Iowa is 15th this year; it was 14th in 2007.

Strengths: Strengths include a low infant mortality rate at 5.0 deaths per 1,000 live births, few poor mental and physical health days per month at 2.5 days and 2.9 days in the previous 30 days, respectively, and a high rate of high school graduation with 86.6 percent of incoming ninth graders who graduate within four years.

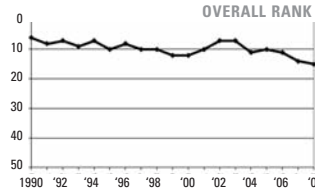
Challenges: Challenges include a high prevalence of binge drinking at 20.2 percent of the population, low public health funding at \$45 per person and limited access to primary care with 83.0 primary care physicians per 100,000 population. Iowa ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 14.4 percent to 13.5 percent of persons under age 18.
- ▼ In the past year, immunization coverage decreased from 85.1 percent to 80.0 percent of children ages 19 to 35 months receiving complete immunizations.
- ▼ Since 1990, the prevalence of smoking decreased from 28.1 percent to 19.8 percent of the population.
- ▲ Since 1990, the prevalence of obesity increased from 12.8 percent to 27.7 percent of the population.

Health Disparities: In Iowa, cardiovascular death rates vary by race, with all races experiencing 277.9 deaths per 100,000 population in contrast to blacks who experience 379.0 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 44.5 percent of Hispanics lack health insurance compared to 11.1 percent of non-Hispanic whites.

State Health Department Web Site: www.idph.state.ia.us



Overall Rank: 15

Change: ▼ 1

Strengths:

- High rate of high school graduation
- Low infant mortality rate
- Few poor mental and physical health days

Challenges:

- High prevalence of binge drinking
- Low per capita public health funding
- Limited access to primary care

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 6%
- In the past year, immunization coverage declined by 6%
- Since 1990, the prevalence of smoking declined by 30%
- Since 1990, the prevalence of obesity increased by 116%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.8↓	25	21.4	31	23.2	25	28.1	13
Prevalence of Binge Drinking (Percent of population)	20.2	48	19.6	48	18.2*	42	—	—
Prevalence of Obesity (Percent of population)	27.7↑	31	25.7	29	22.9	29	12.8	38
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	86.6	3	85.8	4	82.8*	4*	86.6*	5
Violent Crime (Offenses per 100,000 population)	295	19	284	18	269	13	231	10
Occupational Fatalities (Deaths per 100,000 workers)	6.2	27	6.6	32	5.9	29	11.6*	35
Infectious Disease (Cases per 100,000 population)	6.2	9	6.1	6	7.4	8	9.8	1
Children in Poverty (Percent of persons under age 18)	13.5	16	14.4	22	7.6	1	13.9	10
Air Pollution (Micrograms of fine particles per cubic meter)	11.6↑	24	11.0	23	11.1	18.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	9.9	9	9.4	4	8.2	2	7.6	4
Public Health Funding (Dollars per person)	\$45	44	\$38	45	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.0↓	26	85.1	6	78.7	13	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	80**	—	83.0	5	83.85*	5	80.6*	1
Primary Care Physicians (Number per 100,000 population)	83.0	47	81.8	47	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	69.5	18	69.5	18	71.5	20	—	—
ALL DETERMINANTS								
	5.8	21	5.8	19	12.4	4	9.2	6
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.5	3	2.5	3	2.6	5	—	—
Poor Physical Health Days (Days in previous 30 days)	2.9	4	2.9	3	2.6	3	—	—
Geographic Disparity (Relative standard deviation)	9.5	18	8.9	13	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.0	2	4.9	1	6.0	11	8.8	6
Cardiovascular Deaths (Deaths per 100,000 population)	277.9	23	286.4	23	319.1	0	374.6	18
Cancer Deaths (Deaths per 100,000 population)	191.1	21	191.7	20	190.6	12	182.6	15
Premature Death (Years lost per 100,000 population)	6,168↑	8	5,939	5	6,354	9	7,097	6
ALL HEALTH OUTCOMES								
	5.7	2	4.9	3	3.5	9	7.8	4
OVERALL								
	11.6	15	10.7	14	14.6	7	17.0	6

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 22 Change: ▲1

Strengths:

- Few poor mental and physical health days
- High immunization coverage
- Low prevalence of smoking

Challenges:

- Low per capita public health funding
- Limited access to primary care
- Moderate rate of preventable hospitalizations

Significant Changes:

- In the past year, the prevalence of smoking decreased by 11%
- In the past year, the percentage of children in poverty declined by 12%
- Since 1990, the incidence of infectious disease decreased by 67%
- Since 1990, the rate of uninsured population increased by 39%

Ranking: Kansas is 22nd this year; it was 23rd in 2007.

Strengths: Strengths include few poor mental and physical health days per month at 2.6 days and 3.1 days in the previous 30 days, respectively, a low incidence of infectious disease at 7.7 cases per 100,000 population, a low prevalence of smoking at 17.9 percent of the population and high immunization coverage with 81.7 percent of children ages 19 to 35 months receiving complete immunizations.

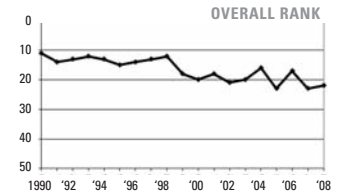
Challenges: Challenges include low public health funding at \$39 per person, limited access to primary care with 100.5 primary care physicians per 100,000 population, a high occupational fatalities rate at 7.3 deaths per 100,000 workers and a moderate rate of preventable hospitalizations with 80.8 discharges per 1,000 Medicare enrollees. Kansas ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 20.0 percent to 17.9 percent of the population.
- ▼ In the past year, the percentage of children in poverty decreased from 19.7 percent to 17.4 percent of persons under age 18.
- ▼ Since 1990, the incidence of infectious disease declined from 23.3 to 7.7 cases per 100,000 population.
- ▲ Since 1990, the rate of uninsured population increased from 9.0 percent to 12.5 percent.

Health Disparities: In Kansas, low birth weight babies are more common among non-Hispanic blacks at 13.4 percent than non-Hispanic whites at 7.0 percent. Access to health care varies significantly by race and ethnicity in the state; 44.0 percent of Hispanics lack health insurance compared to 12.4 percent of non-Hispanic whites.

State Health Department Web Site: www.kdheks.gov



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	17.9↓	13	20.0	24	22.1	17	30.2	27
Prevalence of Binge Drinking (Percent of population)	15.0↑	20	13.9	17	15.3*	24	—	—
Prevalence of Obesity (Percent of population)	27.7↑	31	25.9	30	22.8	28	13.1	40
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	79.2	21	77.9	22	74.5*	17*	84.1*	8
Violent Crime (Offenses per 100,000 population)	453	31	425	27	405	27	361	21
Occupational Fatalities (Deaths per 100,000 workers)	7.3	38	6.1	25	6.5	38	11.5*	32
Infectious Disease (Cases per 100,000 population)	7.7	11	7.9	11	12.2	17	23.3	16
Children in Poverty (Percent of persons under age 18)	17.4↓	30	19.7	38	14.4	26	14.3	11
Air Pollution (Micrograms of fine particles per cubic meter)	10.9	20	10.7	19	12.1	23.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	12.5	19	11.3	14	10.4	17	9.0	12
Public Health Funding (Dollars per person)	\$39	46	\$37	46	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	81.7	13	79.2	35	66.8	45	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	69.8*	—	79.1	16	81.07*	11	76.2*	9
Primary Care Physicians (Number per 100,000 population)	100.5	39	101.6	38	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	80.8	34	80.8	34	81.3	33	—	—
ALL DETERMINANTS								
	3.6	23	2.2	26	5.6	19	5.9	14
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.6	6	2.9	9	2.6	5	—	—
Poor Physical Health Days (Days in previous 30 days)	3.1	9	3.0	6	2.6	3	—	—
Geographic Disparity (Relative standard deviation)	10.6	25	11.0	30	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.8	28	6.7	27	7.1	27	9.2	14
Cardiovascular Deaths (Deaths per 100,000 population)	283.9	24	295.8	24	319.4	0	363.2	14
Cancer Deaths (Deaths per 100,000 population)	191.3	22	190.7	18	188.1	10	175.1	8
Premature Death (Years lost per 100,000 population)	7,277	23	7,236	24	7,079	22	7,581	14
ALL HEALTH OUTCOMES								
	3.1	17	2.0	20	1.3	23	6.0	9
OVERALL								
	6.7	22	4.1	23	8.3	20	11.9	11

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Kentucky is 37th this year; it was 43rd in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 8.4 percent of the population, a low incidence of infectious disease at 10.3 cases per 100,000 population and high immunization coverage with 80.9 percent of children ages 19 to 35 months receiving complete immunizations.

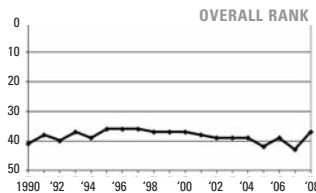
Challenges: Challenges include a high prevalence of smoking at 28.2 percent of the population, a high rate of cancer deaths at 226.2 deaths per 100,000 population, a high rate of preventable hospitalizations with 113.8 discharges per 1,000 Medicare enrollees, a high rate of deaths from cardiovascular disease at 343.3 deaths per 100,000 population and high levels of air pollution at 14.8 micrograms of fine particulate per cubic meter.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 23.5 percent to 21.0 percent of persons under age 18.
- ▲ In the past year, public health funding increased from \$64 to \$71 per person.
- ▼ Since 1990, the incidence of infectious disease decreased from 27.4 to 10.3 cases per 100,000 population.
- ▲ Since 1990, the prevalence of obesity increased from 12.2 percent to 28.7 percent of the population.

Health Disparities: In Kentucky, cardiovascular death rates vary by race, with all races experiencing 343.3 deaths per 100,000 population in contrast to blacks who experience 415.9 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 32.0 percent of Hispanics lack health insurance compared to 18.4 percent of non-Hispanic whites.

State Health Department Web Site: www.chfs.ky.gov



Overall Rank: 37
Change: ▲ 6

Strengths:

- Low prevalence of binge drinking
- Low incidence of infectious disease
- High immunization coverage

Challenges:

- High prevalence of smoking
- High rate of cancer deaths
- High rate of preventable hospitalizations

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 11%
- In the past year, per capita public health funding increased by 12%
- Since 1990, the incidence of infectious disease declined by 62%
- Since 1990, the prevalence of obesity increased by 135%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	28.2	49	28.5	50	32.6	50	35.3	49
Prevalence of Binge Drinking (Percent of population)	8.4↓	1	9.5	3	8.3*	1	—	—
Prevalence of Obesity (Percent of population)	28.7	40	28.0	42	24.5	42	12.2	31
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	75.9↑	29	73.0	34	64.2*	37*	67.9*	42
Violent Crime (Offenses per 100,000 population)	295↑	20	263	11	257	10	338	19
Occupational Fatalities (Deaths per 100,000 workers)	8.1	41	8.3	38	6.3	34	13.8*	40
Infectious Disease (Cases per 100,000 population)	10.3↓	18	12.1	19	14.5	19	27.4	21
Children in Poverty (Percent of persons under age 18)	21.0↓	42	23.5	47	17.2	35	23.7	40
Air Pollution (Micrograms of fine particles per cubic meter)	14.8	43	14.3	41	16.0	42.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	14.5	30	13.9	26	12.3	25	15.6	37
Public Health Funding (Dollars per person)	\$71	26	\$64	31	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.9	18	83.8	11	72.3	37	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	71.1*	—	76.4*	19	81.04*	11	69.7*	26
Primary Care Physicians (Number per 100,000 population)	103.2	36	103.0	36	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	113.8	49	113.8	49	115.6	48	—	—
ALL DETERMINANTS								
	-2.6	36	-5.6	38	0.5	31	-3.6	39
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.6↓	38	4.3	47	5.5	50	—	—
Poor Physical Health Days (Days in previous 30 days)	4.8	49	5.2	49	5.5	49	—	—
Geographic Disparity (Relative standard deviation)	12.3	30	12.2	32	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.5	24	6.4	23	6.6	22	9.8	23
Cardiovascular Deaths (Deaths per 100,000 population)	343.3	44	356.5	45	388.3	0	443.3	45
Cancer Deaths (Deaths per 100,000 population)	226.2	50	227.7	50	226.1	47	207.5	39
Premature Death (Years lost per 100,000 population)	9,059	42	9,008	42	8,700	41	9,160	38
ALL HEALTH OUTCOMES								
	-1.0	39	-5.0	45	-4.1	41	-3.3	41
OVERALL								
	-3.6	37	-10.6	43	-7.0	39	-7.0	41

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 50 Change: ▼ 1

Strengths:

- Low prevalence of binge drinking
- Few poor mental health days
- Strong per capita public health funding

Challenges:

- High percentage of children in poverty
- High rate of uninsured population
- High rate of preventable hospitalizations

Significant Changes:

- In the past year, the high school graduation rate decreased by 8%
- In the past year, per capita public health funding increased by 37%
- In the past year, access to primary care increased by 5%
- Since 1990, the prevalence of obesity increased by 150%

Ranking: Louisiana is 50th this year; it was 49th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 13.3 percent of the population, strong public health funding at \$95 per person and few poor mental health days per month at 3.0 days in the previous 30 days.

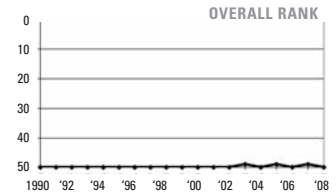
Challenges: Challenges include a high rate of uninsured population at 20.2 percent, a high percentage of children in poverty at 22.7 percent of persons under age 18, a high rate of preventable hospitalizations with 111.9 discharges per 1,000 Medicare enrollees, a high infant mortality rate at 10.3 deaths per 1,000 live births, a high premature death rate with 11,125 years of potential life lost before age 75 per 100,000 population, and a high rate of cancer deaths at 223.8 deaths per 100,000 population.

Significant Changes:

- ▼ In the past year, the high school graduation rate decreased from 69.4 percent to 63.9 percent of incoming ninth graders who graduate within four years.
- ▲ In the past year, public health funding increased from \$69 to \$95 per person.
- ▲ In the past year, access to primary care increased from 113.5 to 119.4 primary care physicians per 100,000 population.
- ▲ Since 1990, the prevalence of obesity increased from 12.3 percent to 30.7 percent of the population.

Health Disparities: In Louisiana, low birth weight babies are more common among non-Hispanic blacks at 15.3 percent than non-Hispanic whites at 8.1 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 349.2 deaths per 100,000 population in contrast to blacks who experience 422.6 deaths per 100,000 population.

State Health Department Web Site: www.dhh.louisiana.gov/



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	22.6	41	23.4	43	23.9	32	29.1	22
Prevalence of Binge Drinking (Percent of population)	13.3	13	13.6	15	13.7*	15	—	—
Prevalence of Obesity (Percent of population)	30.7↑	47	27.1	38	25.5	45	12.3	33
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	63.9↓	46	69.4	39	58.5*	43*	61.6*	50
Violent Crime (Offenses per 100,000 population)	730	47	698	46	687	45	693	43
Occupational Fatalities (Deaths per 100,000 workers)	8.5	42	8.4	41	6.9	39	11.8*	37
Infectious Disease (Cases per 100,000 population)	27.1	46	28.3	45	32.8	44	31.4	26
Children in Poverty (Percent of persons under age 18)	22.7↓	47	23.8	48	23.1	46	38.5	49
Air Pollution (Micrograms of fine particles per cubic meter)	13.6	35	13.6	35	12.7	27.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	20.2	47	19.8	46	18.0	47	22.7	48
Public Health Funding (Dollars per person)	\$95↑	15	\$69	26	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	77.7↑	39	72.3	49	66.8	45	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	81.7**	—	82.8	6	78.38*	20	67*	34
Primary Care Physicians (Number per 100,000 population)	119.4↑	20	113.5	26	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	111.9	48	111.9	48	115.6	48	—	—
ALL DETERMINANTS	-12.9	50	-14.3	50	-9.6	48	-10.1	49
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.0	8	3.2	18	2.8	10	—	—
Poor Physical Health Days (Days in previous 30 days)	3.6	30	3.3	17	3.0	16	—	—
Geographic Disparity (Relative standard deviation)	9.6	19	9.2	15	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	10.3	49	9.9	49	9.4	47	11.8	45
Cardiovascular Deaths (Deaths per 100,000 population)	349.2	45	354.1	43	378.0	0	446.8	46
Cancer Deaths (Deaths per 100,000 population)	223.8	49	226.9	49	230.7	48	216.0	48
Premature Death (Years lost per 100,000 population)	11,125	49	10,802	49	10,202	49	10,178	47
ALL HEALTH OUTCOMES	-2.4	48	-4.3	43	-7.1	48	-4.1	46
OVERALL	-15.2	50	-18.6	49	-19.5	49	-14.3	50

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Maine is 9th this year; it was 7th in 2007.

Strengths: Strengths include a low violent crime rate at 118 offenses per 100,000 population, a low incidence of infectious disease at 6.6 cases per 100,000 population, a low rate of uninsured population at 9.0 percent, low geographic disparity within the state at 8.4 percent and ready access to primary care with 125.3 primary care physicians per 100,000 population. Maine ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time.

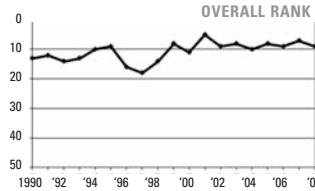
Challenges: Challenges include a high rate of cancer deaths at 212.2 deaths per 100,000 population and low immunization coverage with 77.6 percent of children ages 19 to 35 months receiving complete immunizations.

Significant Changes:

- ▲ In the past year, the prevalence of obesity increased from 23.1 percent to 25.2 percent of the population.
- ▲ In the past year, the percentage of children in poverty increased from 13.2 percent to 14.4 percent of persons under age 18.
- ▼ In the past five years, the rate of uninsured population declined from 10.6 percent to 9.0 percent.
- ▼ Since 1990, the rate of deaths from cardiovascular disease decreased from 408.0 to 265.3 deaths per 100,000 population.

Health Disparities: In Maine, low birth weight babies are more common among non-Hispanic blacks at 8.5 percent than Hispanics at 4.7 percent.

State Health Department Web Site: www.maine.gov/dhhs



Overall Rank: 9 Change: ▼ 2

Strengths:

- Low violent crime rate
- Low incidence of infectious disease
- Low rate of uninsured population
- Low geographic disparity within the state

Challenges:

- Low immunization coverage
- High rate of cancer deaths

Significant Changes:

- In the past year, the prevalence of obesity increased by 9%
- In the past year, the percentage of children in poverty increased by 9%
- In the past five years, the rate of uninsured population decreased by 15%
- Since 1990, the rate of deaths from cardiovascular disease decreased by 35%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	20.2	30	20.9	29	23.6	30	30.3	28
Prevalence of Binge Drinking (Percent of population)	16.1	28	15.1	27	15.4*	25	—	—
Prevalence of Obesity (Percent of population)	25.2↑	17	23.1	14	20.7	20	12.2	31
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	78.6	23	77.6	23	76.1*	11*	78.8*	17
Violent Crime (Offenses per 100,000 population)	118	1	116	1	112	1	153	7
Occupational Fatalities (Deaths per 100,000 workers)	5.1	19	4.2	8	5.1	21	9.1*	24
Infectious Disease (Cases per 100,000 population)	6.6	10	6.5	9	6.5	5	16.3	8
Children in Poverty (Percent of persons under age 18)	14.4↑	21	13.2	14	12.4	18	21.6	33
Air Pollution (Micrograms of fine particles per cubic meter)	9.9↓	16	10.2	16	10.1	12.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	9.0	5	9.8	5	10.6	19	9.6	15
Public Health Funding (Dollars per person)	\$51	38	\$51	40	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	77.6↓	40	79.8	32	80.7	8	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	83.9**	—	85.3	3	83.45*	7	74.8*	12
Primary Care Physicians (Number per 100,000 population)	125.3↑	12	122.4	14	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	66.0	15	66.0	15	72.4	21	—	—
ALL DETERMINANTS								
	12.2	6	12.8	5	11.6	5	5.9	14
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.5	32	3.2	18	3.3	31	—	—
Poor Physical Health Days (Days in previous 30 days)	3.7	36	3.6	35	3.6	40	—	—
Geographic Disparity (Relative standard deviation)	8.4	11	8.9	13	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.4	23	6.3	21	5.5	5	8.5	3
Cardiovascular Deaths (Deaths per 100,000 population)	265.3	18	274.8	16	313.5	0	408.0	28
Cancer Deaths (Deaths per 100,000 population)	212.2	44	213.3	44	212.2	39	213.0	46
Premature Death (Years lost per 100,000 population)	6,831↑	20	6,551	18	6,476	12	7,354	11
ALL HEALTH OUTCOMES								
	3.1	17	1.8	23	2.3	16	4.0	15
OVERALL								
	15.3	9	14.6	7	13.8	8	9.9	13

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 26 Change: ▲ 2

Strengths:

- Ready access to primary care
- Low percentage of children in poverty
- High immunization coverage
- Strong per capita public health funding

Challenges:

- High incidence of infectious disease
- High violent crime rate

Significant Changes:

- In the past year, immunization coverage increased by 15%
- In the past five years, the percentage of children in poverty increased 53%
- Since 1990, the infant mortality rate declined by 39%
- Since 1990, the rate of uninsured population increased by 55%

Ranking: Maryland is 26th this year; it was 28th in 2007.

Strengths: Strengths include ready access to primary care with 178.6 primary care physicians per 100,000 population, a low percentage of children in poverty at 11.6 percent of persons under age 18, high immunization coverage with 92.4 percent of children ages 19 to 35 months receiving complete immunizations and strong public health funding at \$126 per person.

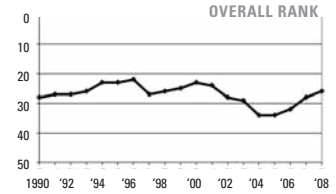
Challenges: Challenges include a high incidence of infectious disease at 37.0 cases per 100,000 population, a high violent crime rate at 642 offenses per 100,000 population and high levels of air pollution at 13.9 micrograms of fine particulate per cubic meter.

Significant Changes:

- ▲ In the past year, immunization coverage increased from 80.1 percent to 92.4 percent of children ages 19 to 35 months receiving complete immunizations.
- ▲ In the past five years, the percentage of children in poverty increased from 7.6 percent to 11.6 percent of persons under age 18.
- ▼ Since 1990, the infant mortality rate decreased from 11.6 to 7.1 deaths per 1,000 live births.
- ▲ Since 1990, the rate of uninsured population increased from 8.9 percent to 13.8 percent.

Health Disparities: In Maryland, low birth weight babies are more common among non-Hispanic blacks at 13.1 percent than non-Hispanics whites at 7.2 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 301.6 deaths per 100,000 population in contrast to blacks who experience 365.2 deaths per 100,000 population.

State Health Department Web Site: www.dhmh.state.md.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	17.1	10	17.7	7	21.9	15	29.7	26
Prevalence of Binge Drinking (Percent of population)	13.2	12	12.9	12	13.2*	14	—	—
Prevalence of Obesity (Percent of population)	26.3↑	25	24.9	23	19.4	12	12.0	29
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	79.3	20	79.5	17	74.4*	18*	76.5*	25
Violent Crime (Offenses per 100,000 population)	642↓	42	679	43	783	49	768	45
Occupational Fatalities (Deaths per 100,000 workers)	4.9	17	5.2	18	3.5	4	5.7*	5
Infectious Disease (Cases per 100,000 population)	37.0	49	36.9	48	43.6	47	41.1	38
Children in Poverty (Percent of persons under age 18)	11.6	5	10.9	6	7.6	1	16.4	17
Air Pollution (Micrograms of fine particles per cubic meter)	13.9	38	14.2	39	15.8	41.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	13.8	25	13.6	24	12.0	24	8.9	11
Public Health Funding (Dollars per person)	\$126↑	5	\$111	6	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	92.4↑	2	80.1	29	78.7	13	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	67.9**	—	70.1	38	74.47*	29	75.3*	11
Primary Care Physicians (Number per 100,000 population)	178.6	1	179.0	1	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	75.1	26	75.1	26	77.3	26	—	—
ALL DETERMINANTS								
	2.2	25	1.1	29	0.2	32	3.2	23
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.1	17	3.1	21	—	—
Poor Physical Health Days (Days in previous 30 days)	3.2	12	3.0	6	3.1	18	—	—
Geographic Disparity (Relative standard deviation)	13	36	13.5	36	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.1	31	7.5	33	7.8	37	11.6	41
Cardiovascular Deaths (Deaths per 100,000 population)	301.6	29	310.8	30	334.8	0	415.8	32
Cancer Deaths (Deaths per 100,000 population)	198.9	31	201.2	32	210.4	35	221.1	49
Premature Death (Years lost per 100,000 population)	7,615↓	27	7,899	33	8,138	35	9,145	36
ALL HEALTH OUTCOMES								
	1.2	28	0.7	30	-1.2	33	-1.5	33
OVERALL								
	3.4	26	1.8	28	0.8	29	1.7	28

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Massachusetts is 6th this year; it was 9th in 2007.

Strengths: Massachusetts is among the top ten states on 10 of the 22 measures. Strengths include a low rate of uninsured population at 7.9 percent, a low occupational fatalities rate at 3.3 deaths per 100,000 workers, a low prevalence of obesity at 21.7 percent of the population, ready access to primary care with 189.1 primary care physicians per 100,000 population, low geographic disparity within the state at 6.2 percent and a low premature death rate with 5,801 years of potential life lost before age 75 per 100,000 population.

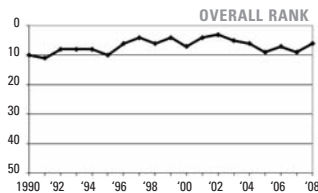
Challenges: Challenges include a high prevalence of binge drinking at 17.7 percent of the population and a high rate of preventable hospitalizations with 79.9 discharges per 1,000 Medicare enrollees.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 13.6 percent to 17.1 percent of persons under age 18.
- ▼ In the past year, the incidence of infectious disease decreased from 20.9 to 14.6 cases per 100,000 population.
- ▼ Since 1990, the rate of deaths from cardiovascular disease declined from 388.4 to 253.7 deaths per 100,000 population.
- ▼ Since 1990, the prevalence of smoking decreased from 28.2 percent to 16.4 percent of the population.

Health Disparities: In Massachusetts, low birth weight babies are more common among non-Hispanic blacks at 11.8 percent than non-Hispanic whites at 7.2 percent. Access to health care varies significantly by race and ethnicity in the state; 31.2 percent of Hispanics lack health insurance compared to 8.1 percent of non-Hispanic whites.

State Health Department Web Site: www.mass.gov/dph



Overall Rank: 6
Change: ▲ 3

Strengths:

- Low rate of uninsured population
- Low prevalence of obesity
- Ready access to primary care
- Low geographic disparity within the state
- Low premature death rate

Challenges:

- High prevalence of binge drinking

Significant Changes:

- In the past year, the percentage of children in poverty increased by 26%
- In the past year, the incidence of infectious disease declined by 30%
- Since 1990, the rate of deaths from cardiovascular disease decreased by 35%
- Since 1990, the prevalence of smoking decreased by 42%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	16.4↓	4	17.8	8	18.9	3	28.2	14
Prevalence of Binge Drinking (Percent of population)	17.7	39	16.7	39	18.2*	42	—	—
Prevalence of Obesity (Percent of population)	21.7↑	2	20.3	2	18.3	6	10.1	11
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	78.7	22	79.3	18	75.3*	13*	76*	28
Violent Crime (Offenses per 100,000 population)	432	29	447	31	480	31	565	37
Occupational Fatalities (Deaths per 100,000 workers)	3.3	1	3.1	1	2.7	1	3.8*	1
Infectious Disease (Cases per 100,000 population)	14.6↓	26	20.9	36	23.0	32	36.9	34
Children in Poverty (Percent of persons under age 18)	17.1↑	29	13.6	19	11.9	15	18.8	23
Air Pollution (Micrograms of fine particles per cubic meter)	10.5	19	10.9	22	12.1	22.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	7.9↓	1	9.8	5	8.5	5	8.4	7
Public Health Funding (Dollars per person)	\$109↑	11	\$83	18	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	83.9	8	86.9	1	86.2	1	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	80.7**	—	83.1	4	85.15*	4	78.9*	3
Primary Care Physicians (Number per 100,000 population)	189.1	1	187.3	1	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	79.9	32	79.9	32	81.8	34	—	—
ALL DETERMINANTS								
	12.0	7	9.6	9	10.3	8	8.1	9
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.2	18	3.4	37	—	—
Poor Physical Health Days (Days in previous 30 days)	3.3	15	3.1	10	3.4	33	—	—
Geographic Disparity (Relative standard deviation)	6.2	1	6.3	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.1	4	5.2	6	4.8	1	7.8	1
Cardiovascular Deaths (Deaths per 100,000 population)	253.7	9	264.6	9	289.7	0	388.4	22
Cancer Deaths (Deaths per 100,000 population)	196.4	25	200.1	28	207.4	28	207.5	39
Premature Death (Years lost per 100,000 population)	5,801	2	5,973	6	6,046	3	7,270	8
ALL HEALTH OUTCOMES								
	5.7	2	3.9	10	4.3	5	5.6	11
OVERALL								
	17.7	6	13.5	9	16.3	5	13.8	10

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 27
Change: ▲ 4

Strengths:

- Low rate of uninsured population
- Low geographic disparity within the state
- Low occupational fatalities rate

Challenges:

- High prevalence of binge drinking
- High violent crime rate
- Low per capita public health funding

Significant Changes:

- In the past year, the prevalence of smoking decreased by 6%
- In the past year, the percentage of children in poverty declined by 18%
- Since 1990, the rate of uninsured population increased by 53%
- Since 1990, the percentage of children in poverty declined by 29%

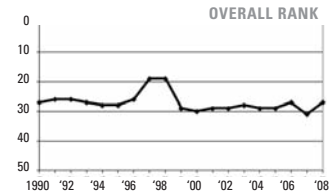
Ranking: Michigan is 27th this year; it was 31st in 2007.

Strengths: Strengths include a low rate of uninsured population at 11.0 percent, a low occupational fatalities rate at 3.7 deaths per 100,000 workers and low geographic disparity within the state at 8.8 percent.

Challenges: Challenges include a high violent crime rate at 536 offenses per 100,000 population, a high prevalence of binge drinking at 18.0 percent of the population, low public health funding at \$49 per person and a high rate of deaths from cardiovascular disease at 327.0 deaths per 100,000 population.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 22.4 percent to 21.1 percent of the population.
- ▼ In the past year, the percentage of children in poverty decreased from 19.3 percent to 15.8 percent of persons under age 18.
- ▲ Since 1990, the rate of uninsured population increased from 7.2 percent to 11.0 percent.
- ▼ Since 1990, the percentage of children in poverty declined from 22.1 percent to 15.8 percent of persons under age 18.



Health Disparities: In Michigan, low birth weight babies are more common among non-Hispanic blacks at 14.4 percent than Hispanics at 6.5 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 327.0 deaths per 100,000 population in contrast to blacks who experience 452.5 deaths per 100,000 population.

State Health Department Web Site: www.michigan.gov/mdch

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	21.1↓	34	22.4	38	24.2	33	34.0	45
Prevalence of Binge Drinking (Percent of population)	18.0	41	17.1	41	17.5*	39	—	—
Prevalence of Obesity (Percent of population)	28.2	35	28.8	44	25.4	44	14.1	46
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	73.0	38	72.5	37	74.7*	16*	76.1*	26
Violent Crime (Offenses per 100,000 population)	536↓	41	562	41	555	38	780	46
Occupational Fatalities (Deaths per 100,000 workers)	3.7	5	3.8	5	4.2	11	7.4*	9
Infectious Disease (Cases per 100,000 population)	12.3↓	23	13.5	23	19.1	23	23.6	17
Children in Poverty (Percent of persons under age 18)	15.8↓	28	19.3	37	13.0	22	22.1	38
Air Pollution (Micrograms of fine particles per cubic meter)	14.2	39	14.0	37	15.4	38.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	11.0	13	10.4	10	10.3	15	7.2	3
Public Health Funding (Dollars per person)	\$49	41	\$55	38	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.6	21	80.1	29	81.6	6	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	77.9**	—	80.8	11	79.68*	17	76.6*	8
Primary Care Physicians (Number per 100,000 population)	112.9	29	112.1	28	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	77.6	30	77.6	30	77.8	28	—	—
ALL DETERMINANTS								
	0.7	26	0.8	31	4.6	24	1.9	29
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.6	38	3.6	39	3.6	40	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.6	35	3.6	40	—	—
Geographic Disparity (Relative standard deviation)	8.8	13	8.8	12	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.6	35	7.8	36	8.1	39	11.0	39
Cardiovascular Deaths (Deaths per 100,000 population)	327.0↓	41	337.4	40	371.2	0	451.2	48
Cancer Deaths (Deaths per 100,000 population)	199.3	33	200.1	28	204.4	24	200.1	27
Premature Death (Years lost per 100,000 population)	7,642	29	7,526	27	7,878	31	8,969	34
ALL HEALTH OUTCOMES								
	1.3	27	-1.4	35	-2.1	36	0.3	27
OVERALL								
	2.0	27	-0.6	31	1.8	28	2.1	27

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Minnesota is 4th this year; it was 2nd in 2007.

Strengths: Minnesota is among the top ten states on 11 of the 22 measures. Strengths include a low premature death rate with 5,407 years of potential life lost before age 75 per 100,000 population, a low rate of deaths from cardiovascular disease at 219.4 deaths per 100,000 population, a low rate of uninsured population at 8.8 percent and a low prevalence of smoking at 16.5 percent of the population.

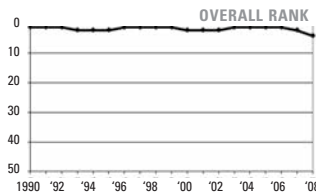
Challenges: Challenges include low public health funding at \$45 per person and moderate geographic disparity within the state at 10.9 percent.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 18.3 percent to 16.5 percent of the population.
- ▲ In the past year, the percentage of children in poverty increased from 11.1 percent to 13.7 percent of persons under age 18.
- ▼ In the past year, public health funding decreased from \$62 to \$45 per person.
- ▲ Since 1990, the prevalence of obesity increased from 10.2 percent to 26.0 percent of the population.

Health Disparities: In Minnesota, low birth weight babies are more common among non-Hispanic blacks at 10.7 percent than non-Hispanic whites at 5.9 percent. Access to health care varies significantly by race and ethnicity in the state; 23.0 percent of non-Hispanics blacks lack health insurance compared to 7.7 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.mn.us



Overall Rank: 4 Change: ▼ 2

Strengths:

- Low premature death rate
- Low rate of cardiovascular deaths
- Low rate of uninsured population
- Low prevalence of smoking

Challenges:

- Low per capita public health funding
- Moderate geographic disparity within the state

Significant Changes:

- In the past year, the prevalence of smoking declined by 10%
- In the past year, the percentage of children in poverty increased by 23%
- In the past year, per capita public health funding decreased by 27%
- Since 1990, the prevalence of obesity increased by 155%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	16.5↓	5	18.3	15	21.7	14	28.7	19
Prevalence of Binge Drinking (Percent of population)	16.0↓	27	18.2	47	20.4*	48	—	—
Prevalence of Obesity (Percent of population)	26.0↑	24	24.7	21	22.3	26	10.2	12
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	85.9↑	6	84.7	7	82.3*	5*	88.7*	1
Violent Crime (Offenses per 100,000 population)	289	16	312	21	264	12	286	16
Occupational Fatalities (Deaths per 100,000 workers)	3.5	3	3.7	4	3.4	2	5*	4
Infectious Disease (Cases per 100,000 population)	10.0	16	10.0	14	10.7	12	13.0	5
Children in Poverty (Percent of persons under age 18)	13.7	17	11.1	7	8.4	5	21.2	31
Air Pollution (Micrograms of fine particles per cubic meter)	9.9	17	9.7	13	11.8	21.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	8.8	4	8.6	1	7.5	1	8.7	8
Public Health Funding (Dollars per person)	\$45↓	43	\$62	32	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	84.7	7	84.7	7	76.8	23	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	71.3**	—	75.9	27	75.09*	28	72.2*	17
Primary Care Physicians (Number per 100,000 population)	137.7	9	138.0	9	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	65.6	14	65.6	14	65.8	13	—	—
ALL DETERMINANTS								
	12.7	5	14.0	2	13.8	3	8.8	7
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.5	3	2.4	1	2.8	10	—	—
Poor Physical Health Days (Days in previous 30 days)	3.1	9	3.0	6	2.8	7	—	—
Geographic Disparity (Relative standard deviation)	10.9	28	9.9	22	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.2	7	5.1	2	5.5	5	8.9	8
Cardiovascular Deaths (Deaths per 100,000 population)	219.4	1	227.4	1	262.1	0	350.6	7
Cancer Deaths (Deaths per 100,000 population)	182.8	11	187.0	13	189.1	11	180.1	11
Premature Death (Years lost per 100,000 population)	5,407	1	5,364	1	5,762	1	6,541	1
ALL HEALTH OUTCOMES								
	6.1	1	6.5	1	5.0	3	11.3	1
OVERALL								
	18.8	4	20.5	2	24.3	1	20.1	1

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 49 Change: ▲ 1

Strengths:

- Low prevalence of binge drinking
- Low violent crime rate

Challenges:

- High percentage of children in poverty
- High prevalence of obesity
- High rate of cardiovascular deaths
- Low high school graduation rate

Significant Changes:

- In the past year, the prevalence of smoking decreased by 5%
- In the past year, the incidence of infectious disease decreased by 17%
- Since 1990, the infant mortality rate declined by 22%
- Since 1990, the prevalence of obesity increased by 117%

Ranking: Mississippi is 49th this year; it was 50th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 10.3 percent of the population and a low violent crime rate at 291 offenses per 100,000 population.

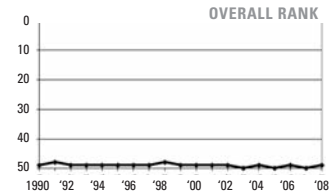
Challenges: Mississippi is among the bottom five states on 12 of the 22 measures. Challenges include a high percentage of children in poverty at 32.8 percent of persons under age 18, a low high school graduation rate with 63.3 percent of incoming ninth graders who graduate within four years, a high prevalence of obesity at 32.6 percent of the population, a high percentage of children in poverty at 32.8 percent of persons under age 18 and a high rate of deaths from cardiovascular disease at 387.0 deaths per 100,000 population.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 25.1 percent to 23.9 percent of the population.
- ▼ In the past year, the incidence of infectious disease declined from 22.0 to 18.2 cases per 100,000 population.
- ▼ Since 1990, the infant mortality rate decreased from 13.0 to 10.2 deaths per 1,000 live births.
- ▲ Since 1990, the prevalence of obesity increased from 15.0 percent to 32.6 percent of the population.

Health Disparities: In Mississippi, low birth weight babies are more common among non-Hispanic blacks at 15.6 percent than Hispanics at 6.4 percent. Access to health care varies significantly by race and ethnicity in the state; 30.5 percent of non-Hispanic blacks lack health insurance compared to 19.0 percent of non-Hispanic whites.

State Health Department Web Site: www.msdh.state.ms.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	23.9↓	44	25.1	47	27.3	45	31.1	34
Prevalence of Binge Drinking (Percent of population)	10.3	4	9.6	4	12.1*	8	—	—
Prevalence of Obesity (Percent of population)	32.6↑	50	31.4	50	26.8	49	15.0	49
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	63.3	47	62.7	47	56.9*	46*	65.6*	47
Violent Crime (Offenses per 100,000 population)	291	18	299	20	350	20	269	14
Occupational Fatalities (Deaths per 100,000 workers)	11.1	46	11.4	47	10.5	46	15.4*	46
Infectious Disease (Cases per 100,000 population)	18.2↓	35	22.0	38	32.3	43	27.3	20
Children in Poverty (Percent of persons under age 18)	32.8↑	50	28.8	50	23.2	47	36.3	49
Air Pollution (Micrograms of fine particles per cubic meter)	13.2	29	13.1	31	13.0	29.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	19.8	46	18.8	44	16.1	40	19.0	44
Public Health Funding (Dollars per person)	\$61	31	\$57	34	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	78.7↑	34	76.2	43	75.7	28	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	73.6**	—	81.3	8	76.47*	24	70.1*	24
Primary Care Physicians (Number per 100,000 population)	81.5	48	81.1	48	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	109.8	47	109.8	47	114.3	47	—	—
ALL DETERMINANTS	-10.5	49	-12.3	49	-9.7	49	-6.0	45
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	4.0	49	4.4	47	3.3	31	—	—
Poor Physical Health Days (Days in previous 30 days)	4.0	44	4.0	44	4.1	46	—	—
Geographic Disparity (Relative standard deviation)	13	36	13.5	36	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	10.2	49	10.0	49	10.6	49	13.0	49
Cardiovascular Deaths (Deaths per 100,000 population)	387.0	50	398.2	50	432.1	0	449.1	47
Cancer Deaths (Deaths per 100,000 population)	215.2	46	216.5	47	222.9	45	197.2	25
Premature Death (Years lost per 100,000 population)	11,308↑	49	10,762	49	11,017	49	10,941	50
ALL HEALTH OUTCOMES	-4.5	50	-7.3	50	-7.9	50	-6.2	49
OVERALL	-15.0	49	-19.6	50	-22.0	50	-12.3	49

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Missouri is 38th this year; it was 35th in 2007.

Strengths: Strengths include a high rate of high school graduation with 80.6 percent of incoming ninth graders who graduate within four years, a low incidence of infectious disease at 11.0 cases per 100,000 population and a moderate rate of uninsured population at 12.9 percent.

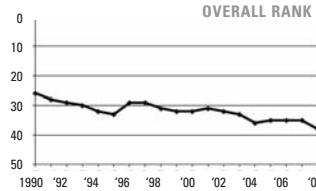
Challenges: Challenges include a high prevalence of smoking at 24.5 percent of the population, a high percentage of children in poverty at 22.1 percent of persons under age 18, low public health funding at \$42 per person and a high rate of preventable hospitalizations with 88.6 discharges per 1,000 Medicare enrollees.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 17.7 percent to 22.1 percent of persons under age 18.
- ▼ In the past year, immunization coverage decreased from 85.2 percent to 77.2 percent of children ages 19 to 35 months receiving complete immunizations
- ▼ In the last five years, the incidence of infectious disease declined from 29.2 to 11.0 cases per 1,000 live births.
- ▲ Since 1990, the prevalence of obesity increased from 11.9 percent to 28.2 percent of the population.

Health Disparities: In Missouri, low birth weight babies are more common among non-Hispanic blacks at 13.9 percent than non-Hispanic whites at 7.2 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 328.4 deaths per 100,000 population in contrast to blacks who experience 437.3 deaths per 100,000 population.

State Health Department Web Site: www.dhss.mo.gov



Overall Rank: 38
Change: ▼ 3

Strengths:

- High rate of high school graduation
- Low incidence of infectious disease
- Moderate rate of uninsured population

Challenges:

- High prevalence of smoking
- High percentage of children in poverty
- Low per capita public health funding

Significant Changes:

- In the past year, the percentage of children in poverty increased by 25%
- In the past year, immunization coverage decreased by 9%
- In the last five years, the incidence of infectious disease declined by 62%
- Since 1990, the prevalence of obesity increased by 137%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	24.5↑	47	23.2	41	26.5	41	27.7	11
Prevalence of Binge Drinking (Percent of population)	16.3	32	15.6	31	15.7*	27	—	—
Prevalence of Obesity (Percent of population)	28.2	35	27.2	40	23.2	32	11.9	27
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	80.6	15	80.4	14	72.5*	24*	76.1*	26
Violent Crime (Offenses per 100,000 population)	505↓	36	546	39	541	37	544	35
Occupational Fatalities (Deaths per 100,000 workers)	6.9	34	6.4	30	6.1	31	6*	6
Infectious Disease (Cases per 100,000 population)	11.0	21	11.2	18	29.2	41	32.3	29
Children in Poverty (Percent of persons under age 18)	22.1↑	45	17.7	32	12.9	21	19.4	27
Air Pollution (Micrograms of fine particles per cubic meter)	13.5	34	13.2	32	14.1	34.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	12.9	21	12.5	19	10.3	15	11.5	24
Public Health Funding (Dollars per person)	\$42	45	\$40	44	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	77.2↓	41	85.2	5	73.0	36	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	76.5**	—	81.9	7	82.59*	8	74.2*	13
Primary Care Physicians (Number per 100,000 population)	106.2	31	106.2	32	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	88.6	41	88.6	41	89.1	40	—	—
ALL DETERMINANTS								
	-4.4	40	-0.3	32	-0.3	33	2.2	27
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.7	43	3.7	42	3.5	38	—	—
Poor Physical Health Days (Days in previous 30 days)	3.8	41	3.8	42	3.5	38	—	—
Geographic Disparity (Relative standard deviation)	10.8	26	10.6	28	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	8.1	41	8.2	42	7.3	32	10.5	32
Cardiovascular Deaths (Deaths per 100,000 population)	328.4↓	42	342.7	42	374.3	0	401.7	26
Cancer Deaths (Deaths per 100,000 population)	206.9	39	207.8	40	208.7	31	197.7	26
Premature Death (Years lost per 100,000 population)	8,284↑	37	8,112	37	8,189	37	8,669	29
ALL HEALTH OUTCOMES								
	-0.5	37	-3.1	42	-2.2	37	1.4	21
OVERALL								
	-4.9	38	-3.4	35	-2.7	33	3.6	26

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 23 Change: ▼5

Strengths:

- Low prevalence of obesity
- Low incidence of infectious disease
- Low levels of air pollution

Challenges:

- Low immunization coverage
- High occupational fatalities rate
- High geographic disparity within the state

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 9%
- In the past year, the violent crime rate increased by 13%
- In the last five years, the rate of uninsured population increased by 17%
- Since 1990, the prevalence of obesity increased by 160%

Ranking: Montana is 23rd this year; it was 18th in 2007.

Strengths: Strengths include a low prevalence of obesity at 22.6 percent of the population, a low incidence of infectious disease at 3.9 cases per 100,000 population, low levels of air pollution at 9.1 micrograms of fine particulate per cubic meter and a low rate of deaths from cardiovascular disease at 252.4 deaths per 100,000 population.

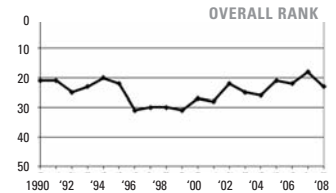
Challenges: Challenges include low immunization coverage with 75.0 percent of children ages 19 to 35 months receiving complete immunizations, a high occupational fatalities rate at 9.9 deaths per 100,000 workers and high geographic disparity within the state at 17.8 percent.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 17.2 percent to 15.7 percent of persons under age 18.
- ▲ In the past year, the violent crime rate increased from 254 to 288 offenses per 100,000 population.
- ▼ In the last five years, the rate of uninsured population increased from 14.0 percent to 16.4 percent.
- ▲ Since 1990, the prevalence of obesity increased from 8.7 percent to 22.6 percent of the population.

Health Disparities: In Montana, low birth weight babies are more common among non-Hispanic blacks at 15.6 percent than Hispanics at 8.6 percent. Access to health care varies significantly by race and ethnicity in the state; 28.9 percent of Hispanics lack health insurance compared to 21.6 percent of non-Hispanic whites.

State Health Department Web Site: www.dphhs.mt.gov



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.5	23	18.9	19	21.2	10	25.9	5
Prevalence of Binge Drinking (Percent of population)	16.5	34	16.3	33	18.3*	45	—	—
Prevalence of Obesity (Percent of population)	22.6↑	8	21.2	5	18.7	8	8.7	2
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	81.5	12	80.4	14	77.3*	10*	84.5*	6
Violent Crime (Offenses per 100,000 population)	288↑	14	254	10	352	23	151	6
Occupational Fatalities (Deaths per 100,000 workers)	9.9	46	10.1	45	13.3	46	23.7*	48
Infectious Disease (Cases per 100,000 population)	3.9	3	4.7	3	5.9	4	23.2	15
Children in Poverty (Percent of persons under age 18)	15.7↓	25	17.2	31	16.4	32	23.8	41
Air Pollution (Micrograms of fine particles per cubic meter)	9.1	8	8.9	7	9.5	8.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	16.4	35	16.4	33	14.0	33	14.7	34
Public Health Funding (Dollars per person)	\$69	27	\$69	25	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	75.0	46	73.6	47	66.6	47	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	73.3**	—	73.7	30	73.2*	33	68.9*	28
Primary Care Physicians (Number per 100,000 population)	103.5	35	103.5	35	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	70.3	22	70.3	22	68.5	15	—	—
ALL DETERMINANTS								
	5.7	22	6.7	16	1.5	29	3.6	20
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.1	14	2.9	9	2.5	2	—	—
Poor Physical Health Days (Days in previous 30 days)	3.4	18	3.4	25	3.4	33	—	—
Geographic Disparity (Relative standard deviation)	17.8↑	47	15.5	43	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.1	17	5.5	10	6.4	17	9.8	23
Cardiovascular Deaths (Deaths per 100,000 population)	252.4↓	8	263.0	8	287.0	0	351.0	10
Cancer Deaths (Deaths per 100,000 population)	190.0	18	190.2	17	195.4	18	182.3	14
Premature Death (Years lost per 100,000 population)	7,765↑	30	7,186	22	7,379	24	8,304	22
ALL HEALTH OUTCOMES								
	0.8	32	2.8	14	0.6	27	2.8	18
OVERALL								
	6.5	23	9.5	18	2.8	25	6.4	21

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Nebraska is 13th this year; it was 10th in 2007.

Strengths: Strengths include a high rate of high school graduation with 87.8 percent of incoming ninth graders who graduate in four years, high immunization coverage with 85.2 percent of children ages 19 to 35 months receiving complete immunizations, few poor mental and physical health days per month at 2.5 days and 2.8 days in the previous 30 days, respectively, and low levels of air pollution at 9.5 micrograms of fine particulate per cubic meter.

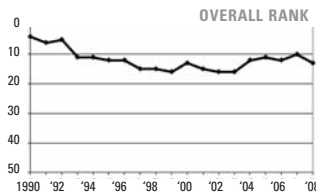
Challenges: Challenges include a high prevalence of binge drinking at 18.0 percent of the population and high geographic disparity within the state at 13.6 percent.

Significant Changes:

- ▲ In the past year, the prevalence of smoking increased from 18.7 percent to 19.9 percent of the population.
- ▲ In the past year, the rate of uninsured population increased from 11.4 percent to 12.8 percent.
- ▼ In the past year, the infant mortality rate declined from 6.5 to 5.7 deaths per 1,000 live births.
- ▼ Since 1990, the rate of deaths from cardiovascular disease declined from 368.7 to 265.0 deaths per 100,000 population.

Health Disparities: In Nebraska, low birth weight babies are more common among non-Hispanic blacks at 12.2 percent than Hispanics at 6.2 percent. Access to health care varies significantly by race and ethnicity in the state; 49.0 percent of Hispanics lack health insurance compared to 13.0 percent of non-Hispanic whites.

State Health Department Web Site: www.hhs.state.ne.us



Overall Rank: 13 Change: ▼ 3

Strengths:

- High rate of high school graduation
- High immunization coverage
- Few poor mental and physical health days
- Low levels of air pollution

Challenges:

- High prevalence of binge drinking
- High geographic disparity within the state

Significant Changes:

- In the past year, the prevalence of smoking increased by 6%
- In the past year, the rate of uninsured population increased by 12%
- In the past year, the infant mortality rate declined by 12%
- Since 1990, the rate of deaths from cardiovascular disease decreased by 28%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.9↑	28	18.7	17	22.7	22	24.9	3
Prevalence of Binge Drinking (Percent of population)	18.0	41	17.6	44	16.1*	28	—	—
Prevalence of Obesity (Percent of population)	26.5	27	26.9	36	23.2	32	11.6	23
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	87.8	1	87.6	1	80*	6*	86.7*	4
Violent Crime (Offenses per 100,000 population)	302	21	282	16	304	16	252	12
Occupational Fatalities (Deaths per 100,000 workers)	6.3↑	29	5.2	18	7.4	43	11.7*	36
Infectious Disease (Cases per 100,000 population)	8.4	13	8.1	12	10.2	11	11.6	4
Children in Poverty (Percent of persons under age 18)	13.1	13	13.1	13	13.5	23	11.3	5
Air Pollution (Micrograms of fine particles per cubic meter)	9.5	10	9.5	12	10.7	14.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	12.8↑	20	11.4	15	9.1	6	10.0	16
Public Health Funding (Dollars per person)	\$68↓	29	\$79	21	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	85.2↑	6	81.0	23	78.2	18	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	65.4*	—	70.3	37	74.36*	30	76.8*	7
Primary Care Physicians (Number per 100,000 population)	115.4	23	114.8	25	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	73.3	24	73.3	24	68.8	16	—	—
ALL DETERMINANTS								
	7.8	15	9.1	13	6.8	14	10.2	3
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.5	3	2.6	5	2.6	5	—	—
Poor Physical Health Days (Days in previous 30 days)	2.8	2	3.0	6	2.8	7	—	—
Geographic Disparity (Relative standard deviation)	13.6	38	14.0	39	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.7	10	6.5	25	7.0	26	9.3	17
Cardiovascular Deaths (Deaths per 100,000 population)	265.0↓	16	277.7	20	307.9	0	368.7	15
Cancer Deaths (Deaths per 100,000 population)	182.4	10	184.7	10	185.4	8	179.8	10
Premature Death (Years lost per 100,000 population)	6,229	10	6,238	12	6,480	12	7,307	10
ALL HEALTH OUTCOMES								
	4.2	10	3.7	11	2.3	16	7.2	6
OVERALL								
	12.0	13	12.8	10	10.1	16	17.4	4

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 42 Change: ▼3

Strengths:

- Low prevalence of obesity
- Low levels of air pollution
- Low rate of preventable hospitalizations

Challenges:

- Low high school graduation rate
- Low immunization coverage
- High violent crime rate

Significant Changes:

- In the past year, the high school graduation rate decreased by 17%
- In the past five years, the percentage of children in poverty increased by 55%
- Since 1990, the prevalence of smoking decreased by 40%
- Since 1990, the incidence of infectious disease declined by 65%

Ranking: Nevada is 42nd this year; it was 39th in 2007.

Strengths: Strengths include a low prevalence of obesity at 24.6 percent of the population, low levels of air pollution at 9.6 micrograms of fine particulate per cubic meter, a low rate of preventable hospitalizations with 65.3 discharges per 1,000 Medicare enrollees and a low infant mortality rate at 6.1 deaths per 1,000 live births.

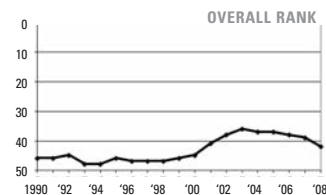
Challenges: Challenges include a low high school graduation rate with 55.8 percent of incoming ninth graders who graduate within four years, a high violent crime rate at 751 offenses per 100,000 population, low immunization coverage with 66.7 percent of children ages 19 to 35 months receiving complete immunizations, low public health funding at \$36 per person and high geographic disparity within the state at 17.6 percent.

Significant Changes:

- ▼ In the past year, the high school graduation rate decreased from 67.0 percent to 55.8 percent of incoming ninth graders who graduate within four years.
- ▲ In the past five years, the percentage of children in poverty increased from 9.1 percent to 14.1 percent of persons under age 18.
- ▼ Since 1990, the prevalence of smoking decreased from 35.7 percent to 21.5 percent of the population.
- ▼ Since 1990, the incidence of infectious disease declined from 49.8 to 17.3 cases per 100,000 population.

Health Disparities: In Nevada, low birth weight babies are more common among non-Hispanic blacks at 14.0 percent than Hispanics at 6.7 percent. Access to health care varies significantly by race and ethnicity in the state; 54.4 percent of Hispanics lack health insurance compared to 14.6 percent of non-Hispanic whites.

State Health Department Web Site: health2k.state.nv.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	21.5	35	22.2	36	26.0	38	35.7	50
Prevalence of Binge Drinking (Percent of population)	16.2	30	16.6	38	18.3*	45	—	—
Prevalence of Obesity (Percent of population)	24.6	13	25.0	24	21.6	23	12.5	36
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	55.8↓	50	67.0	41	68.6*	32*	81.8*	12
Violent Crime (Offenses per 100,000 population)	751	48	742	48	587	40	695	44
Occupational Fatalities (Deaths per 100,000 workers)	6.7	32	7.4	36	5.2	23	12.3*	38
Infectious Disease (Cases per 100,000 population)	17.3↓	33	20.0	33	23.4	34	49.8	43
Children in Poverty (Percent of persons under age 18)	14.1↑	19	12.6	11	9.1	7	14.6	13
Air Pollution (Micrograms of fine particles per cubic meter)	9.6	14	9.5	10	10.8	15.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	18.4	43	18.3	42	17.4	46	20.9	47
Public Health Funding (Dollars per person)	\$36	48	\$34	48	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	66.7↑	50	64.7	50	76.4	25	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	60.7**	—	66.8	45	68.17*	46	65.7*	38
Primary Care Physicians (Number per 100,000 population)	85.3	46	86.3	46	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	65.3	13	65.3	13	64.9	11	—	—
ALL DETERMINANTS	-6.8	43	-6.4	40	-2.7	37	-6.6	47
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.8	45	3.5	37	3.9	47	—	—
Poor Physical Health Days (Days in previous 30 days)	3.7	36	3.7	38	3.5	38	—	—
Geographic Disparity (Relative standard deviation)	17.6	46	15.8	44	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.1	17	6.1	17	6.1	13	9.4	19
Cardiovascular Deaths (Deaths per 100,000 population)	320.3	38	322.6	35	339.8	0	408.8	29
Cancer Deaths (Deaths per 100,000 population)	199.0	32	201.4	34	210.3	35	211.8	45
Premature Death (Years lost per 100,000 population)	8,610↑	41	8,330	39	8,390	39	9,093	35
ALL HEALTH OUTCOMES	-1.1	40	-1.0	34	-1.1	32	-2.9	38
OVERALL	-7.9	42	-7.3	39	-4.6	36	-9.5	46

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: New Hampshire is 3rd this year; it was 4th in 2007.

Strengths: Strengths include a low percentage of children in poverty at 6.5 percent of persons under age 18, high immunization coverage with 93.2 percent of children ages 19 to 35 months receiving complete immunizations, a low violent crime rate at 137 offenses per 100,000 population, low geographic disparity within the state at 5.6 percent, a low premature death rate with 5,858 years of potential life lost before age 75 per 100,000 population and a low infant mortality rate at 5.2 deaths per 1,000 live births.

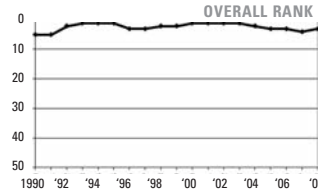
Challenges: Challenges include moderate public health funding at \$59 per person and a moderate number of poor mental health days per month at 3.5 days in the previous 30 days.

Significant Changes:

- ▲ In the past year, immunization coverage increased from 81.8 percent to 93.2 percent of children ages 19 to 35 months receiving complete immunizations.
- ▲ In the past year, the number of poor mental health days per month increased from 3.0 to 3.5 days in the previous 30 days.
- ▼ Since 1990, the prevalence of smoking decreased from 30.7 percent to 19.3 percent of the population.
- ▼ Since 1990, the incidence of infectious disease decreased from 18.3 to 8.1 cases per 100,000 population.

Health Disparities: In New Hampshire, low birth weight babies are more common among non-Hispanic blacks at 10.8 percent than Hispanics at 6.5 percent. Access to health care varies significantly by race and ethnicity in the state; 23.6 percent of Hispanics lack health insurance compared to 12.9 percent of non-Hispanic whites.

State Health Department Web Site: www.dhhs.state.nh.us



Overall Rank: 3
Change: ▲ 1

Strengths:

- Low percentage of children in poverty
- High immunization coverage
- Low violent crime rate
- Low premature death rate

Challenges:

- Moderate per capita public health funding
- Moderate number of poor mental health days

Significant Changes:

- In the past year, immunization coverage increased by 14%
- In the past year, the number of poor mental health days increased by 17%
- Since 1990, the prevalence of smoking declined by 37%
- Since 1990, the incidence of infectious disease decreased by 56%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.3	19	18.7	17	23.2	25	30.7	31
Prevalence of Binge Drinking (Percent of population)	15.3	24	14.9	25	16.2*	31	—	—
Prevalence of Obesity (Percent of population)	25.1↑	14	22.4	9	17.9	4	11.1	19
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	80.1↑	17	78.7	20	75.3*	13*	74.6*	32
Violent Crime (Offenses per 100,000 population)	137	3	139	4	170	5	149	5
Occupational Fatalities (Deaths per 100,000 workers)	4.2	8	4.8	15	4.6	15	8.7*	17
Infectious Disease (Cases per 100,000 population)	8.1↓	12	9.8	13	7.2	7	18.3	12
Children in Poverty (Percent of persons under age 18)	6.5	1	5.6	1	8.2	3	8.9	2
Air Pollution (Micrograms of fine particles per cubic meter)	9.5	10	9.5	11	11.0	16.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	10.9	11	10.6	11	9.2	7	11.2	23
Public Health Funding (Dollars per person)	\$59	34	\$55	37	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	93.2↑	1	81.8	19	83.5	3	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	70.3*	—	86.7	1	87.05*	2	79.8*	2
Primary Care Physicians (Number per 100,000 population)	123.2	16	121.3	17	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.9	12	63.9	12	62.1	8	—	—
ALL DETERMINANTS	14.7	3	13.9	4	14.4	1	10.0	4
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.5	32	3.0	13	2.9	12	—	—
Poor Physical Health Days (Days in previous 30 days)	3.4	18	3.1	10	2.9	10	—	—
Geographic Disparity (Relative standard deviation)	5.6	1	6.1%	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.2	7	5.1	2	4.8	1	8.4	2
Cardiovascular Deaths (Deaths per 100,000 population)	265.9↓	19	280.0	21	309.8	0	392.3	24
Cancer Deaths (Deaths per 100,000 population)	197.2	28	200.1	28	206.6	27	211.3	44
Premature Death (Years lost per 100,000 population)	5,858↑	3	5,658	3	5,840	2	6,989	3
ALL HEALTH OUTCOMES	5.1	7	4.2	8	5.3	2	7.1	7
OVERALL	19.9	3	18.1	4	24.3	1	17.1	5

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 18 Change: ▲3

Strengths:

- High rate of high school graduation
- Low infant mortality rate
- Low percentage of children in poverty

Challenges:

- High incidence of infectious disease
- High rate of preventable hospitalizations
- High rate of uninsured population

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 14%
- In the past year, per capita public health funding increased by 13%
- Since 1990, the rate of uninsured population increased by 77%
- Since 1990, the prevalence of obesity increased by 143%

Ranking: New Jersey is 18th this year; it was 21st in 2007.

Strengths: Strengths include a low infant mortality rate at 5.0 deaths per 1,000 live births, a high rate of high school graduation with 85.1 percent of incoming ninth graders who graduate within four years, a low percentage of children in poverty at 10.7 percent of persons under age 18, a low occupational fatalities rate at 3.6 deaths per 100,000 workers and ready access to primary care with 142.9 primary care physicians per 100,000 population.

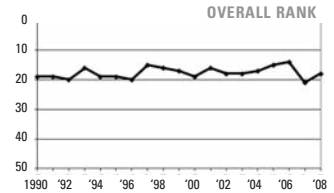
Challenges: Challenges include a high incidence of infectious disease at 22.2 cases per 100,000 population, a high rate of preventable hospitalizations with 83.9 discharges per 1,000 Medicare enrollees and a high rate of uninsured population at 15.6 percent.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 12.5 percent to 10.7 percent of persons under age 18.
- ▲ In the past year, public health funding increased from \$66 to \$74 per person.
- ▲ Since 1990, the rate of uninsured population increased from 8.8 percent to 15.6 percent.
- ▲ Since 1990, the prevalence of obesity increased from 9.9 percent to 24.1 percent of the population.

Health Disparities: In New Jersey, low birth weight babies are more common among non-Hispanic blacks at 13.5 percent than non-Hispanic whites at 7.1 percent. Cardiovascular death rates vary by race in the state with all races experiencing 289.1 deaths per 100,000 population in contrast to blacks who experience 349.8 deaths per 100,000 population.

State Health Department Web Site: www.state.nj.us/health



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	17.1	10	18.0	11	19.0	4	27.9	12
Prevalence of Binge Drinking (Percent of population)	13.9	15	13.7	16	13.7*	15	—	—
Prevalence of Obesity (Percent of population)	24.1↑	10	22.6	10	19.0	10	9.9	9
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	85.1↓	7	86.3	2	88.3*	1*	79.7*	14
Violent Crime (Offenses per 100,000 population)	329	22	352	25	390	26	541	34
Occupational Fatalities (Deaths per 100,000 workers)	3.6	4	4.2	8	3.5	4	4.7*	3
Infectious Disease (Cases per 100,000 population)	22.2↓	42	27.3	44	46.3	49	42.7	39
Children in Poverty (Percent of persons under age 18)	10.7↓	3	12.5	10	9.6	10	15.2	15
Air Pollution (Micrograms of fine particles per cubic meter)	13.2	30	12.9	29	14.5	36.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	15.6	33	15.0	30	13.1	27	8.8	10
Public Health Funding (Dollars per person)	\$74	24	\$66	30	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	82.3↑	11	78.9	36	76.1	26	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	62.9**	—	63.4	49	68.46*	44	72*	19
Primary Care Physicians (Number per 100,000 population)	142.9	8	141.8	8	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	83.9	37	83.9	37	82.4	35	—	—
ALL DETERMINANTS								
	6.4	20	5.3	21	4.8	23	6.6	12
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.4	28	3.2	18	2.9	12	—	—
Poor Physical Health Days (Days in previous 30 days)	3.6	30	3.4	25	2.9	10	—	—
Geographic Disparity (Relative standard deviation)	12.5	32	11.4	31	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.0	2	5.1	2	6.4	17	9.6	21
Cardiovascular Deaths (Deaths per 100,000 population)	289.1↓	25	299.2	26	330.8	0	423.1	34
Cancer Deaths (Deaths per 100,000 population)	196.6	26	199.7	26	208.9	33	213.7	47
Premature Death (Years lost per 100,000 population)	6,339	13	6,450	17	6,962	20	8,723	30
ALL HEALTH OUTCOMES								
	3.4	15	2.7	16	1.2	24	0.4	26
OVERALL								
	9.8	18	8.0	21	8.9	18	7.0	19

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: New Mexico is 29th this year; it was 38th in 2007.

Strengths: Strengths include strong public health funding at \$132 per person, low levels of air pollution at 7.2 micrograms of fine particulate per cubic meter, a low prevalence of binge drinking at 12.7 percent of the population, a low rate of cancer deaths at 172.5 deaths per 100,000 population and a low rate of deaths from cardiovascular disease at 247.9 deaths per 100,000 population.

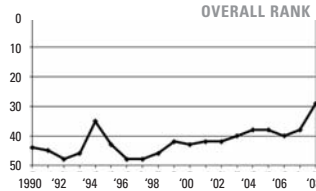
Challenges: Challenges include a high rate of uninsured population at 22.7 percent, a low high school graduation rate with 65.4 percent of incoming ninth graders who graduate within four years, a high violent crime rate at 664 offenses per 100,000 population and a high premature death rate with 8,435 years of potential life lost before age 75 per 100,000 population. New Mexico ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▼ In the past year, the incidence of infectious disease declined from 12.9 to 10.1 cases per 100,000 population.
- ▼ In the past year, the percentage of children in poverty decreased from 23.2 percent to 18.1 percent of persons under age 18.
- ▲ Since 1990, the prevalence of obesity increased from 9.8 percent to 25.1 percent of the population.
- ▼ Since 1990, the infant mortality rate declined from 8.8 to 5.8 deaths per 1,000 live births.

Health Disparities: In New Mexico, low birth weight babies are more common among non-Hispanic blacks at 15.0 percent than Hispanics at 8.5 percent. Access to health care varies significantly by race and ethnicity in the state; 35.2 percent of Hispanics lack health insurance compared to 15.7 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.nm.us



Overall Rank: 29
Change: ▲ 9

Strengths:

- Strong per capita public health funding
- Low levels of air pollution
- Low rates of cancer deaths and cardiovascular deaths

Challenges:

- High rate of uninsured population
- Low high school graduation rate
- High violent crime rate

Significant Changes:

- In the past year, the incidence of infectious disease decreased by 22%
- In the past year, the percentage of children in poverty declined by 22%
- Since 1990, the prevalence of obesity increased by 156%
- Since 1990, the infant mortality rate decreased by 34%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	20.8	31	20.1	25	21.2	10	28.5	15
Prevalence of Binge Drinking (Percent of population)	12.7	10	11.8	9	15.1*	21	—	—
Prevalence of Obesity (Percent of population)	25.1↑	14	22.9	11	19.8	16	9.8	6
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	65.4	42	67.0	41	61*	40*	73.2*	34
Violent Crime (Offenses per 100,000 population)	664	44	643	42	781	48	628	40
Occupational Fatalities (Deaths per 100,000 workers)	6.9↓	34	9.2	43	6.3	34	11.6*	34
Infectious Disease (Cases per 100,000 population)	10.1↓	17	12.9	21	19.8	25	64.2	45
Children in Poverty (Percent of persons under age 18)	18.1↓	33	23.2	46	25.4	49	27.1	46
Air Pollution (Micrograms of fine particles per cubic meter)	7.2	2	7.5	1	7.5	1.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	22.7↑	49	21.6	49	20.4	49	23.8	48
Public Health Funding (Dollars per person)	\$132↑	4	\$120	4	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	78.9	33	76.3	42	64.6	49	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	52.1**	—	57.5	50	56.84*	49	48.8*	50
Primary Care Physicians (Number per 100,000 population)	113.4	28	113.6	26	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	67.0	16	67.0	16	66.7	14	—	—
ALL DETERMINANTS								
	-0.4	30	-6.9	43	-8.5	46	-8.2	48
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.3	27	3.3	30	2.9	12	—	—
Poor Physical Health Days (Days in previous 30 days)	3.6	30	3.9	43	2.9	10	—	—
Geographic Disparity (Relative standard deviation)	12.7	33	13.2	35	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.8	12	6.1	17	6.5	19	8.8	6
Cardiovascular Deaths (Deaths per 100,000 population)	247.9	5	251.7	3	271.1	0	314.7	1
Cancer Deaths (Deaths per 100,000 population)	172.5	4	174.6	4	172.3	4	167.6	4
Premature Death (Years lost per 100,000 population)	8,435	40	8,309	38	8,017	33	9,151	37
ALL HEALTH OUTCOMES								
	2.1	23	1.0	27	1.5	21	0.3	27
OVERALL								
	1.7	29	-5.9	38	-7.5	40	-7.9	44

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 25 Change: ▲ 1

Strengths:

- Ready access to primary care
- High immunization coverage
- Low geographic disparity within the state

Challenges:

- High incidence of infectious disease
- Low high school graduation rate
- High percentage of children in poverty

Significant Changes:

- In the past year, the high school graduation rate increased by 7%
- In the past year, the prevalence of obesity increased by 11%
- Since 1990, the violent crime rate decreased by 59%
- Since 1990, the infant mortality rate decreased by 47%

Ranking: New York is 25th this year; it was 26th in 2007.

Strengths: Strengths include ready access to primary care with 170.3 primary care physicians per 100,000 population, high immunization coverage with 83.0 percent of children ages 19 to 35 months receiving complete immunizations, low geographic disparity within the state at 7.4 percent, a low occupational fatalities rate at 4.2 deaths per 100,000 workers and a low rate of cancer deaths at 182.2 deaths per 100,000 population.

Challenges: Challenges include a high incidence of infectious disease at 39.3 cases per 100,000 population, a low high school graduation rate with 65.3 percent of incoming ninth graders who graduate within four years and a high percentage of children in poverty at 20.4 percent of persons under age 18. New York ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

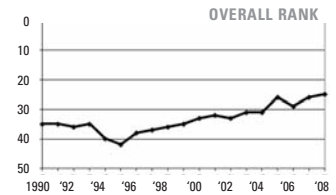
Significant Changes:

- ▲ In the past year, the high school graduation rate increased from 60.9 percent to 65.3 percent of incoming ninth graders who graduate within four years.
- ▲ In the past year, the prevalence of obesity increased from 22.9 percent to 25.5 percent of the population.
- ▼ Since 1990, the violent crime rate decreased from 1,007 to 414 offenses per 100,000 population.
- ▼ Since 1990, the infant mortality rate declined from 10.7 to 5.7 deaths per 1,000 live births.

Health Disparities:

In New York, cardiovascular death rates vary by race, with all races experiencing 313.0 deaths per 100,000 population in contrast to blacks who experience 347.5 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 32.7 percent of Hispanics lack health insurance compared to 10.6 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.ny.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	18.9	16	18.2	13	22.3	18	28.7	19
Prevalence of Binge Drinking (Percent of population)	15.5	25	15.2	29	16.2*	31	—	—
Prevalence of Obesity (Percent of population)	25.5↑	20	22.9	11	20.6	19	9.8	6
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	65.3↑	43	60.9	49	57.8*	45*	66.7*	45
Violent Crime (Offenses per 100,000 population)	414	27	435	29	516	35	1007	49
Occupational Fatalities (Deaths per 100,000 workers)	4.2	8	4.3	12	3.4	2	4.2*	2
Infectious Disease (Cases per 100,000 population)	39.3↓	50	46.0	50	51.7	50	58.8	44
Children in Poverty (Percent of persons under age 18)	20.4↑	40	19.0	36	20.0	39	22.0	36
Air Pollution (Micrograms of fine particles per cubic meter)	12.7	27	12.7	26	14.1	33.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	13.6	22	13.5	23	15.2	36	10.7	20
Public Health Funding (Dollars per person)	\$110	10	\$110	8	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	83.0	9	83.5	12	77.5	21	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	60.8***	—	66.4*	48	67.29*	48	60.3*	47
Primary Care Physicians (Number per 100,000 population)	170.3	3	170.0	3	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	78.7	31	78.7	31	77.6	27	—	—
ALL DETERMINANTS								
	-0.7	31	1.0	30	-4.5	41	-2.4	36
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.2	18	3.1	21	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.4	25	3.1	18	—	—
Geographic Disparity (Relative standard deviation)	7.4	1	7.5	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.7	10	5.9	13	6.1	13	10.7	35
Cardiovascular Deaths (Deaths per 100,000 population)	313.0↓	35	324.2	36	355.5	0	434.5	42
Cancer Deaths (Deaths per 100,000 population)	182.2	9	184.9	11	194.4	16	204.1	34
Premature Death (Years lost per 100,000 population)	6,228	10	6,350	15	6,869	19	9,754	45
ALL HEALTH OUTCOMES								
	4.5	8	2.1	19	2.4	15	-3.5	42
OVERALL								
	3.8	25	3.1	26	-0.5	31	-5.9	35

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: North Carolina is 36th this year, unchanged from 2007.

Strengths: Strengths include a low prevalence of binge drinking at 11.8 percent of the population and a low occupational fatalities rate at 5.2 deaths per 100,000 workers.

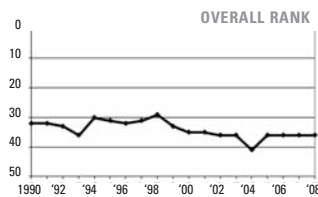
Challenges: Challenges include a high prevalence of smoking at 22.9 percent of the population, a high prevalence of obesity at 28.7 percent of the population, a high infant mortality rate at 8.5 deaths per 1,000 live births and a high percentage of children in poverty at 21.0 percent of persons under age 18.

Significant Changes:

- ▲ In the past year, the prevalence of obesity increased from 26.6 percent to 28.7 percent of the population.
- ▲ In the past five years, the percentage of children in poverty increased from 16.4 percent to 21.0 percent of persons under age 18.
- ▲ Since 1990, the rate of uninsured population increased from 12.6 percent to 17.2 percent.
- ▼ Since 1990, the rate of deaths from cardiovascular disease declined from 430.3 to 306.8 deaths per 100,000 population.

Health Disparities: In North Carolina, low birth weight babies are more common among non-Hispanic blacks at 14.3 percent than Hispanics at 6.3 percent. Access to health care varies significantly by race and ethnicity in the state; 63.8 percent of Hispanics lack health insurance compared to 15.1 percent of non-Hispanic whites.

State Health Department Web Site: www.dhhs.state.nc.us



Overall Rank: 36

Change: no change

Strengths:

- Low prevalence of binge drinking
- Low occupational fatalities rate

Challenges:

- High prevalence of smoking
- High prevalence of obesity
- High percentage of children in poverty
- High infant mortality rate

Significant Changes:

- In the past year, the prevalence of obesity increased by 8%
- In the past five years, the percentage of children in poverty increased by 28%
- Since 1990, the rate of uninsured population increased by 37%
- Since 1990, the rate of deaths from cardiovascular disease decreased by 29%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	22.9	42	22.1	35	26.3	39	31.6	36
Prevalence of Binge Drinking (Percent of population)	11.8	8	10.9	7	10.4*	4	—	—
Prevalence of Obesity (Percent of population)	28.7↑	40	26.6	34	23.5	36	12.9	39
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	72.6↑	39	71.4	38	59.4*	42*	69.1*	40
Violent Crime (Offenses per 100,000 population)	466	32	476	33	494	32	484	31
Occupational Fatalities (Deaths per 100,000 workers)	5.2	20	5.4	21	5.5	26	8.7*	17
Infectious Disease (Cases per 100,000 population)	18.7	37	19.3	32	21.3	28	28.8	22
Children in Poverty (Percent of persons under age 18)	21.0	42	20.5	41	16.4	32	19.3	26
Air Pollution (Micrograms of fine particles per cubic meter)	13.6	35	13.8	36	14.5	37.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	17.2	37	16.6	34	15.1	35	12.6	27
Public Health Funding (Dollars per person)	\$50	39	\$48	41	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.0↓	26	82.3	15	82.4	4	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	78.6**	—	80.8	11	80.19*	14	73.8*	14
Primary Care Physicians (Number per 100,000 population)	115.0	25	115.4	24	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	75.1	26	75.1	26	78.7	30	—	—
ALL DETERMINANTS	-2.8	37	-2.4	35	-1.9	36	-0.5	32
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.5	32	3.3	30	2.7	9	—	—
Poor Physical Health Days (Days in previous 30 days)	3.7	36	3.7	38	2.7	6	—	—
Geographic Disparity (Relative standard deviation)	10.9	28	10.9	29	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	8.5	44	8.8	44	8.6	44	11.7	44
Cardiovascular Deaths (Deaths per 100,000 population)	306.8↓	33	317.1	32	357.6	0	430.3	39
Cancer Deaths (Deaths per 100,000 population)	199.7	34	201.1	31	204.6	25	192.1	21
Premature Death (Years lost per 100,000 population)	8,340	38	8,472	40	8,616	40	9,442	42
ALL HEALTH OUTCOMES	-0.4	36	-2.2	38	-3.4	39	-0.4	31
OVERALL	-3.2	36	-4.7	36	-4.6	36	-0.9	32

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 12 Change: ▼4

Strengths:

- Low violent crime rate
- Few poor mental and physical health days
- High rate of high school graduation
- Low levels of air pollution

Challenges:

- High prevalence of binge drinking
- High geographic disparity within the state

Significant Changes:

- In the past year, per capita public health funding decreased by 14%
- In the past year, the premature death rate increased by 9%
- In the past five years, the percentage of children in poverty decreased by 36%
- Since 1990, the infant mortality rate declined by 29%

Ranking: North Dakota is 12th this year; it was 8th in 2007.

Strengths: Strengths include a low violent crime rate at 142 offenses per 100,000 population, a low incidence of infectious disease at 2.5 cases per 100,000 population, few poor mental and physical health days per month at 2.4 days and 2.7 days in the previous 30 days, respectively, a high rate of high school graduation with 86.3 percent of incoming ninth graders who graduate within four years and low levels of air pollution at 7.3 micrograms of fine particulate per cubic meter.

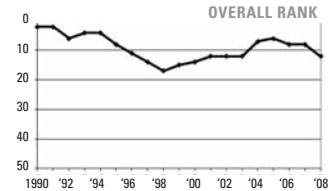
Challenges: Challenges include a high prevalence of binge drinking at 22.1 percent of the population and high geographic disparity within the state at 16.3 percent.

Significant Changes:

- ▼ In the past year, public health funding decreased from \$79 to \$68 per person.
- ▲ In the past year, the premature death rate increased from 5,893 to 6,447 years of potential life lost before age 75 per 100,000 population.
- ▼ In the past five years, the percentage of children in poverty decreased from 19.5 percent to 12.5 percent of persons under age 18.
- ▼ Since 1990, the infant mortality rate decreased from 8.6 to 6.1 deaths per 1,000 live births.

Health Disparities: In North Dakota, low birth weight babies are more common among non-Hispanic blacks at 9.4 percent than Hispanics at 5.8 percent. Access to health care varies significantly by race and ethnicity in the state; 25.8 percent of Hispanics lack health insurance compared to 13.2 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.nd.us

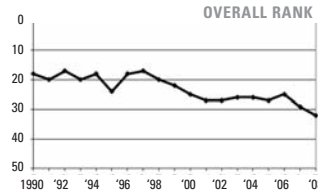


DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	20.9	32	19.5	22	21.5	12	26.4	7
Prevalence of Binge Drinking (Percent of population)	22.1↑	49	20.0	49	22.2*	49	—	—
Prevalence of Obesity (Percent of population)	27.0	28	25.4	27	23.4	34	12.1	30
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	86.3	5	86.1	3	84*	2*	88.4*	1
Violent Crime (Offenses per 100,000 population)	142	4	128	2	80	1	57	1
Occupational Fatalities (Deaths per 100,000 workers)	7.8	39	8.3	38	8.8	45	8.9*	23
Infectious Disease (Cases per 100,000 population)	2.5↓	1	3.8	1	2.4	1	11.1	3
Children in Poverty (Percent of persons under age 18)	12.5↓	8	16.3	28	19.5	37	17.3	20
Air Pollution (Micrograms of fine particles per cubic meter)	7.3	2	7.2	1	7.4	1.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	11.0	13	11.6	16	9.4	9	9.1	13
Public Health Funding (Dollars per person)	\$68↓	28	\$79	20	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	81.7	13	84.2	10	77.7	20	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	69.6**	—	69.8	39	72.61*	37	65.7*	38
Primary Care Physicians (Number per 100,000 population)	121.4	18	121.3	17	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	74.7	25	74.7	25	76.2	24	—	—
ALL DETERMINANTS	9.4	12	9.2	11	8.9	11	8.2	8
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.4	1	2.5	3	2.6	5	—	—
Poor Physical Health Days (Days in previous 30 days)	2.7	1	2.8	2	2.6	3	—	—
Geographic Disparity (Relative standard deviation)	16.3↓	42	18.7	47	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.1	17	6.0	16	8.4	41	8.6	4
Cardiovascular Deaths (Deaths per 100,000 population)	263.7	13	272.8	13	298.1	0	347.4	5
Cancer Deaths (Deaths per 100,000 population)	179.8	7	179.3	8	186.3	9	174.0	7
Premature Death (Years lost per 100,000 population)	6,447↑	17	5,893	4	6,273	6	7,005	4
ALL HEALTH OUTCOMES	3.2	16	4.9	3	2.6	13	11.0	2
OVERALL	12.5	12	14.1	8	12.5	12	19.2	2

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Ohio is 32nd this year; it was 29th in 2007.

Strengths: Strengths include a low rate of uninsured population at 10.9 percent, a high rate of high school graduation with 80.2 percent of incoming ninth graders who graduate within four years and low geographic disparity within the state at 9.0 percent. Ohio ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time.



Challenges: Challenges include high levels of air pollution at 15.5 micrograms of fine particulate per cubic meter, low public health funding at \$38 per person, a high prevalence of smoking at 23.1 percent of the population, many poor mental health days per month at 3.7 days in the previous 30 days and a high rate of cancer deaths at 209.0 deaths per 100,000 population.

Significant Changes:

- ▲ In the past year, the prevalence of smoking increased from 22.4 percent to 23.1 percent of the population.
- ▲ In the past five years, the percentage of children in poverty increased from 16.2 percent to 19.1 percent of persons under age 18.
- ▲ Since 1990, the prevalence of obesity increased from 11.3 percent to 28.1 percent of the population.
- ▼ Since 1990, the rate of deaths from cardiovascular disease decreased from 436.3 to 320.3 deaths per 100,000 population.

Health Disparities: In Ohio, low birth weight babies are more common among non-Hispanic blacks at 13.8 percent than Hispanics at 7.1 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 320.3 deaths per 100,000 population in contrast to blacks who experience 402.6 deaths per 100,000 population.

State Health Department Web Site: www.odh.ohio.gov

Overall Rank: 32

Change: ▼3

Strengths:

- Low rate of uninsured population
- High rate of high school graduation
- Low geographic disparity within the state

Challenges:

- High levels of air pollution
- Low per capita public health funding
- High prevalence of smoking

Significant Changes:

- In the past year, the prevalence of smoking increased by 3%
- In the past five years, the percentage of children in poverty increased by 18%
- Since 1990, the prevalence of obesity increased by 149%
- Since 1990, the rate of deaths from cardiovascular disease decreased by 27%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	23.1	43	22.4	38	26.6	42	32.2	41
Prevalence of Binge Drinking (Percent of population)	16.7	35	15.7	32	16.1*	28	—	—
Prevalence of Obesity (Percent of population)	28.1	34	28.4	43	23.0	31	11.3	21
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	80.2↓	16	81.3	12	70.9*	26*	76.8*	23
Violent Crime (Offenses per 100,000 population)	343	25	350	24	352	22	421	26
Occupational Fatalities (Deaths per 100,000 workers)	4.3	12	4.4	14	4.9	18	7.1*	7
Infectious Disease (Cases per 100,000 population)	10.4	19	10.2	15	11.6	14	17.1	9
Children in Poverty (Percent of persons under age 18)	19.1	36	18.6	34	16.2	31	17.2	19
Air Pollution (Micrograms of fine particles per cubic meter)	15.5	49	15.5	48	17.6	49.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	10.9	11	10.7	12	10.9	20	8.7	8
Public Health Funding (Dollars per person)	\$38	47	\$36	47	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.4	23	81.3	22	75.0	31	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	70.7**	—	80.8	11	82.25*	9	75.7*	10
Primary Care Physicians (Number per 100,000 population)	118.2	21	118.2	20	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	88.0	40	88.0	40	89.7	41	—	—
ALL DETERMINANTS								
	0.2	28	3.8	24	5.7	17	5.3	17
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.7	43	4.0	45	3.3	31	—	—
Poor Physical Health Days (Days in previous 30 days)	3.7	36	3.7	38	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	9.0	15	8.7	11	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	8.1	41	8.1	41	7.6	35	9.9	25
Cardiovascular Deaths (Deaths per 100,000 population)	320.3↓	38	330.9	39	361.3	0	436.3	43
Cancer Deaths (Deaths per 100,000 population)	209.0	40	211.3	42	214.0	40	209.0	43
Premature Death (Years lost per 100,000 population)	7,861↑	32	7,686	30	7,654	27	8,313	23
ALL HEALTH OUTCOMES								
	0.4	34	-2.8	40	-1.7	35	2.4	19
OVERALL								
	0.7	32	1.0	29	2.2	26	7.7	18

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 43 Change: ▲4

Strengths:

- Low prevalence of binge drinking
- Strong per capita public health funding

Challenges:

- High prevalence of smoking
- Limited access to primary care
- High rate of cardiovascular deaths
- Many poor mental and physical health days

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 8%
- In the past year, the levels of air pollution increased by 5%
- Since 1990, the prevalence of obesity increased by 148%
- Since 1990, the incidence of infectious disease declined by 60%

Ranking: Oklahoma is 43rd this year; it was 47th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 13.0 percent of the population and strong public health funding at \$99 per person.

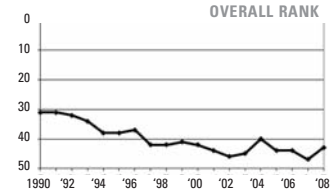
Challenges: Challenges include a high prevalence of smoking at 25.8 percent of the population, limited access to primary care with 79.9 primary care physicians per 100,000 population, many poor mental and physical health days per month at 3.9 days and 4.1 days in the previous 30 days, respectively, and a high rate of deaths from cardiovascular disease at 371.0 deaths per 100,000 population.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 20.7 percent to 19.0 percent of persons under age 18.
- ▲ In the past year, the levels of air pollution increased from 10.7 to 11.2 micrograms of fine particulate per cubic meter.
- ▲ Since 1990, the prevalence of obesity increased from 11.6 percent to 28.8 percent of the population.
- ▼ Since 1990, the incidence of infectious disease decreased from 34.9 to 14.0 cases per 100,000 population.

Health Disparities: In Oklahoma, low birth weight babies are more common among non-Hispanic blacks at 13.6 percent than Hispanics at 6.5 percent. Access to health care varies significantly by race and ethnicity in the state; 56.1 percent of Hispanics lack health insurance compared to 20.8 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.ok.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	25.8	48	25.1	47	26.6	42	33.0	44
Prevalence of Binge Drinking (Percent of population)	13.0	11	13.0	13	12.2*	9	—	—
Prevalence of Obesity (Percent of population)	28.8	43	28.8	44	22.9	29	11.6	23
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	76.9	26	77.0	24	73.4*	19*	75.8*	31
Violent Crime (Offenses per 100,000 population)	500	35	497	34	512	34	419	24
Occupational Fatalities (Deaths per 100,000 workers)	8.8	44	8.3	38	7	40	7.3*	8
Infectious Disease (Cases per 100,000 population)	14.0	25	13.8	24	19.9	26	34.9	32
Children in Poverty (Percent of persons under age 18)	19.0↓	35	20.7	42	21.4	42	17.7	21
Air Pollution (Micrograms of fine particles per cubic meter)	11.2↑	23	10.7	18	11.3	19.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	18.3	42	18.4	43	17.3	45	19.9	46
Public Health Funding (Dollars per person)	\$99	13	\$96	12	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.1	25	80.4	25	65.3	48	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	67.8**	—	69.6	40	68.05*	47	65.2*	41
Primary Care Physicians (Number per 100,000 population)	79.9	49	79.7	50	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	95.9	45	95.9	45	97.9	44	—	—
ALL DETERMINANTS								
	-6.3	41	-8.4	45	-3.9	39	-1.4	33
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.9	47	4.3	47	3.3	31	—	—
Poor Physical Health Days (Days in previous 30 days)	4.1	45	4.5	48	4.0	45	—	—
Geographic Disparity (Relative standard deviation)	10.3	22	10.5	26	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.9	39	8.0	40	7.9	38	10.0	27
Cardiovascular Deaths (Deaths per 100,000 population)	371.0↓	49	385.0	49	402.2	0	415.3	31
Cancer Deaths (Deaths per 100,000 population)	203.7	36	205.2	37	205.4	26	190.0	18
Premature Death (Years lost per 100,000 population)	9,624↑	45	9,307	43	9,048	44	8,551	27
ALL HEALTH OUTCOMES								
	-1.8	45	-6.4	48	-4.7	43	0.6	25
OVERALL								
	-8.1	43	-14.7	47	-12.1	45	-0.8	31

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Oregon is 16th this year; it was 20th in 2007.

Strengths: Strengths include a low prevalence of smoking at 16.9 percent of the population, a low rate of preventable hospitalizations with 51.2 discharges per 1,000 Medicare enrollees, few poor mental health days per month at 3.0 days in the previous 30 days and ready access to primary care with 124.0 primary care physicians per 100,000 population.

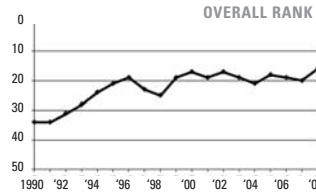
Challenges: Challenges include a high rate of uninsured population at 17.3 percent, low immunization coverage with 72.4 percent of children ages 19 to 35 months receiving complete immunizations and moderate public health funding at \$54 per person. Oregon ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 18.5 percent to 16.9 percent of the population.
- ▼ In the past year, immunization coverage decreased from 78.4 percent to 72.4 percent of children ages 19 to 35 months receiving complete immunizations.
- ▼ Since 1990, the incidence of infectious disease declined from 92.8 to 11.8 cases per 100,000 population.
- ▼ Since 1990, the infant mortality rate decreased from 9.9 to 5.9 deaths per 1,000 live births.

Health Disparities: In Oregon, cardiovascular death rates vary by race, with all races experiencing 265.1 deaths per 100,000 population in contrast to blacks who experience 365.6 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 50.9 percent of Hispanics lack health insurance compared to 16.6 percent of non-Hispanic whites.

State Health Department Web Site: www.oregon.gov/dhs/ph



Overall Rank: 16
Change: ▲4

Strengths:

- Low prevalence of smoking
- Low rate of preventable hospitalizations
- Few poor mental health days

Challenges:

- High rate of uninsured population
- Moderate per capita public health funding
- Low immunization coverage

Significant Changes:

- In the past year, the prevalence of smoking decreased by 9%
- In the past year, immunization coverage declined by 8%
- Since 1990, the incidence of infectious disease decreased by 87%
- Since 1990, the infant mortality rate decreased by 40%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	16.9↓	7	18.5	16	22.4	19	27.1	8
Prevalence of Binge Drinking (Percent of population)	14.8	19	14.0	19	15.5*	26	—	—
Prevalence of Obesity (Percent of population)	26.3↑	25	24.8	22	20.3	18	10.9	17
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	74.2	34	74.2	31	66.2*	34*	70.8*	37
Violent Crime (Offenses per 100,000 population)	288	14	280	13	307	17	540	33
Occupational Fatalities (Deaths per 100,000 workers)	5.3	21	4.9	17	3.7	8	14.4*	43
Infectious Disease (Cases per 100,000 population)	11.8↓	22	13.9	25	18.7	22	92.8	47
Children in Poverty (Percent of persons under age 18)	15.3↓	24	16.7	29	15.1	27	12.4	8
Air Pollution (Micrograms of fine particles per cubic meter)	9.7↓	15	10.7	17	9.8	9.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	17.3	38	16.8	36	13.3	28	14.7	34
Public Health Funding (Dollars per person)	\$54	36	\$54	39	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	72.4↓	49	78.4	38	70.0	40	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	70.5**	—	72.3	33	75.48*	26	68.9*	28
Primary Care Physicians (Number per 100,000 population)	124.0	13	121.9	15	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	51.2	3	51.2	3	53.4	3	—	—
ALL DETERMINANTS								
	7.4	18	6.2	18	6.0	16	-0.2	31
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.0	8	2.9	9	3.2	25	—	—
Poor Physical Health Days (Days in previous 30 days)	3.6	30	3.6	35	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	9.4	16	9.3	17	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.9	14	5.9	13	5.5	5	9.9	25
Cardiovascular Deaths (Deaths per 100,000 population)	265.1	16	275.9	19	295.5	0	370.0	16
Cancer Deaths (Deaths per 100,000 population)	196.2	24	198.3	24	199.9	21	191.3	20
Premature Death (Years lost per 100,000 population)	6,678	19	6,711	20	6,591	18	8,120	20
ALL HEALTH OUTCOMES								
	3.9	13	2.2	18	2.5	14	-4.6	47
OVERALL								
	11.3	16	8.4	20	8.8	19	-4.8	34

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 27 Change: ▼3

Strengths:

- Low rate of uninsured population
- High rate of high school graduation
- Low geographic disparity within the state
- Ready access to primary care

Challenges:

- High levels of air pollution
- High rate of preventable hospitalizations

Significant Changes:

- In the past year, the prevalence of obesity increased by 16%
- In the past year, the percentage of children in poverty decreased by 13%
- Since 1990, the prevalence of obesity increased by 122%
- Since 1990, the rate of cardiovascular deaths decreased by 28%

Ranking: Pennsylvania is 27th this year; it was 24th in 2007.

Strengths: Strengths include a high rate of high school graduation with 82.5 percent of incoming ninth graders who graduate within four years, a low rate of uninsured population at 9.8 percent, ready access to primary care with 125.9 primary care physicians per 100,000 population and low geographic disparity within the state at 7.4 percent.

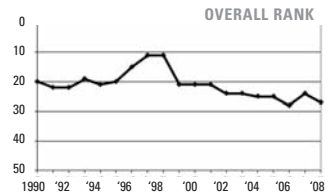
Challenges: Challenges include high levels of air pollution at 15.3 micrograms of fine particulate per cubic meter and a high rate of preventable hospitalizations with 84.7 discharges per 1,000 Medicare enrollees.

Significant Changes:

- ▲ In the past year, the prevalence of obesity increased from 24.0 percent to 27.8 percent of the population.
- ▼ In the past year, the percentage of children in poverty decreased from 17.0 percent to 14.8 percent of persons under age 18.
- ▲ Since 1990, the prevalence of obesity increased from 12.5 percent to 27.8 percent of the population.
- ▼ Since 1990, the rate of deaths from cardiovascular disease decreased from 429.0 to 308.5 deaths per 100,000 population.

Health Disparities: In Pennsylvania, low birth weight babies are more common among non-Hispanic blacks at 13.7 percent than non-Hispanic whites at 7.1 percent. Access to health care varies significantly by race and ethnicity in the state; 25.0 percent of non-Hispanic blacks lack health insurance compared to 11.5 percent of non-Hispanic whites.

State Health Department Web Site: www.dsf.health.state.pa.us



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	21.0	33	21.5	32	24.5	35	29.3	23
Prevalence of Binge Drinking (Percent of population)	16.4	33	16.3	33	16.3*	33	—	—
Prevalence of Obesity (Percent of population)	27.8↑	33	24.0	18	24.0	40	12.5	36
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	82.5	10	82.2	10	75.3*	12*	81.1*	13
Violent Crime (Offenses per 100,000 population)	417	28	439	30	410	28	368	22
Occupational Fatalities (Deaths per 100,000 workers)	5.5	22	5.4	21	4.2	11	7.4*	10
Infectious Disease (Cases per 100,000 population)	18.5	36	18.4	30	21.7	30	22.5	14
Children in Poverty (Percent of persons under age 18)	14.8↓	23	17.0	30	14.0	25	18.2	22
Air Pollution (Micrograms of fine particles per cubic meter)	15.3	46	15.3	47	16.4	46.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	9.8	8	9.9	7	9.6	11	7.7	5
Public Health Funding (Dollars per person)	\$53↓	37	\$73	23	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	81.4↓	16	84.6	8	74.7	32	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	56.9*	—	65.2*	43	73.55*	31	71.5*	22
Primary Care Physicians (Number per 100,000 population)	125.9	11	125.4	11	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	84.7	38	84.7	38	86.2	37	—	—
ALL DETERMINANTS	0.5	27	4.1	23	4.3	25	5.7	16
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.4	28	3.3	30	3.6	40	—	—
Poor Physical Health Days (Days in previous 30 days)	3.7	36	3.3	17	3.4	33	—	—
Geographic Disparity (Relative standard deviation)	7.4	1	8.2	9	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.7	37	7.6	34	7.2	29	10.3	30
Cardiovascular Deaths (Deaths per 100,000 population)	308.5	34	317.3	33	348.4	0	429.0	38
Cancer Deaths (Deaths per 100,000 population)	204.1	37	204.8	36	208.0	30	207.9	42
Premature Death (Years lost per 100,000 population)	7,635	28	7,503	26	7,580	26	8,545	26
ALL HEALTH OUTCOMES	1.5	25	-0.3	33	-1.0	31	1.0	23
OVERALL	2.0	27	3.8	24	4.1	24	6.7	20

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Rhode Island is 11th this year, unchanged from 2007.

Strengths: Strengths include a low rate of uninsured population at 9.7 percent, a low prevalence of obesity at 21.7 percent of the population, a low violent crime rate at 227 offenses per 100,000 population, ready access to primary care with 167.6 primary care physicians per 100,000 population and low geographic disparity within the state at 7.2 percent. Rhode Island ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time.

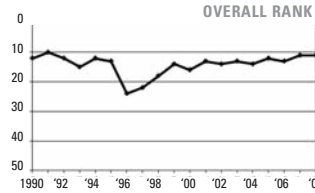
Challenges: Challenges include a high prevalence of binge drinking at 18.2 percent of the population and many poor mental and physical health days per month at 3.8 days and 3.9 days, respectively, in the previous 30 days.

Significant Changes:

- ▼ In the past year, the prevalence of smoking decreased from 19.2 percent to 17.0 percent of the population.
- ▲ In the past year, the prevalence of binge drinking increased from 16.4 percent to 18.2 percent of the population.
- ▲ In the past five years, the percentage of children in poverty increased from 11.0 percent to 15.7 percent of persons under age 18.
- ▼ Since 1990, the prevalence of smoking declined from 34.4 percent to 17.0 percent of the population.

Health Disparities: In Rhode Island, cardiovascular death rates vary by race, with all races experiencing 290.9 deaths per 100,000 population in contrast to blacks who experience 331.3 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 39.5 percent of Hispanics lack health insurance compared to 9.9 percent of non-Hispanic whites.

State Health Department Web Site: www.health.state.ri.us



Overall Rank: 11 Change: no change

Strengths:

- Low rate of uninsured population
- Low prevalence of obesity
- Ready access to primary care
- Low violent crime rate

Challenges:

- High prevalence of binge drinking
- Many poor mental and physical health days

Significant Changes:

- In the past year, the prevalence of smoking decreased by 12%
- In the past year, the prevalence of binge drinking increased by 11%
- In the last five years, the percentage of children in poverty increased by 43%
- Since 1990, the prevalence of smoking decreased by 51%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	17.0↓	8	19.2	20	22.4	19	34.4	48
Prevalence of Binge Drinking (Percent of population)	18.2↑	45	16.4	37	16.4*	34	—	—
Prevalence of Obesity (Percent of population)	21.7	2	21.4	7	18.5	7	11.1	19
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	78.4↑	24	75.9	29	69.6*	29*	72*	35
Violent Crime (Offenses per 100,000 population)	227	6	228	7	310	18	360	20
Occupational Fatalities (Deaths per 100,000 workers)	4.8↑	15	3.4	2	4.8	17	8.7*	17
Infectious Disease (Cases per 100,000 population)	15.0↓	29	17.4	28	22.1	31	29.8	23
Children in Poverty (Percent of persons under age 18)	15.7	25	15.7	27	11.0	13	11.7	6
Air Pollution (Micrograms of fine particles per cubic meter)	11.2	21	11.3	24	12.4	24.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	9.7	7	10.1	8	8.4	3	7.0	2
Public Health Funding (Dollars per person)	\$99	14	\$90	16	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.0	26	82.2	16	84.5	2	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	71**	—	81.2	9	87.72*	1	77.5*	6
Primary Care Physicians (Number per 100,000 population)	167.6↑	4	163.1	5	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	80.4	33	80.4	33	80.3	32	—	—
ALL DETERMINANTS								
	11.0	10	10.9	7	9.3	10	7.5	10
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.8	45	3.4	34	3.2	25	—	—
Poor Physical Health Days (Days in previous 30 days)	3.9	43	3.5	31	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	7.2	1	7.3	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.8	28	6.5	25	6.5	19	8.9	8
Cardiovascular Deaths (Deaths per 100,000 population)	290.9	27	295.6	24	308.0	0	392.3	24
Cancer Deaths (Deaths per 100,000 population)	198.3	30	201.3	32	208.8	31	207.7	41
Premature Death (Years lost per 100,000 population)	6,222	9	6,136	9	6,471	11	7,698	15
ALL HEALTH OUTCOMES								
	2.9	19	1.6	24	1.5	21	2.9	17
OVERALL								
	14.0	11	12.5	11	12.1	13	10.5	12

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 48 Change: ▼6

Strengths:

- High immunization coverage
- Low prevalence of binge drinking
- Moderate per capita public health funding

Challenges:

- Low high school graduation rate
- High violent crime rate
- High infant mortality rate

Significant Changes:

- In the past year, the incidence of infectious disease decreased by 11%
- In the past year, the percentage of children in poverty increased by 35%
- In the last five years, the rate of uninsured population increased by 36%
- Since 1990, the rate of deaths from cardiovascular disease declined by 31%

Ranking: South Carolina is 48th this year; it was 42nd in 2007.

Strengths: Strengths include high immunization coverage with 81.1 percent of children ages 19 to 35 months receiving complete immunizations, a low prevalence of binge drinking at 13.7 percent of the population and moderate public health funding at \$81 per person.

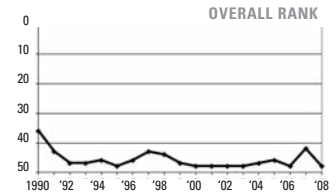
Challenges: Challenges include a low high school graduation rate with 60.1 percent of incoming ninth graders who graduate within four years, a high violent crime rate at 788 offenses per 100,000 population, a high prevalence of obesity at 29.0 percent of the population, a high infant mortality rate at 8.6 deaths per 1,000 live births and a high premature death rate with 9,559 years of potential life lost before age 75 per 100,000 population. South Carolina ranks lower for health determinants than for health outcomes, indicating that overall healthiness may decline over time as was the case this year.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 15.6 percent to 21.0 percent of persons under age 18.
- ▲ In the past five years, the rate of uninsured population increased from 11.9 percent to 16.2 percent.
- ▼ Since 1990, the rate of deaths from cardiovascular disease decreased from 458.9 to 316.1 deaths per 100,000 population.
- ▼ Since 1990, the infant mortality rate decreased from 13.0 to 8.6 deaths per 1,000 live births.

Health Disparities: In South Carolina, cardiovascular death rates vary by race, with all races experiencing 316.1 deaths per 100,000 population in contrast to blacks who experience 398.6 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 42.0 percent of Hispanics lack health insurance compared to 16.3 percent of non-Hispanic whites.

State Health Department Web Site: www.scdhec.net



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	21.9	36	22.3	37	26.6	42	27.1	8
Prevalence of Binge Drinking (Percent of population)	13.7	14	13.1	14	12.4*	10	—	—
Prevalence of Obesity (Percent of population)	29.0	44	29.4	47	25.8	48	13.6	43
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	60.1	49	60.6	50	48*	50*	67.8*	43
Violent Crime (Offenses per 100,000 population)	788	50	766	50	720	46	665	42
Occupational Fatalities (Deaths per 100,000 workers)	8.7	43	8.5	42	6.3	34	7.6*	12
Infectious Disease (Cases per 100,000 population)	22.8↓	43	25.6	42	28.8	39	36.7	33
Children in Poverty (Percent of persons under age 18)	21.0↑	42	15.6	26	23.0	45	21.3	32
Air Pollution (Micrograms of fine particles per cubic meter)	13.7	37	13.9	37	14.0	32.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	16.2	34	16.6	34	11.9	23	12.8	28
Public Health Funding (Dollars per person)	\$81	20	\$77	22	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	81.1↓	17	83.2	14	78.8	12	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	66.8*	—	70.5*	29	73.24*	33	56.7*	49
Primary Care Physicians (Number per 100,000 population)	105.5	34	106.6	30	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	76.2	29	76.2	29	79.2	31	—	—
ALL DETERMINANTS	-9.4	47	-7.1	44	-9.5	47	-2.5	37
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.6	38	3.4	34	3.3	31	—	—
Poor Physical Health Days (Days in previous 30 days)	3.5	23	3.5	31	3.3	30	—	—
Geographic Disparity (Relative standard deviation)	10.8	26	10.3	23	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	8.6	45	8.9	45	8.8	45	13.0	49
Cardiovascular Deaths (Deaths per 100,000 population)	316.1↓	36	327.9	38	373.5	0	458.9	50
Cancer Deaths (Deaths per 100,000 population)	204.7	38	205.8	38	209.2	34	193.7	22
Premature Death (Years lost per 100,000 population)	9,559	44	9,493	45	9,597	47	10,599	49
ALL HEALTH OUTCOMES	-1.3	42	-3.0	41	-5.1	44	-3.7	43
OVERALL	-10.7	48	-10.1	42	-15.5	48	-6.2	36

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: South Dakota is 21st this year; it was 16th in 2007.

Strengths: Strengths include a low violent crime rate at 169 offenses per 100,000 population, a low incidence of infectious disease at 5.6 cases per 100,000 population, high immunization coverage with 87.1 percent of children ages 19 to 35 months receiving complete immunizations, a high rate of high school graduation with 82.3 percent of incoming ninth graders who graduate within four years and few poor mental and physical health days per month at 2.4 days and 2.8 days, respectively, in the previous 30 days.

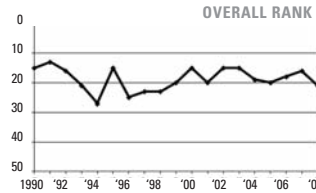
Challenges: Challenges include high geographic disparity within the state at 26.5 percent, a high prevalence of binge drinking at 17.7 percent of the population, limited access to primary care with 107.2 primary care physicians per 100,000 population and a high occupational fatalities rate at 7.9 deaths per 100,000 workers.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 13.4 percent to 14.5 percent of persons under age 18.
- ▲ In the past year, public health funding increased from \$68 to \$75 per person.
- ▲ In the past five years, the incidence of infectious disease increased from 4.4 to 5.6 cases per 100,000 population.
- ▲ Since 1990, the infant mortality rate decreased from 11.6 to 7.4 deaths per 1,000 live births.

Health Disparities: In South Dakota, cardiovascular death rates vary by race, with all races experiencing 266.4 deaths per 100,000 population in contrast to non-whites and non-blacks who experience 401.8 deaths per 100,000 population.

State Health Department Web Site: www.state.sd.us/doh



Overall Rank: 21
Change: ▼ 5

Strengths:

- Few poor mental and physical health days
- Low incidence of infectious disease
- High immunization coverage

Challenges:

- High prevalence of binge drinking
- High occupational fatalities rate
- High geographic disparity within the state

Significant Changes:

- In the past year, the percentage of children in poverty increased by 8%
- In the past year, per capita public health funding increased by 10%
- In the past five years, the percentage of children in poverty increased by 77%
- Since 1990, the infant mortality rate decreased by 36%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.8	25	20.3	26	22.6	21	28.6	16
Prevalence of Binge Drinking (Percent of population)	17.7	39	18.1	46	18.5*	47	—	—
Prevalence of Obesity (Percent of population)	27.2↑	29	25.4	27	21.2	21	10.7	13
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	82.3↓	11	83.7	8	71.9*	25*	86.9*	1
Violent Crime (Offenses per 100,000 population)	169	5	171	5	155	4	120	1
Occupational Fatalities (Deaths per 100,000 workers)	7.9↓	40	9.4	44	10.5	46	9.2*	25
Infectious Disease (Cases per 100,000 population)	5.6	6	5.0	4	4.4	2	18.0	10
Children in Poverty (Percent of persons under age 18)	14.5↑	22	13.4	17	8.2	3	19.3	24
Air Pollution (Micrograms of fine particles per cubic meter)	9.4	9	9.4	9	9.0	6.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	11.0	13	11.8	17	9.8	14	12.9	30
Public Health Funding (Dollars per person)	\$75	21	\$68	27	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	87.1↑	5	82.2	16	79.9	11	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	74.2**	—	75.4	28	71.69*	39	65.3*	40
Primary Care Physicians (Number per 100,000 population)	107.2	30	106.3	31	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	76.1	28	76.1	28	78.2	29	—	—
ALL DETERMINANTS								
	8.8	13	6.9	15	7.8	12	3.3	22
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	2.4	1	2.4	1	2.5	2	—	—
Poor Physical Health Days (Days in previous 30 days)	2.8	2	2.7	1	2.8	7	—	—
Geographic Disparity (Relative standard deviation)	26.5	50	27.7	50	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.4	34	7.6	34	6.5	19	11.6	41
Cardiovascular Deaths (Deaths per 100,000 population)	266.4	20	272.7	13	304.4	0	375.0	19
Cancer Deaths (Deaths per 100,000 population)	190.2	19	187.5	14	191.9	15	178.9	9
Premature Death (Years lost per 100,000 population)	7,343	24	7,343	25	7,013	21	7,939	19
ALL HEALTH OUTCOMES								
	-1.4	43	2.8	14	3.7	7	5.3	13
OVERALL								
	7.5	21	9.7	16	11.5	15	8.7	15

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 47 Change: ▼ 1

Strengths:

- Low prevalence of binge drinking
- Moderate per capita public health funding
- Moderate immunization coverage

Challenges:

- High infant mortality rate
- High violent crime rate
- High rate of cardiovascular deaths

Significant Changes:

- In the past year, the prevalence of smoking increased by 8%
- In the past year, per capita public health funding increased by 12%
- In the past five years, the rate of uninsured population increased by 33%
- Since 1990, the violent crime rate increased by 41%

Ranking: Tennessee is 47th this year; it was 46th in 2007.

Strengths: Strengths include a low prevalence of binge drinking at 8.9 percent of the population, moderate immunization coverage with 80.5 percent of children ages 19 to 35 months receiving complete immunizations, moderate public health funding at \$81 per person, ready access to primary care with 121.6 primary care physicians per 100,000 population and a moderate rate of uninsured population at 14.0 percent.

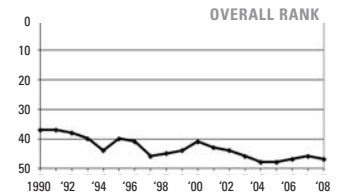
Challenges: Challenges include a high prevalence of smoking at 24.3 percent of the population, a high prevalence of obesity at 30.7 percent of the population, many preventable hospitalizations with 97.8 discharges per 1,000 Medicare enrollees, high levels of air pollution at 14.7 micrograms of fine particulate per cubic meter, a high violent crime rate at 753 offenses per 100,000 population and a high infant mortality rate at 9.5 deaths per 1,000 live births.

Significant Changes:

- ▲ In the past year, public health funding increased from \$72 to \$81 per person.
- ▲ In the past year, the high school graduation rate increased from 66.1 percent to 68.5 percent of incoming ninth graders who graduate within four years.
- ▼ Since 1990, the percentage of children in poverty decreased from 29.6 percent to 20.2 percent of persons under age 18.
- ▲ Since 1990, the violent crime rate increased from 534 to 753 offenses per 100,000 population.

Health Disparities: In Tennessee, low birth weight babies are more common among non-Hispanic blacks at 14.5 percent than Hispanics at 6.0 percent. Access to health care varies significantly by race and ethnicity in the state as well as by gender; 16.5 percent of males lack health insurance compared to 13.8 percent of females.

State Health Department Web Site: www.state.tn.us/health



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	24.3↑	46	22.6	40	27.7	47	30.8	33
Prevalence of Binge Drinking (Percent of population)	8.9	1	8.6	1	7.5*	1	—	—
Prevalence of Obesity (Percent of population)	30.7↑	47	28.8	44	24.6	43	11.8	26
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	68.5↑	40	66.1	45	55.3*	47*	67.2*	44
Violent Crime (Offenses per 100,000 population)	753	49	760	49	745	47	534	32
Occupational Fatalities (Deaths per 100,000 workers)	6.1	26	6.0	24	5.7	27	9.4*	26
Infectious Disease (Cases per 100,000 population)	20.7↓	40	23.5	39	26.3	36	32.0	28
Children in Poverty (Percent of persons under age 18)	20.2	39	20.9	43	20.4	40	29.6	48
Air Pollution (Micrograms of fine particles per cubic meter)	14.7↑	41	14.3	40	15.8	39.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	14.0	27	13.6	24	10.5	18	13.2	31
Public Health Funding (Dollars per person)	\$81	19	\$72	24	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.5	22	81.7	20	78.2	18	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	59.7*	—	71.6*	22	76.44*	25	69.2*	27
Primary Care Physicians (Number per 100,000 population)	121.6	17	121.9	15	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	97.8	46	97.8	46	98.4	45	—	—
ALL DETERMINANTS	-7.5	45	-8.5	46	-5.8	42	-4.1	41
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.2	18	3.0	17	—	—
Poor Physical Health Days (Days in previous 30 days)	4.1	45	4.3	46	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	9.4	16	9.8	20	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	9.5	48	9.5	48	8.9	46	11.3	40
Cardiovascular Deaths (Deaths per 100,000 population)	353.8↓	47	367.5	47	391.5	0	428.7	37
Cancer Deaths (Deaths per 100,000 population)	216.0	47	216.0	46	215.4	44	200.2	29
Premature Death (Years lost per 100,000 population)	9,647	46	9,524	46	9,488	46	9,504	43
ALL HEALTH OUTCOMES	-2.2	47	-5.5	46	-5.7	46	-2.3	37
OVERALL	-9.7	47	-14.0	46	-13.2	46	-6.3	37

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Texas is 46th this year; it was 37th in 2007.

Strengths: Strengths include a low prevalence of smoking at 19.3 percent of the population, a low prevalence of binge drinking at 15.0 percent of the population, a low rate of cancer deaths at 186.3 deaths per 100,000 population and a moderate infant mortality rate at 6.5 deaths per 1,000 live births.

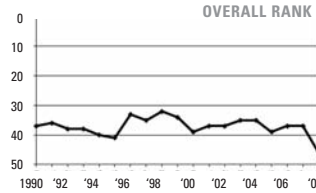
Challenges: Challenges include a high rate of uninsured population at 24.9 percent, a high percentage of children in poverty at 25.0 percent of persons under age 18, a high incidence of infectious disease at 23.8 cases per 100,000 population and limited access to primary care with 95.0 primary care physicians per 100,000 population. Texas ranks lower for health determinants than for health outcomes, indicating that overall healthiness may remain low in future years.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 22.0 percent to 25.0 percent of persons under age 18.
- ▲ In the past year, the prevalence of smoking increased from 17.9 percent to 19.3 percent of the population.
- ▼ Since 1990, the infant mortality rate decreased from 9.3 to 6.5 deaths per 1,000 live births.
- ▲ Since 1990, the prevalence of obesity increased from 12.3 percent to 28.6 percent of the population.

Health Disparities: In Texas, low birth weight babies are more common among non-Hispanic blacks at 13.9 percent than Hispanics at 7.2 percent. Access to health care varies significantly by race and ethnicity in the state; 29.3 percent of non-Hispanic blacks and 55.7 percent of Hispanics lack health insurance compared to 16.8 percent of non-Hispanic whites.

State Health Department Web Site: www.dshs.state.tx.us



Overall Rank: 46 Change: ▼9

Strengths:

- Low rate of cancer deaths
- Moderate prevalence of smoking

Challenges:

- Limited access to primary care
- High rate of uninsured population
- High percentage of children in poverty
- High incidence of infectious disease

Significant Changes:

- In the past year, the prevalence of smoking increased by 8%
- In the past year, the percentage of children in poverty increased by 14%
- In the last five years, immunization coverage increased by 15%
- Since 1990, the infant mortality rate decreased by 30%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.3↑	19	17.9	9	22.9	24	30.6	29
Prevalence of Binge Drinking (Percent of population)	15.0	20	14.5	22	16.5*	35	—	—
Prevalence of Obesity (Percent of population)	28.6↑	39	26.1	32	25.5	45	12.3	33
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	74.0↓	35	76.7	27	61.9*	39*	65.9*	46
Violent Crime (Offenses per 100,000 population)	511	37	516	36	573	39	632	41
Occupational Fatalities (Deaths per 100,000 workers)	6.3	29	6.2	27	5.1	21	13.6*	39
Infectious Disease (Cases per 100,000 population)	23.8↓	44	26.3	43	28.8	39	47.8	41
Children in Poverty (Percent of persons under age 18)	25.0↑	49	22.0	45	21.1	41	22.6	39
Air Pollution (Micrograms of fine particles per cubic meter)	13.4	33	13.3	33	12.5	26.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	24.9	50	24.1	50	24.4	50	23.7	48
Public Health Funding (Dollars per person)	\$47	42	\$44	43	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	78.2	38	76.7	41	67.9	43	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	63.2*	—	71.6	34	71.8*	38	58.9*	48
Primary Care Physicians (Number per 100,000 population)	95.0	42	95.5	42	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	87.6	39	87.6	39	91.5	42	—	—
ALL DETERMINANTS								
	-9.5	48	-6.4	40	-6.0	44	-6.3	46
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.5	32	3.0	13	2.9	12	—	—
Poor Physical Health Days (Days in previous 30 days)	3.8	41	3.3	17	2.9	10	—	—
Geographic Disparity (Relative standard deviation)	15.1	40	14.4	40	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.5	24	6.4	23	5.8	9	9.3	17
Cardiovascular Deaths (Deaths per 100,000 population)	302.8↓	30	317.8	34	346.8	0	386.6	21
Cancer Deaths (Deaths per 100,000 population)	186.3	15	189.8	16	195.5	18	181.8	13
Premature Death (Years lost per 100,000 population)	7,505	25	7,541	28	7,658	28	8,654	28
ALL HEALTH OUTCOMES								
	0.6	33	1.0	27	1.2	24	0.0	29
OVERALL								
	-9.0	46	-5.5	37	-3.8	35	-6.3	37

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 5 Change: ▲ 1

Strengths:

- Low prevalence of smoking
- Low prevalence of binge drinking
- Low rate of cancer deaths

Challenges:

- Limited access to primary care
- Moderate immunization coverage
- High geographic disparity within the state

Significant Changes:

- In the past year, the prevalence of smoking increased by 19%
- In the past year, the incidence of infectious disease decreased by 24%
- In the past five years, the prevalence of obesity increased by 28%
- Since 1990, the rate of uninsured population increased by 27%

Ranking: Utah is 5th this year; it was 6th in 2007.

Strengths: Utah ranks among the top ten states on 14 of the 22 measures. Strengths include a low prevalence of smoking at 11.7 percent of the population, a low infant mortality rate at 5.1 deaths per 1,000 live births, few preventable hospitalizations with 46.8 discharges per 1,000 Medicare enrollees, a high rate of high school graduation with 84.4 percent of incoming ninth graders who graduate within four years, a low violent crime rate at 235 offenses per 100,000 population and a low prevalence of binge drinking at 9.5 percent of the population.

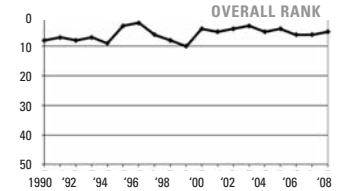
Challenges: Challenges include limited access to primary care with 89.6 primary care physicians per 100,000 population, moderate immunization coverage with 78.5 percent of children ages 19 to 35 months receiving complete immunizations, high geographic disparity within the state at 17.5 percent, a high rate of uninsured population at 15.1 percent and low public health funding at \$61 per person.

Significant Changes:

- ▼ In the past year, the incidence of infectious disease decreased from 7.0 to 5.3 cases per 100,000 population.
- ▲ In the past year, the prevalence of smoking increased from 9.8 percent to 11.7 percent of the population.
- ▲ In the past five years, the prevalence of obesity increased from 17.5 percent to 22.4 percent of the population.
- ▲ Since 1990, the rate of uninsured population increased from 11.9 percent to 15.1 percent.

Health Disparities: In Utah, low birth weight babies are more common among non-Hispanic blacks at 12.0 percent than Hispanics at 7.3 percent. Access to health care varies significantly by race and ethnicity in the state; 44.8 percent of Hispanics lack health insurance compared to 13.7 percent of non-Hispanic whites.

State Health Department Web Site: www.health.utah.gov



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	11.7↑	1	9.8	1	12.8	1	14.1	1
Prevalence of Binge Drinking (Percent of population)	9.5	3	8.7	1	9.9*	3	—	—
Prevalence of Obesity (Percent of population)	22.4	7	21.9	8	17.5	3	9.3	4
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	84.4	9	83.0	9	83.3*	3*	82.5*	11
Violent Crime (Offenses per 100,000 population)	235	7	224	6	234	7	230	9
Occupational Fatalities (Deaths per 100,000 workers)	6.2	27	6.4	30	5.9	29	14.7*	44
Infectious Disease (Cases per 100,000 population)	5.3↓	5	7.0	10	11.7	16	30.4	24
Children in Poverty (Percent of persons under age 18)	12.6	9	12.6	11	12.5	19	10.3	4
Air Pollution (Micrograms of fine particles per cubic meter)	12.2↓	25	12.8	27	13.0	28.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	15.1↓	32	16.9	38	13.5	30	11.9	26
Public Health Funding (Dollars per person)	\$61	32	\$66	29	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	78.5	37	80.4	25	75.7	28	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	78.6**	—	79.1	16	58.36*	49	72.4*	16
Primary Care Physicians (Number per 100,000 population)	89.6	45	90.9	45	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	46.8	2	46.8	2	47.8	2	—	—
ALL DETERMINANTS	14.5	4	10.4	8	10.5	7	9.7	5
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.0	8	3.2	18	3.2	25	—	—
Poor Physical Health Days (Days in previous 30 days)	2.9	4	3.3	17	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	17.5	45	16.2	45	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.1	4	5.1	2	5.0	3	8.7	5
Cardiovascular Deaths (Deaths per 100,000 population)	243.2↓	3	255.0	5	267.6	0	350.4	7
Cancer Deaths (Deaths per 100,000 population)	145.7	1	147.0	1	156.3	1	141.7	1
Premature Death (Years lost per 100,000 population)	6,029↓	6	6,301	13	6,109	4	7,038	5
ALL HEALTH OUTCOMES	3.7	14	4.3	7	5.9	1	6.0	9
OVERALL	18.2	5	14.8	6	19.5	3	15.7	8

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Vermont is 1st this year, unchanged from 2007.

Strengths: Vermont ranks among the top ten states on 14 of the 22 measures. Strengths include a low percentage of children in poverty at 10.9 percent of persons under age 18, a low prevalence of obesity at 21.9 percent of the population, a high rate of high school graduation with 86.5 percent of incoming ninth graders who graduate within four years and ready access to primary care with 165.1 primary care physicians per 100,000 population. Vermont ranks higher for health determinants than for health outcomes, indicating that overall healthiness should remain high over time.

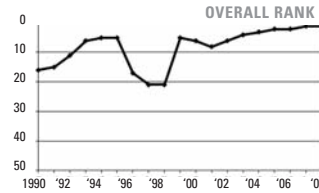
Challenges: The primary challenges are a high prevalence of binge drinking at 21.9 percent of the population and moderate immunization coverage with 79.8 percent of children ages 19 to 35 months receiving complete immunizations.

Significant Changes:

- ▲ In the past year, public health funding increased from \$96 to \$143 per person.
- ▲ In the past year, the percentage of children in poverty increased from 8.9 percent to 10.9 percent of persons under age 18.
- ▲ In the past five years, the rate of uninsured population increased from 9.7 percent to 10.7 percent.
- ▼ Since 1990, the prevalence of smoking decreased from 30.7 percent to 17.6 percent of the population.

Health Disparities: In Vermont, access to health care varies significantly by race and ethnicity as well as by gender; 17.3 percent of males lack health insurance compared to 10.9 percent of females.

State Health Department Web Site: www.healthvermont.gov



Overall Rank: 1 Change: no change

Strengths:

- Low percentage of children in poverty
- Low prevalence of obesity
- High rate of high school graduation
- Low premature death rate

Challenges:

- High prevalence of binge drinking
- High immunization coverage

Significant Changes:

- In the past year, the percentage of children in poverty increased by 23%
- In the past year, per capita public health funding increased by 49%
- Since 1990, the prevalence of smoking decreased by 43%
- Since 1990, the infant mortality rate decreased by 37%

	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
DETERMINANTS								
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	17.6	12	18.0	11	21.1	9	30.7	31
Prevalence of Binge Drinking (Percent of population)	17.3	38	16.3	33	16.1*	28	—	—
Prevalence of Obesity (Percent of population)	21.9	6	21.2	5	18.9	9	10.7	13
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	86.5	4	85.4	6	77.7*	9*	82.7*	10
Violent Crime (Offenses per 100,000 population)	124	2	137	3	105	1	137	1
Occupational Fatalities (Deaths per 100,000 workers)	4.5	13	5.2	18	5.7	27	8.7*	17
Infectious Disease (Cases per 100,000 population)	5.7	7	6.4	8	8.8	10	20.3	13
Children in Poverty (Percent of persons under age 18)	10.9↑	4	8.9	2	12.2	17	15.9	16
Air Pollution (Micrograms of fine particles per cubic meter)	9.5	10	9.8	15	10.1	10.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	10.7	10	10.9	13	9.7	13	10.7	20
Public Health Funding (Dollars per person)	\$143↑	3	\$96	13	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	79.8↓	29	86.0	4	80.9	7	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	—	—	86.4	2	83.77*	6	62.6*	44
Primary Care Physicians (Number per 100,000 population)	165.1↓	5	167.6	4	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	58.1	7	58.1	7	65.0	12	—	—
ALL DETERMINANTS	19.4	1	17.2	1	13.9	2	4.8	19
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.1	14	2.9	9	3.1	21	—	—
Poor Physical Health Days (Days in previous 30 days)	3.1	9	3.1	10	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	5.2%	1	5.6%	1	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.8	12	5.3	7	5.8	9	9.2	14
Cardiovascular Deaths (Deaths per 100,000 population)	255.7↓	10	269.3	10	295.6	0	401.7	26
Cancer Deaths (Deaths per 100,000 population)	185.0	13	187.8	15	200.6	22	203.4	32
Premature Death (Years lost per 100,000 population)	5,905	4	5,535	2	6,258	5	7,842	18
ALL HEALTH OUTCOMES	5.4	6	4.4	6	3.7	7	3.8	16
OVERALL	24.8	1	21.7	1	19.0	4	8.6	16

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 20 Change: ▲ 2

Strengths:

- Low violent crime rate
- Ready access to primary care
- Strong per capita public health funding
- Low percentage of children in poverty

Challenges:

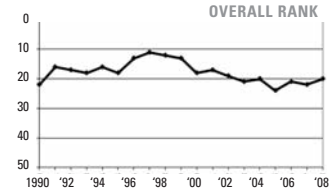
- High geographic disparity within the state
- Low immunization coverage

Significant Changes:

- In the past year, per capita public health funding increased by 6%
- In the past five years, the rate of uninsured population increased by 8%
- In the past five years, the percentage of children in poverty increased by 58%
- Since 1990, the prevalence of obesity increased by 156%

Ranking: Virginia is 20th this year; it was 22nd in 2007.

Strengths: Strengths include a low prevalence of smoking at 18.5 percent of the population, a low percentage of children in poverty at 13.3 percent of persons under age 18, ready access to primary care with 124.0 primary care physicians per 100,000 population, few poor mental health days per month at 3.0 days in the previous 30 days, strong public health funding at \$111 per person and a low violent crime rate at 270 offenses per 100,000 population. Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time as was the case this year.



Challenges: Challenges include a high rate of uninsured population at 14.1 percent, a high infant mortality rate at 7.0 deaths per 1,000 live births, high geographic disparity within the state at 15.5 percent, a high rate of deaths from cardiovascular disease at 291.0 deaths per 100,000 population and a high rate of cancer deaths at 198.0 deaths per 100,000 population.

Significant Changes:

- ▲ In the past year, the rate of uninsured population increased from 13.1 percent to 14.1 percent.
- ▲ In the past year, public health funding increased from \$104 to \$111 per person.
- ▲ In the past five years, the percentage of children in poverty increased from 8.4 percent to 13.3 percent of persons under age 18.
- ▲ Since 1990, the prevalence of obesity increased from 9.9 percent to 25.3 percent of the population.

Health Disparities: In Virginia, cardiovascular death rates vary by race, with all races experiencing 291.0 deaths per 100,000 population in contrast to blacks who experience 378.0 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 30.0 percent of Hispanics lack health insurance compared to 10.8 percent of non-Hispanic whites.

State Health Department Web Site: www.vdh.state.va.us

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	18.5	14	19.3	21	24.6	36	32.7	42
Prevalence of Binge Drinking (Percent of population)	14.7↑	17	12.8	11	15*	19	—	—
Prevalence of Obesity (Percent of population)	25.3	18	25.1	25	23.7	38	9.9	9
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	79.6	18	79.3	18	74.8*	15*	76.6*	24
Violent Crime (Offenses per 100,000 population)	270	11	282	17	291	15	295	17
Occupational Fatalities (Deaths per 100,000 workers)	5.5	22	6.1	25	4.9	18	10.6*	29
Infectious Disease (Cases per 100,000 population)	14.9↓	27	17.9	29	20.2	27	26.0	18
Children in Poverty (Percent of persons under age 18)	13.3	15	13.2	14	8.4	5	14.8	14
Air Pollution (Micrograms of fine particles per cubic meter)	13.2	28	13.4	34	13.9	31.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	14.1	29	13.1	22	11.3	21	11.5	24
Public Health Funding (Dollars per person)	\$111	9	\$104	9	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	79.6↓	30	81.5	21	72.0	38	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	74.9**	—	78.2	20	81*	13	73*	15
Primary Care Physicians (Number per 100,000 population)	124.0	13	123.7	12	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	70.2	21	70.2	21	74.4	23	—	—
ALL DETERMINANTS	7.9	14	5.3	21	7.7	13	5.1	18
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.0	8	3.2	18	3.6	40	—	—
Poor Physical Health Days (Days in previous 30 days)	3.2	12	3.2	14	3.6	40	—	—
Geographic Disparity (Relative standard deviation)	15.5	41	14.9	41	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.0	30	7.3	31	7.2	29	10.6	33
Cardiovascular Deaths (Deaths per 100,000 population)	291.0↓	27	301.9	28	334.6	0	413.2	30
Cancer Deaths (Deaths per 100,000 population)	198.0	29	199.9	27	207.3	28	207.2	38
Premature Death (Years lost per 100,000 population)	7,104	21	6,970	21	7,314	23	8,341	24
ALL HEALTH OUTCOMES	1.1	30	1.0	27	-0.1	30	1.2	22
OVERALL	9.0	20	6.3	22	6.9	21	6.3	22

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. **Data may not be comparable. **See measure description for full details.

Ranking: Washington is 10th this year; it was 12th in 2007.

Strengths: Strengths include a low prevalence of smoking at 16.8 percent of the population, a low percentage of children in poverty at 11.6 percent of persons under age 18, a low infant mortality rate at 4.8 deaths per 1,000 live births and a low rate of preventable hospitalizations with 51.9 discharges per 1,000 Medicare enrollees.

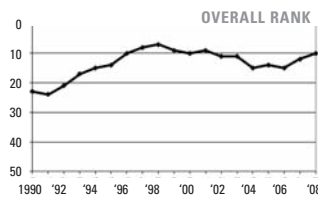
Challenges: Challenges include low immunization coverage with 73.9 percent of children ages 19 to 35 months receiving complete immunizations, a low high school graduation rate with 75.0 percent of incoming ninth graders who graduate within four years, many poor physical health days per month at 3.6 days in the previous 30 days and high geographic disparity within the state at 12.3 percent.

Significant Changes:

- ▲ In the past year, the percentage of children in poverty increased from 10.5 percent to 11.6 percent of persons under age 18.
- ▼ In the past year, the rate of uninsured population decreased from 12.5 percent to 11.6 percent.
- ▼ Since 1990, the infant mortality rate decreased from 9.7 to 4.8 deaths per 1,000 live births.
- ▲ Since 1990, the prevalence of obesity increased from 9.4 percent to 25.9 percent of the population.

Health Disparities: In Washington, low birth weight babies are more common among non-Hispanic blacks at 10.6 percent than Hispanics at 5.9 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 263.7 deaths per 100,000 population in contrast to blacks who experience 329.7 deaths per 100,000 population.

State Health Department Web Site: www.doh.wa.gov



Overall Rank: 10
Change: ▲ 2

Strengths:

- Low prevalence of smoking
- Low rate of preventable hospitalizations
- Low percentage of children in poverty

Challenges:

- Low immunization coverage
- Low high school graduation rate
- High geographic disparity within the state

Significant Changes:

- In the past year, the percentage of children in poverty increased by 11%
- In the past year, the rate of uninsured population decreased by 7%
- Since 1990, the infant mortality rate decreased by 51%
- Since 1990, the prevalence of obesity increased by 176%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	16.8	6	17.1	5	21.5	12	28.6	16
Prevalence of Binge Drinking (Percent of population)	15.0	20	14.0	19	15*	19	—	—
Prevalence of Obesity (Percent of population)	25.9†	23	24.2	20	21.3	22	9.4	5
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	75.0	32	74.6	30	65.9*	35*	78.1*	20
Violent Crime (Offenses per 100,000 population)	333	23	346	23	355	24	439	28
Occupational Fatalities (Deaths per 100,000 workers)	3.7	5	3.8	5	3.5	4	9.9*	28
Infectious Disease (Cases per 100,000 population)	12.4	24	13.3	22	18.6	21	84.1	47
Children in Poverty (Percent of persons under age 18)	11.6†	5	10.5	4	13.7	24	11.8	7
Air Pollution (Micrograms of fine particles per cubic meter)	10.4↓	18	10.8	20	11.7	20.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	11.6	16	12.5	19	13.5	30	10.4	19
Public Health Funding (Dollars per person)	\$92	17	\$98	10	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	73.9↓	48	78.6	37	69.2	42	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	53.1*	—	66.9*	35	72.93*	35	71.7*	21
Primary Care Physicians (Number per 100,000 population)	124.0	13	123.7	12	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	51.9	4	51.9	4	55.0	4	—	—
ALL DETERMINANTS								
	10.7	11	9.2	11	6.4	15	6.6	12
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.2	19	3.2	18	2.9	12	—	—
Poor Physical Health Days (Days in previous 30 days)	3.6	30	3.5	31	2.9	10	—	—
Geographic Disparity (Relative standard deviation)	12.3	30	12.2	32	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	4.8	1	5.3	7	5.5	5	9.7	22
Cardiovascular Deaths (Deaths per 100,000 population)	263.7	13	273.4	15	297.4	0	357.8	12
Cancer Deaths (Deaths per 100,000 population)	189.5	17	191.9	21	195.2	17	189.2	17
Premature Death (Years lost per 100,000 population)	6,131	7	6,168	10	6,283	7	7,725	16
ALL HEALTH OUTCOMES								
	4.2	10	3.0	12	3.5	9	-2.2	36
OVERALL								
	14.9	10	12.2	12	12.9	11	4.5	23

↓ and † indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 39 Change: ▲5

Strengths:

- Low prevalence of binge drinking
- Strong per capita public health funding
- Low violent crime rate

Challenges:

- High levels of air pollution
- High prevalence of obesity
- High rate of cancer deaths

Significant Changes:

- In the past year, the rate of uninsured population decreased by 9%
- In the past year, the percentage of children in poverty increased by 13%
- In the past year, the prevalence of smoking increased by 5%
- Since 1990, the violent crime rate increased by 99%

Ranking: West Virginia is 39th this year; it was 44th in 2007.

Strengths: Strengths include strong public health funding at \$121 per person, a low prevalence of binge drinking at 10.5 percent of the population, a low violent crime rate at 275 offenses per 100,000 population and a low incidence of infectious disease at 9.5 cases per 100,000 population. West Virginia ranks higher for health determinants than for health outcomes, indicating that overall healthiness should improve over time as was the case this year.

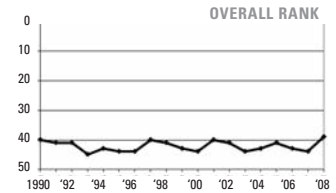
Challenges: Challenges include a high prevalence of smoking at 26.9 percent of the population, a high prevalence of obesity at 30.3 percent of the population, many poor mental and physical health days per month at 4.2 days and 5.1 days, respectively, in the previous 30 days, a high percentage of children in poverty at 24.0 percent of persons under age 18, high levels of air pollution at 15.5 micrograms of fine particulate per cubic meter and many preventable hospitalizations with 114.4 discharges per 1,000 Medicare enrollees.

Significant Changes:

- ▲ In the past year, the prevalence of smoking increased from 25.7 percent to 26.9 percent of the population.
- ▼ In the past year, the uninsured population decreased from 15.2 percent to 13.8 percent.
- ▲ In the past year, the percentage of children in poverty increased from 21.2 percent to 24.0 percent of persons under age 18.
- ▲ Since 1990, the violent crime rate increased from 138 to 275 offenses per 100,000 population.

Health Disparities: In West Virginia, cardiovascular death rates vary by race, with all races experiencing 353.5 deaths per 100,000 population in contrast to blacks who experience 389.6 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in the state; 36.6 percent of Hispanics lack health insurance compared to 21.0 percent of non-Hispanic whites.

State Health Department Web Site: www.wvdhhr.org



DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	26.9↑	49	25.7	49	28.4	48	34.0	45
Prevalence of Binge Drinking (Percent of population)	10.5	5	10.1	5	10.4*	4	—	—
Prevalence of Obesity (Percent of population)	30.3	46	31.0	49	27.5	50	15.0	49
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	77.3	25	76.9	25	73.4*	19*	77.1*	22
Violent Crime (Offenses per 100,000 population)	275	13	280	12	279	14	138	1
Occupational Fatalities (Deaths per 100,000 workers)	9.9↓	46	11.2	47	7.7	44	15*	45
Infectious Disease (Cases per 100,000 population)	9.5	15	10.5	16	10.7	12	14.5	7
Children in Poverty (Percent of persons under age 18)	24.0	48	21.2	44	22.2	43	27.8	47
Air Pollution (Micrograms of fine particles per cubic meter)	15.5	48	15.1	44	16.0	43.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	13.8↓	25	15.2	32	13.5	30	13.6	32
Public Health Funding (Dollars per person)	\$121	7	\$115	5	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	80.7↑	20	77.8	39	76.9	22	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	77.2%**	—	81.1	10	79.93*	15	62.1*	45
Primary Care Physicians (Number per 100,000 population)	106.2	31	104.9	34	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	114.4	49	114.4	49	120.3	50	—	—
ALL DETERMINANTS	-3.2	38	-5.6	38	-1.5	34	-3.9	40
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	4.2	50	4.4	47	4.3	49	—	—
Poor Physical Health Days (Days in previous 30 days)	5.1	49	5.2	49	5.2	49	—	—
Geographic Disparity (Relative standard deviation)	10.2%	21	9.2%	15	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	7.6	35	7.9	38	7.4	33	10.0	27
Cardiovascular Deaths (Deaths per 100,000 population)	353.5↓	46	365.7	46	398.3	0	456.5	49
Cancer Deaths (Deaths per 100,000 population)	219.8	48	220.2	48	224.8	46	204.8	37
Premature Death (Years lost per 100,000 population)	9,438	43	9,326	44	8,972	43	9,228	40
ALL HEALTH OUTCOMES	-1.9	46	-6.2	47	-5.3	45	-3.0	39
OVERALL	-5.0	39	-11.8	44	-11.3	44	-6.9	40

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: Wisconsin is 17th this year; it was 12th in 2007.

Strengths: Strengths include a high rate of high school graduation with 86.7 percent of incoming ninth graders who graduate within four years, a low occupational fatalities rate at 4.2 deaths per 100,000 workers, a low incidence of infectious disease at 5.7 cases per 100,000 population, few poor mental health days at 3.0 days in the previous 30 days and a low rate of uninsured population at 8.5 percent.

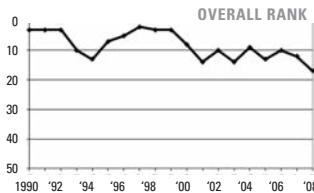
Challenges: Challenges include high geographic disparity within the state at 12.7 percent, a high prevalence of binge drinking at 23.8 percent of the population, a high prevalence of obesity at 25.3 percent of the population and low public health funding at \$34 per person.

Significant Changes:

- ▼ In the last year, the prevalence of smoking decreased from 20.8 percent to 19.6 percent of the population.
- ▲ In the past year, the levels of air pollution increased from 12.4 to 13.3 micrograms of fine particulate per cubic meter.
- ▲ In the past five years, the percentage of children in poverty increased from 12.0 percent to 15.7 percent of persons under age 18.
- ▲ Since 1990, the prevalence of obesity increased from 11.3 percent to 25.3 percent of the population.

Health Disparities: In Wisconsin, low birth weight babies are more common among non-Hispanic blacks at 13.6 percent than Hispanics at 6.3 percent. Cardiovascular death rates vary by race in the state, with all races experiencing 274.3 deaths per 100,000 population in contrast to blacks who experience 348.1 deaths per 100,000 population.

State Health Department Web Site: www.dhfs.state.wi.us



Overall Rank: 17
Change: ▼ 5

Strengths:

- High rate of high school graduation
- Low rate of uninsured population
- Low incidence of infectious disease

Challenges:

- High prevalence of binge drinking
- High geographic disparity within the state
- Low per capita public health funding

Significant Changes:

- In the past year, levels of air pollution increased by 7%
- In the past year, the prevalence of smoking decreased by 6%
- In the past five years, the percentage of children in poverty increased by 31%
- Since 1990, the prevalence of obesity increased by 124%

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	19.6↓	24	20.8	28	23.3	28	26.3	6
Prevalence of Binge Drinking (Percent of population)	23.8	49	23.2	50	25.3*	49	—	—
Prevalence of Obesity (Percent of population)	25.3↓	18	26.6	34	21.6	23	11.3	21
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	86.7	2	85.8	4	78.2*	7*	83.7*	9
Violent Crime (Offenses per 100,000 population)	291	17	284	19	231	6	250	11
Occupational Fatalities (Deaths per 100,000 workers)	4.2	8	3.8	5	4.6	15	7.8*	14
Infectious Disease (Cases per 100,000 population)	5.7	7	6.1	6	8.3	9	14.1	6
Children in Poverty (Percent of persons under age 18)	15.7	25	15.5	25	12.0	16	12.6	9
Air Pollution (Micrograms of fine particles per cubic meter)	13.3↑	31	12.4	25	12.4	25.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	8.5	3	9.1	3	8.4	3	8.3	6
Public Health Funding (Dollars per person)	\$34	49	\$31	50	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	79.4↓	31	86.8	2	80.3	10	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	77**	—	77.4	24	77.59*	21	78.6*	4
Primary Care Physicians (Number per 100,000 population)	119.5	19	118.7	19	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	63.8	11	63.8	11	63.8	9	—	—
ALL DETERMINANTS								
	7.5	17	9.4	10	10.7	6	10.6	2
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.0	8	3.0	13	3.1	21	—	—
Poor Physical Health Days (Days in previous 30 days)	3.4	18	3.2	14	3.2	20	—	—
Geographic Disparity (Relative standard deviation)	12.7↑	33	10.4	24	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	6.5	24	6.2	19	6.8	23	8.9	8
Cardiovascular Deaths (Deaths per 100,000 population)	274.3	22	285.0	22	319.2	0	389.2	23
Cancer Deaths (Deaths per 100,000 population)	192.2	23	192.7	22	342.2	49	187.3	16
Premature Death (Years lost per 100,000 population)	6,496↑	18	6,192	11	6,575	17	7,143	7
ALL HEALTH OUTCOMES								
	2.8	20	2.9	13	1.9	19	7.8	4
OVERALL								
	10.3	17	12.2	12	11.7	14	18.4	3

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Overall Rank: 14 Change: ▲5

Strengths:

- Strong per capita public health funding
- Low incidence of infectious disease
- Low violent crime rate
- Low infant mortality rate

Challenges:

- Low immunization coverage
- High prevalence of smoking
- High prevalence of binge drinking

Significant Changes:

- In the past year, per capita public health funding declined by 10%
- In the past year, the incidence of infectious disease decreased by 46%
- Since 1990, the prevalence of smoking declined by 30%
- Since 1990, the infant mortality rate decreased by 50%

Ranking: Wyoming is 14th this year; it was 19th in 2007.

Strengths: Strengths include low levels of air pollution at 6.1 micrograms of fine particulate per cubic meter, a low violent crime rate at 239 offenses per 100,000 population, strong public health funding at \$121 per person, a low incidence of infectious disease at 2.5 cases per 100,000 population and a low infant mortality rate at 5.1 deaths per 1,000 live births.

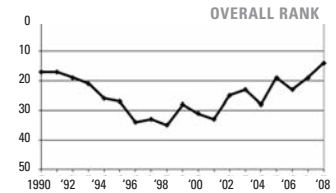
Challenges: Challenges include a high occupational fatalities rate at 14.3 deaths per 100,000 workers, limited access to primary care with 90.1 primary care physicians per 100,000 population, a high prevalence of smoking at 22.1 percent of the population and a high prevalence of binge drinking at 16.7 percent of the population.

Significant Changes:

- ▼ In the past year, public health funding declined from \$135 to \$121 per person.
- ▼ In the past year, the incidence of infectious disease decreased from 4.6 to 2.5 cases per 100,000 population.
- ▼ Since 1990, the prevalence of smoking declined from 31.7 percent to 22.1 percent of the population.
- ▼ Since 1990, the infant mortality rate decreased from 10.1 to 5.1 deaths per 1,000 live births.

Health Disparities: In Wyoming, cardiovascular death rates vary by race, with all races experiencing 262.5 deaths per 100,000 population in contrast to blacks who experience 440.7 deaths per 100,000 population. Access to health care varies significantly by race and ethnicity in Wyoming; 27.6 percent of Hispanics lack health insurance compared to 19.7 percent of non-Hispanic whites.

State Health Department Web Site: wdh.state.wy.us



Wyoming

DETERMINANTS	2008		2007		2003		1990	
	VALUE	RANK	VALUE	RANK	VALUE	RANK	VALUE	RANK
PERSONAL BEHAVIORS								
Prevalence of Smoking (Percent of population)	22.1	37	21.6	33	23.7	31	31.7	37
Prevalence of Binge Drinking (Percent of population)	16.7↑	35	15.5	30	17.1*	38	—	—
Prevalence of Obesity (Percent of population)	24.5↑	12	23.3	16	19.5	14	13.7	45
COMMUNITY & ENVIRONMENT								
High School Graduation (Percent of incoming ninth graders)	76.7	27	76.0	28	72.9*	22*	79.6*	15
Violent Crime (Offenses per 100,000 population)	239	8	240	8	257	11	283	15
Occupational Fatalities (Deaths per 100,000 workers)	14.3↓	46	16.4	47	9.7	46	37.9*	48
Infectious Disease (Cases per 100,000 population)	2.5↓	1	4.6	2	5.8	3	10.4	2
Children in Poverty (Percent of persons under age 18)	12.7↓	12	14.0	20	10.7	12	14.4	12
Air Pollution (Micrograms of fine particles per cubic meter)	6.1	2	6.3	1	7.4	1.0	—	—
PUBLIC & HEALTH POLICIES								
Lack of Health Insurance (Percent without health insurance)	14.0	27	14.6	28	15.9	38	14.0	33
Public Health Funding (Dollars per person)	\$121↓	6	\$135	3	—	—	—	—
Immunization Coverage (Percent of children ages 19 to 35 months)	76.8	43	75.4	44	73.3	34	—	—
CLINICAL CARE								
Adequacy of Prenatal Care (Percent of pregnant women)	66.8**	—	70.4	35	70.14*	41	72.2*	17
Primary Care Physicians (Number per 100,000 population)	90.1	44	91.4	44	—	—	—	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	69.7	19	69.7	19	70.7	19	—	—
ALL DETERMINANTS	7.3	19	6.6	17	3.2	26	2.9	26
HEALTH OUTCOMES								
Poor Mental Health Days (Days in previous 30 days)	3.1	14	3.2	18	3.0	17	—	—
Poor Physical Health Days (Days in previous 30 days)	3.2	12	3.2	14	2.9	10	—	—
Geographic Disparity (Relative standard deviation)	7.5	1	8.2	9	—	—	—	—
Infant Mortality (Deaths per 1,000 live births)	5.1	4	5.9	13	6.3	15	10.1	29
Cardiovascular Deaths (Deaths per 100,000 population)	262.5	12	272.4	12	342.2	0	348.6	6
Cancer Deaths (Deaths per 100,000 population)	183.4	12	183.8	9	339.9	49	168.3	5
Premature Death (Years lost per 100,000 population)	7,839	31	7,587	29	7,395	25	7,289	9
ALL HEALTH OUTCOMES	4.5	8	2.0	20	1.6	20	5.4	12
OVERALL	11.8	14	8.6	19	5.2	23	8.3	17

↓ and ↑ indicate major increases and decreases in the last year. — indicates data not available. *Data may not be comparable. **See measure description for full details.

Ranking: The District of Columbia is not included in the ranking of states, as it is a unique governmental entity and is considerably more urban than the states.

Strengths: Strengths include high immunization coverage with 82.8 percent of children ages 19 to 35 months receiving complete immunizations, a low prevalence of obesity at 22.2 percent of the population and a low prevalence of smoking at 17.9 percent of the population.

Challenges: Challenges include a high violent crime rate at 1,414 offenses per 100,000 population, a high premature death rate with 12,175 years of potential life lost before age 75 per 100,000 population and a high percentage of children in poverty at 29.2 percent of persons under age 18.

Significant Changes:

- ▼ In the past year, the percentage of children in poverty decreased from 31.8 percent to 29.2 percent of persons under age 18.
- ▼ In the past year, the rate of uninsured population decreased from 12.4 percent to 10.5 percent.
- ▼ In the past five years, the levels of air pollution decreased from 17.4 to 14.8 micrograms of fine particulate per cubic meter.
- ▼ In the past five years, the violent crime rate decreased from 1,737 to 1,414 offenses per 100,000 population.

State Health Department Web Site: www.dchealth.dc.gov

Overall Rank: District is not ranked.

Strengths:

- Low rate of cancer deaths
- Low prevalence of smoking
- High immunization coverage

Challenges:

- High violent crime rate
- High percentage of children in poverty
- High premature death rate

Significant Changes:

- In the past year, the percentage of children in poverty decreased by 8%
- In the past year, the rate of uninsured population decreased by 15%
- In the past five years, the levels of air pollution decreased by 15%
- In the past five years, the violent crime rate decreased by 19%

	2008	2007	2003
	VALUE	VALUE	VALUE
DETERMINANTS			
PERSONAL BEHAVIORS			
Prevalence of Smoking (Percent of population)	17.9	17.9	20.4
Prevalence of Binge Drinking (Percent of population)	16.0	16.3	15.9*
Prevalence of Obesity (Percent of population)	22.2	22.5	20.7
COMMUNITY & ENVIRONMENT			
High School Graduation (Percent of incoming ninth graders)	68.8	68.2	57.2*
Violent Crime (Offenses per 100,000 population)	1,414↓	1,508	1,737
Infectious Disease (Cases per 100,000 population)	141.2↓	160.5	50.5
Children in Poverty (Percent of persons under age 18)	29.2↓	31.8	30.8
Air Pollution (Micrograms of fine particles per cubic meter)	14.8	15.0	17.4
PUBLIC & HEALTH POLICIES			
Lack of Health Insurance (Percent without health insurance)	10.5↓	12.4	12.3
Immunization Coverage (Percent of children ages 19 to 35 months)	82.8	82.7	—
CLINICAL CARE			
Adequacy of Prenatal Care (Percent of pregnant women)	55.4**	61.3	64.8*
Primary Care Physicians (Number per 100,000 population)	325.0	320.2	—
Preventable Hospitalizations (Number per 1,000 Medicare enrollees)	65.6	65.6	69.3
HEALTH OUTCOMES			
Poor Mental Health Days (Days in previous 30 days)	3.0	3.1	—
Poor Physical Health Days (Days in previous 30 days)	3.0	2.8	3.0
Infant Mortality (Deaths per 1,000 live births)	21.3↑	18.7	11.3
Cardiovascular Deaths (Deaths per 100,000 population)	334.8	343.9	372.9
Cancer Deaths (Deaths per 100,000 population)	202.0	211.6	241.2
Premature Death (Years lost per 100,000 population)	12,175↓	12,582	13,366

All supporting tables for this report can be found at www.americashealthrankings.org/2008/tables.htm. Several key supporting tables follow.

Index of Supporting Tables

NUMBER	DESCRIPTION	WEB LINK
1	Overall Rankings - 2008	www.americashealthrankings.org/2008/results.html
2	Determinants and Health Outcomes	www.americashealthrankings.org/2008/dando.html
3	Uninsured Rates by Race/Ethnicity and by Gender – United States	www.americashealthrankings.org/2008/disparity.html
4	Low Birth Weight by Race/Ethnicity – United States	www.americashealthrankings.org/2008/disparity.html
5	Cardiovascular Death Rate by Race – United States	www.americashealthrankings.org/2008/disparity.html
6	International Comparisons	www.americashealthrankings.org/2008/othernations.html
7	National Measures of Successes and Challenges: Long Term	www.americashealthrankings.org/2008/1990nat.html
8	States with Greatest Overall Health Score Improvement: 1990 to 2008	www.americashealthrankings.org/2008/1990state.html
9	States with Least Overall Health Score Improvement: 1990 to 2008	www.americashealthrankings.org/2008/1990state.html
10	National Measures of Successes and Challenges: 2007 to 2008	www.americashealthrankings.org/2008/2007nat.html
11	States with Greatest Overall Health Score Improvement: 2007 to 2008	www.americashealthrankings.org/2008/2007state.html
12	States with Least Overall Health Score Improvement: 2007 to 2008	www.americashealthrankings.org/2008/2007state.html
13	Summary Description of Measures	www.americashealthrankings.org/2008/seldes.html
14	Body Mass Index – Definition	www.americashealthrankings.org/2008/determinants.html
15	Immunization Coverage - Definition	www.americashealthrankings.org/2008/determinants.html
16	Geographic Disparity - Examples	www.americashealthrankings.org/2008/outcomes.html
17	Weight of Individual Measures	www.americashealthrankings.org/2008/weight.html

WEB ONLY TABLES

Comparison of Ranks and Scores – 2008 and 1990	www.americashealthrankings.org/2008/changes-1990.html
Comparison of Ranks and Scores – 2008 and 2007	www.americashealthrankings.org/2008/changes-2007.html
Cardiovascular Deaths by Race	www.americashealthrankings.org/2008/disparity-cvd.html
Low Birth Weight Infants by Race/Ethnicity of Mother	www.americashealthrankings.org/2008/disparity-lbw.html
Lack of Health Insurance by Race/Ethnicity and Gender	www.americashealthrankings.org/2008/disparity-insurance.html
Prevalence of Smoking	www.americashealthrankings.org/2008/smoking.html
Prevalence of Binge Drinking	www.americashealthrankings.org/2008/binge.html
Prevalence of Obesity	www.americashealthrankings.org/2008/obesity.html
High School Graduation	www.americashealthrankings.org/2008/graduation.html
Violent Crime	www.americashealthrankings.org/2008/crime.html
Occupational Fatalities	www.americashealthrankings.org/2008/occupational.html
Children in Poverty	www.americashealthrankings.org/2008/poverty.html
Infectious Disease	www.americashealthrankings.org/2008/disease.html
Air Pollution	www.americashealthrankings.org/2008/air.html
Lack of Health Insurance	www.americashealthrankings.org/2008/insurance.html
Public Health Funding	www.americashealthrankings.org/2008/funding.html
Immunization Coverage	www.americashealthrankings.org/2008/immunization.html
Adequacy of Prenatal Care	www.americashealthrankings.org/2008/prenatal.html
Primary Care Physicians	www.americashealthrankings.org/2008/pcp.html
Preventable Hospitalizations	www.americashealthrankings.org/2008/hospitalizations.html
Poor Mental Health Days	www.americashealthrankings.org/2008/mental.html
Poor Physical Health Days	www.americashealthrankings.org/2008/physical.html
Geographic Disparity	www.americashealthrankings.org/2008/geographic.html
Infant Mortality	www.americashealthrankings.org/2008/imr.html
Cardiovascular Deaths	www.americashealthrankings.org/2008/cvd.html
Cancer Deaths	www.americashealthrankings.org/2008/cancer.html
Premature Death	www.americashealthrankings.org/2008/ypll.html

FIGURE DESCRIPTION

1	Components of Health	www.americashealthrankings.org/2008/overview.html
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GRAPH DESCRIPTION

WEB LINK

1	Geographic Disparity for the United States	www.americashealthrankings.org/2008/disparity.html
2	Improvements Since 1990	www.americashealthrankings.org/2008/1990nat.html
3	Prevalence of Smoking Since 1990	www.americashealthrankings.org/2008/1990nat.html
4	Prevalence of Obesity Since 1990	www.americashealthrankings.org/2008/1990nat.html
5	Lack of Health Insurance Since 2002	www.americashealthrankings.org/2008/1990nat.html

Building the Healthiest Nation in One Generation

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Executive Director
American Public Health Association



American
Public Health
Association

Considering our substantial financial investment in health, one might assume that the United States is among the healthiest nations. Reality, however, is far different. Despite spending more on health care than any other nation — more than \$2 trillion a year — Americans are not as healthy as they can or should be. Compared to other developed nations, the people in the United States experience much higher rates of infant mortality, obesity and HIV/AIDS and have a shorter life expectancy. Even within our nation, broad disparities exist when comparing people in different localities, and with different ethnicities and socio-economic status. Our progress has stalled, and we have reached a point where we must examine our health system and the foundation upon which it stands.

Other nations have succeeded in creating health systems that result in better health outcomes for their citizens. The time has come for the United States to not only follow their lead, but to make strides to regain our leadership role. *America's Health Rankings*[™] and the data contained within is a great start. It shows us the areas that need improvement and lays the foundation for the work that needs to be done. However, this report has been produced annually for almost two decades and, although we've made progress, we have neither succeeded in changing our system nor found a way to direct our resources to where they are most needed. Our nation has lacked the national leadership and the political will to take the steps necessary to turn it around.

Now, the time has come to take action. For the first time, Americans are united in their sentiment that our current health care system is failing. Millions lack health care coverage, and those who are insured fear that their coverage will not be adequate should a health emergency arise. Additionally, along with changing public sentiment, our leaders have come to the conclusion that something must be done.

We have the potential to greatly improve our population's health in the future, but changing our health system will require innovation. The old way of doing things hasn't worked, and we must find models that produce better outcomes. To this end, the most important form of innovation we need is strong, national leadership on this crucial issue. From the top down, we need to make a national commitment to the goal of building the healthiest nation in one generation. Our aspiration should be to focus on giving kids a healthy start in life and doing whatever it takes to support their health throughout the lifespan.

With a national commitment, adequate investment and coordination across the public and private sectors, we can reach this goal by focusing on the four components of health addressed in this report.

Personal Behaviors

At the root of healthiness is personal behavior. If individuals were to adopt simple behaviors — not using tobacco, being physically active and eating healthy — millions of lives could be saved. That is because 70 percent of the deaths in our nation each year are the result of chronic diseases — like heart disease, cancer and diabetes — which are largely preventable. Furthermore, even more lives can be saved when you add in behaviors like drinking alcohol in moderation, not using drugs, wearing seatbelts and helmets, and using condoms.

A healthy population will not occur without individuals taking responsibility for their behaviors and their health. As our leaders look for ways to improve the health system, they must invest in the evidence-based programs and promising best practices that are able to educate and provide people with the skills and motivation to adopt healthy behaviors. Investing in healthy behaviors is an investment in prevention, and an investment in prevention is a sound investment. For each dollar spent on prevention, we save several more down the road when we don't have to treat an individual's chronic condition.

By the time they reach early adulthood, a large proportion of American youth have begun the poor practices contributing to the three leading causes of preventable death in the United States: smoking, overweight and obesity and alcohol abuse. As we strive for building the healthiest nation in one generation, it's essential that we invest in our youth and start teaching them the importance of healthy behaviors early on. If we can successfully raise a generation of healthy children and adolescents, we have a much better chance of keeping them healthy as they move through their adult years.

Community and Environment

Individuals do not exist in a bubble, isolated from the external world. In order for people to make healthy choices, they need a community environment that supports a healthy lifestyle. Therefore, along with investing in programs to help individuals adopt healthy behaviors and quit unhealthy habits, a successful health system must recognize and address the fact that where people live and the world to which they are exposed affects their health and well-being.

As a result of this growing recognition of the relationship between our environment and healthy behaviors, communities around the nation have been adopting new strategies to support healthy choices. Schools have begun ensuring that students are served nutritious lunches in order to support them in eating healthy, businesses have begun providing tobacco-cessation counseling to help employees quit smoking, and developers are more frequently building

mixed-use communities where people can walk or bike to run errands and incorporate physical activity into their day. And these are just a few of the innovative strategies taking place.

As we seek ways to reform our health system, it is essential that we support these types of activities as a national priority. Doing so allows all sectors to take responsibility for the role they play in the health of their community. Our leaders should support efforts that focus on work sites, schools, neighborhoods, faith organizations and transportation, places where people spend most of their time. Doing so will go a long way to providing support for the many people that are trying to live healthier.

Public and Health Policy

Along with addressing personal choices and community environment, public policy also has a role to play in health. As we seek to revitalize our health system to one with the potential of producing the healthiest nation in one generation, this component cannot be overlooked.

The most obvious strategy is to use policy as a tool to support healthy behavior. We need only to look to the successes of the past — seatbelt laws, smoking restrictions and mandatory vaccinations — to think of ways that policy can help us address the issues of today.

However, there are applications for legislation beyond those focused explicitly on health. Our goal should be to reach a place in our society where health is a factor in *all* policies. When a new transportation bill is being debated on the floors of Congress, our leaders should be asking whether the bill provides funding for bikeways and public transit. When agricultural policies are being considered, we need to ensure that fresh fruits and vegetables are provided in our nation's schools and at markets in underserved communities. When a community considers the impact of a new development, sidewalks and access to health providers should be assured.

Additionally, we cannot overlook the potential role that policy will play in changing our nation's health system. Interest in health system reform is at an all-time high and real attention is being given to how we can cover the more than 45 million people in our nation who are uninsured. It will be up to our legislators to listen to the will of the people and determine how we address this critical issue. With strong national leadership we stand at the precipice of change and have the potential to move in the right direction. Without that leadership, progress will certainly stall, and we will slip back down the hill to where the status quo continues its reign.

Clinical Care

The final component of health that is central to a properly functioning health system is clinical care. This includes all the services we receive at our doctor's offices, clinics and hospitals. It is the area that people usually think of when they think about health, and it is also where most of our health dollars are currently directed. However, by investing resources into the other components of health, we can turn our attention to reforming our nation's clinical care system.

Most people involved in health reform would likely agree that our clinical care system is struggling. Millions of people have no access to receiving the care the system provides, costs for providers are skyrocketing, and something must be done. As our leaders commit themselves to turning around the health of our nation, at the heart of what they must do is to find a strategy for creating a quality clinical care system that is affordable and accessible. Many proposals were presented during this presidential election cycle and the new administration must move towards implementing its plan.

And simultaneously, as changes are implemented to cover the uninsured and improve access for all, leaders must also seek to change the clinical care system from one in which the emphasis is placed on treatment to one in which it is placed on prevention. Along with the components previously discussed, our clinical care system has a role to play in drastically reducing preventable death. By reducing chronic disease through clinical counseling, screening and other forms of preventative care, our nation has the potential to save millions that would traditionally be spent to treat these patients.

A Call to Action, A Call for Leadership

The steps before us provide a blueprint for action through innovation and change. With the guiding hand of a national leader committed to reforming our health system into one in which the emphasis moves from treatment to prevention, we can direct our resources to supporting the four components that must be addressed in order to improve health. This calls for an investment in programs to support personal behaviors, in strategies to make community environments more conducive to healthy choices, in policies that reflect our health priorities, and in a refocused clinical care system. With these changes as the foundation for our nation's health system, we will improve the health of our nation and cut health care costs at the same time.

Just as we once aspired to be the first nation to land on the moon and directed all the required resources to that goal, so now must we commit ourselves to the national goal of building the healthiest nation in one generation. It will not be easy and it will require sacrifice, compromise and dedication, but the end result will be worth all the effort.

Evaluate America's Health Status

Corinne Husten, M.D., M.P.H.
Interim President
Partnership for Prevention®



The health status of Americans has stagnated. *America's Health Rankings™* shows that after steady improvement from 1990-2000 the health of the American people has leveled off, despite an increase in health care spending and major advances in medical technology.

One reason for this situation is that our health care system is heavily tilted toward *sick care* at the expense of *well care* or keeping people healthy. About 95 cents of every dollar spent in the U.S. on health goes to diagnose or treat disease after it occurs, leaving less than 5 cents on the dollar to prevent disease.

Americans know we must fix our high cost, low yield health system, and they are demanding action. On the eve of the 2008 elections, likely voters said "health care" was the most important issue after the economy.

While the nation looks to the new Administration and Congress to take up health reform, many states are already far ahead. Policymakers in Washington would do well to study and follow the examples of states in this report that are leading the way in increasing access to quality, affordable health care, raising the priority on prevention, incentivizing employers to invest in workforce health, and implementing policies that are proven to improve health.

Real health reform begins with prevention.

It's not enough to just increase access to medical care. As *America's Health Rankings™* points out, health outcomes are the result of multiple factors that are intertwined, including personal behaviors, public and health policy, community and environment, and clinical care. Real reform will address all of those factors.

The meltdown and massive resource commitment to bail out the financial sector combined with the recession has increased pressure to address rising health care costs. This can't be done successfully without addressing the cost drivers which are the same factors that drive poor health. Examples include tobacco use, poor nutrition and physical inactivity.

A bipartisan group of experts convened by Partnership for Prevention developed the framework for health reform outlined below. Following these Principles for Prevention-Centered Health Reform will push health spending upstream to invest in policies, program and care aimed at keeping people healthy.

First Principle: High value clinical preventive services should be a basic benefit of health financing reform.

That means high-quality affordable health care, including high-value preventive services such as screening tests, immunizations, counseling, should be available to everybody. Financial incentives should be put in place to encourage

patients to use preventive services, for doctors and other providers to offer them and for employers to become actively involved in promoting their employees' health.

A 2007 report from the National Commission on Prevention Priorities found that if the U.S. increased the use of just five high value preventive services, it would prevent over 100,000 deaths per year. The report was based on a study by Partnership for Prevention and HealthPartners Research Foundation.

Second Principle: Community preventive services should be an integral part of health reform.

As a country we need to invest in healthy environments and healthy lifestyles. We need to create incentives for public health departments, schools, parks, recreation departments, and nonprofit organizations to offer prevention programs and services and to help implement focused public education and promotion campaigns. Health effects should be factored into all our decision-making, including urban planning, land use, zoning, transportation, and agriculture. The goal should be not only to foster healthy habits but to make the healthy choice the easy choice for all Americans.

Sound regulatory strategies are also needed; one example is the momentum building for smoking bans in public places. These state and local policies have a very high, positive impact on health at very little cost.

Third Principle: Health reforms should be designed to increase the impact of prevention.

Clinical and community-based prevention reinforce each other. When we link clinical services delivered through traditional settings to community services delivered through our public health system and non-traditional settings, we can make real progress, as we have done historically with such health threats as smallpox, infectious diseases, unsanitary water and waste disposal. We need a new push now, at the federal level, to increase research funding on the effectiveness and cost-effectiveness of both community-based and clinical prevention and to develop performance standards to measure our progress. This research will help states and communities to set public health performance standards, hold agencies accountable for meeting them, and identify policies and practices proven to be effective.

These Principles for Prevention-Centered Health Reform and policy recommendations are available at www.prevent.org. Review them, share them with colleagues and other opinion leaders and use them to help your state accelerate the pace of health reform and achieve real health improvement.

Innovation in Health Care – An Employer’s Perspective

Martin Sepulveda, M.D., F.A.C.P.
Vice President for Integrated Health Services
IBM Corporation



A healthy workforce is vital for maximum innovation, productivity and client service — this is the fundamental belief of IBM, and why we embrace our role in health care.

Six years ago, faced with the same rapidly escalating health care costs as the rest of the country, IBM re-evaluated our employee health and well-being programs. The result was a strategic vision for our health benefits that put added emphasis on preventive and primary care, clinical care and coordination of services, and incentivizing healthy behaviors. Executing on the vision required broad reaching changes to policies, programs and the work environments of our global employees.

In health care, this meant presenting clinically meaningful and differentiated benefit choices that provided a viable, affordable, and effective path to better health for employees, while decreasing the impact of health care spending both to our employees and to our bottom line.

Fast forward six years and, by all standards, we have achieved enormous success in our health benefits program.

- IBM employees have health care options that have no premium, as well as free preventative services and first dollar coverage for primary care.
- Our employee smoking rate is in the single digits compared with the 19.8 percent national average found in the 2008 *America’s Health Rankings*[™].
- Our employees receive well-being incentives for healthy behaviors, such as childhood weight and nutrition, smoking cessation, physical activity and adult nutrition, and preventative health care.
- IBM has controlled health care cost trends better than employers of comparable size with rates in the single digits compared with 12 percent to 15 percent for other companies.
- IBM employees have become more educated and efficient health care consumers, shifting from excessive high cost coverage to more affordable plans that are appropriate for their needs.

When accounting for the entire suite of changes made in health care, work safety, and employee program improvements, IBM has saved more than \$1 billion.

Some of the changes we have undertaken have yet to be fully realized. For example, high-performing primary care and medical efficiencies are imperative for our employees to receive excellent comprehensive and coordinated care and treatment as well as curbing costs. We believe strongly in

delivery system transformation through the patient-centered medical home and are participating in several projects including a pilot program with UnitedHealthcare to advance this concept in the Southwest.

A medical home is a whole person and not disease or organ approach to health care. The concept is built on strong patient-physician or care provider relationships with personalized care and decision-making by patients in partnership with their physician across the entire spectrum of health needs. The benefits are wide-reaching including a safer, better coordinated, higher quality, and healthier more satisfying patient experience. In addition, as a result of better coordination, there is the potential for savings to patients and the employer. For example, a medical home can result in fewer emergency room visits, the elimination of redundant tests, better prescription drug elections and adherence, and fewer avoidable hospital admissions because your care team is available to you when you need it.

This pilot program will launch in January 2009 and be monitored over three years. The patient-centered medical home model, we believe, is the future of better health from every dollar spent in health care and where personalized medicine should be rooted. We hope this pilot demonstrates a physician-driven approach to comprehensive primary care that can scale and accelerate wider adoption of the medical home to achieve improved care and significant savings for patients, employers, and the national health care system.

I often get asked, so what’s next?

IBM is continuing to transform our health care approach. We constantly evaluate our plan’s performance in meeting the needs of our employees and IBM on access, quality and affordability. We identify new incentives and well-being programs to respond to the changing needs of our population and their families. We continue to work with the industry and government to realize the potential of an electronically connected, patient-centered medical home. And today, we also are turning our attention to another area that has significant implications for employee health and IBM’s bottom line — applied invention, aka innovation.

Scientific discovery and invention are one of the greatest assets of the U.S. health care system, but they also present the greatest opportunity for improvement. The United States invests heavily in research to unravel human biology and in so doing to find new diagnostics, treatments and better ways to practice medicine; however, there is almost no investment in translating the innovations into everyday practice. Research, discovery and testing are happening in medical

colleges, universities and academic medical centers all over the United States. Yet, those settings provide a very small portion of health care. The result is the discoveries are slow to reach most Americans who receive their care in physician and other provider offices in the community, along with community hospitals and other facilities. With the exception of new blockbuster drugs and diagnostics that are heavily marketed by commercial companies, it takes on average of 10 to 25 years for a new discovery, tested and proven to work well in academic medical centers, to be commonly applied in the normal, community practice of medicine.

IBM is about innovation that matters to our clients. Every day that one of our new services or products sits in a virtual warehouse unused is a day that it is not being used by our customers to grow their business and, therefore, is an invention not adopted and not an innovation which helps us all succeed. Imagine if IBM created wonderfully new and effective solutions that were only used by employees and their friends and family but not shared with the rest of the world. It is nonsensical, and we would not be in business very long.

Yet, this is what is happening with proven new inventions in health care diagnostics, treatments and services. Unlike IBM, however, where a delay in adoption means a delay in profit for both clients and IBM, in medicine, a delay in translation results in needless suffering, needless complications and needless waste.

In our country, no one is directly responsible for the practice of translational medicine from the academic center to the patient and physician in the community—the practice of diffusing effective new modalities and medical process to the non-academic world where you and I and most everyone else receives care. The biomedical research innovators are not responsible — nor why should they be? Their work is exacting enough, and beyond the peer-reviewed journal and academic appointment, there is no recognition or incentive to push adoption, nor do they likely have the means, relevant skills and experience.

Proving something works in the complex world of office practice and individual people with personal beliefs, cultures, social networks and economics is very different than in a clinical trial where everything is artificially controlled. There are people who do effectiveness research in this real world environment and know how best to facilitate adoption. But

these applied and community practice researchers are hardly supported and operate on token funding. Additionally, health care financing systems are slow to adapt reimbursement that are not widely utilized for effective new modalities, and financial and other barriers to the acquisition of health information technology make it impossible for most doctors to have the new insights at their fingertips at the point of care.

A good illustration of the importance and opportunity of translational medicine in the community is the emerging field of personalized medicine — the practice in medicine of using genetic and non-genetic molecular information to make more precise decisions about care for individual patients. I foresee the explosion of applications for personalized medicine during the next five years of medical discovery but, in the absence of community-based translational medicine, it may be 20 to 25 years before most patients benefit.

The development of targeted therapies for unique forms of breast cancer is an example of the profound impact a genetic biomarker test can have on medicine. When commercial interest is not pushing the discovery, however, there is a much slower adoption rate. For example, there is now a genetic profile test that can predict with high levels of accuracy the appropriate patient dosing level of the commonly used blood thinner, Warfarin (brand name Coumadin). Used, for instance, to prevent clotting that can cause strokes or blockages of blood vessels in the lungs and legs, six to nine million people are on Warfarin in any given year, including 600,000 new patients every year.

Finding the right dosing level of Warfarin is a long, trial and error endeavor where the risks are high. Too little could lead to the formation of a clot and cause a stroke, too much could lead to hemorrhage, including life threatening bleeding. One fourth of new Warfarin users have complications of bleeding with more than three percent of those patients having major hemorrhages requiring surgeries and emergency blood transfusions.

With a couple of gene typing tests and a free algorithmic based module from Washington University, doctors could largely predict what Warfarin dosage is right for their patient. A Food and Drug Administration (FDA) study found that this technology, if used on all prescribed Warfarin patients, would result in 85,000 fewer cases of major hemorrhage and 17,000 fewer cases of strokes.

We at IBM are committed to exploring the application of personalized medicine proven to be effective, such as the Warfarin biomarker test, for our employees. We are also highlighting the need for a U.S. system realignment to focus more on translational medicine in the community setting. This is why IBM has collaborated in a major project that makes gene typing for Warfarin available to new IBM users at no cost.

If the United States re-allocated half of the money currently spent on new biomedical discoveries and aggressively applied the proven diagnostics and therapeutics and behavior interventions we currently have, we would be the healthiest and most cost-efficient country in the world by far. I certainly am not a proponent for halting research, but the opportunity for improvement in community-focused translational medicine is mammoth and requires a reprioritization of our public resources. We must invest equally in proving discovery is better than what we have now AND community-oriented translational medicine to bring balance to the two clinical domains. The domain of academic medical centers where discovery is translated into diagnostics, devices and treatments that are studied and tested in humans, and the domain where medicine is largely practiced — outside academic medical centers. Without major investment in the latter, our health won't improve and we will remain number 35 or so in world population health rankings with a system on the verge of collapse.

A word of caution about personalized medicine that actually applies to all evidence-based medical practice — do not be too prescriptive in applying new information, therapies and tests. Medicine is not a cookbook recipe applied indiscriminately. It is using the best available and relevant scientific information for decision-making by individual patients and care providers. This means that the clinical expertise of the care provider and the unique predicament and preferences of the individual patient are just as important. Decision-making in this informed patient-care provider relationship should be the ultimate determinant of what course of action is best for a given individual. That is why a patient-centered medical home, including electronic medical records with clinical decision support, is an urgent priority to get the right health outcome. A health system that preserves the integrity and informed decision-making of the care provider and the physician/patient relationship is a far superior model for appropriately applying the best medical

evidence and effective new approaches to the care of individual people.

The health care system should never let the process metrics be more powerful than the outcome metrics. Existing traditional medical and financing systems of health care will never be able to adapt as fast as research and information are changing. Best practice cannot be the end game. The end game must be improved health outcomes. Although outcome measures are not always available, public and private employer purchasers should not be too rigid in incenting process measures and penalizing deviations. Process measures used in value-based purchasing designs must be open to proven interventions, the provider's clinical expertise and the patient's preferences and values.

A Common Agenda for the Prevention of Cancer, Cardiovascular Disease, and Diabetes

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It is almost universally agreed that the nation's health care system is not delivering the highest quality care possible and, consequently, clinical outcomes are poorer than we should expect. Moreover, the growing burden of chronic disease is contributing significantly to both the rising costs of health care and the poor health outcomes that are increasingly prevalent in our society, and especially among many portions of the population.

The major chronic diseases — cancer, diabetes, heart disease, and stroke — account for three out of every four deaths in the U.S. and the estimated total direct and indirect health care cost for these chronic disease areas exceeds \$700 billion each year. These staggering human and economic costs will continue to increase as the population ages and as risk factors common to cancer, diabetes, and cardiovascular disease rise in prevalence, such as poor nutrition, obesity, and lack of physical activity.

A Common Agenda

Much of the chronic disease burden could be avoided if there were systematic application of what is known about preventing the onset and progression of these conditions. However, the current approaches to health promotion and prevention of cardiovascular disease, cancer, and diabetes do not approach the potential of the existing state of knowledge.

In an effort to address this "prevention gap," the American Cancer Society, the American Diabetes Association, and the American Heart Association are working together to develop and promote a common prevention agenda. The goal of this joint venture is to stimulate substantial improvements in primary prevention and early detection through collaboration between key organizations, greater public awareness about healthy lifestyles, legislative action that results in more funding for and access to primary prevention programs and research, and renewed consideration for including some form of the preventive health encounter as an effective platform for prevention, early detection, and treatment. We believe that

significant reductions in disability and premature mortality could be achieved by addressing the underlying causes of cardiovascular disease, cancer, and diabetes, and by improving the systems to detect and treat early-stage disease when interventions are most effective.

Transforming the Health Care System

Our nation's health care system is largely organized around the delivery of acute and episodic treatment of sickness and disease. Utilization of medical services is often deferred until clear signs of illness emerge and then steps are taken to remedy the problem, often after significant damage has already occurred. While treating the sick should be a high priority, a significant emphasis also must be placed on prevention strategies that we know can avoid or delay the onset of disease.

A new health system capable of consistently delivering the most effective preventive services would not only improve the quality of life and health outcomes for millions of people over time, but also could lead to more efficient use of our nation's health resources.

Our three organizations envision a "prevention-centered" system that utilizes our clinical, technological, public health, and community resources to deliver:

- Programs and counseling that span a range of prevention activities and promote healthy lifestyles across the risk-stratified population;
- Recommended screening and early detection services based on age, gender, race/ethnicity, family history, and other risk factors for chronic disease;
- Support systems and infrastructure for the delivery of patient-centered wellness/health promotion programs in a timely and integrated manner in a variety of settings;
- Incentives to consumers and providers in order to maximize the utilization and coordination of prevention and early detection.

A call for new and improved approaches to the delivery and utilization of prevention should be a focal point of our current national debate around health reform. All Americans deserve timely access to quality, evidence-based preventive and other healthcare services as part of a comprehensive program of health care that includes acute care and biomedical research. Moreover, preventive care must be affordable and available throughout the lifestages in a system with fewer administrative barriers.



New Models for Clinical Preventive Encounters

The transformation in health care we seek will require new strategies for delivering primary and secondary prevention. At present, preventive health receives only sporadic attention, in the context of office visits for acute and episodic medical problems. The need to treat illness(es) in an encounter and simultaneously identify and prioritize opportunities for prevention counseling and early detection results in disappointing and erratic opportunities for adherence with recommended guidelines. Healthcare providers and medical organizations must transform this model into systems that provide preventive care and early detection as an integral part of standard medical practice.

We need to develop appropriate models for periodic encounters dedicated to prevention and to delineate a visit schedule based on age, gender, and other relevant considerations. Clinicians must be fairly reimbursed for encounter-based preventive care, for visits devoted exclusively to prevention and early detection, and for the costs of office systems that improve efficiency and adherence to preventive care. The ambitious health-promotion and disease-prevention goals set by our organizations simply cannot be met unless we acknowledge the critically important and influential role of an individual's primary care provider and provide the incentive, guidance, and opportunity for regular encounters for preventive health.

Health and Physical Education in Schools

Two additional components that are critical for improving the outlook for our nation's health are quality health education and physical education programs delivered in the nation's schools. When properly designed and implemented, these programs can improve the well-being and health of our children and youth. Research studies provide evidence that promoting and establishing healthy behaviors for younger people are more effective, and often easier, than efforts to change unhealthy behaviors already established in adult populations.

School health education programs can reduce health risk behaviors such as tobacco use, poor nutrition, lack of physical activity, drug and alcohol use, as well as actions that increase stress, and risk of injury, and violence. Because these behaviors are amenable to change, quality school health education taught by trained and certified health educators provides the best opportunity to promote positive health behavior among children and adolescents.

Daily quality physical education in the nation's schools is an important part of a student's comprehensive, well-rounded education program. Current recommendations are for children to engage in at least 60 minutes of physical activity each day. Physical education in schools can provide an important opportunity for helping to achieve that goal and teaches students how to integrate exercise into their lives in order to establish a lifetime of healthy living.

A growing body of evidence demonstrates the benefits of physical education beyond fitness such as improvements in students' academic performance and cognitive ability with increased time spent in physical education. Physical activity also has a positive impact on tobacco use, insomnia, depression, and anxiety.

The vast majority of parents of children under 18 (95%) think physical education should be part of a school curriculum for all students in grades K-12. Unfortunately, only 3.8 percent of elementary, 7.9 percent of middle, and 2.1 percent of high schools provide daily physical education or its equivalent for the entire school year. Twenty-two percent of schools do not require students to take any physical education at all.

Physical education policy should prioritize quality while, simultaneously and/or subsequently, trying to increase the amount of time physical education is offered in schools. The optimal physical education program will foster a lifetime commitment to physical activity as part of a healthy lifestyle. Ultimately, improved coordinated school health programs, of which physical education is a central component, will augment other prevention efforts and help to reverse the growing epidemic of childhood obesity and help children avoid a lifetime of chronic disease and disability.

Conclusion

The time has come for a concerted effort to increase the application of public health and clinical interventions of known efficacy in order to reduce the prevalence of tobacco use, poor diet, and insufficient physical activity — the key risk factors for cancer, diabetes, and cardiovascular disease — and to increase appropriate utilization of screening tests for their early detection. These enormously complex and challenging goals can only be reached through a concerted effort driven by cooperation and collaboration across multiple organizations. By working together, we can achieve greater progress in health promotion and disease prevention than by working alone.

Paying for Health: How Can We Link the Way We Finance Health Care with Health Outcomes?

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It seems obvious that investments in medical care should earn returns in the form of improved health status, but time and again, the connection between the two just doesn't work out. Despite spending more on health care per capita than any other nation, the United States ranks in the middle of developed countries on many measures of population health.¹

Within this country, populations in some geographic areas fare better than others, as *America's Health Rankings*TM illustrates, and it appears that there is no consistent relationship between higher levels of medical spending in a community and the population's health status.² This paradoxical situation prompts the question, "How can we invest in better health?" Only a limited number of policy "levers" could address this problem. One is the ability to direct funds to help create the conditions that will make for healthy outcomes. Initiatives in Vermont are testing the idea that we can direct, or redirect, what we do spend for health care in ways that will have a positive effect.

Payment Reform and Population Health in Vermont

Vermont has a long history of attempting to improve population health. As part of broad health system reform, Vermont is pursuing the implementation of a number of payment reform pilot projects that have the explicit goals of improving population health, reducing total per capita costs, and enhancing the patient experience. These activities may help answer whether a payment system based on population health outcomes can increase the value of our medical care system while ultimately improving the health of our communities.

What is a Pay-for-Population-Health System?

A pay-for-population-health system would foster shared accountability and collaboration between the medical and non-medical sectors to improve population health. As *America's Health Rankings*TM highlights, the health of a population is the function of a wide range of factors, including, but not limited to, medical care. To encourage the investment of resources to improve the health of

communities, some have called for a pay-for-population-health framework that would include:

- A medical care payment system that is based on a comprehensive measure of population health and creates incentives for provider and delivery system integration;
- Reinvestment of savings into additional improvements for traditionally under-funded services such as prevention; and
- Community-based entities that expand the activities aimed at improving population health to address non-medical determinants of health.³

Payment Reform in Vermont

Vermont's proposed payment reform pilots have the potential to test the concept of paying for population health. From September 2008 to February 2009, the Health Care Reform Commission for the Vermont legislature is convening a wide range of stakeholders to assess the feasibility of and propose a framework for a population health based payment system, which the state is calling "community-based payment reform." Vermont's feasibility study will address technical program design issues as well as political and professional concerns regarding funding, scope of practice, and linking sectors that have traditionally operated in separate silos.

The Vermont Commission is basing its reform on the principle that system-wide savings should be shared between providers and payers—thereby providing incentives and resources for coordinating care over multiple providers in multiple settings for the length of patients' illnesses.⁴

Vermont's plans for community-based payment reform will draw on other recent health reform activities in the state. These initiatives have employed several delivery system reform models, which emphasize the multiple determinants of population health to varying degrees. The Blueprint for Health, endorsed by the Vermont legislature's comprehensive health care reform legislation in 2006, is the state's vision for improving chronic disease prevention and care. The Blueprint is based on the Chronic Care Model, which emphasizes how a range of factors can affect health outcomes, including interactions between patients, teams of health care providers, the larger health care system, community resources, public health policies and programs, and environmental conditions.⁵ Under the Blueprint, Vermont has been operating several



initiatives designed to refocus chronic disease care in physician offices, enhance care coordination support for patients and families, and develop community programs (like physical activity initiatives) to help prevent chronic disease.

Beyond these community programs, Vermont leaders believe that payment reform is necessary to sustain the improvements over the long term. As a first step toward that goal, they have implemented primary care medical home projects that include incentive payments for primary care providers based on compliance with nationally established clinical protocols. In the pilot program, participating primary care providers receive an enhanced care management fee, which increases as providers demonstrate higher performance on the protocols. Community care coordination teams provide new, shared staff to doctors' offices for care management support and help link patients and providers to community resources.

Vermont's community-based payment reform pilots will eventually broaden their payment reform approach beyond primary care providers to entire local delivery systems and incorporate more comprehensive measures of population health.

Vermont has the opportunity to draw on its experience with these different delivery system reform models and adapt them into a payment system that creates accountability for population health. Such a system could provide the incentives and resources to foster collaboration between the medical and non-medical sectors. In the coming months, Vermont will make technical decisions about the design of the community-based payment reform pilots—choices that will require compromises and collaboration from a broad range of stakeholders.

Three main areas will be especially important in determining whether the pilots reach the goal of paying for population health:

- Defining the scope and scale of the community-based payment reform pilots. How can the state ensure that the intervention population is broad enough to achieve the scale necessary to spur changes within the medical delivery system and collaboration between the medical and non-medical sectors? Can the necessary scale be achieved if certain populations, like Medicare beneficiaries or the uninsured, are excluded? Which providers will be

included in the new system? How will local delivery systems be defined and how will patients be allocated to them?

- Designing the incentive system. Which metric(s) will adequately measure performance on population health as an outcome? How will per capita costs and patient experience be measured? How will payments to providers be calculated?
- Designating a "system integrator." A designated organization will be needed to facilitate care coordination, manage costs, support provider process improvement, and lead community based public health initiatives to improve population health. What new or existing entity will perform these functions? To what extent will the entity's activities focus on integration within the medical care system relative to integration between the medical and non-medical determinants of health?

The process of designing and implementing community-based payment reform pilots in Vermont, including decisions about the issues above, will provide insight into the technical, political, and professional questions that will need to be addressed in order to implement a pay-for-population-health initiative. The experience will identify potential barriers to such reform and will highlight the infrastructure that needs to be in place to undertake such an approach. Vermont's activities will provide much needed information about how hopes of "paying for population health" fare in the field.

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Promoting Quality and Value in Health Reform

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Americans assume because they spend so much on health care that they're getting the best in the world. We have a modern, high-powered health system that pays doctors, hospitals, and other health care professionals for providing care. Yet, *more* is not *better*. We must build value into any health care reform to ensure that Americans get what they deserve — the right care at the right time at a fair price.

The Pacific Business Group on Health (PBGH) is a nonprofit association of many of the nation's largest purchasers of health care. PBGH represents both public and private purchasers, who cover over 3 million Americans, seeking to improve the quality of health care while moderating costs. For almost twenty years, PBGH has been a national leader in promoting performance measurement and public reporting of information to help consumers to make better choices, to help plans change payments and to help providers invest in quality improvement efforts.

Besides representing many of America's largest public and private purchasers, PBGH is proud of its history of working closely with other employer groups, as well as consumer, labor and provider organizations to promote improvements in health care. For example, we are part of the California Chartered Value Exchange, a collaborative of collaboratives recently receiving designation by the Secretary of Health and Human Services; and co-chair of the Consumer-Purchaser Disclosure Project, an initiative that is improving health care quality and affordability by advancing public reporting of provider performance information so it can be used for improvement, consumer choice, and as part of payment reform.

For employers and for consumers — who have faced premium increases of over 125 percent in the last eight years alone — health care costs have stark implications. For many small employers, they are being priced out of the market entirely. And, for large businesses, these costs undercut our global competitiveness.

Americans believe in value — most shop to get the best quality possible for their money. Yet, no one is getting good value for their health care dollar. Our health care system is broken:

- Quality of care varies dramatically between doctors and hospitals, but those differences are invisible to consumers.
- Payments reward quantity over quality and fixing problems over prevention of health risks.

- Lack of standardized performance measures makes it impossible to know which providers are doing a good job and which are not.
- Consumers lack information to make the choices that are right for them.

The good news is that across the political spectrum and the range of interest groups there is agreement that reform must go beyond coverage and financing to improve the quality and cost-effectiveness of care. The good news is that there are solutions that we can work with.

We must reach for universal coverage.

Health care costs and premium increases are unsustainable. Working Americans are losing their insurance, adding to the ranks of 45 million who already are uninsured. The increasing cost of underfunded public programs and care for the uninsured and underinsured continues to be shifted onto the population of insured. At the state and national levels, stakeholders are discussing ways to increase coverage including expanding public programs, mandating that individuals obtain insurance, requiring a payroll tax from employers, or adopting a single-payer system. Whatever the solution, we should seek to cover all Americans.

The starting point for health care reform is to reward better care — understand what works and who's doing the job right.

America's Health Rankings™: A Call to Action for Individuals and Their Communities is a valuable resource for identifying where states are doing well and where improvements are desperately needed. The richness of the information — from health outcomes to public health measures — provides a synopsis on a range of topics important to understanding health and quality of care. It is an important tool for prioritizing our scarce resources so as to have the greatest impact on the health and well-being of Americans.

We must provide consumers with useful quality, price and treatment information.

America's Health Rankings™ reinforces the evidence of the huge variation that exists in the quality of health care. We must create a transparent health care system at all levels — state, region, individual provider (doctor and hospital) and treatment — that will foster accountability, provide incentives



for improvement and tools for consumers and providers. Americans need tools to help them make good health care decisions. Resources for consumers can come in many flavors and sources, including federal and state governments, health plans, consumer groups and private vendors, but all should use the common ingredients of standardized measures.

Without better information, providers cannot improve their performance, consumers cannot make better choices and payers cannot know who to reward. Health care professionals in every community in America want to provide the best quality care and to improve their performance, but they can't get far if they don't know how they're doing. And, consumers and purchasers cannot identify and reward high quality efficient care without measures of what works and who is providing the right care.

We must align payments to providers and incentives for patients to foster better quality care.

Our health care system pays providers for the number of treatments and procedures they provide and pays more for using expensive technology or surgical interventions. It is not designed to reward better quality, to support care coordination or prevention or encourage patients to get the right care at the right time. We need to design the payment system to reward providers for giving the right care at the right time and encourage patients to be actively engaged in their care. We need to reward both providers who deliver high-quality, cost-effective care and providers who improve significantly. Additionally, we need to rebalance the payment equation to better compensate providers engaged in preventive care, time spent coaching patients and coordinating care for those with chronic conditions; and relatively decrease payments for procedures and testing. We need to begin signaling now for today's and tomorrow's physicians that we will reward primary care.

We need to ensure our high quality health care for everyone by reducing disparities in quality of care.

People of color, limited English speakers and poor people often receive lower quality health care, even when they have the same health care coverage as other populations. We must measure and publicly report quality of care information to ensure everyone benefits from improvements and allowing

us to know where disparities exist so they can be addressed. *America's Health Rankings*[™] does this by highlighting disparities within states on key health outcomes. We must identify and implement specific actions to address these gaps to ensure our health care system provides high quality, culturally sensitive care for everyone.

We need better coordinated, more efficient systems of care.

Our current health care system uses outdated methods to deliver care and as a result all too often delivers unnecessary or poor quality care at a high cost. Doctors, hospitals and other providers still rely on paper to record and transfer information, making care delivery slower, more error-prone and harder to measure and coordinate than it should be. We need to encourage the rapid evolution to a health care system that is informed and information rich. Without rapidly making both easy-to-implement and more complex improvements, we will continue to squander precious resources on a broken system.

Too many patients today are not receiving the care we know they should. Far too many doctors and other clinicians are being paid to do more, not to provide care coordination or better care. Most providers are paid the same whether they deliver high quality or low quality care, irrespective of their cost-efficiency. Wasted spending that buys no incremental health likely exceeds 25 percent of current spending. We must change these dynamics — consumers must have the performance measurements and incentives to make the best choices; and providers must be given the tools to improve and be rewarded for doing a better job. These steps, along with many others, will move us toward a health care system that is patient-centered and sustainable.

Tips for a Safe and Healthy Life

Take steps every day to live a safe and healthy life.

Eat healthy.

- Eat a variety of fruits, vegetables, and whole grains every day.
- Limit foods and drinks high in calories, sugar, salt, fat, and alcohol.
- Eat a balanced diet to help keep a healthy weight.

Be active.

- Be active for at least 2½ hours a week. Include activities that raise your breathing and heart rates and that strengthen your muscles.
- Help kids and teens be active for at least 1 hour a day. Include activities that raise their breathing and heart rates and that strengthen their muscles and bones.

Protect yourself.

- Wear helmets, seat belts, sunscreen, and insect repellent.
- Wash hands to stop the spread of germs.
- Avoid smoking and breathing other people's smoke.
- Build safe and healthy relationships with family and friends.
- Be ready for emergencies. Make a supply kit. Make a plan. Be informed.

Manage stress.

- Balance work, home, and play.
- Get support from family and friends.
- Stay positive.
- Take time to relax.
- Get 7-9 hours of sleep each night. Make sure kids get more, based on their age.
- Get help or counseling if needed.

Get check-ups.

- Ask your doctor or nurse how you can lower your chances for health problems based on your lifestyle and personal and family health histories.
- Find out what exams, tests, and shots you need and when to get them.
- See your doctor or nurse as often as he or she says to do so. See him or her sooner if you feel sick, have pain, notice changes, or have problems with medicine.

On Line Access and Resources

America's Health Rankings[™], including additional supporting data tables and success stories, is available online at www.americashealthrankings.org.

You can view and share the entire Rankings by linking your friends and colleagues to the electronic version of this booklet (www.americashealthrankings.org/2008/pdfs/2008.pdf) or find specific sections, such as:

- State snapshots (www.americashealthrankings.org/2008/glance.html)
- State rankings on specific measures (www.americashealthrankings.org/2008/tables.html)
- Commentaries authored by health experts (<http://www.americashealthrankings.org/2008/commentary.html>), or
- Success stories (www.americashealthrankings.org/2008/success.html)

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