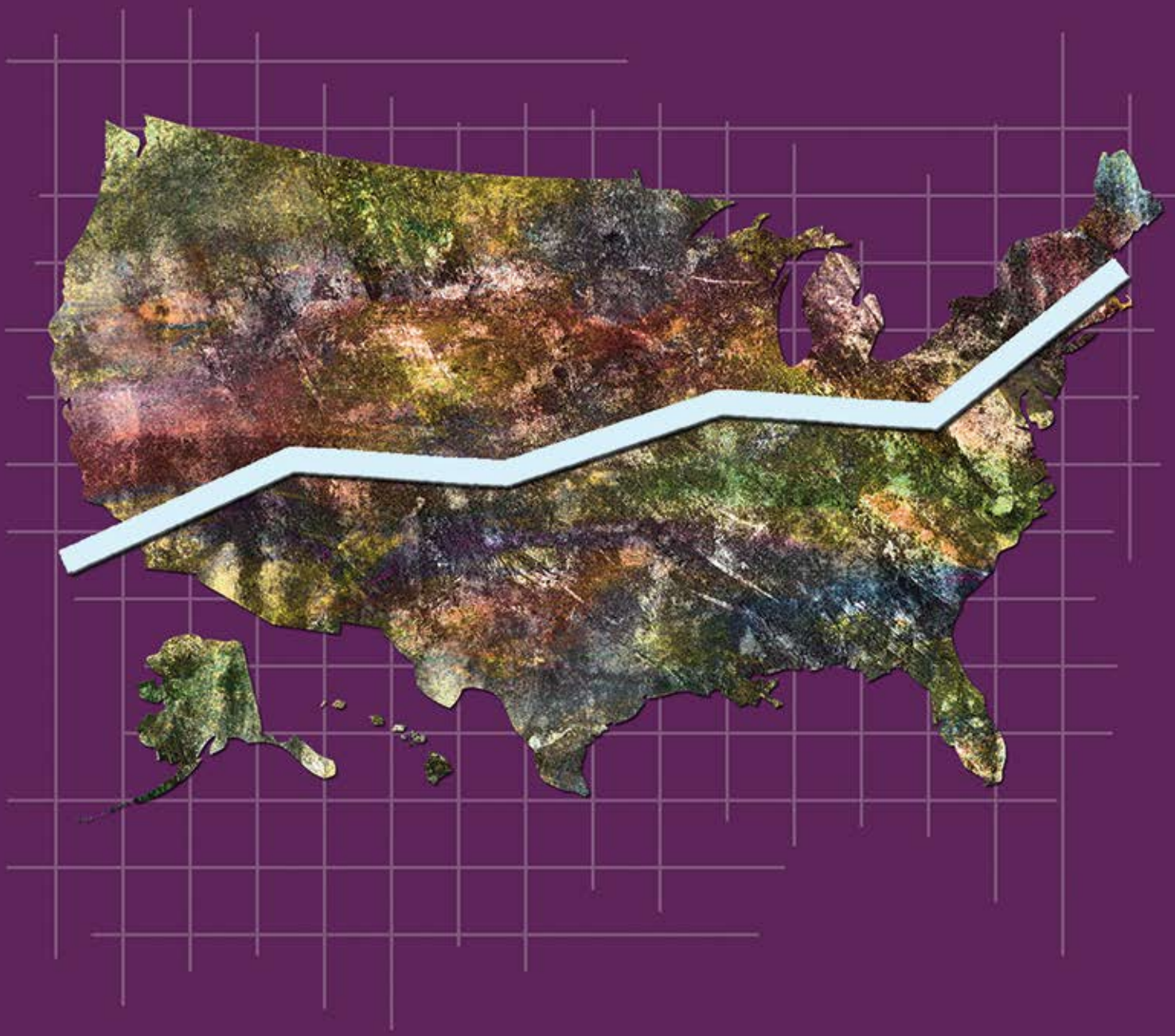

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In Brief

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Introduction

Monitoring the health of the American people is an essential step in making sound health policy and setting research and program priorities. In a Chartbook and detailed tables, *Health, United States* provides an annual picture of the health of the entire nation. *Health, United States, 2015*—which includes a Special Feature on racial and ethnic health disparities—is the 39th report on the health status of the nation and is submitted by the Secretary of the Department of Health and Human Services to the President and the Congress of the United States in compliance with Section 308 of the Public Health Service Act. This report was compiled by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS).

Health, United States, 2015: In Brief is provided as a companion to the full report. This short report contains summary information on the health of the American people, including mortality and life expectancy, morbidity and risk factors such as cigarette smoking and overweight and obesity, health insurance coverage, access to and utilization of health care, and health expenditures. The At a Glance table and Highlights summarize some of these key indicators at the national level and are followed by 27 figures from *Health, United States, 2015*, that focus on these topics in addition to this year's Special Feature on racial and ethnic health disparities.

The full report—*Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*—is available at http://www.cdc.gov/nchs/hus.htm. On this website, users can find:

- The full searchable report in PDF format, consisting of a Preface, the At a Glance table and Highlights, the Chartbook with 27 figures including the Special Feature, 114 detailed Trend Tables, Data Sources, Definitions and Methods, and an Index.
- The Chartbook and Trend Tables available as downloadable PDFs and spreadsheet files.
- Additional years of data for selected Trend Tables, in spreadsheet format.
- Updated data for Trend Tables when available.
- Standard errors for selected estimates in the spreadsheets.
- All charts in PowerPoint format.
- Charts and tables conveniently grouped by specific topics, such as older adults, racial and ethnic groups, and state data.
- *Health, United States, 2015: In Brief* in PDF format.
- Previous editions of *Health, United States*, beginning with 1975.

Health, United States, 2015: At a Glance

	Value (year)			*Health, United States, 2015* Table No.
Life Expectancy and Mortality				
Life expectancy, in years				Table 15
At birth	76.8 (2000)	78.8 (2013)	78.8 (2014)	
Infant deaths per 1,000 live births				Table 11
All infants	6.91 (2000)	5.96 (2013)	5.82 (2014)	
Deaths per 100,000 population, age-adjusted				Table 17
All causes	869.0 (2000)	731.9 (2013)	724.6 (2014)	
Heart disease	257.6 (2000)	169.8 (2013)	167.0 (2014)	
Cancer	199.6 (2000)	163.2 (2013)	161.2 (2014)	
Chronic lower respiratory diseases	44.2 (2000)	42.1 (2013)	40.5 (2014)	
Unintentional injuries	34.9 (2000)	39.4 (2013)	40.5 (2014)	
Stroke	60.9 (2000)	36.2 (2013)	36.5 (2014)	
Alzheimer's disease	18.1 (2000)	23.5 (2013)	25.4 (2014)	
Diabetes	25.0 (2000)	21.2 (2013)	20.9 (2014)	
Influenza and pneumonia	23.7 (2000)	15.9 (2013)	15.1 (2014)	
Nephritis, nephrotic syndrome and nephrosis	13.5 (2000)	13.2 (2013)	13.2 (2014)	
Suicide	10.4 (2000)	12.6 (2013)	13.0 (2014)	
Morbidity and Risk Factors				
Fair or poor health, percent				Table 45
All ages	8.9 (2000)	10.2 (2013)	9.8 (2014)	
65 years and over	26.9 (2000)	23.1 (2013)	21.7 (2014)	
Heart disease (ever told), percent				Table 38
18 years and over	11.3 (2000–2001)	11.4 (2011–2012)	11.5 (2013–2014)	
65 years and over	30.9 (2000–2001)	30.3 (2011–2012)	29.4 (2013–2014)	
Cancer (ever told), percent				Table 38
18 years and over	5.0 (2000–2001)	6.2 (2011–2012)	6.4 (2013–2014)	
65 years and over	15.2 (2000–2001)	18.5 (2011–2012)	18.2 (2013–2014)	
Hypertension,[1] percent				Table 54
20 years and over	30.2 (1999–2002)	32.2 (2007–2010)	33.0 (2011–2014)	
Diabetes,[2] percent				Table 40
20 years and over	9.8 (1999–2002)	12.0 (2007–2010)	12.6 (2011–2014)	
Hypercholesterolemia,[3] percent				Table 55
20 years and over	25.0 (1999–2002)	28.7 (2007–2010)	29.8 (2011–2014)	
Obese, percent				Tables 58 and 59
Obese,[4] 20 years and over	30.5 (1999–2002)	34.9 (2007–2010)	36.5 (2011–2014)	
Obese (BMI at or above sex- and age-specific 95th percentile):				
2–5 years	10.3 (1999–2002)	11.1 (2007–2010)	8.9 (2011–2014)	
6–11 years	15.9 (1999–2002)	18.8 (2007–2010)	17.5 (2011–2014)	
12–19 years	16.0 (1999–2002)	18.2 (2007–2010)	20.5 (2011–2014)	
Cigarette smoking, percent				Table 47
18 years and over	23.2 (2000)	17.8 (2013)	16.8 (2014)	
Aerobic activity and muscle strengthening,[5] percent meeting both guidelines				Table 57
18 years and over	15.1 (2000)	20.4 (2013)	20.9 (2014)	

[1]Having measured high blood pressure (systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg) and/or respondent report of taking antihypertensive medication.

[2]Includes physician-diagnosed and undiagnosed diabetes (fasting plasma glucose of at least 126 mg/dL or a hemoglobin A1c of at least 6.5%).

[3]Having high serum total cholesterol of 240 mg/dL or greater and/or respondent report of taking cholesterol-lowering medication.

[4]Obesity is a body mass index (BMI) greater than or equal to 30 for adults. Height and weight are measured rather than self-reported.

[5]Federal guidelines recommend at least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic physical activity a week and muscle-strengthening activities at least twice a week.

	Value (year)			*Health, United States, 2015* Table No.
Health Care Utilization				
No health care visit in past 12 months, percent				Table 65
Under 18 years	12.3 (2000)	8.2 (2013)	7.9 (2014)	
18–44 years	23.4 (2000)	24.8 (2013)	23.2 (2014)	
45–64 years	14.9 (2000)	15.2 (2013)	15.0 (2014)	
65 years and over	7.4 (2000)	6.4 (2013)	5.6 (2014)	
Emergency room visit in past 12 months, percent				Tables 73 and 74
Under 18 years	20.3 (2000)	17.6 (2013)	16.7 (2014)	
18–44 years	20.5 (2000)	18.5 (2013)	18.4 (2014)	
45–64 years	17.6 (2000)	17.6 (2013)	17.5 (2014)	
65 years and over	23.7 (2000)	21.3 (2013)	21.2 (2014)	
Dental visit in past year, percent				Table 78
2–17 years	74.1 (2000)	83.0 (2013)	83.0 (2014)	
18–64 years	65.1 (2000)	61.7 (2013)	62.0 (2014)	
65 years and over	56.6 (2000)	60.6 (2013)	62.4 (2014)	
Prescription drug in past 30 days, percent				Table 79
Under 18 years	23.8 (1999–2002)	24.7 (2003–2006)	23.5 (2009–2012)	
18–44 years	35.9 (1999–2002)	37.4 (2003–2006)	38.1 (2009–2012)	
45–64 years	64.1 (1999–2002)	65.2 (2003–2006)	67.2 (2009–2012)	
65 years and over	84.7 (1999–2002)	89.4 (2003–2006)	89.8 (2009–2012)	
Hospitalization in past year, percent				Table 81
18–44 years	7.0 (2000)	6.1 (2013)	5.8 (2014)	
45–64 years	8.4 (2000)	7.8 (2013)	7.4 (2014)	
65 years and over	18.2 (2000)	15.3 (2013)	15.3 (2014)	
Health Insurance and Access to Care				
Uninsured, percent				Table 105
Under 65 years	17.0 (2000)	16.7 (2013)	13.3 (2014)	
Under 18 years	12.6 (2000)	6.6 (2013)	5.4 (2014)	
18–44 years	22.4 (2000)	24.2 (2013)	19.7 (2014)	
45–64 years	12.6 (2000)	15.4 (2013)	11.8 (2014)	
Delay or nonreceipt of needed medical care in past 12 months due to cost, percent				Table 63
Under 18 years	4.6 (2000)	3.1 (2013)	2.8 (2014)	
18–44 years	9.5 (2000)	11.9 (2013)	10.7 (2014)	
45–64 years	8.8 (2000)	13.2 (2013)	11.7 (2014)	
65 years and over	4.5 (2000)	4.2 (2013)	4.3 (2014)	
Health Care Resources				
Patient care physicians per 10,000 population[6]				Table 83
United States	22.7 (2000)	26.9 (2012)	27.6 (2013)	
Highest state	54.5 (DC) (2000)	65.9 (DC) (2012)	66.1 (DC) (2013)	
Lowest state	14.4 (ID) (2000)	18.0 (ID,MS) (2012)	18.6 (ID) (2013)	
Community hospital beds per 1,000 population[7]				Table 90
United States	2.9 (2000)	2.6 (2012)	2.5 (2013)	
Highest state	6.0 (ND) (2000)	5.7 (DC) (2012)	5.6 (DC) (2013)	
Lowest state	1.9 (NM,NV,OR,UT,WA) (2000)	1.7 (OR) (2012)	1.7 (OR,WA) (2013)	
Health Care Expenditures				
Personal health care expenditures, in dollars				Table 95
Total, in trillions	$1.2 (2000)	$2.4 (2013)	$2.6 (2014)	
Per capita	$4,121 (2000)	$7,727 (2013)	$8,054 (2014)	

NOTES: Estimates in this table are taken from the PDF, printed, or spreadsheet version of the cited tables. For more information and the spreadsheet version of the tables, see the *Health, United States* website: http://www.cdc.gov/nchs/hus.htm.

Highlights

This Highlights section presents selected data from the four major areas included in the report: health status and determinants, utilization of health resources, health care resources, and health care expenditures and payers, and from this year's Special Feature on racial and ethnic health disparities. The Highlights focus on topics of public health importance and illustrate the breadth of material included in *Health, United States, 2015*. The Highlights section generally presents trends for the recent 10-year period or examines information for the most recent data year available. Highlights from the 2015 Special Feature generally present data from 1999 to the most recent year available, or only data from the latest year (see Technical Notes for additional information). Each highlight includes a reference to the detailed trend table or figure where definitions of terms and additional data can be obtained.

Health Status and Determinants

Life Expectancy and Mortality

In 2014, life expectancy at birth in the United States for the total population was 78.8 years—76.4 years for males and 81.2 years for females (Table 15).

Between 2004 and 2014, life expectancy at birth increased 1.4 years for males and 1.1 years for females. The gap in life expectancy between males and females narrowed from 5.1 years in 2004 to 4.8 years in 2014 (Table 15).

Between 2004 and 2014, life expectancy at birth increased more for the black than for the white population, thereby narrowing the gap in life expectancy between these two racial groups. In 2004, life expectancy at birth for the white population was 5.2 years longer than for the black population; by 2014, the difference had narrowed to 3.4 years (Table 15).

Between 2013 and 2014, life expectancy at birth increased 0.2 years to 81.8 years for Hispanic persons, decreased 0.1 years to 78.8 years for non-Hispanic white persons, and increased 0.1 years to 75.2 years for non-Hispanic black persons. For males between 2013 and 2014, life expectancy at birth increased 0.1 years to 79.2 years for Hispanic males, remained stable at 76.5 years for non-Hispanic white males, and increased 0.2 years to 72.0 years for non-Hispanic black males. For females between 2013 and 2014, life expectancy at birth increased 0.2 years to 84.0 years for Hispanic females, decreased 0.1 years to 81.1 years for non-Hispanic white females, and remained stable at 78.1 years for non-Hispanic black females (Table 15).

Between 2004 and 2014, the death rate for black men aged 45–54 decreased 28%, from 933.3 to 671.8 deaths per 100,000 resident population, while the death rate for non-Hispanic white men remained stable (511.2 in 2014). Between 2004 and 2014, the death rate for black women aged 45–54 decreased 18%, from 558.9 to 455.8, while the death rate for non-Hispanic white women increased 11%, from 293.4 to 325.5 (Table 21).

Between 2004 and 2014, the infant mortality rate decreased 14%, from 6.79 to 5.82 deaths per 1,000 live births and the neonatal mortality rate (among infants under age 28 days) decreased 13%, from 4.52 to 3.94. Between 2004 and 2014, the postneonatal mortality rate (among infants aged 28 days through 11 months) decreased 17%, from 2.27 to 1.88 (Table 11).

In 2014, the 10 leading causes of death were heart disease, cancer, chronic lower respiratory diseases, unintentional injuries, stroke, Alzheimer's disease, diabetes, influenza and pneumonia, kidney disease, and suicide. These 10 causes of death accounted for 74% of the 2.6 million deaths in 2014 (Table 19).

Between 2004 and 2014, the age-adjusted heart disease death rate decreased 25%, from 221.6 to 167.0 deaths per 100,000 resident population. In 2014, 23% of all deaths in the United States were from heart disease (Tables 19 and 22).

Between 2004 and 2014, the age-adjusted cancer death rate decreased 14%, from 186.8 to 161.2 deaths per 100,000 resident population. In 2014, 23% of all deaths in the United States were from cancer (Tables 19 and 24).

Between 2004 and 2014, the suicide death rate increased 21%, from 11.1 to 13.4 deaths per 100,000 resident population. Among adults aged 45–64, suicide death rates increased 27% between 2004 and 2014 (Table 30).

Between 2004 and 2014, the drug poisoning death rate involving heroin increased more than five times, from 0.6 to 3.3 deaths per 100,000 resident population. In 2014, the drug poisoning death rate involving heroin was highest among those aged 25–34 (8.0), followed by those aged 35–44 (5.9), and those aged 45–54 (4.7) (Table 27).

Fertility and Natality

Between 2004 and 2014, the birth rate among teenagers aged 15–19 fell 40%, from 40.5 to 24.2 live births per 1,000 females—a record low for the United States (Table 3).

In 2014, 8.00% of infants were low-birthweight (weighing less than 2,500 grams [5.5 pounds] at birth); low-birthweight was more common among non-Hispanic black infants (13.17%) and Puerto Rican infants (9.54%) than among infants in other racial and ethnic groups (Table 5).

Health Risk Factors for the Noninstitutionalized Population

Children

In 2011–2014, the prevalence of children with obesity among those aged 2–5 years was 8.9%, 17.5% among children aged 6–11, and 20.5% among adolescents aged 12–19 (Table 59 and Figure 8).

In 2014, 4.9% of adolescents aged 12–17 reported smoking cigarettes in the past month. Smoking prevalence has declined since 2004, when 11.9% of adolescents reported smoking cigarettes in the past month (Table 50).

Adults

In 2014, 20.9% of adults aged 18 and over met the 2008 federal physical activity guidelines for both aerobic activity and muscle strengthening (Table 57).

Between 1999–2002 and 2011–2014, the percentage of adults aged 20 and over with Grade 1 obesity (a body mass index [BMI] of 30.0–34.9) increased from 17.9% to 20.6%. Those with Grade 2 obesity (BMI of 35.0–39.9) rose from 7.6% to 8.8%, and those with Grade 3 obesity (BMI of 40 or higher) increased from 4.9% to 6.9% (percentages are age-adjusted) (Table 58).

In 2014, 16.8% of adults aged 18 and over were current cigarette smokers, a decline from 2004 (20.9%). Men (18.8%) were more likely than women (14.8%) to be current cigarette smokers in 2014 (Table 47).

Measures of Health and Disease Prevalence for the Noninstitutionalized Population

In 2012–2014, 4.9% of children under age 18 had an asthma attack in the past year, and 5.6% had a food allergy (Table 35).

Among children aged 5–17, 10.2% were diagnosed with attention deficit/hyperactivity disorder and 5.4% had serious emotional or behavioral difficulties in 2012–2014 (Table 35).

Between 2003 and 2013, the incidence rates of four selected notifiable diseases—tuberculosis, hepatitis A, hepatitis B, and meningococcal disease—decreased, while the incidence rates of Lyme disease increased 57%, to 11.62 new cases per 100,000 population in 2013, and pertussis (a vaccine-preventable disease also known as whooping cough) more than doubled to 9.12 new cases per 100,000 population in 2013. Despite the long-term decline in acute hepatitis B cases, there was a 5% increase in the number of reported cases from 2012 to 2013 (Table 33 and Figure 5).

In 2014, the percentage of adults who reported their health as fair or poor ranged from 6.1% of those aged 18–44 to 24.9% of those aged 75 and over (Table 45).

In 2013–2014, 12.0% of adults aged 45–64 and 29.4% of adults aged 65 and over had ever been told by a physician or other health professional that they had heart disease (Table 38).

In 2013–2014, 6.7% of adults aged 45–64 and 18.2% of adults aged 65 and over had ever been told by a physician or other health professional that they had cancer (excluding squamous and basal cell skin cancers) (Table 38).

In 2011–2014, one-third of adults aged 20 and over had hypertension (having measured high blood pressure or reporting taking antihypertensive medication). Of these adults aged 20 and over with hypertension, nearly one-half (47.0%) had uncontrolled high blood pressure (measured systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg) (Table 54).

In 2014, the prevalence of self-reported serious difficulty concentrating, remembering, or making decisions was highest among men and women aged 75–84 and 85 and over and was similar among men and women in each age group. Difficulty doing errands alone increased with age, and was higher among women than men in all age groups (Figure 6).

Utilization of Health Resources for the Noninstitutionalized Population

Use of Health Care Services

In 2014, 14.9% of persons had no health care visits in the past 12 months, 49.8% had 1–3 health care visits, 23.3% had 4–9 visits, and 11.9% had 10 or more visits. Health care visits for illness, preventive care, or injury include visits to physician offices, emergency departments, clinics, or other locations, in addition to home visits made by health care professionals (Table 65).

In 2014, 83.0% of children aged 2–17 years, 62.0% of adults aged 18–64, and 62.4% of adults aged 65 and over had visited a dentist in the past year (Table 78).

Use of Preventive Medical Care Services for the Noninstitutionalized Population

In 2014, 71.6% of children aged 19–35 months had completed the combined 7-vaccine series of childhood vaccinations (4 or more doses of diphtheria and tetanus toxoids and pertussis vaccine [DTP], diphtheria and tetanus toxoids vaccine [DT], or diphtheria and tetanus toxoids and acellular pertussis vaccine [DTaP]; 3 or more doses of any poliovirus vaccine; 1 or more doses of a measles-containing vaccine [MCV]; 3 or more doses or 4 or more doses of *Haemophilus influenzae* type b vaccine [Hib] depending on Hib vaccine product type [full series Hib]; 3 or more doses of hepatitis B vaccine; 1 or more doses of varicella vaccine; and

4 or more doses of pneumococcal conjugate vaccine [PCV]) (Table 66).

Between 2013 and 2014, receipt of the recommended three doses of human papillomavirus (HPV) vaccine for adolescents aged 13–17 increased among females from 36.8% to 39.7% and among males from 13.4% to 21.6% (Table 67).

In 2013, Pap test utilization was highest among women currently recommended for routine cervical cancer screening; 81.6% of women aged 21–44 and 73.9% of women aged 45–64 received a Pap test in the past 3 years (Table 71 and Figure 10).

In 2014, 42.2% of adults aged 18 and over had received an influenza vaccination in the past 12 months. Influenza vaccination increased with age, with 30.2% of those aged 18–44, 43.3% of those aged 45–64, and 70.1% of those aged 65 and over reporting an influenza vaccination in the past 12 months (Table 68).

In 2014, 61.3% of adults aged 65 and over had ever received a pneumococcal vaccination (Table 69).

Difficulty Accessing Needed Medical Care, Prescription Drugs, and Dental Care Due to Cost for the Noninstitutionalized Population

In 2014, 8.2% of persons reported delaying or not receiving needed medical care due to cost, 5.6% reported not receiving needed prescription drugs due to cost, and 10.0% reported not receiving needed dental care due to cost in the past 12 months (Table 63).

Among adults aged 18–64, the percentage who reported delaying or not receiving needed medical care, not receiving needed prescription drugs, and not receiving needed dental care due to cost in the past 12 months increased 22%–31% during 2004–2010, and then declined 24%–32% during 2010–2014 (Table 63).

Health Care Resources

In 2013, there were 27.6 physicians in patient care per 10,000 civilian population in the United States. The number of patient care physicians per 10,000 population ranged from 18.6 in Idaho to 43.0 in Massachusetts and 66.1 in the District of Columbia (Table 83).

In 2013, the United States had 4,974 community hospitals and 795,603 community hospital beds. Community hospital occupancy averaged 62.9% in 2013, down from 67.3% in 2005 (Table 89).

In 2013, there were 60.46 professionally active dentists per 100,000 civilian population in the United States. The number of dentists per 100,000 population ranged from 40.90 in Arkansas to 81.22 in New Jersey and 89.20 in the District of Columbia (Table 86).

In 2013, about 8 of every 10 office-based physicians had computerized electronic health record components that recorded patient history and demographic information, ordered prescriptions, and submitted prescriptions to the pharmacy. About 7 of 10 had components to provide electronic warnings of drug interactions and contraindications and to order lab tests electronically (Figure 13).

In 2014, there were 15,643 certified nursing homes with 1,693,943 nursing home beds. U.S. nursing home occupancy averaged 80.8% in 2014. Nursing home occupancy rates were highest in North Dakota (92.4%), Rhode Island (91.9%), South Dakota (91.9%), and the District of Columbia (91.8%) in 2014. The lowest occupancy rates were in Oregon (60.1%), Utah (64.3%), and Idaho (64.5%) (Table 92).

Health Care Expenditures and Payers

Health Care Expenditures

In 2014, personal health care expenditures in the United States totaled $2.6 trillion—a 5.0% increase from 2013. The per capita personal health care expenditure for the total U.S. population was $8,054 in 2014—up from $7,727 in 2013 (Table 93).

Expenditures for hospital care accounted for 37.9% of all personal health care expenditures in 2014. Physician and clinical services accounted for 23.5% of total personal health care expenditures, prescription drugs for 11.6%, and nursing care facilities and continuing care retirement communities for 6.1%; the remaining spending was for other types of personal health care expenditures (Table 94).

In 2014, prescription drug expenditures totaled $297.7 billion—up 12.2% from $265.3 billion in 2013 (Table 94).

In 2013, the average cost for the entire hospitalization involving a heart valve procedure was $51,415; a coronary artery bypass graft procedure was $41,274; cardiac pacemaker or defibrillator insertion, revision, replacement, or removal was $35,074; and spinal fusion was $28,696 (Table 96).

Health Care Payers

In 2014, 33.9% of all personal health care expenditures were paid by private health insurance, 22.7% were paid by Medicare, and 17.4% by Medicaid; consumers paid 12.9% out-of-pocket; and the remaining expenditures were paid by other types of insurance, payers, and programs (Table 95).

In 2014, the Medicare program had 53.8 million enrollees and expenditures of $613.3 billion—up from 52.5 million enrollees and $582.9 billion in expenditures the previous year. Expenditures for the Medicare drug program (Part D)

were $78.1 billion in 2014—up from $69.7 billion in 2013 (Table 107).

Health Insurance Coverage for the Noninstitutionalized Population

The Affordable Care Act (ACA) of 2010's major provisions were in effect by January 2014. Many of these provisions are intended to expand health insurance and health benefits coverage. Between 2013 and 2014, the percentage of adults aged 18–64 who were uninsured decreased 20%, from 20.5% to 16.3% (Table 105).

From 2014 to June 2015 (preliminary data), the percentage of adults aged 18–64 who were uninsured declined 22%, to 12.7% (Martinez ME, Cohen RA. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2015. NCHS; 2015. Available from: (http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf) (Table 105).

A provision of ACA requires insurers to extend dependent coverage on a family plan until age 26, effective in 2010. This provision, along with other ACA provisions and changes in insurance coverage, has contributed to the 42% decrease in the percentage of adults aged 19–25 who were uninsured, from 33.8% in 2010 to 19.7% in 2014 (Table 105).

From 2014 to June 2015 (preliminary data), the percentage of adults aged 19–25 who were uninsured declined 19%, to 15.9% (Martinez ME, Cohen RA. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2015. NCHS; 2015. Available from: (http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201511.pdf) (Table 105).

Between 2004 and 2014, the percentage of the population under age 65 with private health insurance obtained through the workplace declined from 64.0% to 56.8% (Table 103).

Between 2004 and 2014, among children in families with income of 100%–199% of the poverty level, the percentage of uninsured children under age 18 decreased from 15.1% to 8.7%, while Medicaid or Children's Health Insurance Program (CHIP) coverage among children in families with income of 100%–199% of poverty increased from 40.2% to 60.0% (Tables 104 and 105).

In 2014, Massachusetts (3.9%), Vermont (5.4%), Hawaii (5.7%), and the District of Columbia (6.1%) had the lowest percentages of persons uninsured (i.e., without public or private coverage) among those under age 65, while Alaska (19.2%), Florida (20.1%), and Texas (21.2%) had the highest percentages uninsured (Table 114).

Special Feature on Racial and Ethnic Health Disparities

The difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian or Pacific Islander) infant mortality rates among the five racial and ethnic groups narrowed from 9.41 deaths per 1,000 live births in 1999 to 7.21 in 2013 (Figure 19).

In 2014, non-Hispanic black mothers had the highest percentage of preterm births before 37 weeks gestation (11.1%) and non-Hispanic Asian or Pacific Islander mothers had the lowest percentage (6.8%) (Figure 20).

In 2011–2014, among children and adolescents aged 2–19, Hispanic children and adolescents had the highest prevalence of obesity (21.9%) and non-Hispanic Asian children and adolescents had the lowest prevalence (8.6%) (Figure 22).

In 2011–2014 among men aged 20 and over, non-Hispanic black men had the highest prevalence of hypertension (42.4%) and Hispanic men had the lowest (27.7%); among women aged 20 and over, non-Hispanic black women had the highest prevalence of hypertension (44.0%) and non-Hispanic Asian women had the lowest (25.0%) (percentages are age-adjusted) (Figure 23).

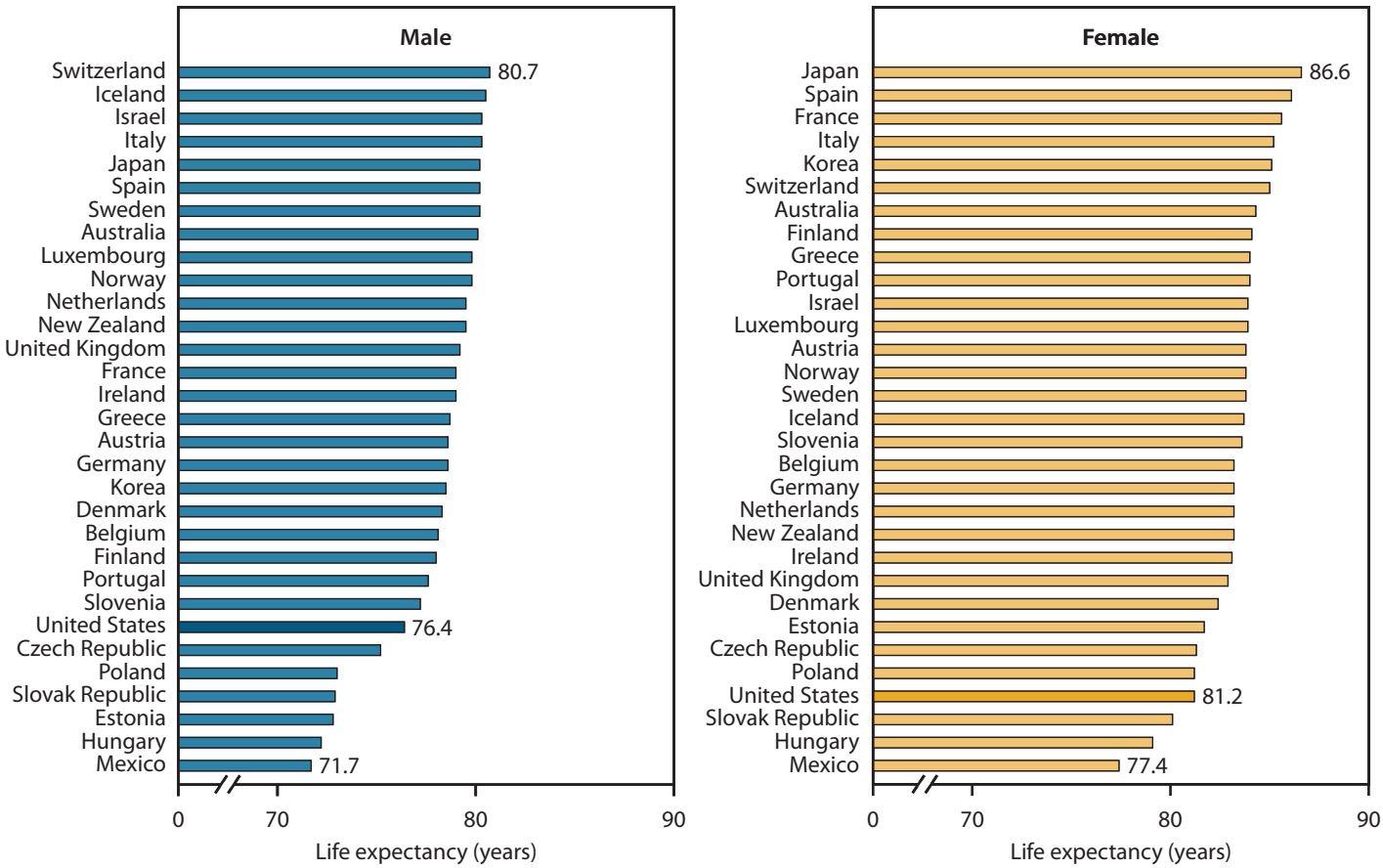
The difference for women between the highest (non-Hispanic white) and lowest (non-Hispanic Asian) percentages of current cigarette smokers among the four racial and ethnic groups narrowed from 17.5 percentage points in 1999 to 13.2 in 2014 (percentages are age-adjusted) (Figure 24).

In 2014 among adults aged 18–64, Hispanic adults had the highest percentage of nonreceipt of dental care in the past 12 months due to cost (15.7%) and non-Hispanic Asian adults had the lowest percentage (6.3%) (Figure 27).

Mortality

Life Expectancy at Birth, by Country

Figure 1. Life expectancy at birth, by sex and country: Organisation for Economic Co-operation and Development (OECD) countries, 2013



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig01

In 2013, U.S. males and females ranked 25th and 27th, respectively, in life expectancy compared with males and females in other OECD countries.

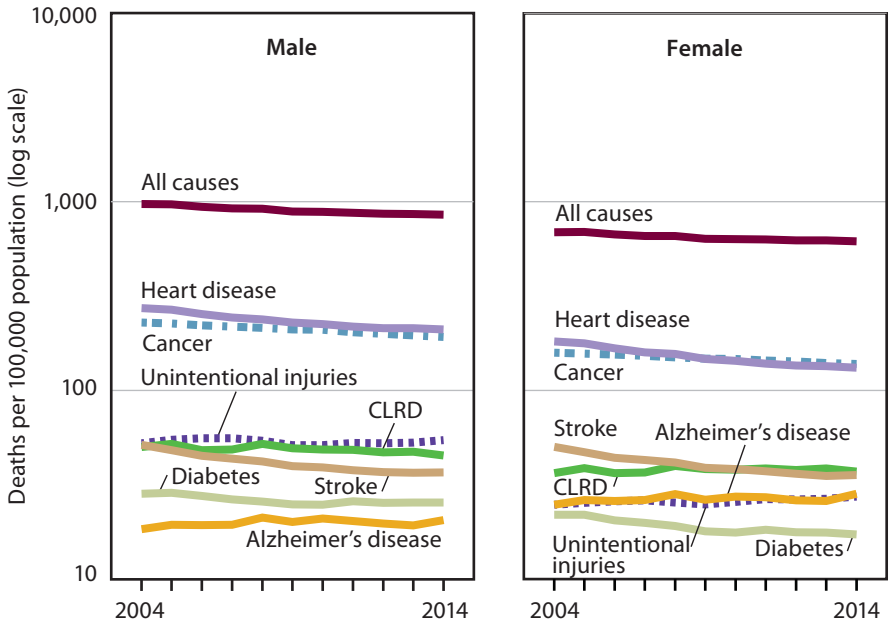
Life expectancy is often used to evaluate the overall health of a population (1). Life expectancy at birth for males and females in the United States was compared with those for males and females in 30 other countries. In 2013, life expectancy at birth for males ranged from a low of 71.7 years for Mexico to a high of 80.7 years for Switzerland, with the United States (76.4 years) ranking 25th out of 31 countries. Life expectancy at birth for females ranged from a low of 77.4 years for Mexico to a high of 86.6 years for Japan, with the United States (81.2 years) tied with Poland and ranking 27th out of 31 countries.

NOTES: Countries with estimated life expectancies or series breaks for 2013 are not presented. Differences in life expectancy may reflect differences in reporting methods, which can vary by country, in addition to actual differences in mortality rates.

SOURCE: CDC/NCHS, *Health, United States, 2015*, Tables 14 and 15. Data for the United States from the National Vital Statistics System (NVSS); all other data from the Organisation for Economic Co-operation and Development (OECD).

Mortality
Selected Causes of Death

Figure 2. Age-adjusted death rates for selected causes of death for all ages, by sex: United States, 2004–2014



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig02

Between 2004 and 2014, the all-cause, age-adjusted death rate decreased 12% among males and 11% among females.

During 2004–2014, age-adjusted death rates among males declined 29% for stroke, 23% for heart disease, 16% for cancer, and 10% for both diabetes and CLRD, and increased 11% for Alzheimer's disease and 4% for unintentional injuries. Among females, age-adjusted death rates declined 29% for stroke, 27% for heart disease, 21% for diabetes, and 13% for cancer, and increased 15% for Alzheimer's disease and 11% for unintentional injuries. In 2014, age-adjusted death rates among males were higher than among females for heart disease, cancer, CLRD, diabetes, stroke, and unintentional injuries and were lower among males than females for Alzheimer's disease.

NOTES: CLRD is chronic lower respiratory diseases. A change in the coding rules for nephritis, nephrotic syndrome and nephrosis caused an increase in the number of deaths attributed to diabetes beginning with 2011 data. Thus, the trend for diabetes death rates should be interpreted with caution.

SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 17. Data from the National Vital Statistics System (NVSS).

Mortality
Suicide and Homicide

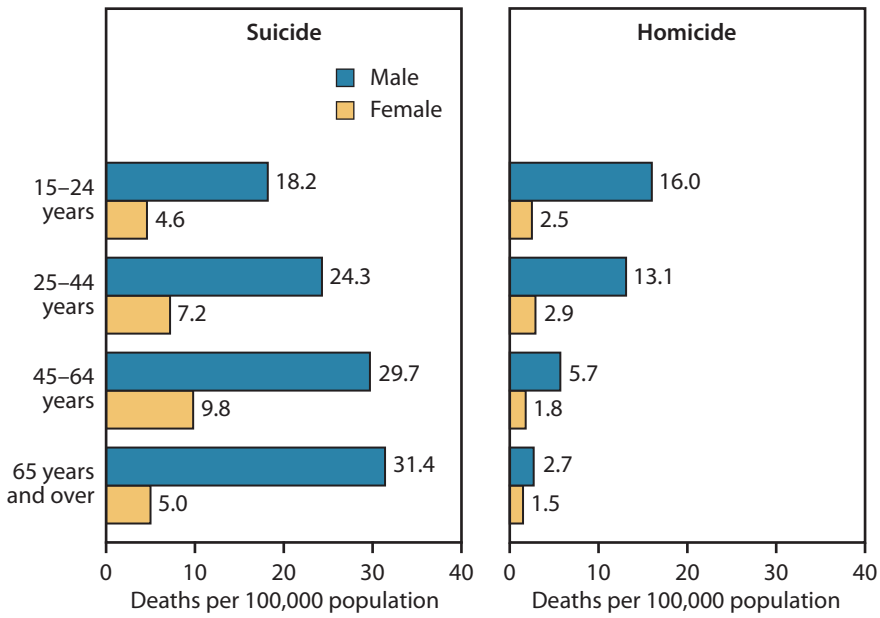
In 2014, suicide rates were higher than homicide rates for males and females of all age groups.

In 2014, suicide was the 10th and homicide the 17th leading cause of death in the U.S. (Table 19) (2). Suicide and homicide deaths impose emotional and financial costs on both families and society, and death rates for these causes differ by age and other factors (3–7). Suicide rates were higher among males than among females overall (21.1 deaths per 100,000 population compared with 6.0) (Table 30) and within each age group. Among males in 2014, suicide rates were higher among those aged 45–64 and 65 and over than among younger age groups. Among females, suicide rates were highest among those aged 45–64.

Homicide rates were higher among males than among females overall (8.0 deaths per 100,000 population compared with 2.0) (Table 29) and within each age group. Among both males and females, homicide rates were higher among those aged 15–24 and 25–44 than among older age groups in 2014.

SOURCE: CDC/NCHS, *Health, United States, 2015,* Tables 29 and 30. *Data from the National Vital Statistics System (NVSS).*

Figure 3. Suicide and homicide death rates among persons aged 15 and over, by age and sex: United States, 2014



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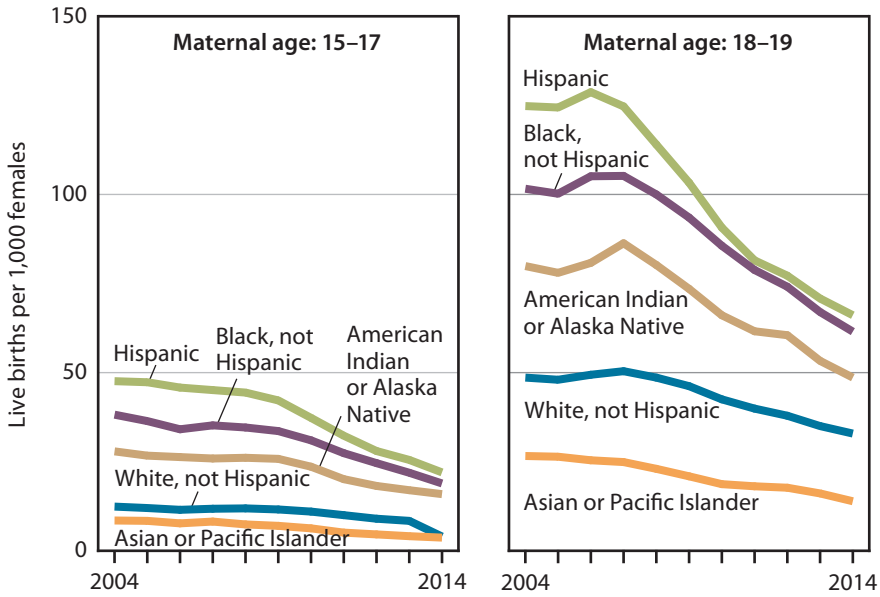
Natality

Teenage Childbearing

Figure 4. Teenage childbearing, by maternal age and race and Hispanic origin: United States, 2004–2014



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig04

Between 2004 and 2014, teenage birth rates declined among all racial and ethnic groups.

Teen childrearing often limits the mother's educational and occupational opportunities, and female babies born to teen mothers are more likely to become teen mothers themselves (8,9). In 2014, teen childbearing fell to a historic low of 24.2 per 1,000 females overall and for each race and Hispanic-origin group (8). Between 2004 and 2014, birth rates declined 50% for teenagers aged 15–17 and 36% for those aged 18–19 (Table 3). Among teenagers aged 15–17, birth rates decreased 44% for non-Hispanic white, 51% for American Indian or Alaska Native, 54% for non-Hispanic black, 59% for Hispanic, and 61% for Asian or Pacific Islander females. Among teenagers aged 18–19, birth rates decreased 32% for non-Hispanic white, 39% for American Indian or Alaska Native, 39% for non-Hispanic black, 47% for Hispanic, and 48% for Asian or Pacific Islander females.

SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 3. Data from the National Vital Statistics System (NVSS).

Morbidity

Notifiable Disease Rates

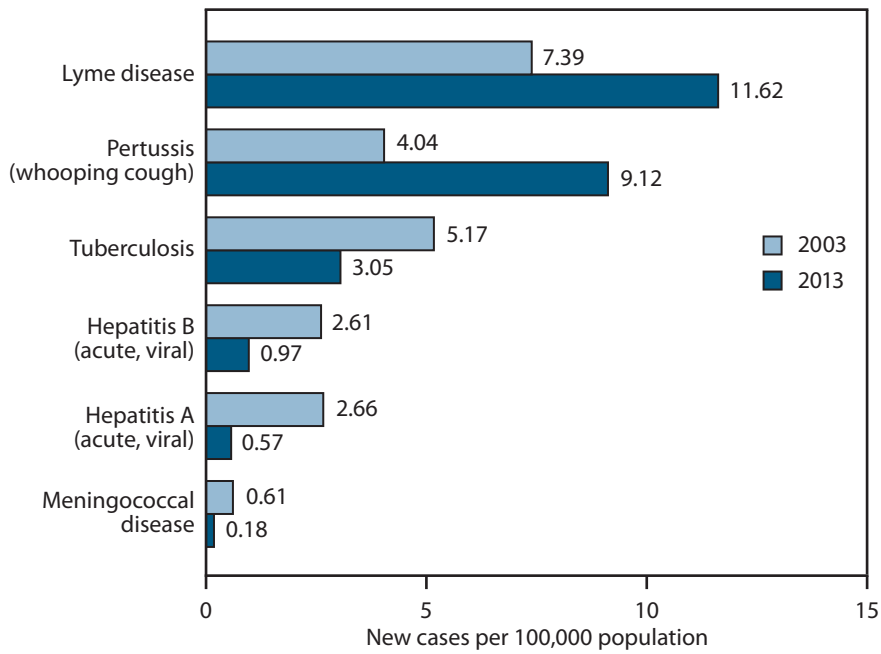
Between 2003 and 2013, the rates for pertussis—a vaccine-preventable disease—and Lyme disease increased, while rates for tuberculosis, hepatitis A, hepatitis B, and meningococcal disease decreased.

Public health officials rely on regular, frequent, timely reporting of notifiable diseases to identify at-risk groups, monitor trends, and control the spread of infectious diseases (10,11). Between 2003 and 2013, the incidence rates of four selected diseases decreased—hepatitis A (79% decrease), meningococcal disease (70%), hepatitis B (63%), and tuberculosis (41%)—while the rates of Lyme disease (57%) and pertussis (whooping cough) (126%) increased. The hepatitis B rate declined in the past decade, but reported cases increased 5% from 2012 to 2013.

NOTES: Diseases with consistent definitions and the greatest changes between 2003 and 2013 were selected for display. Food-borne illnesses were not selected due to year-to-year variation. Rates used the postcensal total resident population and may differ from those elsewhere if different population estimates were used to calculate rates.

SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 33. Data from the National Notifiable Diseases Surveillance System (NNDSS).

Figure 5. Selected notifiable disease rates: United States, 2003 and 2013



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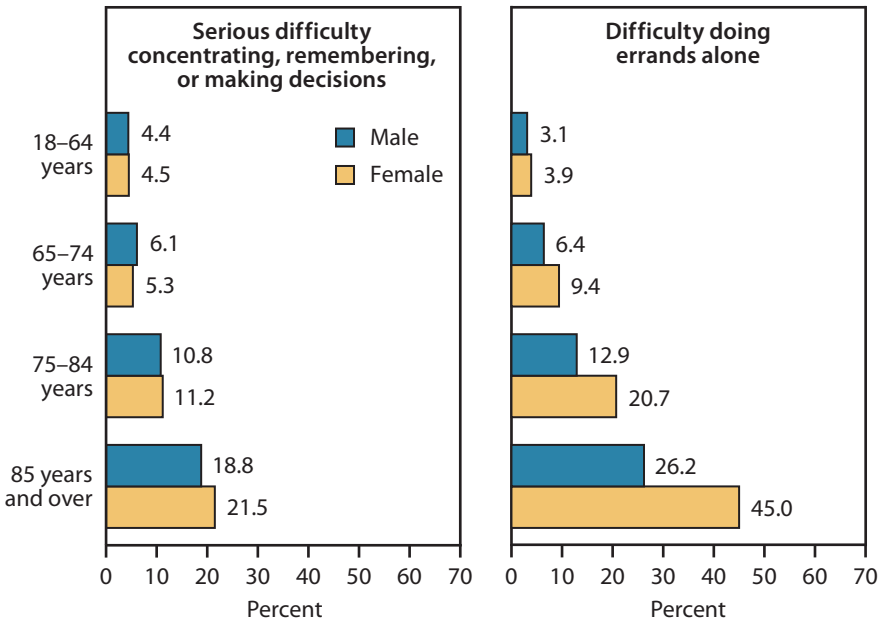
Functional Limitations

Disability

Figure 6. Selected disability indicators among adults aged 18 and over, by sex and age: United States, 2014



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig06

In 2014, disabilities related to cognition and independent living were highest in older age groups; more women than men in each age group reported difficulty doing errands alone.

In 2014, among noninstitutionalized men and women, the prevalence of self-reported serious difficulty concentrating, remembering, or making decisions was higher among older age groups (75–84 and 85 and older) than among younger age groups (18–64 and 65–74) and was similar among men and women in each age group. Difficulty doing errands alone—another disability measure—increased with age. Women in all age groups were more likely than men to report difficulty doing errands alone, ranging from 26% more likely among women aged 18–64 to 72% more likely among women aged 85 and over, compared with men in the same age groups.

NOTE: See data table for Figure 6.
SOURCE: CDC/NCHS, National Health Interview Survey (NHIS).

Health Risk Factors

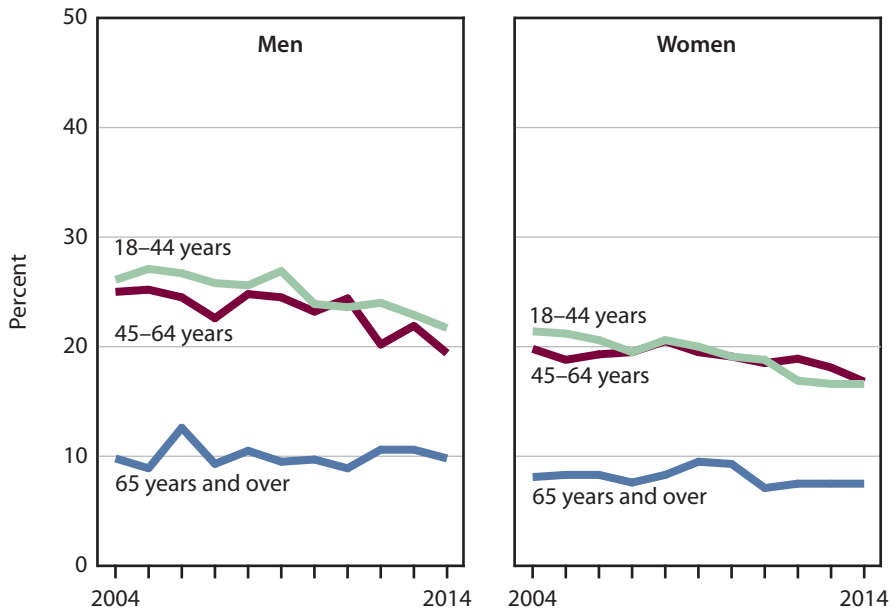
Current Cigarette Smoking

During 2004–2014, cigarette smoking prevalence declined among women aged 18–44 and adults aged 45–64.

Smoking is associated with an increased risk of heart disease, stroke, lung and other types of cancers, and chronic lung diseases (12). During 2004–2014, the percentage of adults who smoked cigarettes declined for women aged 18–44 and for both men and women aged 45–64, and remained stable for men and women aged 65 and over. For men aged 18–44, smoking prevalence was stable from 2004–2009 and then declined through 2014. The prevalence of smoking generally was higher for men aged 18–44 and 45–64 than for women in the same age groups (except for 2012). Among adults aged 65 and over, the prevalence for men and women was similar for most years; from 2011–2014, prevalence was higher among men than women. In 2014, 18.8% of men and 14.8% of women aged 18 and over were current cigarette smokers (Table 47).

SOURCE: CDC/NCHS, *Health, United States, 2015*, Table 47.
Data from the National Health Interview Survey (NHIS).

Figure 7. Current cigarette smoking among adults aged 18 and over, by sex and age: United States, 2004–2014



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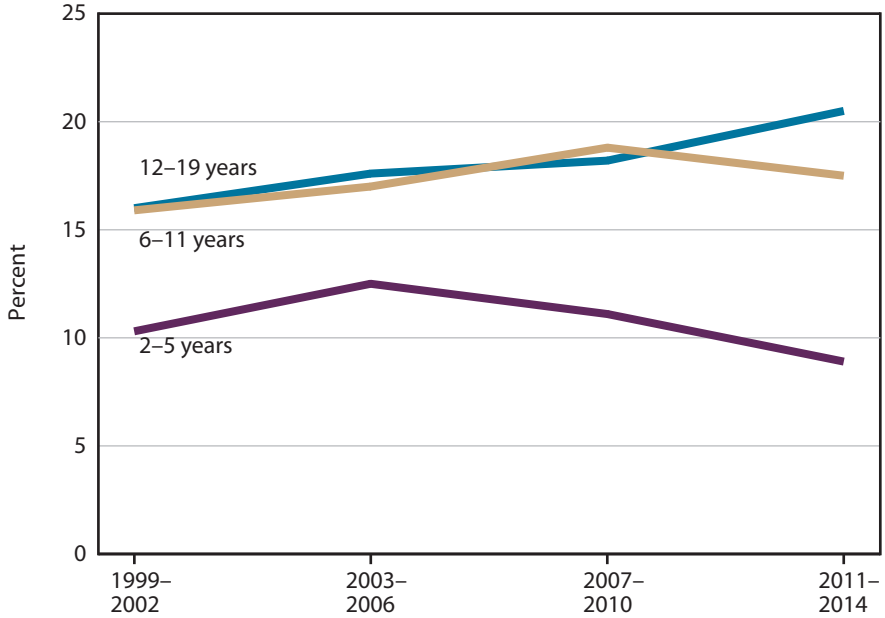
Health Risk Factors

Children and Adolescents With Obesity

Figure 8. Obesity among children and adolescents aged 2–19 years, by age: United States, 1999–2002 through 2011–2014



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig08

Between 1999–2002 and 2011–2014, the prevalence of obesity was stable among children aged 6–11; increased among adolescents aged 12–19; and increased from 1999–2002 to 2003–2006 among those aged 2–5, then declined through 2011–2014.

Excess body weight in children is associated with excess morbidity during childhood and excess body weight in adulthood (13–16). Obesity among children is defined as a body mass index at or above the sex- and age-specific 95th percentile of the CDC growth charts (15,16). From 1988–1994 to 1999–2002, obesity increased among children aged 2–19. Among children aged 2–5, the prevalence of obesity increased from 1999–2002 to 2003–2006 and then declined through 2011–2014. Among children aged 6–11, the prevalence of obesity was stable from 1999–2002 to 2011–2014. Between 1999–2002 and 2011–2014, the prevalence of obesity among adolescents aged 12–19 increased 28%.

SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 59. Data from the National Health and Nutrition Examination Survey (NHANES).

Health Risk Factors

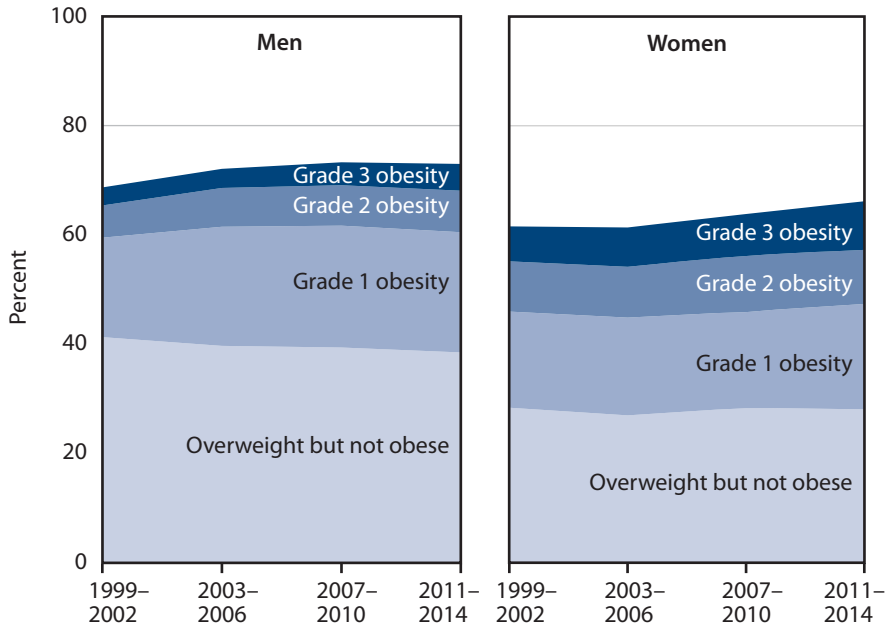
Adults With Overweight and Obesity

Between 1999–2002 and 2011–2014, the prevalence of obesity among men (Grades 1, 2, and 3) and women (Grade 3 only) increased, while the prevalence of overweight but not obese declined among men and remained stable among women aged 20 and over.

Reducing the prevalence of obesity is a public health priority because obesity is correlated with excess morbidity and mortality (17–19). In particular, Grade 2 or higher obesity significantly increases the risk of death (20). Between 1999–2002 and 2011–2014, the percentage of adults aged 20 and over with Grades 1, 2, and 3 obesity increased among men. For women, the percentage of Grade 1 obesity and Grade 2 obesity remained stable while Grade 3 obesity increased. Meanwhile, the percentage of men aged 20 and over who were overweight but not obese declined and was stable among women. In 2011–2014, women were almost twice as likely to have Grade 3 obesity as men (8.9% compared with 4.9%).

NOTES: BMI is body mass index. Overweight but not obese (25 ≤ BMI < 30), Grade 1 obesity (30 ≤ BMI < 35), Grade 2 obesity (35 ≤ BMI < 40), and Grade 3 obesity (BMI ≥ 40).
SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 58. Data from the National Health and Nutrition Examination Survey (NHANES).

Figure 9. Overweight and obesity among adults aged 20 and over, by sex and grade of obesity: United States, 1999–2002 through 2011–2014

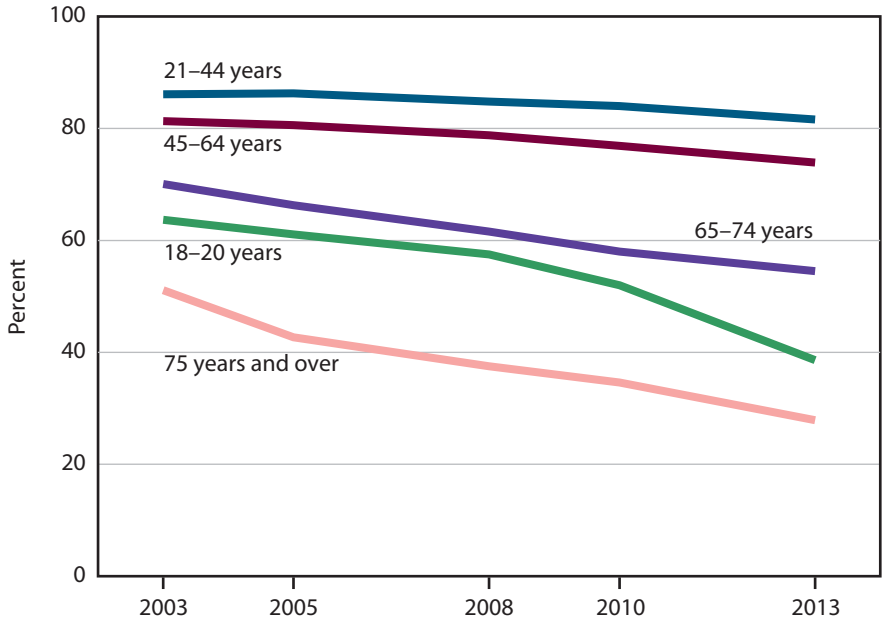


Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig09

Utilization

Pap Test Use

Figure 10. Pap test utilization within the past 3 years, by age: United States, 2003–2013



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig10

From 2003 to 2013, Pap test utilization decreased for all age groups; the largest decreases were for women aged 18–20 and 65 and over (age groups no longer recommended for routine testing).

Pap tests have reduced cervical cancer deaths by detecting cases at earlier and more treatable stages (21). Current Pap test recommendations suggest limiting routine testing to women aged 21–65 and vary based on individual risk factors including cervical cancer risk, human papillomavirus (HPV) testing, and screening history (22). From 2003 to 2013, recent Pap testing declined for all age groups. The refined recommendations may help explain the decrease for women aged 21–44 (5%) and 45–64 (9%). The greatest decreases were for age groups for which routine testing is no longer recommended: 18–20 (39%), 65–74 (22%), and 75 and over (45%).

NOTES: Pap tests (Pap smears) may be used for screening or diagnostic purposes; the purpose cannot be determined from NHIS. See Appendix II, Pap smear. The 65–74 group includes women aged 65 who are still recommended to have routine testing.
SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 71. Data from the National Health Interview Survey (NHIS).

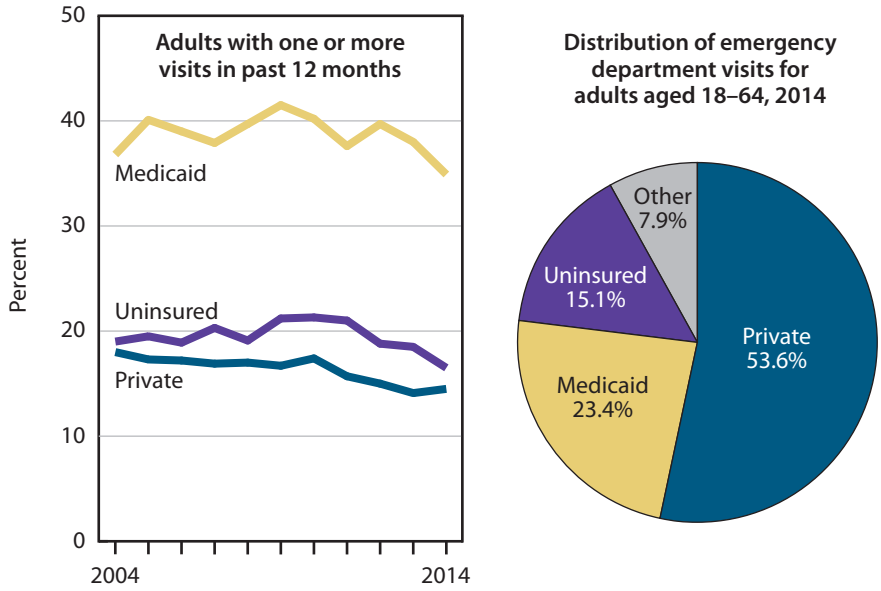
Utilization

Emergency Department Use

During 2004–2014, adults aged 18–64 with Medicaid coverage were more likely to have visited an emergency department within the past year than those with private coverage or the uninsured.

Emergency departments (EDs) are critical in the U.S. health care system, providing emergency and after hours care (23–25). During 2004–2014, adults aged 18–64 with Medicaid coverage were about twice as likely as those with private coverage or the uninsured to have had an ED visit in the past year. During 2004–2014, the percentage with a recent ED visit was stable for adults with Medicaid; for those with private coverage, the percentage was stable through 2010, then declined through 2014; and for the uninsured, the percentage increased during 2004–2011, then declined through 2014. Although adults with Medicaid were more likely to have an ED visit, only 23.4% of all 2014 ED visits were by those with Medicaid; 15.1% were by the uninsured, and 53.6% were by those with private coverage, reflecting the larger percentage of adults with private coverage.

Figure 11. Emergency department utilization within the past 12 months among adults aged 18–64, by type of coverage: United States, 2004–2014



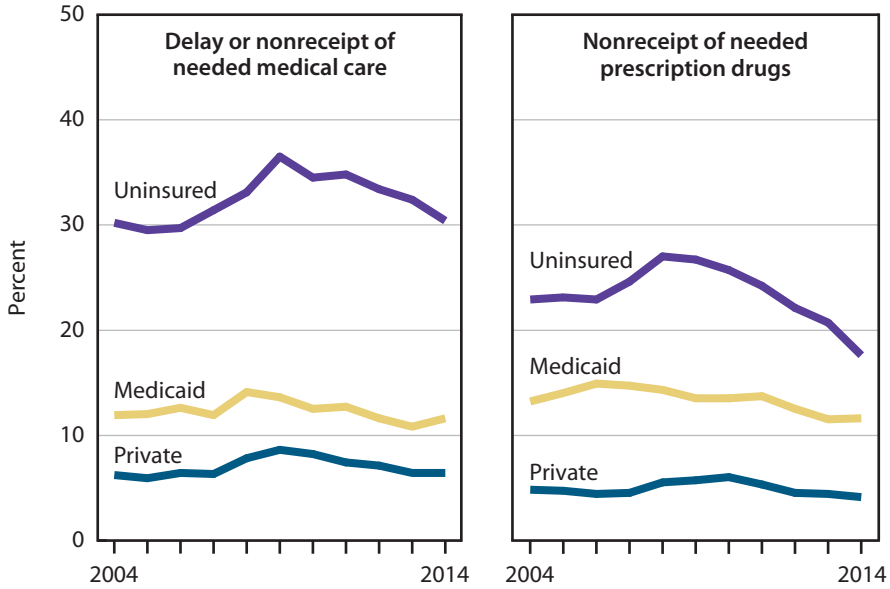
NOTE: See data table for Figure 11.
SOURCE: CDC/NCHS, *Health, United States, 2015,* Table 74. Data from the National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig11

Utilization

Difficulty Accessing Needed Medical Care or Prescription Drugs Due to Cost

Figure 12. Delay or nonreceipt of needed medical care and nonreceipt of needed prescription drugs in the past 12 months due to cost among adults aged 18–64, by health insurance coverage: United States, 2004–2014



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig12

Uninsured adults aged 18–64 are more likely than those with Medicaid or private coverage to report difficulties affording needed medical care and prescription drugs.

Uninsured adults are more likely than the insured to delay or forego needed medical care and prescription drugs due to cost (26,27). During 2004–2014, uninsured adults were 4–5 times more likely than those with private coverage and 1½–3 times more likely than those with Medicaid to report medical care and prescription access problems. For adults with Medicaid, medical care access problems were stable until 2008 and then decreased through 2014. For those with private insurance, medical care access problems increased until 2009 and then declined through 2014. For the uninsured, medical care and prescription access problems increased (until 2010 and 2009, respectively) and then were stable for medical care and decreased through 2014 for access to drugs. Drug access problems were stable in 2004–2014 for those with private insurance but decreased for adults with Medicaid.

SOURCE: CDC/NCHS, *Health, United States, 2015*, Table 63. Data from the National Health Interview Survey (NHIS).

Health Care Resources

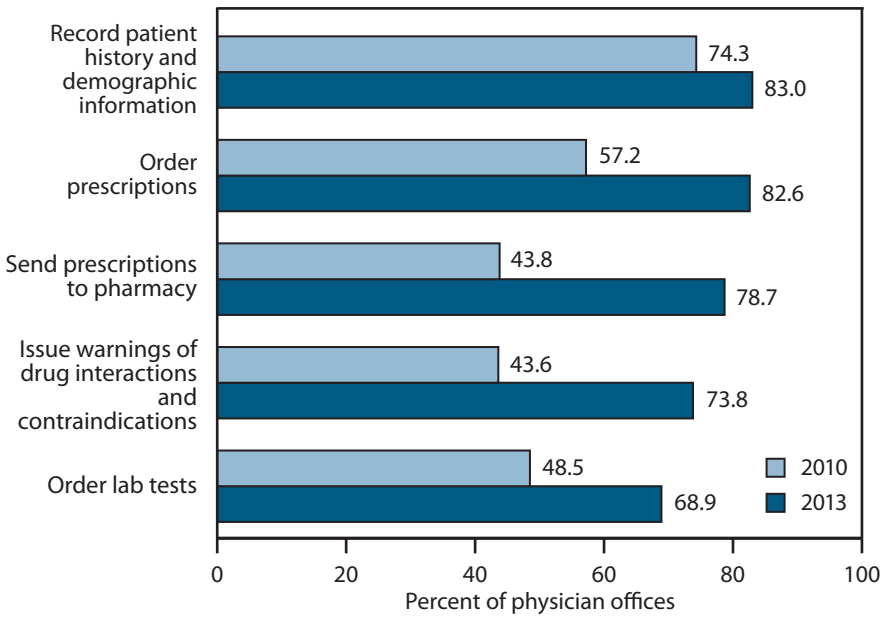
Electronic Health Record Systems

In 2013, most physician offices had electronic health record (EHR) systems that record patient history and demographic information (83.0%), order prescriptions (82.6%), send prescriptions to the pharmacy (78.7%), warn of drug interactions and contraindications (73.8%), and order lab tests (68.9%).

EHR systems are thought to make health care delivery more efficient by improving clinician decision-making, care coordination, health care safety, and patient outcomes (28–30). In 2013, about 8 of every 10 office-based physicians had computerized components that recorded patient history and demographic information, ordered prescriptions, and sent prescriptions to the pharmacy. About 7 of every 10 had a component that warned of drug interactions and contraindications and ordered lab tests. From 2010 to 2013, the percent increase in the use of these EHR components ranged from 12% for components to record patient history and demographic information to 80% for components to send prescriptions to the pharmacy.

NOTE: See data table for Figure 13.
SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey (NAMCS)—National Electronic Health Records Survey.

Figure 13. Electronic health record system components in physician offices, by selected component type: United States, 2010 and 2013

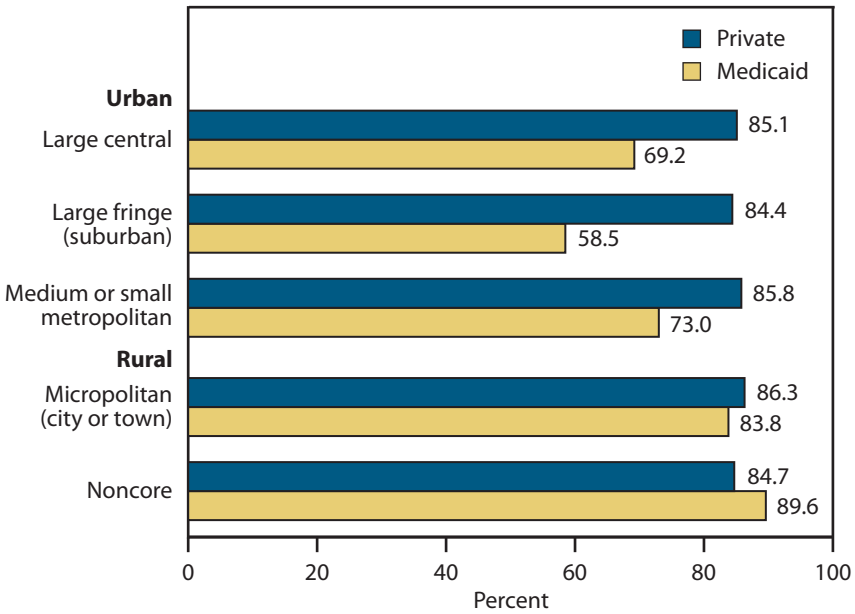


Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig13

Health Care Resources

Physicians Accepting New Patients

Figure 14. Office-based physicians accepting new patients, by patient source of payment and urban–rural status: United States, 2013



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig14

In 2013, physicians in urban large fringe areas (suburbs) were less likely to accept new Medicaid patients than physicians in any other urban–rural category.

Under the ACA, more Americans have health care coverage. In some areas, finding a physician who is accepting new patients may be difficult (31–33). Physician acceptance of new patients was examined by urban–rural status, which classifies physicians by the location of their practice (34). In 2013, Medicaid acceptance rates varied across urban–rural categories, with the lowest acceptance rates for physicians in urban large fringe counties (suburbs). Physicians in rural areas (micropolitan and noncore) were more likely to accept new Medicaid patients than those in urban areas. Comparing physicians' acceptance of new private to new Medicaid patients, physicians in urban areas were less likely to accept new Medicaid than new private patients, while acceptance rates for new Medicaid and private patients were similar for physicians in rural areas.

NOTE: See data table for Figure 14.
SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey (NAMCS)—National Electronic Health Records Survey.

Personal Health Care Expenditures

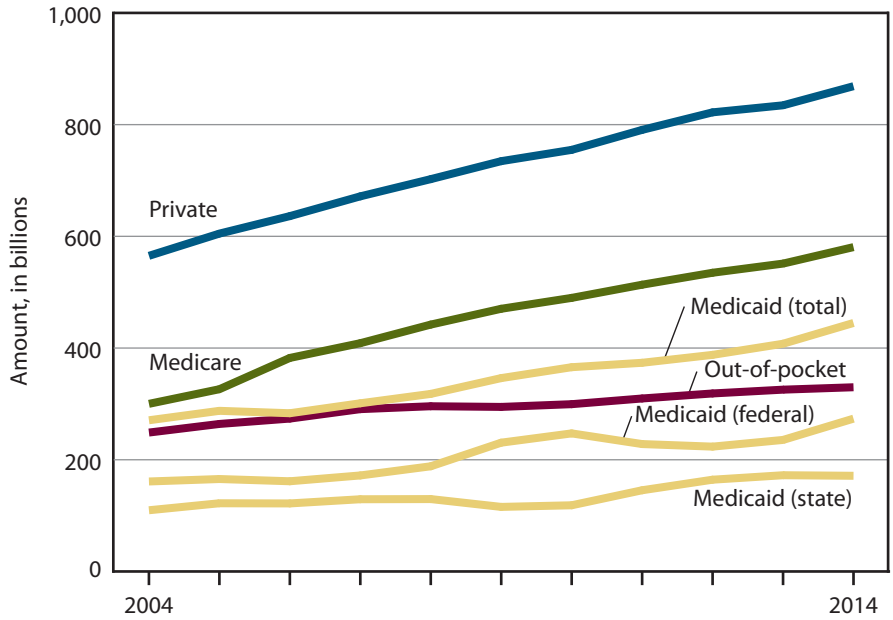
Major Source of Funds

Between 2004 and 2014, Medicare expenditures for personal health care grew more rapidly than out-of-pocket, private insurance spending, and total Medicaid.

Between 2004 and 2014, total personal health care expenditures grew from $1.6 trillion to $2.6 trillion (Table 95). During 2004–2014, the average annual growth in expenditures was 6.8% for Medicare, 5.4% for Medicaid (federal), 4.6% for Medicaid (state), 5.1% for Medicaid (total), 4.4% for private health insurance, and 2.9% for out-of-pocket spending. In 2014, private health insurance accounted for the highest spending on personal health care at $868.8 billion, followed by Medicare at $580.7 billion. Out-of-pocket spending by individuals reached $329.8 billion in 2014, and spending on Medicaid reached $273.6 billion in federal dollars and $171.3 billion in state dollars for a total of $444.9 billion in Medicaid spending. The remainder was paid for by other types of insurance, payers, and programs (Table 95) (35).

NOTES: Personal health care expenditures are outlays relating directly to patient care. See Appendix II, Health expenditures, national.
SOURCE: CDC/NCHS, *Health, United States, 2015*, Table 95. Data from the Centers for Medicare & Medicaid Services, National Health Expenditure Accounts (NHEA).

Figure 15. Personal health care expenditures, by source of funds: United States, 2004–2014

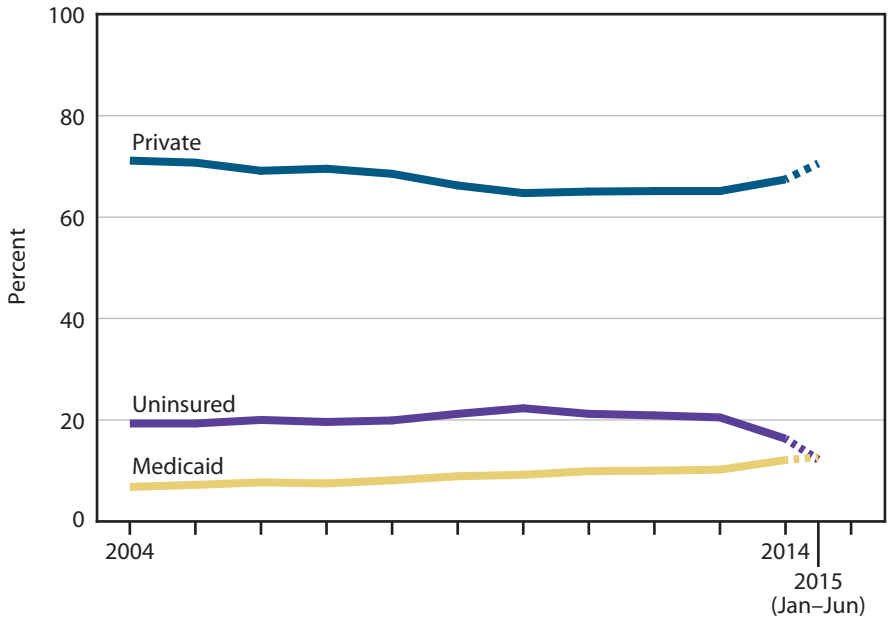


Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig15

Health Insurance

Coverage Among Adults Aged 18–64

Figure 16. Health insurance coverage among adults aged 18–64, by type of coverage: United States, 2004–June 2015 (preliminary data)



Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig16

From 2004 to June 2015, the percentage of adults aged 18–64 with Medicaid coverage increased, the percentage with private coverage decreased through 2012 and then increased through June 2015, and the percentage uninsured increased through 2013 and then declined through June 2015.

Health insurance is a major determinant of access to health care (26). Among adults aged 18–64, the percentage with private coverage declined from 2004 (71.1%) to 2012 (65.1%) and then increased through June 2015 (70.6%) (Table 102) (36). As of June 2015, 8.9 million adults aged 18–64 were covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges (36). The percentage with Medicaid coverage increased from 2004 (6.8%) to June 2015 (12.2%) (Table 104) (37). The percentage of adults aged 18–64 who were uninsured increased from 2004 (19.3%) to 2013 (20.5%) and then declined through June 2015 (12.7%) (Table 105) (36).

NOTE: Preliminary estimates for the first 6 months of 2015 are shown with a dashed line (36).
SOURCE: CDC/NCHS, *Health, United States, 2015*, Tables 102, 104, 105. Data from the National Health Interview Survey (NHIS).

Health Insurance

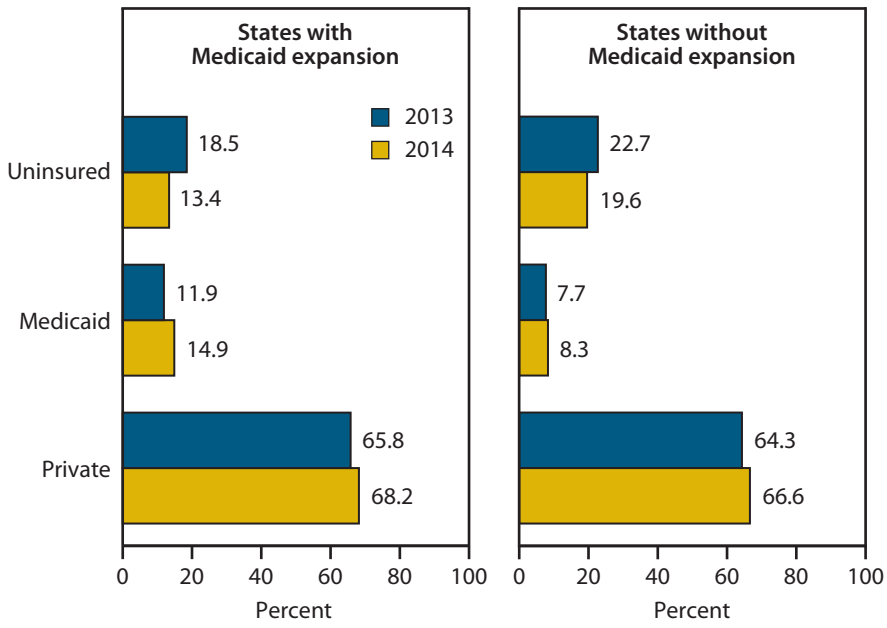
Coverage by Medicaid Expansion State

Between 2013 and 2014, the percentage of adults aged 18–64 who were uninsured declined in both Medicaid expansion states (by 28%) and nonexpansion states (by 14%), and the percentage covered by Medicaid increased by 25% in Medicaid expansion states.

Under the ACA (38), states are authorized to expand Medicaid coverage to adults with low incomes, up to and including 138% of the poverty level (39). Between 2013 and 2014, the percentage of adults aged 18–64 who were uninsured declined in both Medicaid expansion states and nonexpansion states; however, the decline in the uninsured percentage was greater for states that expanded their Medicaid programs (28% compared with 14%). The percentage covered by private insurance increased by about 4% in both Medicaid expansion and nonexpansion states. Medicaid coverage increased 25% in states that expanded their programs and was stable in states that did not expand their programs.

NOTES: States were classified based on their decision to expand Medicaid as of January 1, 2014 (40). See data table for Figure 17.
SOURCE: CDC/NCHS, National Health Interview Survey (NHIS).

Figure 17. Health insurance coverage among adults aged 18–64, by state Medicaid expansion status: United States, 2013 and 2014



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Special Feature on Racial and Ethnic Health Disparities: 30 Years After the Heckler Report

Introduction

The 1985 Report of the Secretary's Task Force on Black and Minority Health, released by then Secretary of Health and Human Services Margaret Heckler, documented significant disparities in the burden of illness and mortality experienced by blacks and other minority groups in the U.S. population compared with whites (41). The report laid out an ambitious agenda, including improving minority access to high-quality health care, expanding health promotion and health education outreach activities, increasing the number of minority health care providers, and enhancing federal and state data collection activities to better report on minority health issues. In the 30 years since the Heckler Report, national efforts to improve minority health through outreach, programming, and monitoring have included the formation of the Department of Health and Human Services (HHS) Office of Minority Health in 1986 (42); the annual National Healthcare Quality and Disparities Reports first issued in 2003 (43); the adoption of disparities elimination as an overarching goal of Healthy People 2010 (44); and most recently, an HHS Action Plan to Reduce Racial and Ethnic Health Disparities—a comprehensive federal commitment to reduce and eventually eliminate disparities in health and health care (45).

Race is a social construct influenced by a complex set of factors (46,47). Because of the complexity and difficulty in conceptualizing and defining race, as well as the increasing representation of racial and ethnic subgroups in the United States, racial classification and data collection systems continue to evolve and expand. In 1977, the Office of Management and Budget (OMB) required that all federal data collection efforts collect data on a minimum of four race groups (American Indian or Alaskan Native, black, Asian or Pacific Islander, and white) and did not allow the reporting of more than one race (48). In 1997, in response to growing interest in more detailed reporting on race and ethnicity, OMB mandated data collection for a minimum of five race groups, splitting Asian or Pacific Islander into two categories (Asian, and Native Hawaiian or Other Pacific Islander) (49). In addition, the 1997 standards allowed respondents to report more than one race. A minimum of two categories for data collection on ethnicity, "Hispanic or Latino" and "Not Hispanic or Latino," were also required under the 1997 OMB standards. Consequently, whereas the Heckler Report primarily documented black–white differences in health and mortality due to data limitations, this Special Feature is able to report on more detailed racial and ethnic groups. For example, Figures 19–21 display trends in infant mortality and low-risk cesarean section deliveries, and the current data on preterm births for five Hispanic-origin groups.

At the time of the Heckler Report, 22.3% of the population were considered racial or ethnic minorities (Table 1). Current Census (2014) estimates identify 37.9% of the population as racial or ethnic minorities (50). In 2014, Hispanic persons, who may be of any race, comprised 17.4% of the U.S. population. Non-Hispanic multiple race persons were 2.0% of the population. For the single race groups, non-Hispanic American Indian or Alaska Native persons were 0.7%, non-Hispanic Asian persons were 5.3%, non-Hispanic black persons were 12.4%, non-Hispanic Native Hawaiian or Other Pacific Islander persons were 0.2%, and non-Hispanic white persons were 62.1% of the U.S. population in 2014 (50).

Understanding the demographic and socioeconomic composition of U.S. racial and ethnic groups is important because these characteristics are associated with health risk factors, disease prevalence, and access to care, which in turn drive health care utilization and expenditures. Non-Hispanic white persons are, on average, older than those in other racial and ethnic groups, with a median age of 43.1 years, and Hispanic individuals are the youngest, with a median age of 28.5 years in 2014 (50). About one-quarter of black only persons (26.2%) and Hispanic persons (23.6%) lived in poverty compared with 10.1% of non-Hispanic white only persons and 12.0% of Asian only persons in 2014 (51). Non-Hispanic black only children and Hispanic children were particularly likely to live in poverty (37.3% and 31.9%, respectively, in 2014) (52). However, Hispanic individuals are often found to have quite favorable health and mortality patterns in comparison with non-Hispanic white persons and particularly with non-Hispanic black persons, despite having a disadvantaged socioeconomic profile—a pattern termed the epidemiologic paradox (53).

HHS defines a racial or ethnic health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group" (54). There are many different ways to measure racial and ethnic differences in health and mortality, which can lead to different conclusions (55–58). This Special Feature on Racial and Ethnic Health Disparities (Special Feature) uses the maximal rate difference, one of three overall measures used in Healthy People 2020 to measure differences among groups of people (see Technical Notes). The maximal rate difference is an overall measure of health disparities calculated as the absolute difference between the highest and lowest group rates in the population for a given characteristic (59). The identification of groups that experience the highest and lowest rates in this Special Feature was based on observed rates and was not tested for a statistically significant difference against other rates. Ties in highest or lowest rates

were resolved by examining decimal places. With respect to changes in health disparities over time, tracking the maximal rate difference over time enables one to determine whether the absolute difference between the highest and lowest group rates is increasing, decreasing, or stable.

The Special Feature charts that follow provide detailed comparisons of key measures of mortality, natality, health conditions, health behaviors, and health care access and utilization, by race, race and ethnicity, or by detailed Hispanic origin, depending on data availability. A majority of the 10 graphs in this year's Special Feature present trends in health from 1999–2014. Results indicate that trends in health were generally positive for the overall population and several graphs illustrate success in narrowing gaps in health by racial and ethnic group. Differences in life expectancy, infant mortality, cigarette smoking among women, influenza vaccinations among those aged 65 and over, and health insurance coverage narrowed among the racial and ethnic groups. For example, the absolute difference in infant mortality rates between infants born to non-Hispanic black mothers (highest rate) and infants born to non-Hispanic Asian or Pacific Islander mothers (lowest rate) narrowed between 1999–2014. Differences by racial and ethnic group in the prevalence of high blood pressure and smoking among adult men remained stable throughout the study period, with non-Hispanic black adults more likely to have high blood pressure than adults in other racial and ethnic groups throughout the period, and non-Hispanic black and non-Hispanic white males more likely to be current smokers than Hispanic and non-Hispanic Asian men. For low-risk cesarean sections, influenza vaccinations among adults aged 18–64, and unmet dental care needs, the gap widened among the racial and ethnic groups between 1999–2014.

Despite improvements over time in many of the health measures presented in this Special Feature, disparities by race and ethnicity were found in the most recent year for all 10 measures, indicating that although progress has been made in the 30 years since the Heckler Report, elimination of disparities in health and access to health care has yet to be achieved.

Life Expectancy at Birth

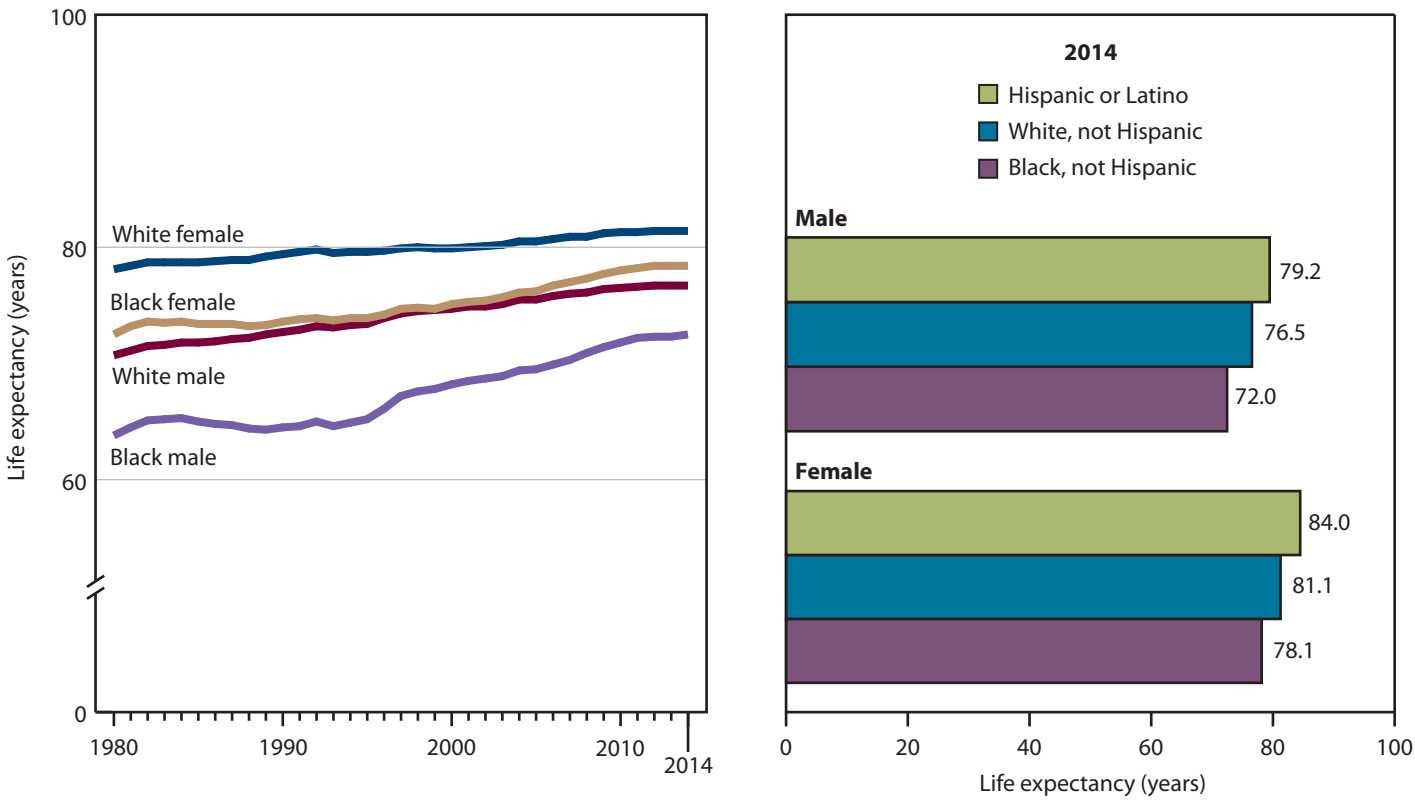
In 2014, life expectancy was longer for Hispanic men and women than for non-Hispanic white or non-Hispanic black men and women.

Life expectancy is a measure often used to gauge the overall health of a population. Life expectancy at birth represents the average number of years that a group of infants would live if the group were to experience the age-specific death rates present in the year of birth. Differences in life expectancy among various demographic subpopulations, including racial and ethnic groups, may reflect subpopulation differences in a range of factors such as socioeconomic status, access to medical care, and the prevalence of specific risk factors in a particular subpopulation (60,61).

During 1980–2014, life expectancy at birth in the United States increased from 70.0 to 76.4 years for males and from 77.4 to 81.2 years for females (Table 15, and data table for Figure 18). During this period, life expectancy at birth for males and females was longest for white persons and shortest for black persons. For both males and females, racial differences in life expectancy at birth narrowed, but persisted during 1980–2014. Life expectancy at birth was 6.9 years longer for white males than for black males in 1980, and this difference narrowed to 4.2 years in 2014. In 1980, life expectancy at birth was 5.6 years longer for white females than for black females, and this difference narrowed to 3.0 years in 2014.

In 2014, Hispanic males and females had the longest life expectancy at birth, and non-Hispanic black males and females had the shortest. In 2014, life expectancy at birth was 7.2 years longer for Hispanic males than for non-Hispanic black males and 5.9 years longer for Hispanic females than for non-Hispanic black females.

Figure 18. Life expectancy at birth, by sex, race and Hispanic origin: United States, 1980–2014



NOTES: Life expectancy data by Hispanic origin were available starting in 2006 and were corrected to address racial and ethnic misclassification. See Technical Notes and data table for Figure 18.

SOURCE: CDC/NCHS, National Vital Statistics System (NVSS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig18

Infant Mortality

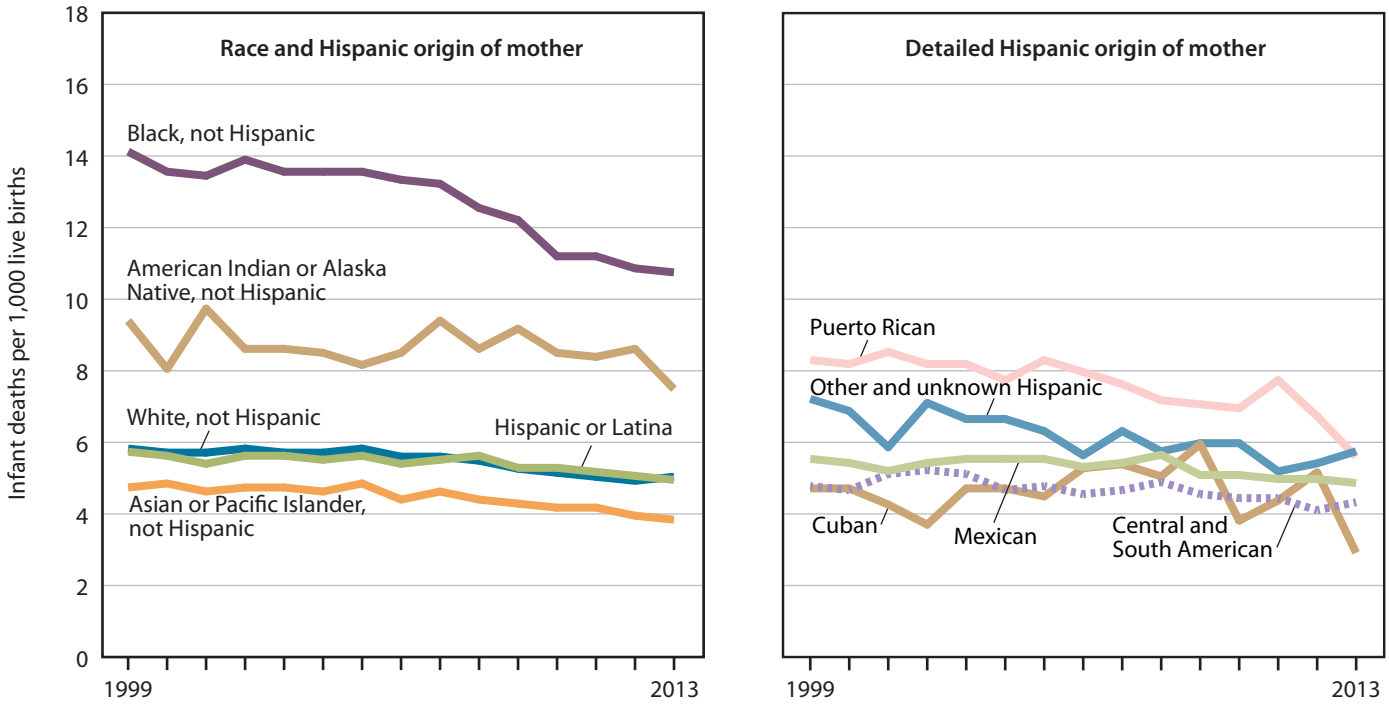
During 1999–2013, infant mortality rates were highest among infants born to non-Hispanic black women (11.11 infant deaths per 1,000 live births in 2013).

Infant mortality, the death of a baby before his or her first birthday, is an important indicator of the health and wellbeing of a country. It not only measures the risk of infant death but it is used as an indicator of maternal health, community health status, and availability of quality health services and medical technology (62,63).

The infant mortality rate in the United States decreased from 7.04 infant deaths per 1,000 live births in 1999 to 6.75 in 2007, and then decreased at a faster rate to 5.96 in 2013. Trends in infant mortality rates during 1999–2013 varied among the five racial and ethnic groups. During 1999–2013, infants born to non-Hispanic black mothers experienced the highest rates of infant mortality (11.11 in 2013) and infants born to non-Hispanic Asian or Pacific Islander mothers experienced the lowest rates (3.90 in 2013). The difference between the highest and lowest infant mortality rates among the five racial and ethnic groups was stable from 1999 to 2006 and then narrowed from 2006 to 2013. The difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian or Pacific Islander) infant mortality rates was 9.41 deaths per 1,000 live births in 1999, compared with 7.21 in 2013.

For infants born to Hispanic mothers, the infant mortality rate remained stable during 1999–2008 (5.71 infant deaths per 1,000 live births in 1999) and then decreased to 5.00 in 2013. During 1999–2013, the infant mortality rate for Hispanic infants varied by the mother's Hispanic-origin group. Throughout this period, infants born to Puerto Rican mothers experienced the highest mortality rates. In all years except 2009, infants born to Cuban mothers and those born to Central and South American mothers experienced the lowest mortality rates at alternate times throughout 1999–2013. The difference between the highest (Puerto Rican) and lowest (Cuban) infant mortality rates among Hispanic-origin groups narrowed from 3.71 deaths per 1,000 live births in 1999 to 2.88 in 2013. During 1999–2013, the difference in infant mortality rates was narrower for mothers in the Hispanic-origin groups than for mothers in the five racial and ethnic groups.

Figure 19. Infant mortality rates, by race and Hispanic origin and detailed Hispanic origin of mother: United States, 1999–2013



NOTES: Highest and lowest rates are based on observed rates and were not tested for statistically significant differences against other rates. Ties in highest and lowest rates were resolved by looking at additional decimal places. See Technical Notes and data table for Figure 19.

SOURCE: CDC/NCHS, National Vital Statistics System (NVSS), Linked Birth/Infant Death Data Set.

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig19

Preterm Births

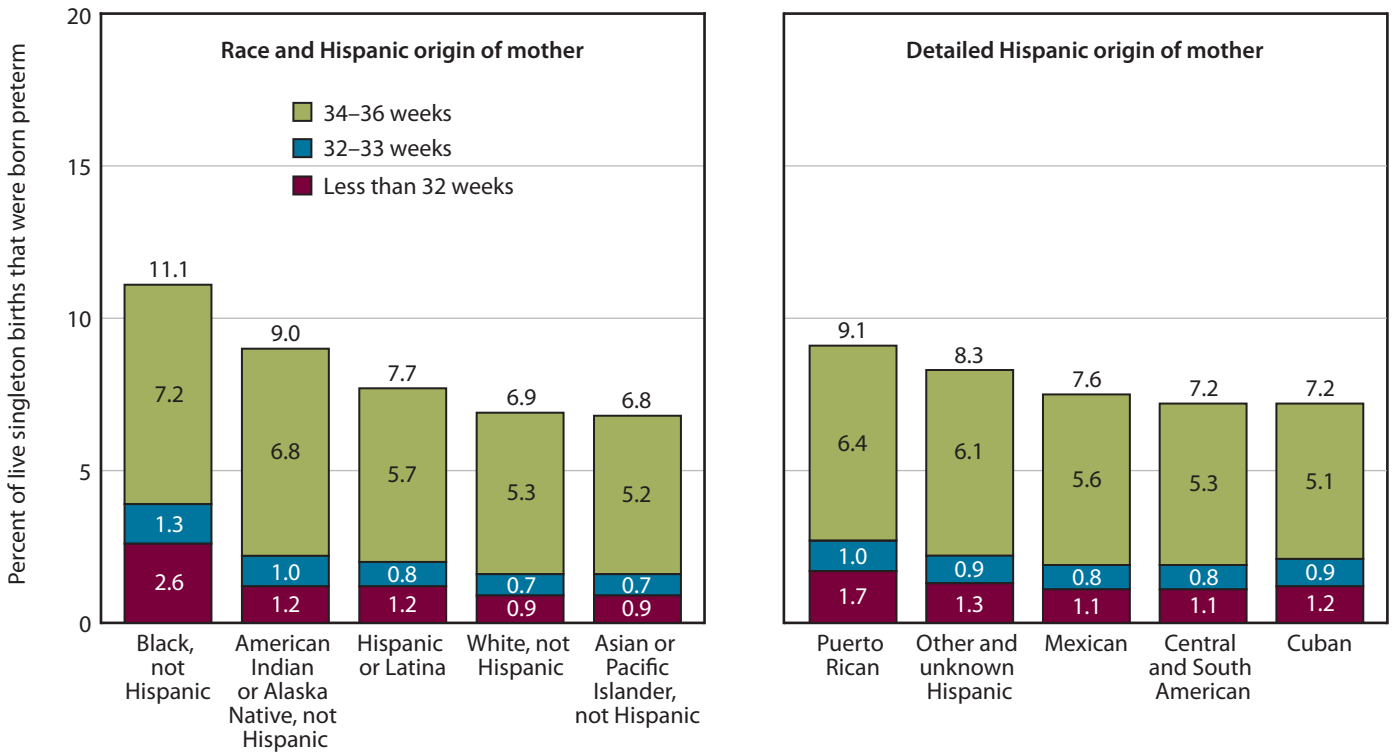
In 2014, non-Hispanic black mothers had the highest percentage of preterm births of the five racial and ethnic groups, and Puerto Rican mothers had the highest percentage of preterm births of the five Hispanic-origin groups.

An infant's gestational age is an important predictor of his or her survival and subsequent health (64–70). Preterm birth prior to 37 weeks gestation affects infant mortality rates and racial and ethnic disparities in infant mortality (Figure 19) (71). The degree of prematurity matters—infants born prior to 32 weeks gestation are at greatest risk of death during infancy, with the risk of infant death decreasing as gestational age increases (72).

In 2014, 7.7% of singleton births occurred before 37 weeks of gestation; 5.7% at 34–36 weeks; 0.8% at 32–33 weeks gestation; and 1.2% before 32 weeks (data table for Figure 20). In 2014, among the five racial and ethnic groups, non-Hispanic black women had the highest percentage of singleton births before 37 weeks (11.1%) and non-Hispanic Asian or Pacific Islander women had the lowest percentage (6.8%). Non-Hispanic black women also had the highest percentage of singleton preterm births at each preterm gestational age. The difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian or Pacific Islander) percentages of singleton preterm births among the five racial and ethnic groups was 4.3 percentage points (before 37 weeks), 2.0 percentage points (34–36 weeks), 0.6 percentage points (32–33 weeks), and 1.7 percentage points (before 32 weeks).

Among Hispanic-origin groups in 2014, Puerto Rican mothers had the highest percentage of singleton births before 37 weeks (9.1%) and Cuban mothers had the lowest percentage (7.2%). The difference between the highest (Puerto Rican) and lowest (Cuban) percentages of singleton preterm births among the Hispanic-origin groups was 1.9 percentage points (before 37 weeks) and 1.3 percentage points (34–36 weeks). Central and South American mothers had the lowest percentage of singleton births before 34 weeks. For preterm births before 34 weeks, the difference between the highest (Puerto Rican) and lowest (Central and South American) percentages was 0.2 percentage points (32–33 weeks) and 0.6 percentage points (before 32 weeks).

Figure 20. Preterm births, by gestational age and race and Hispanic origin and detailed Hispanic origin of mother: United States, 2014



NOTES: Preterm births are based on the obstetric estimate of gestational age and are for all singleton births (73). Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. Ties in highest and lowest percentages were resolved by looking at additional decimal places. See Technical Notes and data table for Figure 20.

SOURCE: CDC/NCHS, National Vital Statistics Survey (NVSS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig20

Low-risk Births Delivered by Cesarean Section

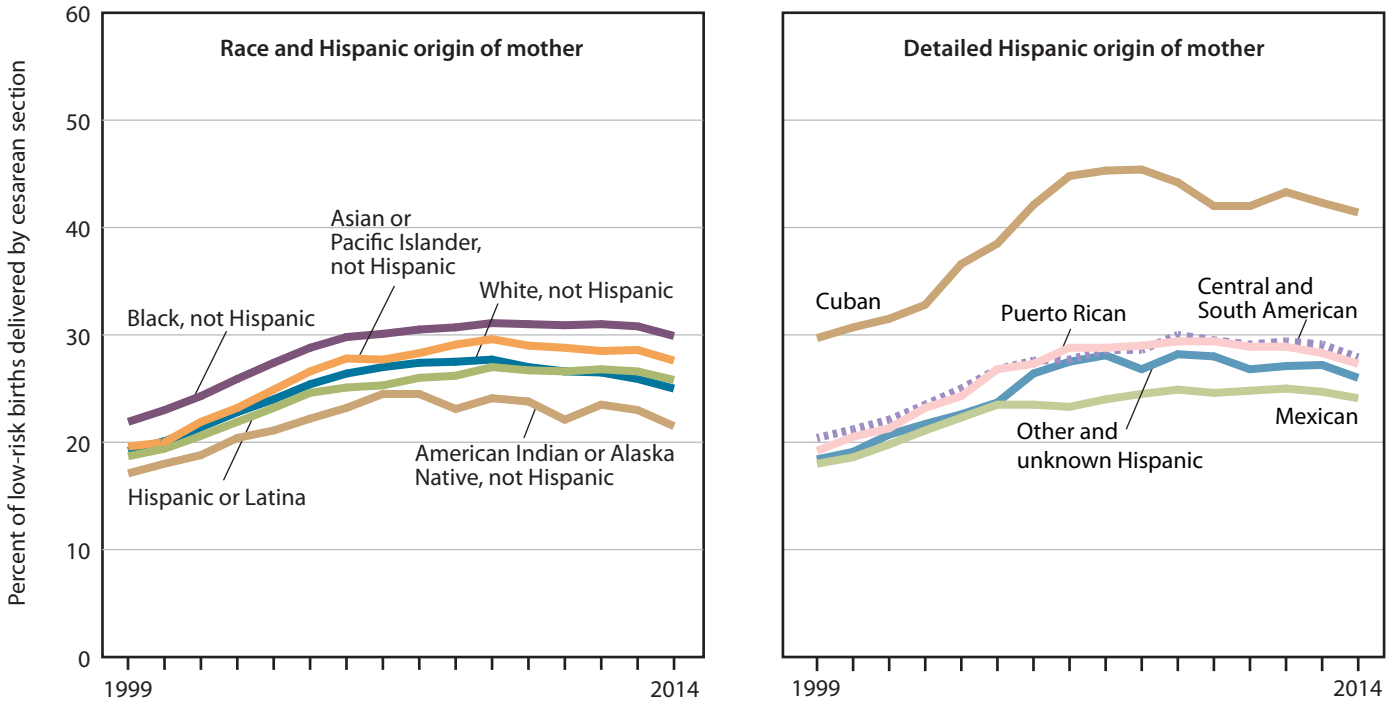
During 1999–2014 non-Hispanic black mothers experienced the highest percentage of low-risk cesarean deliveries among the five racial and ethnic groups (29.9% in 2014); Cuban mothers experienced the highest percentage of low-risk cesarean deliveries among the five Hispanic-origin groups (41.4% in 2014).

Cesarean deliveries comprise approximately one-third of all births in the United States (32.2% in 2014) and can place mothers and infants at increased risk for poor health outcomes (74). Over the past decade, professional medical groups have attempted to reduce low-risk cesarean deliveries defined as cesarean deliveries among full term (37 or more completed weeks of gestation), singleton, vertex (head first) births to women giving birth for the first time (75,76).

The percentage of low-risk births that were delivered by cesarean section increased from 19.5% to 26.6% during 1999–2005, stabilized during 2005–2009, and then decreased to 26.0% in 2014 (data table for Figure 21). Throughout the period 1999–2014, non-Hispanic black mothers experienced the highest percentage of low-risk cesarean deliveries (29.9% in 2014) among the five racial and ethnic groups, while non-Hispanic American Indian or Alaska Native mothers experienced the lowest percentage (21.5% in 2014). The difference between the highest (non-Hispanic black) and lowest (non-Hispanic American Indian or Alaska Native) percentages widened from 4.8 percentage points in 1999 to 8.4 percentage points in 2014.

Among Hispanic mothers, the percentage of low-risk births that were delivered by cesarean section increased from 18.7% to 24.6% during 1999–2004, increased at a slower rate from 2004–2009, and then remained stable during 2009–2014 (data table for Figure 21). Throughout the period 1999–2014 Cuban mothers experienced the highest percentage of low-risk cesarean deliveries (41.4% in 2014), while Mexican mothers experienced the lowest percentage (24.1% in 2014). Among Hispanic-origin groups, the difference between the highest and lowest percentages of low-risk cesarean deliveries was stable during 1999–2002, widened sharply during 2002–2006, and then narrowed during 2006–2014. The difference between the highest (Cuban) and lowest (Mexican) percentages was 11.7 percentage points in 1999, 21.5 percentage points in 2006, and 17.3 percentage points in 2014.

Figure 21. Low-risk births delivered by cesarean section, by race and Hispanic origin and detailed Hispanic origin of mother: United States, 1999–2014



NOTES: The term low-risk cesarean delivery is not meant to imply that a cesarean delivery may not be medically necessary for low-risk women (75). Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. Ties in highest and lowest percentages were resolved by looking at additional decimal places. See Technical Notes and data table for Figure 21.

SOURCE: CDC/NCHS, National Vital Statistics System (NVSS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig21

Children and Adolescents With Obesity

In 2011–2014 for children and adolescents aged 2–19 years, Hispanic children and adolescents had the highest prevalence of obesity and non-Hispanic Asian children had the lowest prevalence.

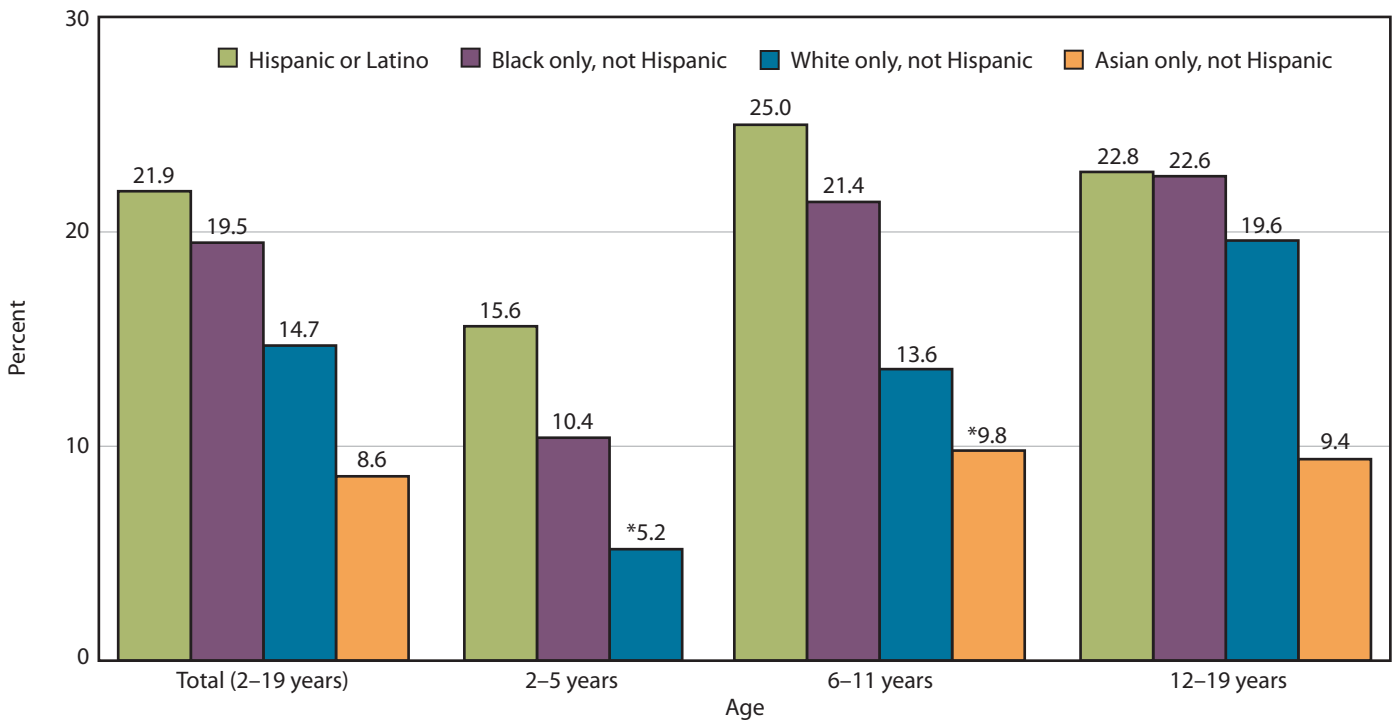
Childhood obesity is a serious public health challenge in the United States and many other industrialized nations in the world (Figure 8) (19,77,78). Excess body weight in children is associated with excess morbidity in childhood and excess body weight in adulthood (13,14). Obesity among children and adolescents is defined as a body mass index at or above the sex- and age-specific 95th percentile of the CDC growth charts (15). Between 1999–2000 and 2013–2014, the percentage of children and adolescents aged 2–19 with obesity increased from 13.9% to 17.2% (79). However, among youth aged 2–19, the prevalence of obesity did not change from 2003–2004 through 2013–2014 (79).

In 2011–2014 for children and adolescents aged 2–19, the percentage with obesity was highest for Hispanic children and adolescents and lowest for non-Hispanic Asian children and adolescents. For those aged 2–19, the difference between the highest (Hispanic) and lowest (non-Hispanic Asian) percentages was 13.3 percentage points.

For children aged 2–5, the percentage with obesity was highest for Hispanic children and lowest for non-Hispanic white children. (The estimate for non-Hispanic Asian children aged 2–5 was not stable and is not shown.) The difference between the highest (Hispanic) and lowest (non-Hispanic white) percentages was 10.4 percentage points for children aged 2–5. For children aged 6–11, the percentage with obesity was highest for Hispanic children and lowest for non-Hispanic Asian children. For children aged 6–11, the difference between the highest (Hispanic) and lowest (non-Hispanic Asian) percentages was 15.2 percentage points.

In 2011–2014 for adolescents aged 12–19, the percentage with obesity was highest for Hispanic adolescents and lowest for non-Hispanic Asian adolescents. The difference between the highest (Hispanic) and lowest (non-Hispanic Asian) percentages was 13.4 percentage points for adolescents aged 12–19 years.

Figure 22. Obesity among children and adolescents aged 2–19 years, by age and race and Hispanic origin: United States, 2011–2014



* Relative standard error (RSE) of 20%–30%. The estimate for non-Hispanic Asian children aged 2–5 is not shown because the RSE is greater than 30%.

NOTES: Obesity is defined as a body mass index at or above the sex- and age-specific 95th percentile of the CDC growth charts. Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. See Technical Notes and data table for Figure 22.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey (NHANES).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig22

Hypertension

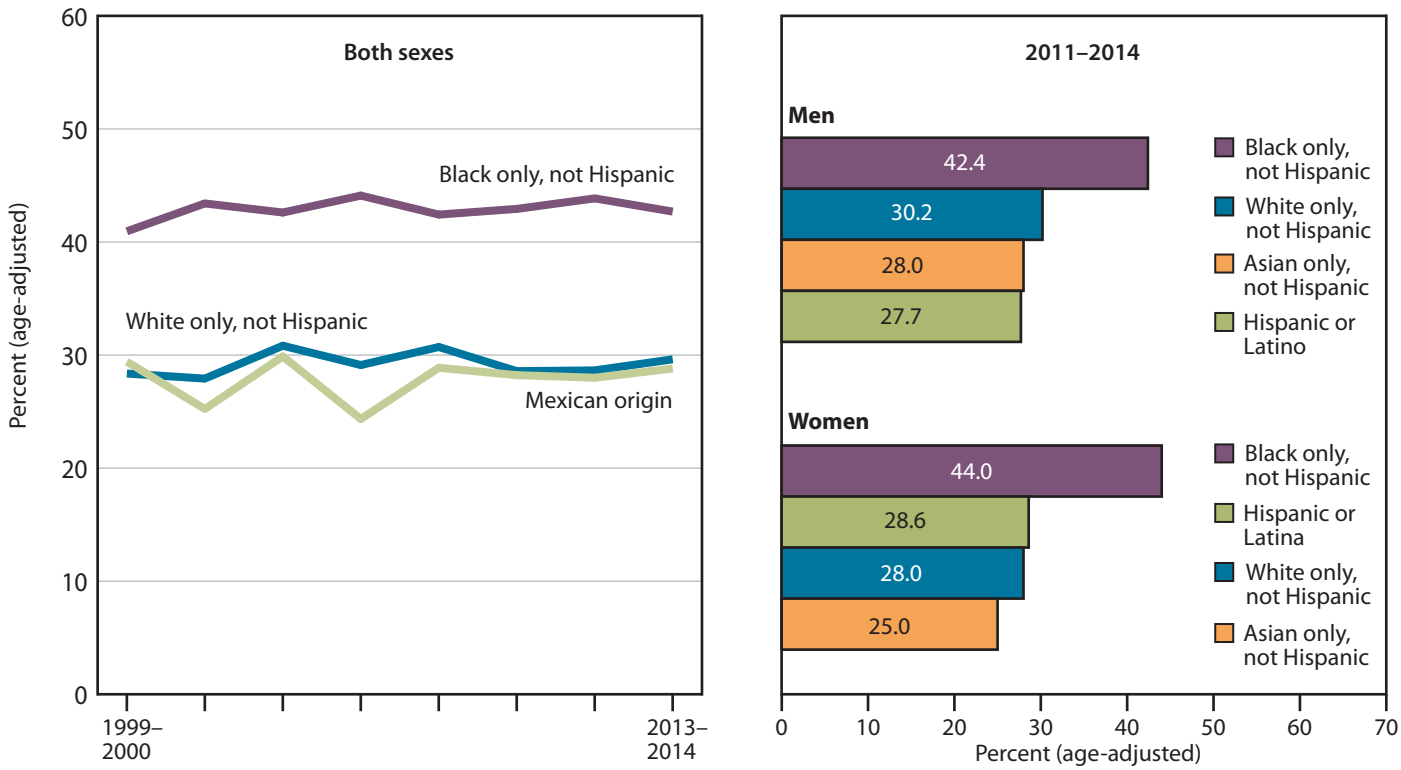
In 2011–2014, non-Hispanic black men and women were the most likely to have hypertension compared with adults in the other racial and ethnic groups.

Hypertension is an important risk factor for cardiovascular disease, stroke, kidney failure, and other health conditions (80,81). In 2011–2014, 84.1% of adults with hypertension were aware of their status, and 76.1% were taking medication to lower their blood pressure (82). Despite improvement in increasing the awareness, treatment, and control of hypertension, diagnosis and treatment of hypertension among minority groups remains a challenge (83).

Hypertension is defined as reporting taking antihypertensive medication and/or having a measured systolic blood pressure of at least 140 mm Hg or a measured diastolic blood pressure of at least 90 mm Hg. The age-adjusted percentage of adults aged 20 and over with hypertension was stable during 1999–2014 (30.8% in 2013–2014) (data table for Figure 23). During 1999–2014, non-Hispanic black adults had the highest percentage with hypertension among the three racial and ethnic groups (42.7%, age-adjusted in 2013–2014), while with the exception of 1999–2000, adults of Mexican origin had the lowest percentage with hypertension (28.8%, age-adjusted in 2013–2014). The difference between the highest and lowest age-adjusted percentages of adults with hypertension among the three racial and ethnic groups was stable during 1999–2014; in 2013–2014, the difference between the highest (non-Hispanic black) and lowest (Mexican-origin) percentages was 13.9 percentage points.

In 2011–2014, the age-adjusted percentage of adult men and women with hypertension was similar (31.0% and 29.7%, respectively, data table for Figure 23). The difference between the highest (non-Hispanic black) and lowest (Hispanic) age-adjusted percentages of men with hypertension among the four racial and ethnic groups was 14.7 percentage points; for women, the difference between the highest (non-Hispanic black) and lowest (non-Hispanic Asian) was 19.0 percentage points in 2011–2014.

Figure 23: Hypertension among adults aged 20 and over, by sex and race and Hispanic origin: United States, 1999–2000 through 2013–2014



NOTES: Estimates are age-adjusted. Hypertension is having measured high blood pressure (systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg) and/or respondent report of taking antihypertensive medication. Data for Hispanic adults were available starting in 2007–2008 and for non-Hispanic Asian adults in 2011–2012. Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. See Technical Notes and data table for Figure 23.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey (NHANES).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig23

Current Cigarette Smoking

During 1999–2014, differences in cigarette smoking between racial and ethnic groups were larger for women than for men.

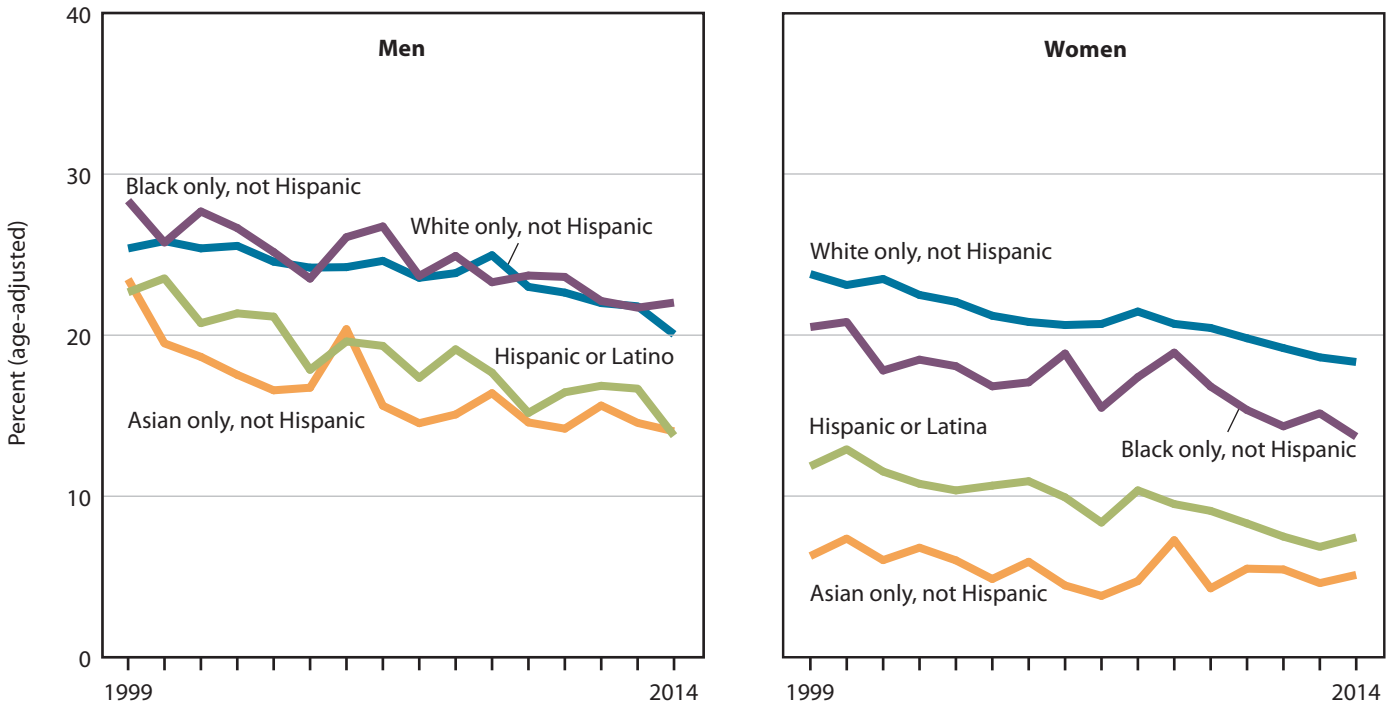
Smoking causes more than 480,000 deaths each year, accounting for about one in five deaths in the United States (84). Smokers are more likely to develop heart disease, stroke, and cancer. Smoking also increases the risk for diabetes, cataracts, rheumatoid arthritis, and stillbirth (85).

During 1999–2014, the age-adjusted percentage of adults aged 18 and over who were current cigarette smokers decreased from 25.2% to 19.0% for men and from 21.6% to 15.1% for women (data table for Figure 24). Within each of the four racial and ethnic groups, men were more likely to be current cigarette smokers than women.

In 2014 for men, the age-adjusted percentage of current cigarette smokers was highest for non-Hispanic black men (22.0%) and lowest for Hispanic men (13.8%). The difference between the highest and lowest age-adjusted percentages of current cigarette smokers among the four racial and ethnic groups remained stable during 1999–2014 because levels for men in all racial and ethnic groups declined similarly during this period. The difference between the highest (non-Hispanic black) and lowest (Hispanic) percentages for men was 8.2 percentage points in 2014.

For women, non-Hispanic white women consistently had the highest age-adjusted percentage of current cigarette smokers among the four racial and ethnic groups throughout 1999–2014 (18.3% in 2014), while non-Hispanic Asian women had the lowest age-adjusted percentage (5.1% in 2014). For women, the difference between the highest (non-Hispanic white) and lowest (non-Hispanic Asian) percentages narrowed from 17.5 percentage points in 1999 to 13.2 in 2014. During 1999–2014, racial and ethnic differences in cigarette smoking prevalence were larger for women than for men.

Figure 24. Current cigarette smoking among adults aged 18 and over, by sex and race and Hispanic origin: United States, 1999–2014



NOTES: Estimates are age-adjusted. Three-year average annual estimates for the American Indian or Alaska Native population are available in the data table for Figure 24. Estimates for non-Hispanic Asian women in 2001 and 2005 have a relative standard error of 20%–30%. Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. Ties in highest and lowest percentages were resolved by looking at additional decimal places. See Technical Notes and data table for Figure 24.

SOURCE: CDC/NCHS, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig24

Influenza Vaccination

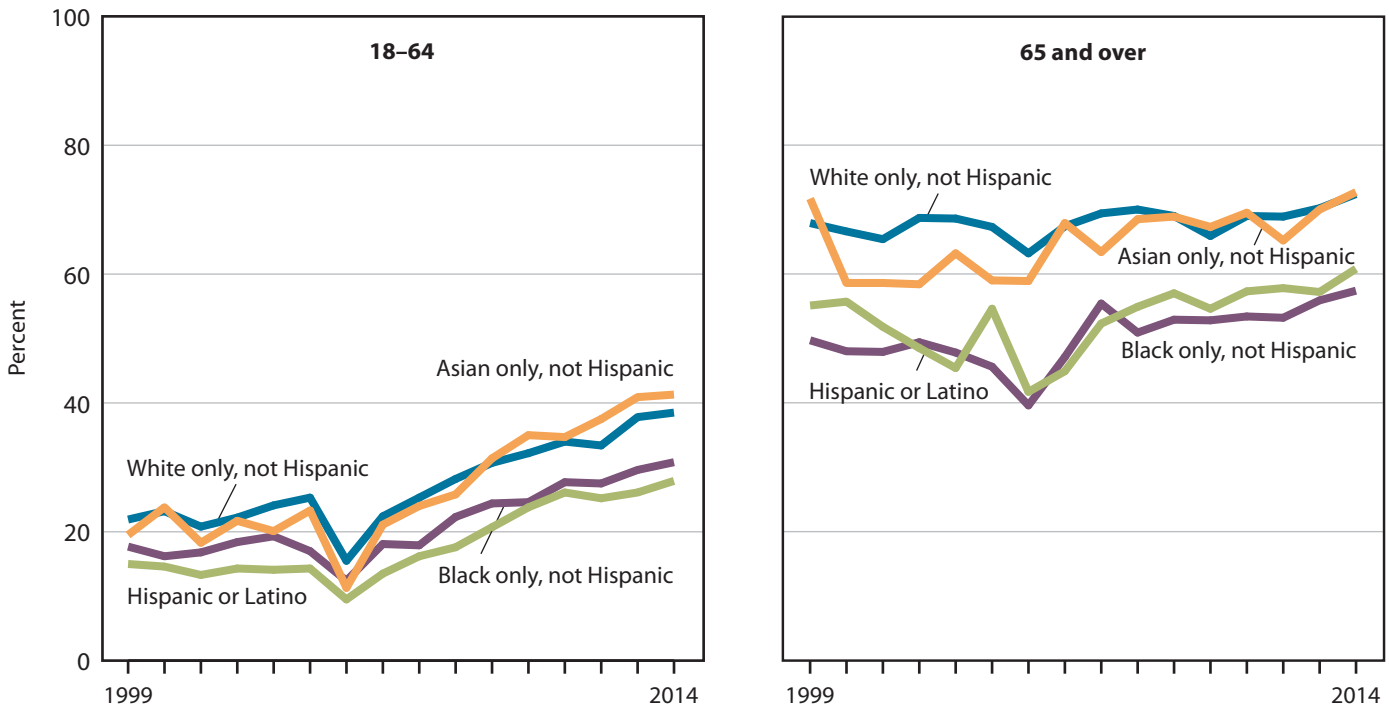
During 1999–2014, influenza vaccination was highest for those aged 65 and over and lowest for those aged 18–64, for all racial and ethnic groups.

Influenza is a serious illness that can lead to hospitalization and sometimes death. Influenza vaccination is especially important for people who are at risk of getting seriously ill from influenza, including those with chronic conditions, older adults, and young children.

The percentage of adults aged 18–64 who received an influenza vaccination in the past 12 months remained stable during 1999–2006 and then increased to 35.8% in 2014 (data table for Figure 25). This pattern was present for all racial and ethnic groups. Decreases in influenza vaccination coverage in 2005 were related to a vaccine shortage (86). For those aged 18–64, no racial and ethnic group was consistently the most likely to receive influenza vaccination during 1999–2014. In 2014, non-Hispanic Asian adults had the highest percentage for influenza vaccination receipt (41.3%) and Hispanic adults had the lowest percentage (27.9%). For adults aged 18–64, the difference between the highest and lowest percentages of adults receiving an influenza vaccination among the four racial and ethnic groups widened from 6.9 percentage points in 1999 (non-Hispanic white compared with Hispanic) to 13.4 in 2014 (non-Hispanic Asian compared with Hispanic).

For adults aged 65 and over, the percentage who received an influenza vaccination in the past 12 months increased from 65.7% to 70.1% during 1999–2014. During this period, trends in influenza vaccination coverage varied by racial and ethnic group, and no racial and ethnic group was consistently the most or least likely to receive influenza vaccination. In 2014, non-Hispanic Asian adults had the highest percentage for receipt of influenza vaccination (72.7%) and non-Hispanic black adults had the lowest (57.4%). For adults age 65 and over, the difference between the highest (non-Hispanic Asian) and lowest (non-Hispanic black) percentages of older adults receiving an influenza vaccination among the four racial and ethnic groups was stable during 1999–2003 and then narrowed to 15.3 percentage points in 2014.

Figure 25. Influenza vaccination among adults aged 18 and over, by age and race and Hispanic origin: United States, 1999–2014



NOTES: Three-year average annual estimates for the American Indian or Alaska Native population are available in the data table for Figure 25. Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. Ties in highest and lowest percentages were resolved by looking at additional decimal places. See Technical Notes and data table for Figure 25.

SOURCE: CDC/NCHS, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig25

Health Insurance Coverage

During 1999 through the first 6 months of 2015 among adults aged 18–64, lack of health insurance coverage was highest among Hispanic adults.

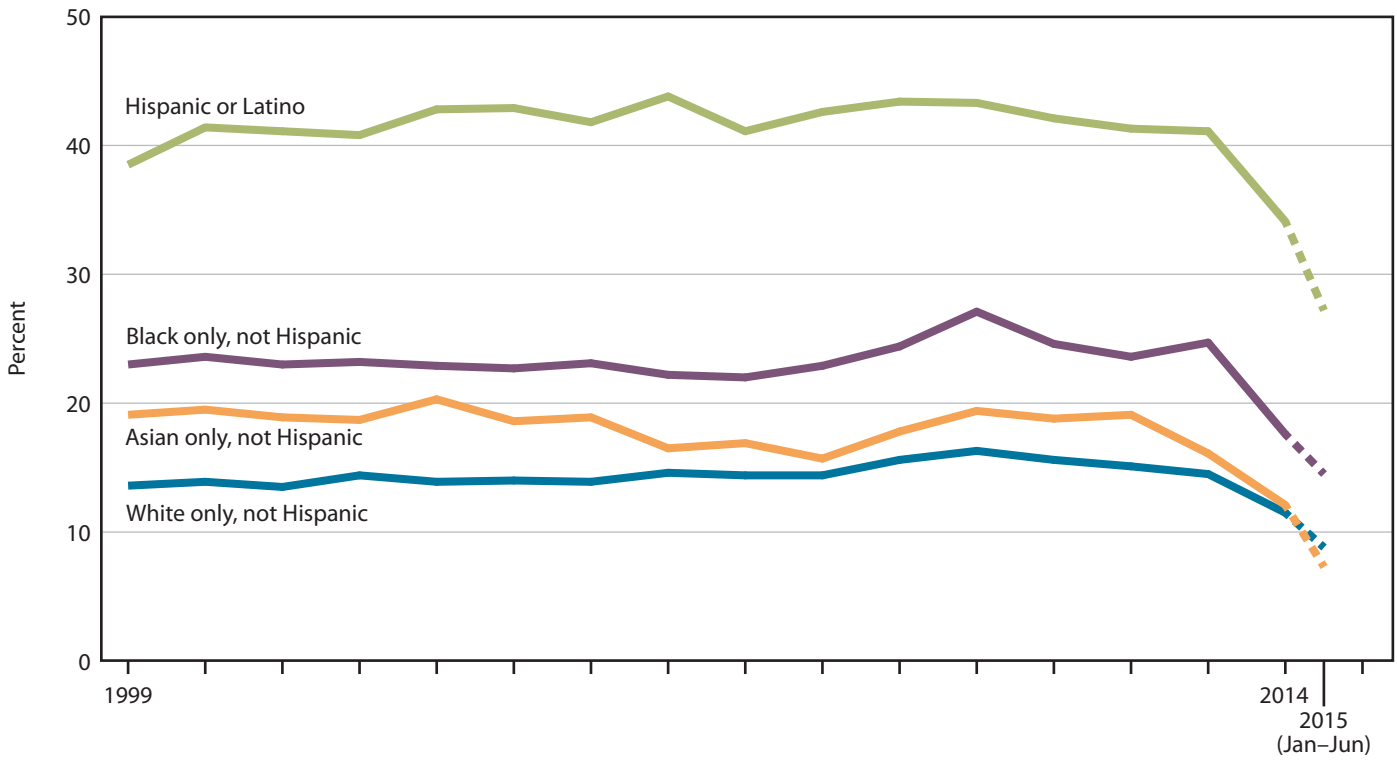
Health insurance is a major determinant of access to health care. Children are less likely to be uninsured than adults aged 18–64 because they are more likely to qualify for public coverage, primarily Medicaid and the Children's Health Insurance Program (CHIP) (see data table for Figure 26 for estimates for children) (26,87). Passage of the Affordable Care Act (ACA) in 2010 (38) authorized states to expand Medicaid eligibility (88) and to establish the health insurance marketplace in 2014.

For adults aged 18–64, the percentage without coverage increased from 17.9% to 20.5% during 1999–2013, and then decreased to 12.7% in the first 6 months of 2015 (36). During this period, the trend for lack of coverage varied by racial and ethnic group.

During 1999–June 2015, Hispanic adults aged 18–64 had the highest percentage without coverage (27.2% in the first 6 months of 2015), and non-Hispanic white adults aged 18–64 had the lowest, except in the first 6 months of 2015, when non-Hispanic Asian adults had the lowest percentage without coverage.

The difference between the highest and lowest percentages of adults aged 18–64 without health insurance among the four racial and ethnic groups narrowed from 1999–June 2015. This difference was 24.9 percentage points in 1999 (Hispanic adults compared with non-Hispanic white adults) and 19.9 percentage points in the first 6 months of 2015 (Hispanic adults compared with non-Hispanic Asian adults).

Figure 26. No health insurance coverage among adults aged 18–64, by race and Hispanic origin: United States, 1999–June 2015 (preliminary data)



NOTES: Preliminary estimates for the first 6 months of 2015 are shown with a dashed line (36). Three-year average annual estimates for the American Indian or Alaska Native population are available in the data table for Figure 26. Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. Ties in highest and lowest percentages were resolved by looking at additional decimal places. See Technical Notes and data table for Figure 26.

SOURCE: CDC/NCHS, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig26

Difficulty Accessing Needed Dental Care Due to Cost

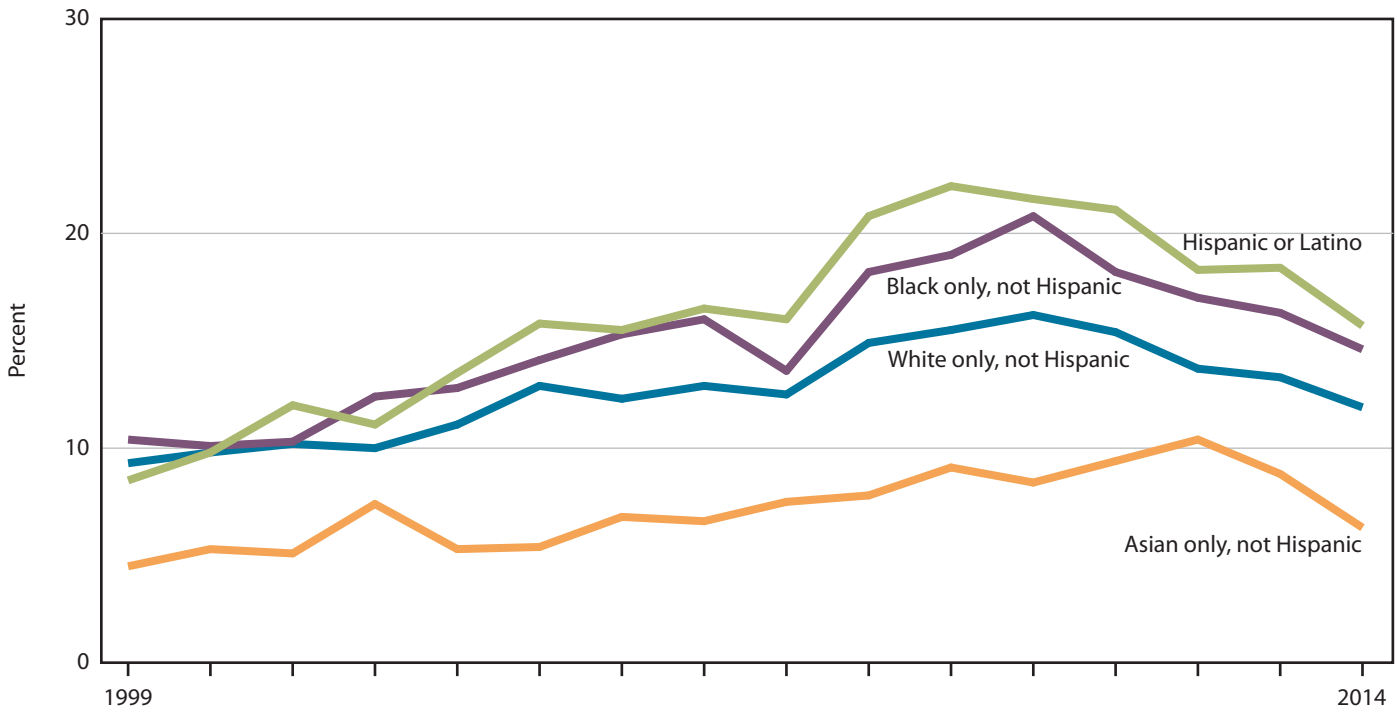
During 1999–2014 among adults aged 18–64, nonreceipt of needed dental care due to cost was lowest among non-Hispanic Asian adults.

Oral health is integral to general health and wellbeing, and forgoing needed dental health care can have serious health effects (89). In general, fewer adults have dental coverage than medical coverage, and dental coverage tends to be less comprehensive (90–92). In 2012, 44% of dental expenditures among adults aged 18–64 were paid out of pocket, a higher out-of-pocket percentage than for any other type of personal health care expenditure (93).

The percentage of adults aged 18–64 who did not receive needed dental care in the past 12 months due to cost increased from 9.3% to 17.3% during 1999–2010, and then decreased to 12.6% in 2014 (data table for Figure 27).

During 1999–2014, non-Hispanic Asian adults aged 18–64 had the lowest percentage of not receiving needed dental care due to cost (6.3% in 2014) among the four racial and ethnic groups. No racial and ethnic group consistently had the highest percentage of not receiving needed dental care due to cost during 1999–2014. The difference between the highest and lowest percentages of adults not receiving needed dental care due to cost among the four racial and ethnic groups widened during 1999–2010, and then remained stable from 2010–2014 for those aged 18–64. This difference was 5.9 percentage points in 1999 (non-Hispanic black compared with non-Hispanic Asian) and 9.4 percentage points in 2014 (Hispanic compared with non-Hispanic Asian).

Figure 27. Nonreceipt of needed dental care in the past 12 months due to cost among adults aged 18–64, by race and Hispanic origin: United States, 1999–2014



NOTES: Three-year average annual estimates for the American Indian or Alaska Native population are available in the data table for Figure 27. Highest and lowest percentages are based on observed percentages and were not tested for statistically significant differences against other percentages. See Technical Notes and data table for Figure 27.

SOURCE: CDC/NCHS, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig27

All 27 chartbook figures have an accompanying data table either in this section or the Trend Table section.

Data table for Figure 6. Selected disability indicators among adults aged 18 and over, by sex and age: United States, 2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig06

Sex and age	*Serious difficulty concentrating, remembering, or making decisions*		*Difficulty doing errands alone*	
	Percent	*SE*	*Percent*	*SE*
Male				
18–64 years	4.4	0.2	3.1	0.2
65–74 years	6.1	0.6	6.4	0.7
75–84 years	10.8	1.3	12.9	1.3
85 years and over	18.8	2.9	26.2	3.3
Female				
18–64 years	4.5	0.2	3.9	0.2
65–74 years	5.3	0.5	9.4	0.7
75–84 years	11.2	1.1	20.7	1.4
85 years and over	21.5	2.1	45.0	2.6

SE is standard error.

NOTES: Respondents were asked, "Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?" See Appendix II, Instrumental activities of daily living (IADL). Proxy reporting was 3.3% for those aged 18–64, 4.8% for those aged 65–74, 6.9% for those aged 75–84, and 14.4% for those aged 85 and over. Respondents were asked, "Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?" Proxy reporting was 3.7% for those aged 18–64, 6.5% for those aged 65–74 and 75–84, and 8.8% for those aged 85 and over.

SOURCE: CDC/NCHS, National Health Interview Survey. Sample family disability questionnaire. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 11. Distribution of emergency department visits within the past 12 months for adults aged 18–64, by type of coverage: United States, 2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig11

Insurance coverage	*Percent*	*SE*
Private	53.6	1.0
Medicaid	23.4	0.8
Uninsured	15.1	0.7
Other	7.9	0.5

SE is standard error.

NOTES: Insurance categories are based on coverage at the time of interview and are mutually exclusive. Persons who reported both Medicaid and private coverage are classified as having private coverage. Medicaid coverage includes persons covered by state-sponsored health plans or the Children's Health Insurance Program (CHIP). The other insured category includes military, other government, and Medicare coverage. Persons not covered by private insurance, Medicaid, or other plans are classified as uninsured. Persons with only Indian Health Service coverage are considered uninsured. The count of emergency department visits in 2014 was determined by using the midpoint of the response categories and then summing the count. Response category None was recoded to 0 visits. Response category 1 was recoded to 1 visit. Response category 2–3 was recoded to 2.5 visits. Response category 4–5 was recoded to 4.5 visits. Response category 6–7 was recoded to 6.5 visits. Response category 8–9 was recoded to 8.5 visits. Response category 10–12 was recoded to 11 visits. Response category 13–15 was recoded to 14 visits. Response category 16 or more was recoded to 16 visits. See Appendix II, Emergency department or emergency room visit; Health insurance coverage.

SOURCE: CDC/NCHS, National Health Interview Survey (NHIS). Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 13. Electronic health record system components in physician offices, by selected component type: United States, 2010 and 2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig13

Type of component	2010		2013	
	Percent	SE	Percent	SE
Record patient history and demographic information	74.3	0.9	83.0	0.9
Order prescriptions	57.2	1.0	82.6	0.9
Send prescriptions to pharmacy	43.8	1.1	78.7	1.0
Issue warnings of drug interactions and contraindications	43.6	1.0	73.8	1.1
Order lab tests	48.5	1.1	68.9	1.1

SE is standard error.

NOTES: Missing values are included in the denominator. Estimates for 2010 are based on the combined in-person and mail survey file. Estimates for 2013 are based on the mail survey file. The Health Information Technology for Economic and Clinical Health (HITECH) Act authorizes Medicare and Medicaid incentive payments to providers for the "meaningful use" of EHR—that is, using EHR components to improve care. The selected components in Figure 13 are among those designated "meaningful use." For more information see: Hsiao CJ, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001–2013. NCHS data brief, no 143. Hyattsville, MD: NCHS; 2014. Available from: http://www.cdc.gov/nchs/data/databriefs/db143.htm.

SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey—National Electronic Health Records Survey. See Appendix I, National Ambulatory Medical Care Survey (NAMCS).

Data table for Figure 14. Office-based physicians accepting new patients, by patient source of payment and urban–rural status: United States, 2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig14

Insurance coverage and urban–rural category	*Percent*	*SE*
Accepting new patients	95.9	0.5
Urban:		
Large central metropolitan	97.1	0.9
Large fringe metropolitan (suburbs)	95.9	1.1
Medium or small metropolitan	94.7	0.8
Rural:		
Micropolitan (city/town)	93.6	1.6
Noncore	97.8	0.8
Accepting new Medicaid patients	69.5	1.2
Urban:		
Large central metropolitan	69.2	2.3
Large fringe metropolitan (suburbs)	58.5	2.4
Medium or small metropolitan	73.0	1.8
Rural:		
Micropolitan (city/town)	83.8	3.2
Noncore	89.6	3.3
Accepting new privately insured patients	85.2	0.9
Urban:		
Large central metropolitan	85.1	1.8
Large fringe metropolitan (suburbs)	84.4	1.8
Medium or small metropolitan	85.8	1.3
Rural:		
Micropolitan (city/town)	86.3	2.2
Noncore	84.7	3.4

SE is standard error.

NOTES: The target universe consists of physicians classified as providing direct patient care in office-based practices. Radiologists, anesthesiologists, and pathologists are excluded. Physician offices were classified by the 2013 NCHS urban–rural classification scheme for counties. The medium and small metropolitan categories were combined for this analysis. For more information, see: Ingram DD, Franco SJ. 2013 NCHS urban–rural classification scheme for counties. Vital and health statistics reports; series 2 no 166. Hyattsville, MD: NCHS. 2014. Available from: http://www.cdc.gov/nchs/data_access/urban_rural.htm. Estimates presented here may differ from estimates based on the same data presented elsewhere if different rules were used for including observations in the analysis.

SOURCE: CDC/NCHS, National Ambulatory Medical Care Survey—National Electronic Health Records Survey. See Appendix I, National Ambulatory Medical Care Survey (NAMCS).

Data table for Figure 17. Health insurance coverage among adults aged 18–64, by state Medicaid expansion status: United States, 2013 and 2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig17

Medicaid expansion status and insurance coverage	2013		2014	
	Percent	SE	Percent	SE
States that expanded Medicaid program				
Private	65.8	0.5	68.2	0.5
Medicaid	11.9	0.3	14.9	0.4
Uninsured	18.5	0.3	13.4	0.3
States that did not expand Medicaid program				
Private	64.3	0.6	66.6	0.6
Medicaid	7.7	0.2	8.3	0.3
Uninsured	22.7	0.5	19.6	0.4

SE is standard error.

NOTES: Insurance categories are mutually exclusive. Insurance is at the time of interview. See Appendix II, Health insurance coverage. Under provisions of the Affordable Care Act (ACA) of 2010 (P.L. 111–148, P.L. 111–152), states are authorized to expand Medicaid to a new adult population. There is no deadline for states to implement the Medicaid expansion, and they may do so at any time. States were classified based on their decision to expand Medicaid as of January 1, 2014. As of January 1, 2014, 25 states and the District of Columbia have expanded their Medicaid program (40). They were: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Iowa, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Rhode Island, Vermont, Washington, and West Virginia. States that had not expanded their Medicaid programs as of January 1, 2014, were: Alabama, Alaska, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 18 (page 1 of 2). Life Expectancy at birth, by sex, race and Hispanic origin: United States, 1980–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig18

Year	All races			White			Black or African American		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
	Life expectancy (years)								
1980	73.7	70.0	77.4	74.4	70.7	78.1	68.1	63.8	72.5
1981	74.1	70.4	77.8	74.8	71.1	78.4	68.9	64.5	73.2
1982	74.5	70.8	78.1	75.1	71.5	78.7	69.4	65.1	73.6
1983	74.6	71.0	78.1	75.2	71.6	78.7	69.4	65.2	73.5
1984	74.7	71.1	78.2	75.3	71.8	78.7	69.5	65.3	73.6
1985	74.7	71.1	78.2	75.3	71.8	78.7	69.3	65.0	73.4
1986	74.7	71.2	78.2	75.4	71.9	78.8	69.1	64.8	73.4
1987	74.9	71.4	78.3	75.6	72.1	78.9	69.1	64.7	73.4
1988	74.9	71.4	78.3	75.6	72.2	78.9	68.9	64.4	73.2
1989	75.1	71.7	78.5	75.9	72.5	79.2	68.8	64.3	73.3
1990	75.4	71.8	78.8	76.1	72.7	79.4	69.1	64.5	73.6
1991	75.5	72.0	78.9	76.3	72.9	79.6	69.3	64.6	73.8
1992	75.8	72.3	79.1	76.5	73.2	79.8	69.6	65.0	73.9
1993	75.5	72.2	78.8	76.3	73.1	79.5	69.2	64.6	73.7
1994	75.7	72.4	79.0	76.5	73.3	79.6	69.5	64.9	73.9
1995	75.8	72.5	78.9	76.5	73.4	79.6	69.6	65.2	73.9
1996	76.1	73.1	79.1	76.8	73.9	79.7	70.2	66.1	74.2
1997	76.5	73.6	79.4	77.1	74.3	79.9	71.1	67.2	74.7
1998	76.7	73.8	79.5	77.3	74.5	80.0	71.3	67.6	74.8
1999	76.7	73.9	79.4	77.3	74.6	79.9	71.4	67.8	74.7
2000	76.8	74.1	79.3	77.3	74.7	79.9	71.8	68.2	75.1
2001	77.0	74.3	79.5	77.5	74.9	80.0	72.0	68.5	75.3
2002	77.0	74.4	79.6	77.5	74.9	80.1	72.2	68.7	75.4
2003	77.2	74.5	79.7	77.7	75.1	80.2	72.4	68.9	75.7
2004	77.6	75.0	80.1	78.1	75.5	80.5	72.9	69.4	76.1
2005	77.6	75.0	80.1	78.0	75.5	80.5	73.0	69.5	76.2
2006	77.8	75.2	80.3	78.3	75.8	80.7	73.4	69.9	76.7
2007	78.1	75.5	80.6	78.5	76.0	80.9	73.8	70.3	77.0
2008	78.2	75.6	80.6	78.5	76.1	80.9	74.3	70.9	77.3
2009	78.5	76.0	80.9	78.8	76.4	81.2	74.7	71.4	77.7
2010	78.7	76.2	81.0	78.9	76.5	81.3	75.1	71.8	78.0
2011	78.7	76.3	81.1	79.0	76.6	81.3	75.3	72.2	78.2
2012	78.8	76.4	81.2	79.1	76.7	81.4	75.5	72.3	78.4
2013	78.8	76.4	81.2	79.1	76.7	81.4	75.5	72.3	78.4
2014	78.8	76.4	81.2	79.0	76.7	81.4	75.6	72.5	78.4

See footnotes at end of table.

Data table for Figure 18 (page 2 of 2). Life Expectancy at birth, by sex, race and Hispanic origin: United States, 1980–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig18

Year	Hispanic[1]			Not Hispanic or Latino					
				White			Black or African American		
	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female
2014	81.8	79.2	84.0	78.8	76.5	81.1	75.2	72.0	78.1

[1]Persons of Hispanic origin may be of any race. See Appendix II, Hispanic origin. Life expectancies for the Hispanic population are adjusted for underreporting of Hispanic ethnicity on the death certificate, but are not adjusted to account for the potential effects of return migration. To address the effects of age misstatement at the oldest ages, the probability of death for Hispanic persons ages 80 and over is estimated as a function of non-Hispanic white mortality with the use of the Brass relational logit model. See Appendix II, Race, for a discussion of sources of bias in death rates by race and Hispanic origin.

NOTES: Populations for computing life expectancy for 1991–1999 are 1990-based postcensal estimates of the U.S. resident population. Populations for computing life expectancy for 2001–2009 were based on intercensal population estimates of the U.S. resident population. Populations for computing life expectancy for 2010 were based on 2010 census counts. Life expectancy for 2011 and beyond was computed using 2010-based postcensal estimates. See Appendix I, Population Census and Population Estimates. In 1997, life table methodology was revised to construct complete life tables by single years of age that extend to age 100. (Anderson RN. Method for constructing complete annual U.S. life tables. NCHS. Vital Health Stat 2(129). 1999.) Previously, abridged life tables were constructed for 5-year age groups ending with 85 and over. In 2000, the life table methodology was revised. The revised methodology is similar to that developed for the 1999–2001 decennial life tables. In 2008, the life table methodology was further refined. See Appendix II, Life expectancy. Starting with 2003 data, some states allowed the reporting of more than one race on the death certificate. The multiple-race data for these states were bridged to the single-race categories of the 1977 Office of Management and Budget standards, for comparability with other states. The race groups, white and black include persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race. See Appendix II, Race. Life expectancy is not currently available for persons of other racial and ethnic groups. Also see Table 15 and Figure 1.

SOURCE: CDC/NCHS, National Vital Statistics System, public-use Mortality Files; Arias E. United States life tables by Hispanic origin. Vital health statistics; vol 2 no 152. Hyattsville, MD: NCHS. 2010. NCHS. Deaths: Final data for 2014. National vital statistics reports (forthcoming). Available from: http://www.cdc.gov/nchs/products/nvsr.htm. See Appendix I, National Vital Statistics System (NVSS).

Data table for Figure 19. Infant mortality rates, by race and Hispanic origin of mother: United States, 1999–2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig19

Year	Total[2]	Race and Hispanic origin of mother[1]				
		Hispanic or Latina	Not Hispanic or Latina			
			White	Black or African American	Asian or Pacific Islander	American Indian or Alaska Native
	Infant deaths per 1,000 live births[3]					
1999	7.04	5.71	5.76	14.14	4.73	9.35
2000	6.89	5.59	5.70	13.59	4.79	8.19
2001	6.84	5.44	5.72	13.46	4.65	9.67
2002	6.95	5.62	5.80	13.89	4.66	8.67
2003	6.84	5.65	5.70	13.60	4.68	8.72
2004	6.78	5.55	5.66	13.60	4.55	8.62
2005	6.86	5.62	5.76	13.63	4.77	8.31
2006	6.68	5.41	5.58	13.35	4.40	8.64
2007	6.75	5.51	5.63	13.32	4.60	9.38
2008	6.61	5.59	5.53	12.67	4.39	8.66
2009	6.39	5.29	5.33	12.40	4.28	9.17
2010	6.14	5.25	5.18	11.46	4.17	8.65
2011	6.07	5.15	5.07	11.45	4.18	8.52
2012	5.98	5.11	5.04	11.19	3.97	8.74
2013	5.96	5.00	5.06	11.11	3.90	7.72

Year	Detailed Hispanic origin of mother[1]				
	Mexican	Puerto Rican	Cuban	Central and South American	Other and unknown Hispanic or Latina
	Infant deaths per 1,000 live births[3]				
1999	5.51	8.35	4.64	4.67	7.24
2000	5.43	8.20	4.57	4.64	6.88
2001	5.22	8.53	4.25	4.97	6.02
2002	5.42	8.19	3.74	5.06	7.15
2003	5.49	8.18	4.59	5.04	6.66
2004	5.47	7.82	4.57	4.65	6.72
2005	5.53	8.31	4.45	4.69	6.44
2006	5.34	8.02	5.06	4.52	5.78
2007	5.42	7.72	5.21	4.57	6.41
2008	5.58	7.29	4.88	4.76	5.86
2009	5.12	7.19	5.75	4.47	6.06
2010	5.12	7.09	3.81	4.43	6.09
2011	4.99	7.84	4.34	4.35	5.41
2012	5.02	6.86	4.99	4.14	5.59
2013	4.90	5.92	3.04	4.30	5.88

[1]Persons of Hispanic origin may be of any race. Starting with 2003 data, some states reported multiple-race data. The multiple-race data for these states were bridged to the single-race categories of the 1977 Office of Management and Budget standards, for comparability with other states. See Appendix II, Hispanic origin; Race.

[2]Includes all infant deaths not shown separately.

[3]Infant is under age 1 year.

NOTES: Rates based on a period file using weighted data. Also see Table 10.

SOURCE: CDC/NCHS, National Vital Statistics System, public-use Linked Birth/Infant Death Data Set. See Appendix I, National Vital Statistics System (NVSS).

Data table for Figure 20. Preterm births, by gestational age and race and Hispanic origin and detailed Hispanic origin of mother: United States, 2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig20

Preterm births by gestational age, in weeks[2]	Total[3]	Race and Hispanic origin of mother[1]				
			Not Hispanic or Latina			
		Hispanic or Latina	White	Black or African American	Asian or Pacific Islander	American Indian or Alaska Native
	Percent of live singleton births that were preterm					
Less than 37	7.7	7.7	6.9	11.1	6.8	9.0
34–36	5.7	5.7	5.3	7.2	5.2	6.8
32–33	0.8	0.8	0.7	1.3	0.7	1.0
Less than 32	1.2	1.2	0.9	2.6	0.9	1.2
	Standard error					
Less than 37	0.01	0.03	0.02	0.04	0.05	0.15
34–36	0.01	0.02	0.02	0.03	0.04	0.13
32–33	0.00	0.01	0.01	0.02	0.02	0.05
Less than 32	0.01	0.01	0.01	0.02	0.02	0.06

Preterm births by gestational age, in weeks[2]	Detailed Hispanic origin of mother[1]				
	Mexican	Puerto Rican	Cuban	Central and South American	Other and unknown Hispanic or Latina
	Percent of live singleton births that were preterm				
Less than 37	7.6	9.1	7.2	7.2	8.3
34–36	5.6	6.4	5.1	5.3	6.1
32–33	0.8	1.0	0.9	0.8	0.9
Less than 32	1.1	1.7	1.2	1.1	1.3
	Standard error				
Less than 37	0.04	0.11	0.18	0.07	0.07
34–36	0.03	0.09	0.16	0.06	0.06
32–33	0.01	0.04	0.07	0.02	0.03
Less than 32	0.01	0.05	0.08	0.03	0.03

0.00 Quantity more than zero but less than 0.005.

[1]Persons of Hispanic origin may be of any race. Starting with 2003 data, some states reported multiple-race data. The multiple-race data for these states were bridged to the single-race categories of the 1977 Office of Management and Budget standards, for comparability with other states. See Appendix II, Hispanic origin; Race.

[2]Preterm births are based on the obstetric estimate of gestational age and are for all singleton births. For more information on the obstetric estimates, see: Martin JA, Osterman MJK, Kirmeyer SE, Gregory ECW. Measuring gestational age in vital statistics data: Transitioning to the obstetric estimate. National vital statistics reports; vol 64 no 5. Hyattsville, MD: NCHS. 2015. Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_05.pdf.

[3]Includes all preterm births not shown separately.

NOTES: Ties in highest and lowest rates were resolved by looking at additional decimal places. See Technical Notes.

SOURCE: CDC/NCHS, National Vital Statistics System, public-use Birth File. See Appendix I, National Vital Statistics System (NVSS).

Data table for Figure 21 (page 1 of 2). Low-risk births delivered by cesarean section, by race and Hispanic origin and detailed Hispanic origin of mother: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig21

Year	Total[2]	Race and Hispanic origin of mother[1]				
			Not Hispanic or Latina			
		Hispanic or Latina	White	Black or African American	Asian or Pacific Islander	American Indian or Alaska Native
		Percent of low-risk births delivered by cesarean section[3]				
1999	19.5	18.7	19.2	21.9	19.6	17.1
2000	20.3	19.4	20.1	23.0	20.0	18.0
2001	21.6	20.6	21.4	24.3	21.9	18.8
2002	23.1	21.9	22.8	25.9	23.2	20.4
2003	24.3	23.2	24.0	27.4	24.9	21.1
2004	25.7	24.6	25.4	28.8	26.6	22.2
2005	26.6	25.1	26.4	29.8	27.8	23.2
2006	27.1	25.3	27.0	30.1	27.7	24.5
2007	27.5	26.0	27.4	30.5	28.3	24.5
2008	27.8	26.2	27.5	30.7	29.1	23.1
2009	28.1	27.0	27.7	31.1	29.6	24.1
2010	27.6	26.7	27.0	31.0	29.0	23.8
2011	27.3	26.6	26.6	30.9	28.8	22.1
2012	27.3	26.8	26.5	31.0	28.5	23.5
2013	26.9	26.6	25.9	30.8	28.6	23.0
2014[4]	26.0	25.8	25.0	29.9	27.6	21.5
			Standard error			
1999	0.03	0.08	0.04	0.10	0.15	0.37
2000	0.03	0.08	0.04	0.10	0.14	0.37
2001	0.04	0.08	0.05	0.10	0.15	0.37
2002	0.04	0.08	0.05	0.10	0.15	0.38
2003	0.04	0.08	0.05	0.11	0.15	0.38
2004	0.04	0.08	0.05	0.11	0.15	0.39
2005	0.04	0.08	0.05	0.11	0.15	0.39
2006	0.04	0.08	0.05	0.11	0.15	0.39
2007	0.04	0.08	0.05	0.11	0.15	0.39
2008	0.04	0.08	0.05	0.11	0.15	0.38
2009	0.04	0.08	0.05	0.11	0.15	0.39
2010	0.04	0.09	0.05	0.11	0.15	0.39
2011	0.04	0.09	0.05	0.11	0.15	0.39
2012	0.04	0.09	0.05	0.11	0.15	0.40
2013	0.04	0.09	0.05	0.11	0.15	0.40
2014[4]	0.04	0.09	0.05	0.11	0.14	0.40

See footnotes at end of table.

Data table for Figure 21 (page 2 of 2). Low-risk births delivered by cesarean section, by race and Hispanic origin and detailed Hispanic origin of mother: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig21

Year	Detailed Hispanic origin of mother[1]				
	Mexican	Puerto Rican	Cuban	Central and South American	Other and unknown Hispanic or Latina
	Percent of low-risk births delivered by cesarean section[3]				
1999	18.0	19.2	29.7	20.4	18.4
2000	18.6	20.5	30.7	21.2	19.1
2001	19.8	21.3	31.5	22.1	20.7
2002	21.1	23.2	32.8	23.5	21.7
2003	22.3	24.3	36.6	25.0	22.6
2004	23.5	26.8	38.5	26.8	23.7
2005	23.5	27.3	42.1	27.6	26.4
2006	23.3	28.8	44.8	27.7	27.5
2007	24.0	28.8	45.3	28.6	28.1
2008	24.5	29.0	45.4	28.6	26.8
2009	24.9	29.4	44.2	30.0	28.2
2010	24.6	29.4	42.0	29.5	28.0
2011	24.8	28.9	42.0	29.1	26.8
2012	25.0	28.9	43.3	29.4	27.1
2013	24.7	28.3	42.3	29.1	27.2
2014[4]	24.1	27.3	41.4	27.9	26.0
	Standard error				
1999	0.09	0.29	0.66	0.22	0.30
2000	0.09	0.30	0.65	0.21	0.31
2001	0.09	0.30	0.63	0.21	0.32
2002	0.09	0.31	0.63	0.21	0.32
2003	0.10	0.31	0.63	0.20	0.33
2004	0.10	0.32	0.64	0.20	0.34
2005	0.10	0.31	0.64	0.20	0.32
2006	0.10	0.31	0.63	0.20	0.30
2007	0.10	0.30	0.62	0.20	0.28
2008	0.10	0.30	0.62	0.21	0.23
2009	0.10	0.30	0.62	0.22	0.23
2010	0.11	0.31	0.62	0.22	0.23
2011	0.11	0.30	0.61	0.23	0.21
2012	0.11	0.31	0.62	0.24	0.21
2013	0.11	0.30	0.58	0.24	0.22
2014[4]	0.11	0.30	0.55	0.22	0.21

[1]Persons of Hispanic origin may be of any race. Starting with 2003 data, some states reported multiple-race data. The multiple-race data for these states were bridged to the single-race categories of the 1977 Office of Management and Budget standards, for comparability with other states. See Appendix II, Hispanic origin; Race.

[2]Includes all low-risk cesarean section births not shown separately.

[3]Low-risk cesarean delivery is defined as singleton, term (37 or more weeks of gestation by last menstrual period estimate for data years 1999–2013 and the obstetric estimate for 2014), vertex (not breech) cesarean delivery to women having a first birth per 100 women delivering singleton, term, vertex, first births.

[4]For 2014, the definition of term birth was based on the obstetric estimate of gestational age. For more information on the obstetric estimate, see: Martin JA, Osterman MJK, Kirmeyer SE, Gregory ECW. Measuring gestational age in vital statistics data: Transitioning to the obstetric estimate. National vital statistics reports; vol 64 no 5. Hyattsville, MD: NCHS. 2015. Available from: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_05.pdf. Use of the obstetric estimate instead of the last menstrual period had a statistically significant but small impact on the percentage of women with low-risk cesarean section births.

NOTES: Ties in highest and lowest rates were resolved by looking at additional decimal places. See Technical Notes.

SOURCE: CDC/NCHS, National Vital Statistics System, public-use Birth File. See Appendix I, National Vital Statistics System (NVSS).

Data table for Figure 22. Obesity among children and adolescents aged 2–19, by age and race and Hispanic origin: United States, 2011–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig22

Age	Total[2]	Race and Hispanic origin[1]			
		Hispanic or Latino	Not Hispanic or Latino		
			White only	Black or African American only	Asian only
	Percent with obesity[3]				
2–19	17.0	21.9	14.7	19.5	8.6
2–5 years	8.9	15.6	*5.2	10.4	*
6–11 years	17.5	25.0	13.6	21.4	*9.8
12–19 years	20.5	22.8	19.6	22.6	9.4
	Standard error				
2–19	0.7	0.9	1.2	1.2	1.1
2–5 years	0.9	1.6	1.2	1.5	*
6–11 years	1.2	1.4	2.0	2.0	2.0
12–19 years	1.4	1.6	2.5	2.3	1.6

[1]Persons of Hispanic origin may be of any race. Starting with 1999 data, race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity.* The three non-Hispanic race categories shown in the table conform to the 1997 Standards. Race-specific estimates are for persons who reported only one racial group. See Appendix II, Hispanic origin; Race.

[2]Includes all persons not shown separately.

[3]Obesity is defined as a body mass index at or above the sex- and age-specific 95th percentile of the CDC growth charts. Pregnant women are excluded.

NOTE: Also see Table 59 and Figure 8.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

Data table for Figure 23 (page 1 of 2). Hypertension among adults aged 20 and over, by sex and race and Hispanic origin: United States, 1999–2000 through 2013–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig23

Characteristic	*1999–2000*	*2001–2002*	*2003–2004*	*2005–2006*	*2007–2008*	*2009–2010*	*2011–2012*	*2013–2014*
				Percent with hypertension[1]				
Both sexes								
20 years and over, crude[2]	28.9	28.9	32.5	31.7	32.6	31.9	32.5	33.5
20 years and over, age-adjusted[2,3]	30.0	29.7	32.1	30.5	31.2	30.0	30.0	30.8
Race and Hispanic origin[3,4]								
Mexican origin	29.4	25.2	29.9	24.4	28.9	28.2	28.0	28.8
Not Hispanic or Latino:								
White only	28.4	27.9	30.8	29.1	30.7	28.6	28.6	29.6
Black only	40.9	43.4	42.6	44.1	42.4	42.9	43.9	42.7
				Standard error				
Both sexes								
20 years and over, crude[2]	1.5	1.3	1.3	1.2	0.9	1.3	1.5	1.0
20 years and over, age-adjusted[2,3]	1.4	1.0	1.0	1.2	0.7	0.8	0.7	0.8
Race and Hispanic origin[3,4]								
Mexican origin	1.5	1.1	2.0	1.6	1.4	1.1	2.5	1.5
Not Hispanic or Latino:								
White only	1.7	1.1	1.2	1.3	1.0	1.1	0.8	0.9
Black only	1.1	1.9	1.8	1.7	1.8	1.6	1.0	1.5

See footnotes at end of table.

Data table for Figure 23 (page 2 of 2). Hypertension among adults aged 20 and over, by sex and race and Hispanic origin: United States, 1999–2000 through 2013–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig23

Characteristic	*2011–2014*	
	Percent	Standard error
Both sexes		
20 years and over, crude[2]	33.0	0.9
20 years and over, age-adjusted[2,3]	30.4	0.5
Race and Hispanic origin[3,4]		
Hispanic or Latino	28.2	1.1
Not Hispanic or Latino:		
White only	29.1	0.6
Black only	43.3	0.9
Asian only	26.5	1.1
Men		
20 years and over, crude[2]	32.6	1.1
20 years and over, age-adjusted[2,3]	31.0	0.7
Race and Hispanic origin[3,4]		
Hispanic or Latino	27.7	1.5
Not Hispanic or Latino:		
White only	30.2	1.0
Black only	42.4	1.2
Asian only	28.0	2.0
Women		
20 years and over, crude[2]	33.4	1.0
20 years and over, age-adjusted[2,3]	29.7	0.8
Race and Hispanic origin[3,4]		
Hispanic or Latina	28.6	1.1
Not Hispanic or Latina:		
White only	28.0	0.8
Black only	44.0	1.4
Asian only	25.0	1.0

[1]Hypertension is having measured high blood pressure (systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg) and/or respondent report of taking antihypertensive medication. Excludes pregnant women.

[2]Includes all persons not shown separately.

[3]Estimates are age-adjusted to the year 2000 standard population using five age groups: 20–34 years, 35–44 years, 45–54 years, 55–64 years, and 65 years and over. Age-adjusted estimates in this table may differ from other age-adjusted estimates based on the same data and presented elsewhere if different age groups are used in the adjustment procedure. See Appendix II, Age adjustment.

[4]Persons of Mexican or Hispanic origin may be of any race. Starting with 1999 data, race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* and are not strictly comparable with estimates for earlier years. The three non-Hispanic race categories shown in the table conform to the 1997 Standards. Starting with 1999 data, race-specific estimates are for persons who reported only one racial group. Data for Hispanic adults became available in 2007–2008 and for Asian adults starting in 2011–2012. See Appendix II, Hispanic origin; Race.

NOTE: Also see Table 54.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

Data table for Figure 24 (page 1 of 3). Current cigarette smoking among adults aged 18 and over, by sex and race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig24

Sex, age, and year	Total[2]		Race and Hispanic origin[1]			
				Not Hispanic or Latino[3]		
	Crude	Age-adjusted[3]	Hispanic or Latino[3]	White only	Black only	Asian only
Men, 18 years and over	Percent current smokers[4]					
1999	25.7	25.2	22.7	25.4	28.4	23.5
2000	25.6	25.2	23.5	25.8	25.7	19.5
2001	25.1	24.6	20.7	25.4	27.7	18.7
2002	25.1	24.6	21.4	25.5	26.7	17.5
2003	24.1	23.7	21.2	24.6	25.2	16.6
2004	23.4	23.0	17.9	24.2	23.5	16.7
2005	23.9	23.4	19.6	24.2	26.1	20.4
2006	23.9	23.6	19.3	24.6	26.8	15.6
2007	22.3	22.0	17.4	23.6	23.7	14.5
2008	23.1	22.8	19.1	23.9	24.9	15.1
2009	23.5	23.2	17.7	25.0	23.3	16.4
2010	21.5	21.2	15.2	23.0	23.7	14.6
2011	21.6	21.2	16.5	22.6	23.6	14.2
2012	20.5	20.6	16.9	22.0	22.1	15.6
2013	20.5	20.5	16.7	21.8	21.7	14.6
2014	18.8	19.0	13.8	20.1	22.0	14.0
Women, 18 years and over						
1999	21.5	21.6	11.9	23.8	20.5	*6.3
2000	20.9	21.1	12.9	23.1	20.8	7.4
2001	20.6	20.7	11.5	23.5	17.8	*6.0
2002	19.8	20.0	10.8	22.5	18.5	6.8
2003	19.2	19.4	10.4	22.1	18.1	6.0
2004	18.5	18.7	10.6	21.2	16.8	*4.9
2005	18.1	18.3	10.9	20.8	17.1	*5.9
2006	18.0	18.1	9.9	20.6	18.8	4.5
2007	17.4	17.5	8.4	20.7	15.5	*3.8
2008	18.3	18.5	10.4	21.5	17.4	4.7
2009	17.9	18.1	9.5	20.7	18.9	7.3
2010	17.3	17.5	9.1	20.4	16.8	4.3
2011	16.5	16.8	8.3	19.8	15.3	5.5
2012	15.8	15.9	7.5	19.2	14.3	5.4
2013	15.3	15.5	6.8	18.6	15.1	4.6
2014	14.8	15.1	7.4	18.3	13.7	5.1

See footnotes at end of table.

Data table for Figure 24 (page 2 of 3). Current cigarette smoking among adults aged 18 and over, by sex and race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig24

Sex, age, and year	Total[2]		Race and Hispanic origin[1]			
				Not Hispanic or Latino[3]		
	Crude	Age-adjusted[3]	Hispanic or Latino[3]	White only	Black only	Asian only
Men, 18 years and over			Standard error			
1999	0.5	0.5	1.1	0.6	1.5	2.9
2000	0.5	0.4	1.1	0.5	1.2	2.1
2001	0.4	0.4	1.0	0.5	1.3	2.4
2002	0.5	0.4	1.0	0.5	1.3	2.1
2003	0.4	0.4	1.1	0.5	1.2	2.1
2004	0.4	0.4	0.9	0.5	1.2	2.1
2005	0.5	0.5	0.9	0.6	1.3	2.3
2006	0.5	0.5	1.2	0.7	1.6	1.6
2007	0.6	0.5	1.3	0.7	1.4	1.6
2008	0.6	0.6	1.3	0.7	1.5	1.9
2009	0.5	0.5	0.9	0.7	1.2	1.5
2010	0.5	0.5	0.9	0.6	1.1	1.6
2011	0.4	0.4	0.9	0.6	1.1	1.3
2012	0.4	0.4	0.9	0.6	1.1	1.4
2013	0.5	0.5	1.0	0.6	1.2	1.6
2014	0.4	0.4	0.8	0.6	1.1	1.6
Women, 18 years and over						
1999	0.4	0.4	0.7	0.5	0.9	1.3
2000	0.4	0.4	0.8	0.5	0.9	1.4
2001	0.4	0.4	0.7	0.5	0.8	1.2
2002	0.4	0.4	0.7	0.5	0.9	1.3
2003	0.4	0.4	0.7	0.5	0.9	1.1
2004	0.4	0.4	0.7	0.5	0.9	1.1
2005	0.4	0.4	0.7	0.5	0.9	1.2
2006	0.4	0.4	0.8	0.6	1.0	0.8
2007	0.5	0.5	0.7	0.6	0.9	0.8
2008	0.5	0.5	0.8	0.7	1.0	0.8
2009	0.4	0.4	0.7	0.6	1.1	1.3
2010	0.4	0.4	0.6	0.6	0.9	0.7
2011	0.4	0.4	0.6	0.5	0.8	0.8
2012	0.4	0.4	0.6	0.5	0.7	0.8
2013	0.4	0.4	0.5	0.6	0.8	0.8
2014	0.4	0.4	0.5	0.7	0.8	0.9

See footnotes at end of table.

Data table for Figure 24 (page 3 of 3). Current cigarette smoking among adults aged 18 and over, by sex and race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig24

Sex, age, and year[5]	Race and Hispanic origin[1]					
		Not Hispanic or Latino[3]				
	Hispanic or Latino[3]	White only	Black only	Asian only	American Indian or Alaska Native only	2 or more races
Men, 18 years and over	Percent current smokers[4]					
1999–2001	22.2	25.5	27.2	20.1	32.6	35.2
2003–2005	19.5	24.3	24.9	18.1	36.4	31.4
2006–2008	18.6	24.0	25.1	15.2	39.2	24.8
2009–2011	16.4	23.5	23.5	15.0	31.1	28.9
2012–2014	15.7	21.3	21.9	14.8	28.0	29.8
Women, 18 years and over						
1999–2001	12.1	23.5	19.7	6.6	36.3	31.6
2003–2005	10.6	21.4	17.3	5.6	29.0	27.0
2006–2008	9.5	20.9	17.2	4.3	28.2	25.9
2009–2011	9.0	20.3	17.0	5.6	26.2	24.8
2012–2014	7.3	18.7	14.4	5.0	24.0	25.1
Men, 18 years and over	Standard error					
1999–2001	0.6	0.3	0.8	1.4	4.4	2.6
2003–2005	0.6	0.3	0.8	1.3	3.8	2.7
2006–2008	0.7	0.4	0.9	1.0	5.7	2.7
2009–2011	0.5	0.4	0.7	0.9	4.6	2.6
2012–2014	0.5	0.4	0.7	0.9	3.5	2.2
Women, 18 years and over						
1999–2001	0.4	0.3	0.5	0.7	3.5	2.5
2003–2005	0.4	0.3	0.5	0.7	3.6	2.4
2006–2008	0.4	0.4	0.6	0.5	3.8	2.4
2009–2011	0.4	0.4	0.6	0.6	3.4	2.0
2012–2014	0.3	0.3	0.5	0.5	3.2	2.1

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error of 20%–30%.

[1]Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The single-race categories plus multiple-race category shown in the table conform to the 1997 Standards. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[2]Includes all persons not shown separately.

[3]Estimates are age-adjusted to the year 2000 standard population using five age groups: 18–24 years, 25–34 years, 35–44 years, 45–64 years, and 65 years and over. Age-adjusted estimates in this table may differ from other age-adjusted estimates based on the same data and presented elsewhere if different age groups are used in the adjustment procedure. See Appendix II, Age adjustment.

[4]Current cigarette smokers are defined as ever smoking 100 cigarettes in their lifetime and now smoke every day or some days. See Appendix II, Cigarette smoking.

[5]Three-year average annual estimates are shown in order to present estimates for the American Indian or Alaska Native and the multiple-race populations. Annual estimates are not stable for smaller population groups.

NOTES: Ties in highest and lowest rates were resolved by looking at additional decimal places. See Technical Notes. Also see Figure 7.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 25 (page 1 of 3). Influenza vaccination among adults aged 18 and over, by age and race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig25

Age and year	Total[2]	Race and Hispanic origin[1]			
		Hispanic or Latino	Not Hispanic or Latino		
			White only	Black only	Asian only
18–64 years		Percent with influenza vaccination in the past year[3]			
1999	20.6	15.0	21.9	17.7	19.5
2000	21.4	14.6	23.2	16.2	23.8
2001	19.3	13.3	20.8	16.8	18.3
2002	20.8	14.3	22.2	18.4	21.7
2003	22.1	14.1	24.1	19.3	20.1
2004	22.7	14.3	25.3	17.0	23.3
2005	14.1	9.5	15.5	12.4	11.3
2006	20.5	13.5	22.4	18.1	21.1
2007	23.0	16.2	25.3	17.9	24.0
2008	25.8	17.6	28.2	22.3	25.8
2009	28.3	20.7	30.7	24.4	31.4
2010	30.1	23.8	32.2	24.6	35.0
2011	31.9	26.1	34.0	27.7	34.7
2012	31.5	25.2	33.4	27.5	37.5
2013	35.0	26.1	37.8	29.6	40.9
2014	35.8	27.9	38.5	30.8	41.3
65 years and over					
1999	65.7	55.1	67.9	49.7	71.7
2000	64.4	55.7	66.6	48.0	58.6
2001	63.1	51.8	65.4	47.9	58.6
2002	65.7	48.5	68.7	49.4	58.4
2003	65.5	45.4	68.6	47.8	63.3
2004	64.6	54.6	67.3	45.6	59.0
2005	59.7	41.7	63.2	39.6	58.9
2006	64.3	44.9	67.4	47.1	67.9
2007	66.7	52.3	69.4	55.4	63.4
2008	67.2	54.9	70.0	50.9	68.5
2009	66.8	57.0	69.0	52.9	68.9
2010	63.9	54.6	65.9	52.8	67.3
2011	66.9	57.3	69.0	53.4	69.5
2012	66.5	57.8	68.9	53.2	65.2
2013	67.9	57.2	70.2	55.9	70.0
2014	70.1	60.8	72.4	57.4	72.7

See footnotes at end of table.

Data table for Figure 25 (page 2 of 3). Influenza vaccination among adults aged 18 and over, by age and race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig25

Age and year	Total[2]	Race and Hispanic origin[1]			
		Hispanic or Latino	Not Hispanic or Latino		
			White only	Black only	Asian only
		Standard error			
18–64 years					
1999	0.3	0.7	0.4	0.8	1.7
2000	0.3	0.7	0.4	0.7	1.9
2001	0.3	0.6	0.4	0.8	1.5
2002	0.3	0.7	0.4	0.8	1.7
2003	0.3	0.6	0.4	0.8	1.6
2004	0.3	0.6	0.4	0.8	1.7
2005	0.3	0.5	0.3	0.7	1.3
2006	0.4	0.7	0.5	0.9	1.5
2007	0.4	0.8	0.6	0.9	1.8
2008	0.4	0.8	0.5	1.0	1.7
2009	0.4	0.8	0.5	1.1	1.8
2010	0.4	0.8	0.6	0.9	1.6
2011	0.4	0.8	0.5	0.9	1.4
2012	0.4	0.8	0.5	0.9	1.6
2013	0.4	0.8	0.5	1.0	1.6
2014	0.4	0.9	0.6	1.0	1.6
65 years and over					
1999	0.8	2.7	0.8	2.3	5.9
2000	0.7	2.6	0.8	2.3	5.9
2001	0.7	2.6	0.8	2.4	6.2
2002	0.7	2.7	0.8	2.3	5.5
2003	0.7	2.7	0.8	2.3	6.0
2004	0.7	2.7	0.8	2.4	6.0
2005	0.8	2.8	0.8	2.1	4.7
2006	0.9	2.9	1.1	2.3	3.9
2007	0.8	3.1	1.0	2.3	4.5
2008	0.9	3.1	1.0	2.5	3.7
2009	0.8	2.9	0.9	2.3	3.3
2010	0.8	2.6	0.9	2.1	3.5
2011	0.7	2.2	0.8	1.8	3.4
2012	0.8	2.3	0.9	2.1	3.2
2013	0.7	2.2	0.9	2.0	3.4
2014	0.7	2.2	0.8	2.0	2.8

See footnotes at end of table.

Data table for Figure 25 (page 3 of 3). Influenza vaccination among adults aged 18 and over, by age and race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig25

Age and year[4]	Race and Hispanic origin[1]					
		Not Hispanic or Latino				
	Hispanic or Latino	White only	Black only	Asian only	American Indian or Alaska Native	2 or more races
	Percent with influenza vaccination in the past year[3]					
18–64 years						
1999–2001	14.3	22.0	16.9	20.5	24.1	20.2
2003–2005	12.6	21.6	16.2	18.1	20.9	20.8
2006–2008	15.8	25.3	19.4	23.6	26.8	24.5
2009–2011	23.6	32.3	25.5	33.7	33.4	24.8
2012–2014	26.4	36.5	29.3	39.9	43.0	30.8
65 years and over						
1999–2001	54.2	66.6	48.5	62.8	54.9	67.5
2003–2005	47.2	66.4	44.3	60.2	60.4	63.6
2006–2008	50.9	68.9	51.1	66.8	69.9	59.2
2009–2011	56.3	68.0	53.0	68.6	63.0	71.9
2012–2014	58.7	70.6	55.6	69.5	65.1	56.5
	Standard error					
18–64 years						
1999–2001	0.4	0.2	0.4	1.0	2.2	1.7
2003–2005	0.4	0.2	0.4	0.9	2.4	1.7
2006–2008	0.5	0.4	0.5	1.0	4.5	2.1
2009–2011	0.5	0.3	0.5	0.9	3.1	1.7
2012–2014	0.5	0.3	0.5	0.9	3.1	1.7
65 years and over						
1999–2001	1.6	0.5	1.4	3.6	8.1	5.2
2003–2005	1.6	0.5	1.4	3.2	7.7	5.3
2006–2008	1.7	0.6	1.4	2.4	6.5	5.2
2009–2011	1.5	0.5	1.2	2.1	7.9	4.4
2012–2014	1.3	0.5	1.2	1.9	6.1	4.1

[1]Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The single-race categories plus multiple-race category shown in the table conform to the 1997 Standards. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[2]Includes all persons not shown separately.

[3]Influenza vaccination is based on respondent report of receipt of a seasonal flu shot or influenza nasal spray (starting in 2005). Questions concerning use of influenza vaccination differed slightly on the National Health Interview Survey across the years for which data are shown. See Appendix II, Vaccination.

[4]Three-year average annual estimates are shown in order to present estimates for the American Indian or Alaska Native and the multiple-race populations. Annual estimates are not stable for smaller population groups.

NOTES: Also see Table 68. Ties in highest and lowest rates were resolved by looking at additional decimal places. See Technical Notes. Prevalence of influenza vaccination during the past 12 months is different from season-specific coverage, see: CDC. Surveillance of influenza vaccination coverage—United States, 2007–08 through 2011–12 influenza seasons. MMWR 2013;62(ss04):1–29. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6204a1.htm?s_cid=ss6204a1_w; and CDC. FluVaxView. Available from: http://www.cdc.gov/flu/fluvaxview/. The recommendations of the Advisory Committee on Immunization Practices regarding who should receive an influenza vaccination have changed over the years, and changes in coverage estimates may reflect changes in recommendations. An influenza vaccine shortage occurred during the 2004–2005 influenza season. Delays in the availability of influenza shots also occurred in fall 2000 and, to a lesser extent, in fall 2001.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 26 (page 1 of 3). No health insurance coverage among persons under age 65, by age and race and Hispanic origin: United States, 1999–June 2015 (preliminary data)

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig26

Age and year	Total[2]	Race and Hispanic origin[1]			
		Hispanic or Latino	Not Hispanic or Latino		
			White only	Black only	Asian only
	Percent without health insurance coverage[3]				
Under 18 years					
1999	11.9	26.7	8.1	11.9	10.4
2000	12.6	25.9	8.7	12.2	12.5
2001	11.2	24.6	7.2	10.6	12.6
2002	10.9	21.9	7.5	10.0	13.4
2003	9.8	20.2	6.4	8.9	12.0
2004	9.2	19.5	6.4	6.9	10.5
2005	9.3	17.5	6.5	8.9	11.4
2006	9.5	19.4	6.2	7.8	8.3
2007	9.0	15.3	7.1	6.2	8.0
2008	9.0	16.8	6.7	7.5	6.5
2009	8.2	14.7	6.0	6.6	7.5
2010	7.8	13.0	5.8	6.4	8.7
2011	7.0	12.3	4.8	5.5	7.8
2012	6.6	10.9	5.2	4.4	7.8
2013	6.6	11.8	4.7	5.1	5.9
2014	5.4	9.7	4.1	3.5	*4.3
2015, Jan–Jun[4]	4.5	8.0	3.6	2.9	*
18–64 years					
1999	17.9	38.5	13.6	23.0	19.1
2000	18.9	41.4	13.9	23.6	19.5
2001	18.5	41.1	13.5	23.0	18.9
2002	19.3	40.8	14.4	23.2	18.7
2003	19.3	42.8	13.9	22.9	20.3
2004	19.3	42.9	14.0	22.7	18.6
2005	19.3	41.8	13.9	23.1	18.9
2006	20.0	43.8	14.6	22.2	16.5
2007	19.6	41.1	14.4	22.0	16.9
2008	19.9	42.6	14.4	22.9	15.7
2009	21.2	43.4	15.6	24.4	17.8
2010	22.3	43.3	16.3	27.1	19.4
2011	21.2	42.1	15.6	24.6	18.8
2012	20.9	41.3	15.1	23.6	19.1
2013	20.5	41.1	14.5	24.7	16.1
2014	16.3	34.1	11.5	17.6	12.1
2015, Jan–Jun[4]	12.7	27.2	8.8	14.5	7.3

See footnotes at end of table.

Data table for Figure 26 (page 2 of 3). No health insurance coverage among persons under age 65, by age and race and Hispanic origin: United States, 1999–June 2015 (preliminary data)

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig26

Age and year	Total[2]	Race and Hispanic origin[1]			
		Hispanic or Latino	Not Hispanic or Latino		
			White only	Black only	Asian only
		Standard error			
Under 18 years					
1999	0.3	0.9	0.4	0.8	1.5
2000	0.3	0.9	0.4	0.8	1.9
2001	0.4	0.9	0.4	0.9	2.1
2002	0.3	0.8	0.4	0.8	1.9
2003	0.3	0.8	0.4	0.7	2.1
2004	0.3	0.8	0.4	0.6	1.8
2005	0.3	0.7	0.4	0.7	1.9
2006	0.3	0.9	0.4	0.7	1.3
2007	0.4	0.8	0.5	0.6	1.4
2008	0.4	0.8	0.6	0.8	1.1
2009	0.4	0.8	0.5	0.6	1.1
2010	0.3	0.6	0.3	0.6	1.1
2011	0.3	0.6	0.3	0.6	1.1
2012	0.3	0.6	0.3	0.5	1.4
2013	0.3	0.6	0.3	0.6	1.0
2014	0.2	0.5	0.3	0.4	0.9
2015, Jan–Jun[4]	0.4	0.7	0.5	0.6	*
18–64 years					
1999	0.3	0.8	0.3	0.7	1.4
2000	0.3	0.9	0.3	0.7	1.4
2001	0.3	0.8	0.3	0.7	1.3
2002	0.3	0.8	0.3	0.7	1.3
2003	0.3	0.8	0.3	0.7	1.4
2004	0.3	0.8	0.3	0.6	1.4
2005	0.3	0.7	0.3	0.7	1.2
2006	0.3	0.9	0.3	0.7	1.1
2007	0.3	0.8	0.3	0.7	1.1
2008	0.3	0.9	0.3	0.7	1.0
2009	0.3	0.9	0.3	0.7	1.1
2010	0.3	0.8	0.4	0.7	0.9
2011	0.3	0.7	0.3	0.6	0.9
2012	0.3	0.7	0.3	0.7	1.0
2013	0.3	0.8	0.3	0.6	0.8
2014	0.3	0.7	0.3	0.6	0.7
2015, Jan–Jun[4]	0.3	0.9	0.3	0.7	0.6

See footnotes at end of table.

Data table for Figure 26 (page 3 of 3). No health insurance coverage among persons under age 65, by age and race and Hispanic origin: United States, 1999–June 2015 (preliminary data)

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig26

Age and year[5]	Race and Hispanic origin[1]					
		Not Hispanic or Latino				
	Hispanic or Latino	White only	Black only	Asian only	American Indian or Alaska Native only	2 or more races
	Percent without health insurance coverage[3]					
Under 18 years						
1999–2001	25.7	8.0	11.6	11.9	34.1	10.3
2003–2005	19.1	6.4	8.2	11.3	31.6	6.3
2006–2008	17.1	6.7	7.2	7.6	*24.2	9.2
2009–2011	13.3	5.5	6.2	8.0	*26.1	6.0
2012–2014	10.8	4.7	4.3	5.9	13.8	4.6
18–64 years						
1999–2001	40.4	13.7	23.2	19.2	39.8	21.1
2003–2005	42.5	13.9	22.9	19.2	36.9	21.1
2006–2008	42.5	14.5	22.4	16.4	39.1	22.4
2009–2011	42.9	15.8	25.4	18.7	39.9	25.3
2012–2014	38.8	13.7	22.0	15.7	33.2	19.4
	Standard error					
Under 18 years						
1999–2001	0.6	0.2	0.5	1.1	4.0	1.1
2003–2005	0.5	0.2	0.4	1.1	4.0	0.9
2006–2008	0.5	0.3	0.4	0.8	7.2	1.0
2009–2011	0.4	0.2	0.4	0.7	7.3	0.7
2012–2014	0.4	0.2	0.3	0.7	2.6	0.5
18–64 years						
1999–2001	0.6	0.2	0.4	0.8	3.2	1.3
2003–2005	0.5	0.2	0.4	0.8	2.7	1.3
2006–2008	0.6	0.2	0.4	0.7	5.8	1.2
2009–2011	0.5	0.2	0.4	0.6	6.0	1.2
2012–2014	0.6	0.2	0.4	0.5	2.8	1.0

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error (RSE) of 20%–30%. Data not shown have an RSE greater than 30%.

[1]Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The single-race categories plus multiple-race category shown in the table conform to the 1997 Standards. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[2]Includes all persons not shown separately.

[3]Persons not covered by private insurance, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans (starting in 1997), Medicare, or military plans are considered to have no health insurance coverage. Persons with only Indian Health Service coverage are considered to have no health insurance coverage. Health insurance coverage is at the time of interview.

[4]Preliminary data based on the National Health Interview Survey's Early Release program. Estimates based on the preliminary 6-month file may differ from estimates based on the final annual file and have larger standard errors associated with them than standard errors based on a final annual file. Available from: Martinez ME, Cohen RA. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2015. NCHS. November 2015. Available from: http://www.cdc.gov/nchs/nhis/releases.htm and National Health Interview Survey, 2015 preliminary file. For more information, visit: http://www.cdc.gov/nchs/nhis.htm.

[5]Three-year average annual estimates are shown in order to present estimates for the American Indian or Alaska Native and the multiple-race populations. Annual estimates are not stable for smaller population groups.

NOTES: Also see Tables 102–105 and Figure 16. Ties in highest and lowest rates were resolved by looking at additional decimal places. See Technical Notes.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 27 (page 1 of 2). Nonreceipt of needed dental care in the past 12 months due to cost among adults aged 18–64, by race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig27

Age and year	Total[2]	Race and Hispanic origin[1]			
		Hispanic or Latino	Not Hispanic or Latino		
			White only	Black only	Asian only
18–64 years	Percent who did not receive needed dental care in the past 12 months due to cost[3]				
1999	9.3	8.5	9.3	10.4	4.5
2000	9.7	9.8	9.8	10.1	5.3
2001	10.4	12.0	10.2	10.3	5.1
2002	10.4	11.1	10.0	12.4	7.4
2003	11.5	13.5	11.1	12.8	5.3
2004	13.2	15.8	12.9	14.1	5.4
2005	13.0	15.5	12.3	15.3	6.8
2006	13.6	16.5	12.9	16.0	6.6
2007	13.0	16.0	12.5	13.6	7.5
2008	15.9	20.8	14.9	18.2	7.8
2009	16.8	22.2	15.5	19.0	9.1
2010	17.3	21.6	16.2	20.8	8.4
2011	16.4	21.1	15.4	18.2	9.4
2012	14.8	18.3	13.7	17.0	10.4
2013	14.3	18.4	13.3	16.3	8.8
2014	12.6	15.7	11.9	14.6	6.3
			Standard error		
1999	0.2	0.5	0.3	0.7	0.9
2000	0.2	0.6	0.3	0.6	0.9
2001	0.2	0.6	0.3	0.6	0.9
2002	0.2	0.6	0.3	0.8	1.1
2003	0.3	0.7	0.3	0.7	0.9
2004	0.3	0.7	0.3	0.7	0.8
2005	0.3	0.6	0.3	0.8	1.0
2006	0.3	0.8	0.4	0.9	1.0
2007	0.3	0.8	0.4	0.8	0.9
2008	0.4	1.1	0.5	0.9	1.0
2009	0.4	1.0	0.5	0.9	1.0
2010	0.3	0.8	0.4	0.8	0.9
2011	0.3	0.7	0.4	0.8	0.9
2012	0.3	0.7	0.4	0.8	1.0
2013	0.3	0.7	0.4	0.7	0.9
2014	0.3	0.6	0.4	0.8	0.7

See footnotes at end of table.

Data table for Figure 27 (page 2 of 2). Nonreceipt of needed dental care in the past 12 months due to cost among adults aged 18–64, by race and Hispanic origin: United States, 1999–2014

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2015.htm#fig27

Age and year[4]	Race and Hispanic origin[1]					
		Not Hispanic or Latino				
	Hispanic or Latino	White only	Black only	Asian only	American Indian or Alaska Native only	2 or more races
	Percent who did not receive needed dental care in the past 12 months due to cost[3]					
18–64 years						
1999–2001	10.2	9.8	10.3	5.0	11.6	18.7
2003–2005	14.9	12.1	14.1	5.8	18.9	19.5
2006–2008	17.8	13.5	15.9	7.3	15.8	21.7
2009–2011	21.6	15.7	19.4	9.0	19.6	25.2
2012–2014	17.4	12.9	16.0	8.5	11.1	19.5
	Standard error					
1999–2001	0.3	0.2	0.4	0.5	1.7	1.7
2003–2005	0.4	0.2	0.4	0.5	2.8	1.6
2006–2008	0.5	0.3	0.5	0.6	3.0	2.0
2009–2011	0.5	0.3	0.5	0.5	2.6	1.8
2012–2014	0.4	0.3	0.5	0.5	1.9	1.5

[1]Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. The single-race categories plus multiple-race category shown in the table conform to the 1997 Standards. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[2]Includes all persons not shown separately.

[3]Based on persons responding to the question, "During the past 12 months was there any time when [person] needed dental care (including checkups) but didn't get it because [person] couldn't afford it?"

[4]Three-year average annual estimates are shown in order to present estimates for the American Indian or Alaska Native and the multiple-race populations. Annual estimates are not stable for smaller population groups.

NOTE: Also see Table 63.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data Sources

Data for the *Health, United States, 2015* Chartbook come from many surveys and data systems and cover a broad range of years. Detailed descriptions of the data sources included in the Chartbook are provided in Appendix I. Data Sources. Additional information clarifying and qualifying the data is included in the table notes and in Appendix II. Definitions and Methods.

Data Presentation

Many measures in the Chartbook are shown for people in specific age groups because of the strong effect of age on most health outcomes. Age-adjusted rates and age-adjusted percentages are computed to eliminate differences in observed rates that result from age differences in population composition (see Appendix II, Age adjustment). Age-adjusted rates and age-adjusted percentages are noted as such in the text; rates and percentages without this notation are crude rates and crude percentages. For some charts, data years are combined to increase sample size and the reliability of the estimates. Some charts present time trends, and others focus on differences in estimates among population subgroups for the most recent time point available. Figures 1–17 and the Highlights section generally present trends for the recent 10-year period. For some indicators, a slightly longer or shorter period may be shown due to design or data comparability issues. Trends are generally shown on a linear scale to emphasize absolute differences over time. The time trends for the overall mortality measures are shown on a logarithmic (log) scale to enable measures with large differences in magnitude to be shown on the same chart.

Point estimates and standard errors for Figures 1–17 are available either in the Trend Table and Excel spreadsheet specified in the note below the chart, or in the Chartbook tables section. For the Special Feature on racial and ethnic health disparities (Figures 18–27), data tables with point estimates and standard errors are contained in the Chartbook tables section. These data tables may include additional data that were not graphed because of space considerations.

Reliability of Estimates

Overall estimates generally have relatively small sampling errors, but estimates for certain population subgroups may be based on small numbers and have relatively large sampling errors. Numbers of deaths obtained from the National Vital Statistics System represent complete counts and therefore are not subject to sampling error. They are, however, subject to random variation, which means that the number of events that actually occur in a given year may be considered as one of a large series of possible results that could have arisen under the same circumstances. When the number of events is small and the probability of such an event is small, considerable caution must be observed in interpreting the conditions described by the charts. Estimates that are unreliable because of large sampling errors or small numbers of events have been noted with an asterisk. The criteria used to designate or suppress unreliable estimates are indicated in the notes to the applicable tables or charts.

For NCHS surveys, point estimates and their corresponding variances were calculated using the SUDAAN software package, which takes into consideration the complex survey design (94). Standard errors for other surveys or data sets were computed using the methodology recommended by the programs providing the data, or were provided directly by those programs.

Statistical Testing

Data trends can be described in many ways. For most trend analyses presented in the Chartbook, increases or decreases in the estimates during the entire time period shown are assessed by the weighted least squares regression method in the National Cancer Institute's Joinpoint software (with Grid search and Bayesian Information Criterion (BIC) model selection). The default maximum number of joinpoints based on the number of available data points in the trend was used. Statistically significant changes in the trend were assessed at the 0.05 level. For more information on Joinpoint, see: http://surveillance.cancer.gov/joinpoint. Statistical significance of differences between regression coefficients at the 0.05 level was also taken into account to select a model with the fewest joinpoints or changes in trend. For some trend charts, there were too few observations for Joinpoint analysis. In those cases, either the difference between two points was assessed for statistical significance using *z*-tests or the statistical testing methods recommended by the data systems were used. Trend analyses using weighted least squares regression for Figures 1–17 were carried out on the log scale so that results provide estimates of percent change. However, as discussed below, trend analyses for figures in the Special Feature were carried out on the linear scale.

For analyses that show two time points, differences between the two points were assessed for statistical significance at the 0.05 level using two-sided significance tests (*z*-tests) without correction for multiple comparisons. Trend and data tables include point estimates and standard errors for users who would like to perform additional statistical tests.

Terms such as "similar," "stable," and "no difference" used in the text indicate that the statistics being compared were not significantly different. Lack of comment regarding the difference between statistics does not necessarily suggest that the difference was tested and found to be not significant. Because statistically significant differences or trends are partly a function of sample size (the larger the sample, the smaller the change that can be detected), they do not necessarily have public health significance (95).

Special Feature on Racial and Ethnic Health Disparities (Figures 18–27)

In general, the starting time period for trend analysis in the Special Feature is 1999. This is the earliest year for which National Health Interview Survey (NHIS) data were available for detailed racial and ethnic groups (see Appendix II, Race). Trend data on race and ethnicity are presented in the greatest detail possible after taking into account the quality of the data, the amount of missing data, and the number of observations. These issues significantly affect the availability of reportable data for certain populations, such as the Native Hawaiian or Other Pacific Islander population and the American Indian or Alaska Native population. Estimates for the Native Hawaiian or Other Pacific Islander population were unstable and are not presented. Three years of data were combined in order to present estimates for the American Indian or Alaska Native population in the data tables that accompany Figures 24–27.

There are various ways to quantify racial and ethnic differences in health and mortality, and different measures of disparity may lead to different conclusions (55–58). This Special Feature uses the maximal rate difference, one of three overall measures used in Healthy People 2020, to measure racial and ethnic disparities (59). The maximal rate difference is an overall measure of health disparities calculated as the absolute difference between the highest and lowest group rates in the population for a given characteristic, irrespective of other, intermediate rates (59). A decrease in the maximal rate difference does not capture whether the population health outcome overall is improving; rather it reflects progress toward eliminating disparities. As the absolute difference between the highest and lowest rates decreases toward 0, all the pairwise absolute differences between population subgroups will tend to 0. For determination of the highest and lowest group rates, estimates were ranked from highest to lowest based on the observed value to six decimal places, to avoid ties. Tests of statistical significance against other rates were not conducted. For consistency with the use of the absolute difference to measure disparity, all analyses in the Special Feature are carried out on the linear scale. For each figure in the Special Feature that shows trends (Figures 19, 21, 23–27) the following analyses were carried out:

(a) trend analysis of overall estimates;
(b) trend analysis of estimates for each racial and ethnic group; and
(c) trend analysis of the maximal rate difference.

These trend analyses provide information used to:

(a) describe the trend in overall estimates as increasing, decreasing, or stable, and any changes in trend over the time period;
(b) indicate whether the trend in estimates for different racial and ethnic groups is similar to the overall trend; and
(c) describe the trend in disparity as measured by the maximal difference in rates as increasing, decreasing, or stable and any changes in trend over the time period.

In addition, a one-sided *z*-test was conducted to test whether the maximal difference in rates was 0 vs. >0 at the most recent time point (59). For figures in the Special Feature that only show estimates at a single time point, the maximal rate difference was calculated for that time point, and a one-sided *z*-test was conducted to test whether the maximal difference in rates was 0 vs. >0.

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Trend Tables in *Health, United States, 2015*

The Chartbook section of *Health, United States, 2015* is followed by 114 Trend Tables organized around four major subject areas: health status and determinants, utilization of health resources, health care resources, and health care expenditures and payers. Trend Tables present data for selected years, to highlight major trends in health statistics. A key criterion used in selecting topics for the Trend Tables is the availability of comparable national data over a period of several years. A summary of the Trend Table topics for the 2015 edition is given below. Earlier editions of *Health, United States* may present data for additional years that are not included in the current printed report. Where available, these additional years of data are provided in spreadsheet files on the *Health, United States* website at: http://www.cdc.gov/nchs/hus.htm.

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