

Health Issues



Connecticut Health
FOUNDATION

ELIMINATING HEALTH DISPARITIES IN CONNECTICUT: A 10-Year Analysis

OVERVIEW

In 1999, the Connecticut Department of Public Health (DPH) released its Multicultural Health Report — the state's first comprehensive health disparities surveillance. In 2000, the federal Department of Health and Human Services released [Healthy People 2010](#), a set of 10-year national public health objectives, which made eliminating racial and ethnic health disparities by 2010 an aspirational goal.

Today, over a decade after the 1999 state report and on the eve of the release of Healthy People 2020, the question must be asked: During 10 years of increased awareness and efforts to close racial and ethnic health disparities gaps, how has the needle moved in Connecticut?

A LACK OF TREND ANALYSIS

The [2009 Connecticut Health Disparities Report](#) was released in January 2009 by the [Connecticut Health Disparities Project](#) of the DPH with private funding from the [Connecticut Health Foundation](#) (CT Health). Reducing racial and ethnic health disparities is one of CT Health's priorities. CT Health funded the 2009 report because:

- A state report had not been published since 1999.
- CT Health believes that public health data must inform health disparities-related policy, program planning, resource allocation and evaluation.

The 2009 report is an invaluable state resource. But, it lacks trend analysis about whether racial and ethnic health disparities have decreased, remained largely unchanged, or increased since 1999. The DPH attributes this to data changes during the decade-long interim (e.g., changes in coding race and ethnicity, changes in standardizing populations) that make straightforward historical comparisons difficult.

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POINTS OF INTEREST:

For all-cause mortality, Black risk relative to the White rate decreased slightly, though relative risks for HIV and homicide mortality increased.

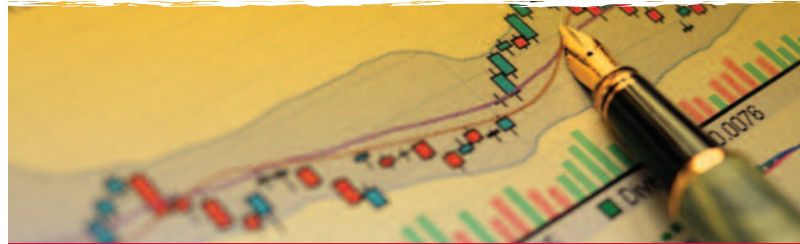
The Hispanic-White gap in reporting fair or poor health status increased.

See trend analysis chart for 13 health indicators on page 2.

Trend Analysis (Continued from page 1)

The table below compares Connecticut data reported between 1999 and 2009 by state and federal public health agencies. Methodological adjustments make comparisons possible. Statistical significance tests were not possible with the data provided.

The purpose is to make at-a-glance observations about trends in Black/African-American and Hispanic/Latino disparities compared to the White population for select health indicators where methodologically possible. Detailed information about the methods, data sources and magnitude of change over time for each indicator is available on request by emailing info@cthealth.org.



The 10-year trends tell Connecticut that the Healthy People 2010 goal of eliminating racial and ethnic health disparities still has a long way to go.

RACIAL AND ETHNIC HEALTH DISPARITIES TRENDS FOR SELECT INDICATORS 1999 - 2009

↓ = disparities decreased ↔ = little change ↑ = disparities increased

HEALTH INDICATOR	BLACK-WHITE GAP	HISPANIC-WHITE GAP	COMMENTS
Mortality	↓	↔	For all-cause mortality, Black risk relative to the White rate decreased slightly, though relative risks for HIV and homicide mortality increased.
Fair or Poor Health Status	↔	↑	The Hispanic-White gap in reporting fair or poor health status increased.
Health Insurance	↔	↑	The Black-White uninsurance gap remained essentially constant; the Hispanic-White gap increased markedly.
Infectious Disease	↓	↓	Most infectious disease risk ratios for Blacks and Hispanics decreased or remained constant. However, striking gaps, while narrowed, persist.
Hospitalization	↔	↔	Racial/ethnic hospitalization disparities generally persisted.
Smoking	↓	↓	Smoking decreased in all populations, but White rates decreased the most and gaps persist. This may in part be due to the younger age distribution of Black and Hispanic residents, and the decline of smoking with age.
Binge Drinking	↓	↓	White and Hispanic rates of binge drinking remained higher than the Black rate, but the Black rate is growing, thus decreasing the gap in an unfavorable direction.
Physical Activity	↔	↔	Physical activity levels for Black and Hispanic populations continue to lag behind the level of the White population.
Obesity	↔	↔	Obesity steadily increased in all populations and racial/ethnic disparities persist.
Cholesterol Test	↓	↑	The Black-White gap in cholesterol testing decreased; the Hispanic-White gap increased.
Prenatal Care	↔	↔	Racial/ethnic prenatal care disparities generally remained constant.
Teen Births	↔	↓	Teen births decreased in all populations, with the Hispanic-White gap narrowing, but racial/ethnic disparities persist.
Very Low Birth Weight Babies	↔	↔	Racial/ethnic very low birth weight gaps persist.

DISCUSSION

The 10-year trends tell Connecticut that the Healthy People 2010 goal of eliminating racial and ethnic health disparities still has a long way to go. For many health indicators included in the table, racial and ethnic health disparities between Black and White Americans, and Hispanic and White Americans persist to some extent. The exception is binge drinking, which disproportionately impacts the White population.

- For some indicators, such as teen births, public health improvements have benefitted all populations over the last 10 years, including populations of color. But work still needs to be done to close gaps.
- Other indicators show the health of all populations is worsening and disparities persist. For example, obesity is increasing for all Americans, but remains more prevalent in Black and Hispanic populations.
- Cholesterol testing and some other indicators show disparities between Black and White, and Hispanic and White populations moved in different directions, suggesting a need for targeted efforts.

People committed to eliminating racial and ethnic health disparities have long known the problem is rooted in generations of inequity

and will take decades of multifaceted efforts to resolve. Even so, this 10-year retrospective is sobering.

It is important, however, to maintain a view of the big picture. While efforts and investments over the past 10 years may not have eliminated or even markedly reduced health disparities, is there evidence that conditions have improved that may, over a longer timeline, produce more equitable health?

Surveillance data cannot answer this question. This suggests a need to systematically collect data that would allow citizens and policymakers to know whether “conditions” related to disparities have changed. Examples of “conditions” are:

- Services of school-based health centers
- Out-of-school programs that include physical activity
- Environmental justice achievements
- Availability of federal and private support for local health disparities elimination programs and research

RECOMMENDATIONS

Public Demand and Public Accountability – Increased public demand is needed for health equity in Connecticut. A Connecticut priority should be achieving health equity by reducing racial and ethnic health disparities. Connecticut residents should demand public funding for regular health disparities surveillance and “conditions” reporting.

Concerned citizens should ask policymakers, state agencies, health care providers and corporate leaders how they are going to reduce racial and ethnic health disparities and then hold them accountable for measurable progress, such as requesting report cards.

Data Improvements – While some have understandably argued that less effort should be invested in measuring disparities and more effort should be invested in actions that will close the gaps, data is an ally of a health disparities elimination agenda. Implementing data improvements by health officials at all levels will result in:

- A more standardized and nuanced understanding of how disparities affect different populations of color
- Better monitoring of progress over time

Possible data improvements include:

- Adopting federal guidelines to translate rates published in the 1980s and 1990s to reflect the 2000 population, so all rates will be comparable
- Making race and ethnicity data specific to remove double counting of Black Hispanics, White Hispanics and Other Hispanics (sometimes counted in both race and Hispanic categories, making comparison of data for White and Black non-Hispanics difficult)
- Including more comparable indicators of disparities in health care quality, such as avoidable hospitalizations, and developing

and implementing indicators of disparities in the adequacy of follow-up in the care setting

- In addition to federal Office of Management and Budget race and ethnicity categories, collecting more standardized, granular, locally relevant ethnicity and language data in line with new recommendations from the [Institute of Medicine Subcommittee on Standardized Collection of Race/Ethnicity Data for Health-care Quality Improvement](#). This will make data more meaningful and actionable at the local level
- Issuing state racial and ethnic disparities surveillance reports every two to three years to assess and report progress at regular intervals and to reduce methodological challenges of tracking trends over time

Health Care Reform – As the nation moves toward health care reform, a window of opportunity is open to ensure that reducing disparities is paramount in the public debate and eventual plan. In addition to expanding coverage to populations of color, health care reform should encompass improvements in disparities-related data collection and monitoring as part of ensuring quality, equitable care.

Increased Commitment – An alternative to feeling discouraged by the slow pace of progress is to renew and heighten commitment to health disparities elimination. Moving forward, there is an opportunity to apply lessons learned over the past 10 years to take a more sophisticated approach to promoting health equity while engaging new partners in the process.

ABOUT THE AUTHORS

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