



Health Disparities in Connecticut: Causes, Effects, and What We Can Do

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By many measures, Connecticut is one of the nation's healthiest states. Yet a closer look at health data reveals major disparities in health by race and ethnicity. Black and Hispanic state residents are far more likely to suffer severe consequences of conditions including asthma and diabetes. Black women are far more likely than white women to have a baby who dies before turning one. Black state residents die at a faster rate than white residents.

Put simply, compared to their white peers, people of color in Connecticut are more likely to live in poor health¹ and – for black residents – to die younger.²

Huge gaps also exist in factors related to health, such as having stable housing, a regular source of medical care, reliable transportation, and enough money to buy food. Yet while socioeconomic

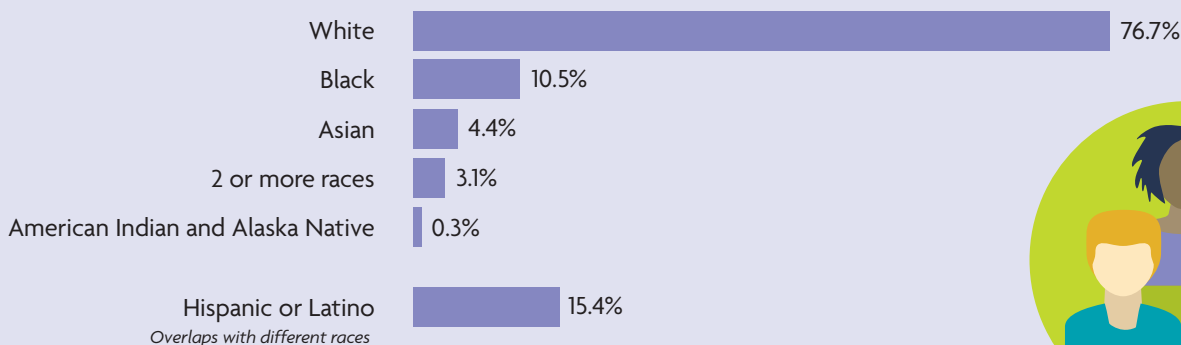
factors are a significant driver of health disparities, they alone do not explain why black and Hispanic state residents face worse health outcomes. Instead, research shows that disparities are partially caused by factors specific to race and ethnicity, including disparate treatment within health care and the physiological effects of experiencing racism.³

Health disparities and the conditions that cause them are significant problems with deep roots, and they have steep costs to individuals, communities, and the economy. Yet they are not intractable. Other states and health systems have made progress in reducing or even eliminating disparities. Connecticut can learn from these examples to make the state one where everyone can be as healthy as possible, regardless of race, ethnicity, or socioeconomic status.

Health disparities in Connecticut

Health outcomes vary widely by race and ethnicity in Connecticut. These disparities affect people of all ages, across a wide range of conditions.

Connecticut's population⁴



Infant mortality

Babies born to black mothers in Connecticut are **more than four times** as likely to die before their first birthday than babies born to white mothers.⁵

This gap reflects two very different realities.

Overall, Connecticut's infant mortality rate is among the lowest in the nation – 4.8 infant deaths per 1,000 births.⁶ For some groups, the rates are especially low. Among babies born to Hispanic mothers, Connecticut has the lowest infant mortality rate in the country (3.7 per 1,000 births), while for babies born to white mothers, Connecticut's infant mortality rate is second-lowest in the U.S. (2.9 per 1,000 births).⁷

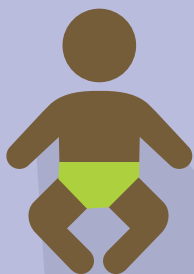
Yet the picture is far different for babies born to black mothers, who die at a rate of 11.7 per 1,000 births. This disparity – babies born to black women dying at a higher rate than babies born to white or

Hispanic women – exists across the country. However, unlike the rates for other racial and ethnic groups, Connecticut's infant mortality rate for babies born to black women is higher than the national average.

In other words, the disparity does not exist simply because white residents have exceptional outcomes and black residents' outcomes are not as good; it exists because while white and Hispanic residents have among the best outcomes in the country, exceeding the national average, black residents' outcomes are below average even accounting for the higher infant mortality rate among black infants nationwide.

There are also significant gaps in the rate of low birthweight babies – those born weighing less than 5½ pounds. Babies born to black women are **nearly twice** as likely to be born at low birthweight than babies born to white women.⁸

4x



Health disparities in Connecticut (continued)

Health outcomes vary widely by race and ethnicity in Connecticut. These disparities affect people of all ages, across a wide range of conditions.

Asthma

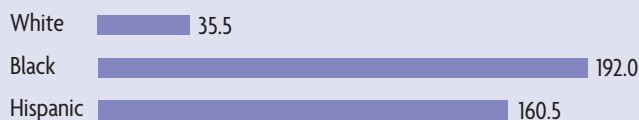
Asthma is a chronic condition that can be managed through medication, monitoring, and avoiding triggers. It is the top cause of preventable hospitalization among children.⁹ The condition disproportionately affects children of color in Connecticut.

Compared to their white peers, black children and teens are nearly **5½ times** more likely to go to the emergency department because of asthma, while Hispanic children and teens are **4½ times** as likely.¹⁰

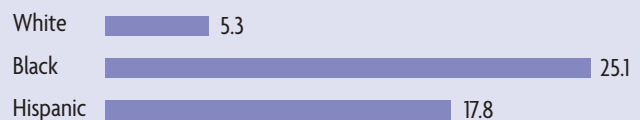
Similarly, black children and teens are **more than 4½ times** more likely to be hospitalized because of asthma than their white counterparts, while Hispanic children and teens are **more than three times** more likely.¹¹



Emergency department visit age-adjusted rates, per 10,000 population, ages 0 to 17, 2018



Hospitalization rate, age-adjusted, per 10,000 population, ages 0-17, 2018



Cancer

Black men are significantly more likely than white or Hispanic men to die from cancer.¹²

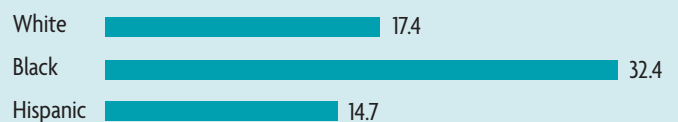


The disparities are particularly stark in prostate cancer. Black men are **nearly twice** as likely to die from prostate cancer as white men.¹³

Cancer in men, age-adjusted mortality rate per 100,000, 2011-2015



Prostate cancer, age-adjusted mortality rate per 100,000 people, 2011-2015





Diabetes

Diabetes is a chronic condition that affects nearly one in 10 adults in Connecticut, but has disproportionately devastating effects on black and Hispanic residents.¹⁴

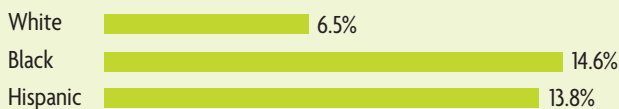
Black and Hispanic Connecticut residents are **more than twice as likely** as white residents to have diabetes, and they are even more likely to suffer severe complications from it.¹⁵

One consequence of diabetes is having a leg or foot amputated – a preventable complication that experts say should be unnecessary.¹⁶ Yet it continues to occur, disproportionately among black and Hispanic individuals.

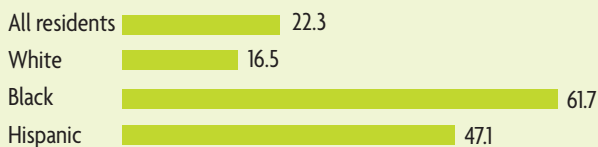
- Black residents are **nearly four times** as likely as white residents to have a diabetes-related lower-extremity amputation.¹⁷
- Among Hispanics, the rate is **nearly three times** higher than among whites.

Black Connecticut residents are **more than twice** as likely to die from diabetes as whites.¹⁸

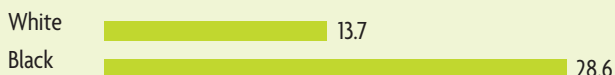
Adults with diabetes, Connecticut, 2012-2014, age-adjusted



Rates of hospital discharge for nontraumatic lower extremity amputation per 100,000 residents, age-adjusted



Diabetes deaths per 100,000 population, 2017, age-adjusted



Both categories include people of Hispanic origin

Life expectancy

The life expectancy for a baby born in Connecticut – 80.8 years – is higher than the national average, but the overall number obscures vast differences between cities, towns, even from one neighborhood to the next.¹⁹

In Northeast Hartford, life expectancy is just 68.9 years – nearly 12 years shorter than the state average and more than 20 years less than part of Westport, the affluent coastal town that boasts the longest life expectancy in Connecticut.

These disparities fall along racial lines. In the portion of Westport with the 89.1-year life expectancy, for example, 91 percent of residents are white, just 0.4 percent are black, and 1.4 percent are Hispanic. Overall, black residents make up 10.5 percent of Connecticut's population, while Hispanics make up 15.4 percent.

By contrast, Northeast Hartford is 69 percent black and 29 percent Hispanic. Of the neighborhoods in the state with the lowest life expectancies, nearly all have black or Hispanic populations that exceed the state average.

Life expectancy

- Northeast Hartford
- Westport



1.2x

Excess deaths

Disparities add up. Connecticut data indicates that from 2000 to 2004, black residents died at 1.2 times the rate of white residents. State officials estimated that if that rate were instead equal to white residents, **376** fewer black residents would die every year.²⁰

What causes disparities?

Disparities stem from a wide range of factors. Some of the major ones are described below.

Differences in insurance coverage

Having health care coverage is key to good health. Research shows that people without insurance are less likely to receive preventive care, while those who are uninsured but have chronic diseases have worse clinical outcomes than people with coverage.²¹ People without insurance also have lower survival rates.²²

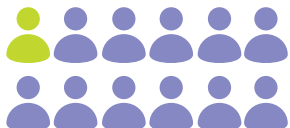
While Connecticut's uninsured rate is among the nation's lowest, significant disparities exist.

Uninsured rate for Connecticut residents under 65, in 2017:²³

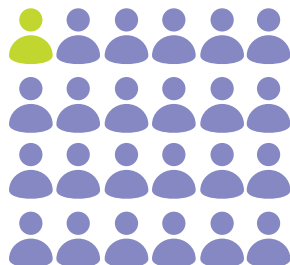
Among Hispanics, **one in six** was uninsured (15%).



For black residents, the uninsured rate was **one in 12** (8%).



For white residents, the uninsured rate was **one in 24** (4%).^a



Access to a regular health care provider

Another key to good health is having a usual source of care – a regular health care provider to go to for preventive care or to address a problem. Building a relationship with a health care provider can be especially important for people who are wary or mistrustful of the health care system.²⁴

In Connecticut, there are big gaps in access to care.

More than **one in four** Hispanic adults said they did not have a personal doctor in 2017 (27.6%).



Among white adults, it was just **over one in 10** (11%).²⁵



Hispanic adults were more than twice as likely as white residents to say they went without seeing a doctor in the past 12 months because of the cost.²⁶



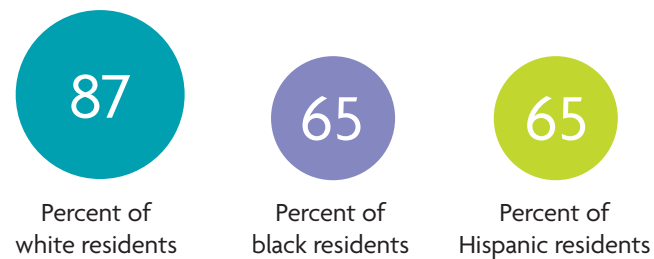
^a Although this is a big disparity, it actually represents an improvement. In 2010, while 7 percent of white Connecticut residents under 65 were uninsured, the uninsured rate among Hispanics under 65 was 23 percent and the rate for black residents was 14 percent. (Kaiser Family Foundation analysis of Census Bureau's American Community Survey, 2008-2017.)



Social factors that influence health

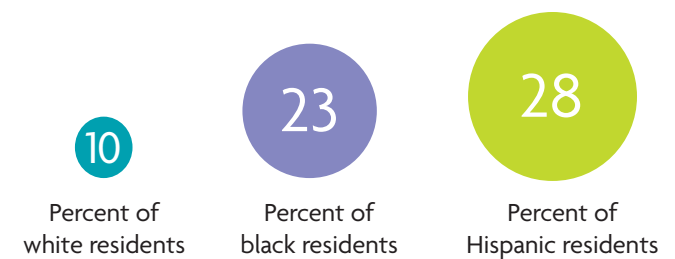
Many factors in people's lives influence their health, including the resources available in their neighborhood, their ability to afford healthy food, and whether they have stable housing and access to transportation. Data indicates there are big racial and ethnic gaps in access to these resources. For example, according to a 2018 survey of Connecticut residents:²⁷

Access to transportation



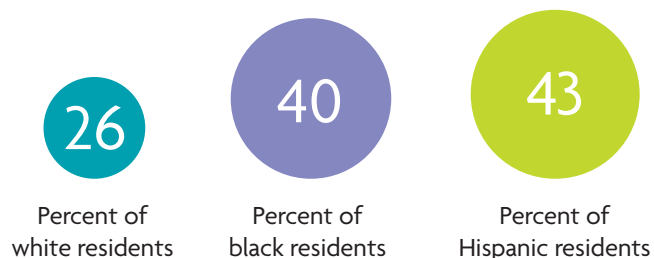
Answered “yes” when asked if they “very often” had **access to a car** when they needed it.

Lack of access to food



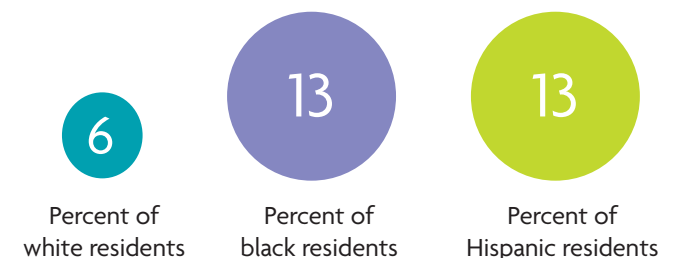
Answered “yes” when asked if there were times in the past 12 months when they **did not have enough money to buy food** that they or their family needed.

Neighborhood safety



Strongly or somewhat agreed when asked about the statement “I do **not feel safe** to go on walks in my neighborhood at night.”

Difficulty affording housing



Answered “yes” when asked if they **did not have enough money to provide adequate shelter or housing** for themselves or their family within the past 12 months.

What causes disparities? (continued)

It's not just socioeconomic status.

While socioeconomic differences can contribute to disparate outcomes, research shows that health disparities exist even when controlling for education and income.²⁸ For example, nationwide, black women with a college degree or higher were **1.6 times** more likely to die from pregnancy-related causes than white women without a high school diploma.²⁹

In other words, income and education alone do not explain why people of color face worse health outcomes than their white counterparts.

Research offers insights into other causes of disparities that are more directly related to race and ethnicity.

Disparate treatment

Many studies have shown that black and Latino patients receive less aggressive treatment³¹ than white patients. Research has found that, for example, Hispanic patients were **half as likely** to be given pain medication when they went to the emergency room with a broken bone.³² Among pediatric patients with appendicitis, black patients were significantly less likely to be given opioids to treat pain.³³

Black patients with heart issues were found to be significantly less likely than white patients to receive therapeutic interventions, including implanted defibrillator devices that can prolong long-term survival.³⁴

The physical toll of discrimination

A growing body of research suggests that people can suffer a physical toll from the stress of experiencing racism and discrimination – both in the form of overt racist acts and more routine forms of unfair treatment – sometimes called “everyday discrimination” – such as receiving poorer service than others in stores or restaurants, being threatened or harassed, or having people act as if they are afraid of you.³⁵

Studies have found links between experiencing discrimination and negative physical and mental health consequences including depression, anxiety, hypertension,³⁶ breast cancer,³⁷ and giving birth preterm or having a low-birthweight baby.³⁸ Research suggests that one way discrimination could lead to poorer health is through repeated activation of the body's stress response system, which can have negative long-term physiological and psychological effects.³⁹

The cost of disparities



Health disparities have deep human consequences: Poor health, lost limbs, emergency department visits, hospital stays, shorter lives.

There is also an economic cost to society – in the form of higher health care spending, lost productivity from illness, and the costs stemming from premature death.

One cost is the additional hospital care people of color need. A 2018 Connecticut study linked disparities to an estimated \$384 million in excess hospital costs for black residents and \$121 million for Hispanic residents.⁴⁰

“This analysis suggests that in order to address healthcare costs in Connecticut, there need to be specific strategies to identify and address health and healthcare disparities,” the authors wrote.

Another study, using national data from 2003 to 2006, estimated the cost of excess medical costs and lost productivity from illness and premature death: \$309.3 billion per year.⁴¹

“We should address health disparities because such inequities are inconsistent with the values of our society. Addressing them is the right thing to do. However, what our analysis shows is that social justice can be cost effective,” the authors wrote.⁴²

“Usually we think of change as coming with costs, that doing something will cost more than continuing to do what we are accustomed to doing,” they added. **“But in the case of health inequalities, doing nothing has a cost we should not continue to bear.”**

Case study: Delaware



Universal cancer screening and targeted pushes⁴³

Delaware made major strides in diagnosing and treating colorectal cancer through a comprehensive statewide cancer control program. It featured strategies to reach all state residents 50 and older, as well as targeted efforts for black Delaware residents, who were less likely to have been screened and more likely to die from the disease.

The effort, which began in 2001 and received state funding, included:

- A comprehensive screening program for colorectal cancer, including free screenings for those with no insurance who were below a certain income level.
- Nurse navigators and care coordinators who helped recruit people to be screened and assisted those who were diagnosed.
- Coverage for two years of treatment costs for uninsured patients diagnosed with colorectal cancer.
- Targeted marketing campaigns and other locally developed programs designed to reach black state residents.

Their efforts made a big difference

- **The disparity in screening for colorectal cancer was eliminated.** From 2002 to 2009, rates of colorectal cancer screening for all Delaware residents 50 and older rose from 57 percent to 74 percent. At the start of the effort, in 2001, black residents were less likely to be screened – only 48 percent had ever received a screening colonoscopy. By 2009, however, the rate of screening among black residents was equal to the overall screening rate for state residents.
- **The disparity in colorectal cancer rates disappeared.** The rates of colorectal cancer fell among both white and black Delaware residents. In 2001, 67 black residents and 58 white residents per 100,000 had colorectal cancer. In 2009, the rate was down to 45 per 100,000 for both white and black residents.

- **Those who had colorectal cancer found it earlier.** Black residents with colorectal cancer were increasingly likely to be diagnosed at earlier stages of the disease. Among black residents diagnosed with colorectal cancer, the percentage found to have cancer at the local stage rose from 16 percent to 50 percent from 2001 to 2009. In that time, the percentage diagnosed once the cancer had reached advanced or regional stages fell from 79 percent to 40 percent.

- **The disparity in death rates fell significantly.** The mortality rate fell among both white and black residents, and the gap narrowed considerably. In 2001, the death rate from colorectal cancer was 31 per 100,000 for black residents and 20 for white residents. In 2009, the rate among black residents fell to 18 per 100,000, while for whites it fell to 17.

“For all of the discussion about health care disparities, it sometimes seems that it has been so extensively documented that we have become numb to its implications or decided that it is too complex to fix,” wrote several officials with the Delaware Cancer Consortium, an organization that led the initiative. “That there are complexities and nuances we do not deny, but the State of Delaware has shown us that if we have the will, there is a way.”⁴⁴

Four things Connecticut can do



1

Improve data collection and act on it

It's hard to solve a problem without being able to pinpoint the challenges and evaluate potential solutions. While there is enough data available to know disparities exist, Connecticut would benefit from having more health data on race and ethnicity, ensuring that it is standardized, and making sure that it is used to improve care.

Most publicly available health data in Connecticut is not broken down by race and ethnicity. Although Connecticut agencies collect data on race and ethnicity, much of it remains unpublished.⁴⁵

Some states have taken action to improve data collection. North Carolina, for example, requires medical providers to collect self-reported race and ethnicity data.⁴⁶ California laws require detailed race and ethnicity data be included in state agency reports on health and housing information.⁴⁷ Michigan has the companies that handle health benefits in its Medicaid program report care quality measures by patients' race and ethnicity.⁴⁸ Minnesota requires health care providers to collect data about race, ethnicity, language preference, and country of origin, and publicly reports health care quality measures by each of those categories.⁴⁹

Even when data is collected, it is not always used. A recent survey of 23 Connecticut hospitals and health systems found that all but one collect data about patients' race and ethnicity, but only five of the 23 said they used race and ethnicity data to measure both clinical performance and care experience. Two-thirds said they did not use race and ethnicity data to identify potential health disparities.⁵⁰

An additional challenge in Connecticut is that for some groups, such as Native Americans, the small population means they are often left out of data reports because of the small sample size in surveys or other measures. This can make it even more difficult to identify health challenges and disparities.

What Connecticut can do:

- Set reporting guidelines so all reports produced by state agencies include data on race and ethnicity and use the same categories and information.⁵¹
- Require the organizations that administer Medicaid to report health outcomes by race and ethnicity.

What health systems can do:

- Track clinical outcomes by patients' race and ethnicity to identify disparities and take action based on the findings.



2

Focus on getting more people covered

Because having health care coverage is so critical to health, ensuring that everyone can get covered is a key way to address disparities.

In Connecticut, approximately **192,300 people under 65 – 7% of the population⁵² – were uninsured** as of 2017. Research suggests that this group can be divided into four roughly equal parts.⁵³

Who are the uninsured?

Of the uninsured...

25%

Are eligible for Medicaid or other public coverage but not enrolled.

26%

Have incomes above the Medicaid threshold but qualify for federal financial aid to buy insurance through the state's health insurance exchange, Access Health CT.

26%

Are not eligible for any financial assistance to buy insurance, either because their incomes are too high or they are offered coverage by an employer.

23%

Are not eligible for other forms of coverage because they are not in the country legally.

What Connecticut can do:

- Support outreach to ensure people who qualify for Medicaid are enrolled and examine eligibility system procedures to ensure those who are covered by Medicaid do not get dropped unnecessarily.
- Target enrollment efforts to communities with the highest rates of uninsured residents.
- Focus on affordable coverage options for those earning just above the Medicaid threshold – the group most likely to be uninsured.⁵⁴
- Consider offering state-funded Medicaid coverage to undocumented residents. Six states (California, Illinois, Massachusetts, New York, Oregon, and Washington) and Washington D.C. currently do this for children and California is poised to begin covering undocumented young adults.⁵⁵

Four things Connecticut can do (continued)

3

Support community health workers

Community health workers are frontline public health workers who serve as a bridge between their communities and the health care and social services systems. They are often trusted members of a community, people who neighbors turn to for help and advice.

Extensive research shows that community health workers can improve health outcomes and ensure people receive preventive care.⁵⁶ Experts consider the use of community health workers a key strategy in reducing disparities.⁵⁷

While community health workers can be effective both in improving health and reducing health care costs, they have not been widely incorporated into the health care system. A new state law, passed in 2019, calls for the state Department of Public Health to create a voluntary certification program for community health workers, which could help give the workforce credibility with potential employers and payers.

What Connecticut can do:

- Implement voluntary certification for community health workers.

What health systems can do:

- Hire community health workers to reach specific patient populations.

What public and private insurers can do:

- Test ways to pay for community health worker services.


4

Promote clinical practice guidelines and evidence-based treatments

One approach to eliminating disparate treatment in health care is to promote the use of clinical practice guidelines – that is, to have care providers follow specific evidence-based protocols when treating patients. For example, one study examined 443 hospitals participating in a voluntary guidelines program for patients recovering from acute heart attacks, and measured the proportion of white and black patients who received evidence-based care including being put on aspirin, beta blockers, and statins, and receiving smoking cessation counseling. At the start of the study, there were significant disparities in the rate of white and black patients receiving optimal care, but by the end of the five-year study, the gap had been eliminated.⁵⁸

Similarly, a recent Connecticut study examined the use of evidence-based treatments for children with mental health needs, and compared outcomes to those from “usual care” methods such as generic talk therapy. While children in both groups showed improvements, the reduction in symptoms was lower among those receiving usual care, and black and Latinx children had lower rates of improvement than white children. By contrast, children receiving evidence-based treatments showed higher rates of improvements overall, and racial and ethnic disparities in outcomes were reduced or eliminated.⁵⁹



A photograph of three women of different ethnicities (Black, Hispanic, and White) looking forward, likely at a presentation or event. The woman in the foreground is Hispanic with glasses and a black and white hoodie. The woman behind her is Black with a blue headband. The woman in the background is White with glasses. The text 'Making Connecticut as healthy as possible, regardless of race, ethnicity, or socioeconomic status.' is overlaid on the right side of the image.

**Making Connecticut
as healthy as
possible, regardless
of race, ethnicity, or
socioeconomic
status.**

Conclusion

Anyone can face health challenges, and many people of all races and ethnicities struggle with health conditions and the cost of care. Yet the challenges black and Hispanic state residents face are often compounded. People of color do not enjoy the same health outcomes as their white counterparts. This is true for infants and children – children of color are far more likely to die before their first birthday, to be born weighing less than 5½ pounds, or to be hospitalized for asthma, for example. It is also true for adults: Race and ethnicity make a significant difference in a person's likelihood of a wide range of poor outcomes, from losing a limb from diabetes to dying from cancer.

These and other disparities have many causes. Compared to white Connecticut residents, people of color are less likely to have health insurance, have a usual source of health care, or have access to many of the types of resources that are linked to health, such as stable housing, transportation, and healthy food.

Yet these differences, and differences in socioeconomic status more generally, are not the only culprits. Research shows that people of color are less likely to receive aggressive or appropriate medical treatment. There are physiological consequences of experiencing discrimination.

It would be a mistake to view health disparities as inevitable or insurmountable. There are examples to draw from, including Delaware's significant progress in eliminating disparities related to colorectal cancer through universal and targeted approaches. Connecticut can learn from these and other strategies to make the state one in which everyone can be as healthy as possible, regardless of race, ethnicity, or socioeconomic status.

Endnotes

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