THE 2009 CONNECTICUT HEALTH DISPARITIES REPORT

The Connecticut Health Disparities Project
Connecticut Department of Public Health
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PREFACE

> *[H]ow we develop, grow, age, ail, and die necessarily reflects a constant interplay, within our bodies, of our intertwined and inseparable social and biological history.*
> —Nancy Krieger (1999, 296)

Over the last ten years, the Connecticut Department of Public Health (DPH) has published three reports that highlighted health disparities among population groups in Connecticut. The first report, *Multicultural Health: The Health Status of Minority Groups in Connecticut*, called attention to areas of health disparities and examined these differences in the context of social and economic conditions of Connecticut (Hynes, Mueller, Bower, and Hofmann 1999, 1). In 2001, *Connecticut Women's Health* presented the social context of health problems, disparities, and access to health care experienced by women in the state (Hofmann and Hooper 2001). In 2005, *Mortality and its Risk Factors in Connecticut, 1989–1998* (Hynes, Mueller, Li and Amadeo 2005) assessed trends in the leading causes of death among Connecticut residents by gender, race, ethnicity, and age.

In 2006, the Connecticut Health Foundation (CHF) awarded DPH a two-year grant to improve the statewide infrastructure for documenting, reporting and addressing health disparities among racial and ethnic minority residents. This initiative is known as the Connecticut Health Disparities Project. This report, *The 2009 Connecticut Health Disparities Report*, is one product of the Connecticut Health Disparities Project, and provides a recent picture of health disparities in Connecticut.

The purpose of this report is to describe and contextualize health disparities experienced by various populations in Connecticut. Herein, we clarify and describe what is meant by "health disparities" and compare statewide data on key health and socioeconomic indicators for racial and ethnic minorities and other disparity populations with those of the majority (White) population in Connecticut. The report provides a descriptive monitoring and analysis—or surveillance—of data on various populations who experience health inequalities. Underlying factors that contribute to inequalities in people's health outcomes, and their access to and quality of health care are examined. This report

will be helpful to policy makers, researchers, health professionals, advocates, and others who are working to improve health of all people in Connecticut.

The report is divided into five major sections: Part I: Introduction and Background, Part II: Health Indicators, Part III: Other Vulnerable Populations, Part IV: Summary and Discussion, and Part V: Appendices and References. Part I provides a brief discussion of health disparities, race and ethnicity, and selected sociodemographic determinants of health disparities. A general description of the state's social context is presented, and summary background information is provided for Connecticut's racial and ethnic populations. Part II provides data and narratives for selected health indicators of Connecticut's populations. Part III focuses on health disparity populations for whom there is little or no consistently-reported health data (e.g., homeless persons, persons with disabilities, ethnic subpopulations, or sexual and gender minorities). Part IV summarizes and discusses the report findings, and Part V provides supporting material for the report.

Selection of health indicators in this report was based on established national and state indicators, including the leading causes of death, reportable diseases, maternal and child health, chronic disease, oral health, injury, environmental health, and occupational health indicators. The choice of indicators for display in this report was accomplished in consultation with Connecticut Department of Public Health program and analytic staff.

Wherever appropriate, statistical tests of significance were conducted for all analyses in this report, including all mortality, all hospitalization, infant mortality, and all behavioral risk factor surveillance indicators. Whenever subgroup differences are noted in the report narrative, tests of statistical significance have indicated that these differences are significant at the $p \leq .05$ level. Whenever subgroup rates are reported as not being different, tests of statistical significance have shown that differences are not significant at the $p \leq .05$ level.

In this report, designations for all racial and ethnic groups are capitalized (e.g., Hispanic or Latino, White, Black or African American), and reflect the federal Office of Management and Budget's (OMB) race and ethnicity classification standards. The reader will also find a Technical Note on this topic and on classifications such as "Other" or "Unknown," which are often used in health data collection and reporting. We have made a concerted effort to include all racial and ethnic groupings that the OMB classifications suggest. However, many data are not yet consistently available for these categories.

Moreover, in Connecticut the population numbers for American Indians and Alaska Natives, Asians, and Native Hawaiians and Other Pacific Islanders are small, or are unstable for statistical analysis. In addition, because data sources use different race and ethnicity categories, the report's narrative and table and figure headings reflect these differences in terminology. This report focuses on the racial and ethnic groups that form the majority of our population, and for which we have the best available data. Therefore, not all racial and ethnic categories may be listed in all of the data tables and figures.

Finally, unless otherwise noted, all racial groupings (e.g., "Black," "Asian/Pacific Islander," "White") *exclude* persons of Hispanic ethnicity. A Hispanic or Latino ethnicity category is included in figures and tables reflecting data separate from race categories. Therefore, the modifier "Non-Hispanic or Latino" is assumed, and exceptions (e.g., "Hispanic Whites") will be marked in the text. Further discussions of race and ethnicity classifications may be found in Appendices III, IV, and VII.

EXECUTIVE SUMMARY

INTRODUCTION

The 2009 Connecticut Health Disparities Report provides the contexts and descriptions for health disparities experienced by various populations in Connecticut. The Connecticut Department of Public Health's definition of "health disparities" and sociodemographic characteristics of Connecticut's population are presented as background for the report's findings. Health indicator data reported herein are the result of careful analysis of available information by Connecticut Department of Public Health staff. Indicators of health status are presented by race, ethnicity, and/or other sociodemographic factors such as education or income level. Findings about the health issues of other vulnerable populations, such as homeless persons, sexual and gender minorities, and immigrants and refugees are also included in the report. Despite excellent overall health among Connecticut residents, we have documented the existence of a number of significant health disparities that present a formidable challenge to public health. Key findings are summarized below.

BACKGROUND

- Health disparities refer to those *avoidable* differences in health that *result from cumulative social disadvantage.*
- Public health research has demonstrated that a wide variety of health outcomes are influenced by social factors such as socioeconomic status, behaviors, social support, stress, discrimination, and environmental exposures. Health disparities are evidence of inequalities in these social factors.
- Racial and ethnic diversity is increasing in Connecticut. From 2000–2007, the state's Asian population increased by 38.2%, the Native Hawaiian or Other Pacific Islander population increased by 29.3%, and the Hispanic or Latino population increased by 24.8%. Hispanics or Latinos have shown the most growth of any Connecticut racial or ethnic subgroup in terms of overall numbers from 2000–2007.
- In 2007, the Hispanic or Latino population comprised 11.5% of the Connecticut population, Black or African Americans, 9.3%, and Asians, 3.4%.
- Compared with the White population in Connecticut, Blacks or African Americans were almost 3.6 times, American Indians or Alaska Natives about 3.3 times, Hispanics or Latinos about 4.7 times, and persons reporting "Some Other Race" about 5.4 times more likely to be living in poverty in 1999.
- While Connecticut compares favorably with the nation and with other states in terms of overall health statistics and broad measures of socioeconomic position, data in this report consistently show that there are striking health and social inequalities between racial and ethnic population groups in our state. Connecticut data provide evidence for health disparities, and mirror the findings of many such studies nationwide.
- The federal Office of Management and Budget (OMB) requires that all producers of federal statistics be compliant with OMB 1997 data collection and reporting standards by January 1, 2003, in order to standardize race and ethnicity categories across all federal agencies. Inconsistent implementation of these standards across federal and state agencies continues to lead to inconsistent or absent data.

KEY FINDINGS

All-Cause Mortality

- The mortality rate for all causes is a key measure of health status across populations. From 2000–2004, Black or African American Connecticut residents had the highest death rate from all causes, approximately 1.2 times higher that White residents. White residents had the second highest death rate from all causes followed by Hispanic and American Indian or Alaska Native residents, both of whom had about 0.8 times the all-cause death rate of Whites. Asian or Pacific Islander residents of Connecticut had the lowest death rate from all causes, which was approximately 0.4 times that of White residents.

Chronic Disease

- In 2000–2004, heart disease was the leading cause of death in Connecticut. Black or African American Connecticut residents had the highest death rate from heart disease, about 1.2 times higher than that of White residents. American Indians or Alaska Natives had similar heart disease death rates as Whites. Hispanic and Asian or Pacific Islander residents had lower heart disease death rates compared with White residents (0.7 and 0.4 times the death rate of Whites, respectively).

- In 2000–2004, cancer was the second leading cause of death in Connecticut. Black or African American Connecticut residents had the highest death rate from cancer, about 1.1 times higher than that of White residents. Hispanic, American Indian or Alaska Native, and Asian or Pacific Islander residents had lower cancer death rates compared with White residents.

- In 2000–2004, cerebrovascular disease or stroke was the third leading cause of death in Connecticut. Black or African American Connecticut residents had the highest death rate from stroke, about 1.4 times higher than that of White residents. Hispanic and Asian or Pacific Islander residents had lower stroke death rates compared with White residents (0.8 and 0.5 times the death rate of Whites, respectively). There were too few reported deaths due to stroke among American Indian or Alaska Native residents to calculate reliable rates.

- In 2004–2006, an estimated 5.9% of Connecticut adults aged 18 years and older had diagnosed diabetes. Connecticut adults aged 60 years and over have the highest rates, and lower-income adults are more likely to have diagnosed diabetes than are adults with higher income. Black or African American and Hispanic adults have significantly higher age-adjusted diabetes prevalence rates than White adults.

- Diabetes was the seventh leading cause of death in Connecticut in 2000–2004. Black or African American Connecticut residents had the highest death rate from diabetes, about 2.5 times higher than that of White residents. Hispanics had about 1.5 times the death rate from diabetes compared with Whites. There were too few reported diabetes deaths among Asian or Pacific Islander and American Indian or Alaska Native residents to calculate reliable rates.

- In 2005, Black or African American Connecticut residents had the highest hospitalization rate for diabetes and lower-extremity amputations of all racial and ethnic groups, with 3.8 times the hospitalization rate of White residents for both conditions. Hispanics had 2.3 times the rate of diabetes and 3.1 times the rate of lower extremity hospitalizations compared with Whites.

Behavioral Risk Factors for Chronic Disease

- In 2004–2006, lower-income adults in Connecticut were much less likely to obtain recommended screening tests for certain types of cancers compared with those of higher income. Low-income women were less likely to receive a recommended mammogram in the past two years and a recommended Pap test in the past three years compared with higher-income women. Among Connecticut adults aged 50 years and over, those with low income were less likely to have had a colonoscopy or sigmoidoscopy screening for colorectal cancer compared with those of high income.

- Cigarette smoking has been linked to numerous chronic diseases including cancer, cardiovascular diseases, respiratory diseases, and pneumonia. In 2005, 16% of Connecticut adults reported being current smokers. Connecticut adult smokers are more likely to be younger and have lower incomes and less education than non-smokers. In 2004–2006, an estimated 33.4% of adults with less than a high school education smoked compared with only 9% of adults who graduated from college.

- Obesity and overweight have been linked to numerous health problems including high blood pressure, high blood cholesterol, high triglycerides, diabetes, and heart disease, and increased likelihood of developing certain types of cancers. Lower-income adults are more likely to be obese than higher-income adults. In 2004–2006, an estimated 25.4% of adults with household incomes of less than $25,000 per year were obese, compared with 17.3% of adults with household incomes of $75,000 or more per year.

- High blood pressure (HBP) is a major risk factor for heart attack and the most important modifiable risk factor for stroke. In 2004–2005, about 25.1% of Connecticut adults reported that they had HBP, and Black or African American adults experienced high blood pressure more than White and Hispanic adults. Black or African American adults were also more likely to report taking medication for HBP.

- High blood cholesterol is a major risk factor for heart disease and a moderate risk factor for stroke. During 2004–2006, an estimated 17.8% of Connecticut adults had never had their blood cholesterol checked. Persons without health insurance, and those with lower incomes and less education were more likely to report never having had their blood cholesterol checked.

- Physical inactivity is linked to increased risk of several chronic health conditions, including cardiovascular disease, diabetes, some cancers, high blood pressure, overweight and obesity, back problems, and osteoporosis. Physical inactivity increases with age. 2005 Behavioral Risk Factor Surveillance Survey (BRFSS) data show that about 59% of Connecticut adults aged 65 years and older did not meet the federally recommended physical activity levels.

Injury

- Unintentional injury deaths include those due to motor vehicle injuries, poisonings, falls and fall-related injuries, and suffocation. In 2000–2004, unintentional injury was the fifth-ranked leading cause of death in Connecticut and the first-ranked leading cause of death for Connecticut residents aged one to 44 years.

- In 2000–2004, suicide was the 12th leading cause of death in Connecticut and the second leading cause for residents aged 15–19 and 25–34 years. Connecticut males were 4.1 times more likely to commit suicide than females. Firearms were the most common method, followed by suffocation by hanging and other means, drug or alcohol poisoning, and poisoning by carbon monoxide and other substances.

- In 2000–2004, homicide was the 17th leading cause of death overall, but it was the sixth leading cause of death among Black or African American males and the seventh leading cause of death among Hispanic males. Homicide deaths and death rates were highest among males, and highest among 25–29 year-olds.

Infectious and Sexually Transmitted Diseases

- Diagnosed cases of HIV/AIDS for 2001–2005 were most prevalent in persons of Hispanic origin and Blacks. These groups experienced 7.4 and 6.6 times the rates of HIV/AIDS diagnoses as Whites, respectively.
- During 2001–2005, African Americans in Connecticut disproportionately experienced chlamydia infection, gonorrhea, and syphilis compared with Whites and Hispanics. For chlamydia, the incidence rate among African Americans was 18 times that of Whites; for gonorrhea, the rate was 29 times that of Whites; and for primary and secondary syphilis, the rate was three times that of Whites.
- The incidence rates of invasive pneumococcal disease in Connecticut among Blacks and Hispanics were three and two times that of Whites, respectively, during 2001–2005.
- Tuberculosis (TB) trends in Connecticut mirror those of the nation. From 2000 to 2005, the incidence rates of TB among foreign-born persons and racial and ethnic minorities were higher than the incidence among Whites in Connecticut. The Connecticut TB incidence rate for 2000–2005 was highest among Asians (23 times that of Whites).

Maternal and Child Health

- The infant mortality rate (IMR) is a key measure of population health status. Between 2001–2005, the Connecticut IMR was 5.9 deaths per 1,000 live births. During this time, the IMR for White infants was 3.9, while for Black or African American infants, the IMR was 13.0, and for Hispanics, it was 6.5 per 1,000 live births.
- Hispanic women and Black women had the highest percentages of those with late or no prenatal care in the first trimester of pregnancy, at 23.6% and 21.8% of women, respectively. Black women had the highest percentage of low birth weight infants, at 12.9%, compared with 6.7% for White infants, 8.2% Asian/Pacific Islanders, and 8.5% for Hispanics.

Oral Health

- Good oral health is key to maintaining good overall health. An oral health survey of Connecticut kindergarteners and third graders conducted in 2006–2007 demonstrated that 41% of third graders surveyed had experienced tooth decay, as had 31% of children enrolled in Head Start and 27% of kindergarteners.
- There were statistically significant differences between the White kindergarten and third grade students' oral health screening results and that of racial and ethnic minority children. Hispanic children had the largest percentage of tooth decay experience (49.3%), followed by African American (42.8%) and Asian students (42.0%). Among the White children surveyed, 28.9% had experienced tooth decay.

Environmental and Occupational Health

- In 2001–2005, New Haven, Connecticut had the highest asthma hospitalization rates for children 0–17 years old (71.6 hospitalizations per 10,000), compared with Hartford (41.5), Waterbury (38.6), Bridgeport (24.2) and Stamford (17.5). In 2004, Hispanic and Black children 0–17 years old had the highest rate of emergency department visits, at 169.7 and 151.2 per 10,000, respectively, compared with White children (32.7 per 10,000). Connecticut Black and Hispanic residents of all ages had the highest asthma hospitalization rates in

2005: 316.7 and 331 per 100,000 population, respectively, compared with the White rate of 84.5 per 100,000 population.

- In 2006, New Haven had the highest percent of screened children who had a confirmed elevated lead blood level (≥10µg/dL) (5.7%), compared with the state overall (1.6%). Although there were relatively few Native American children in Connecticut screened that year, almost three times as many of them had elevated blood lead compared with screened White children. Likewise, Black children also had high rates of elevated blood lead, with 2.7 times that of White children who were screened.

- Hispanics in Connecticut had about 2.4 times more non-fatal work-related injuries and illnesses than White workers in 2006, a disparity that has remained despite an overall decrease in injuries and illnesses in the workplace over the last several years.

Access to Health Care; Health Care Workforce

- Lack of health insurance is an urgent health problem facing many state residents. In Connecticut, Hispanic residents are about 5.4 times more likely, and Black residents 2.7 times more likely, to be uninsured than White residents.

- During fiscal years 2000–2006, the number of preventable hospitalizations in Connecticut grew by nearly 4%. Racial and ethnic minority populations accounted for 100% of the growth in preventable hospitalizations between FYs 2000 and 2006, while preventable hospitalizations among Whites decreased 3% over this same time period. Hispanics and Blacks represented 44% and 31%, respectively, of the increase in preventable hospitalizations between FY2000 and FY2006.

- Connecticut ranks fifth in the nation in terms of physicians per 100,000 population. However, health care providers are not evenly distributed throughout the state, and there are 95 federally designated health care workforce shortages areas in the state. In order to better address health disparities, a more detailed description of the health care workforce is necessary.

Other Vulnerable Populations

- Many other populations suffer from health disparities, including: rural residents, older and younger persons, sexual and gender minorities, persons with disabilities, immigrants and refugees, limited English proficient (LEP) populations, and homeless persons. Health data for these populations are inconsistently collected and often are not easily accessed. Therefore, public health professionals, health care providers, and policy makers have incomplete understandings of their health status and needs.

Future Directions

- Current state data provide a limited picture of the health status of various populations in Connecticut. Health data (e.g., births, deaths, risk factor prevalence) collected on smaller population subgroups, specifically American Indians or Alaska Natives, Asians, and Native Hawaiians or Other Pacific Islanders, are often limited due to low numbers of reported occurrences. More information about the health and health-related experiences of these groups is needed.

- Compared with other population subgroups, there is relatively more health information available for Hispanics or Latinos in Connecticut. However, because the Connecticut Hispanic or Latino population is rapidly increasing in both size and diversity, more detailed in-

formation, particularly on issues related to access to quality health care and language barriers, is needed.

- Mortality data show that compared with other racial and ethnic subgroups in Connecticut, Blacks or African Americans suffer disproportionately from the major chronic diseases (heart disease, stroke, diabetes) and other causes of death such as HIV/AIDS and homicide. Detailed information is lacking, however, on subgroups within the Black or African American population, as well as the influences of poverty, low-income neighborhood environments, and discrimination on health outcomes.
- The amount of available health and social data are generally good for the White, non-Hispanic population in Connecticut relative to other subgroups; however, White residents are socioeconomically and ethnically diverse, and detailed information is lacking on the role of socioeconomic status, geographic area of residence, and living environments on health, as well as access to appropriate health care in this population.
- Creation of a more detailed picture of the health status of Connecticut population subgroups is achievable through increased collaboration between local communities and public and private agencies who are committed to providing more in-depth descriptions (and understanding) of the health needs and health status of the residents of our state. Such an effort would entail use of both qualitative (ethnography, participant observation, focus groups) and quantitative (survey) methods as well increased use of GIS (Geographic Information Systems) technology so that accurate and vivid depictions of the health status and needs of smaller, diverse subgroups are captured.