

PART IV
SUMMARY AND CONCLUSION

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SUMMARY

This report emphasizes health disparities experienced by racial and ethnic minority residents relative to the White resident population of Connecticut. However, disparities due to income level, educational attainment, and gender are also apparent for many of the health indicators presented. While the data presented highlight certain statuses (race, ethnicity, gender, income), individuals have multiple statuses that may put them in a higher risk category for certain health outcomes. Thus, when discussing health disparities, it is especially important to identify the multiple levels of disparities affecting individuals.

Limitations of the data used in this report (see pages 36–38) include limited reporting of reliable statistics due to small numbers of some population groups and use of relative risk and excess events as overall measures of disparities. Health data collected on smaller population subgroups, specifically Asians, Native Hawaiians or Other Pacific Islanders, and American Indians or Alaska Natives, are often limited due to the small numbers of occurrences. Because the Asian/Pacific Islander and American Indian or Alaska Native resident populations of Connecticut are relatively small, the numbers of estimated annual excess or fewer events represented by these relative risks are not large.

Inconsistent use of racial and ethnic classifications within and between data sources and missing information or misclassification of race and ethnicity in databases are other important limitations. Some, but not all, of the data used in this report are compliant with current federal standards (OMB 1997) for the classification and collection of race and ethnicity information. Differences in terminology used by the different data sources are reflected throughout this report.

Table 38 summarizes selected findings of this report, using two measures of disparities, relative risks and excess events. There is no absolute standard against which to compare health indicators for various population groups. In this report, the White population is used as the comparison group because it is by far the largest population in Connecticut, and there are sufficient data for all health conditions with which to compare health indicators for smaller population groups. While some methodologists have advocated use of “the best group” approach for racial and ethnic subgroup comparisons, this is largely not

possible in Connecticut due to the small numbers of, and unreliable rate estimates for, the main racial and ethnic subgroup populations (Keppel, Pamuk, Lynch, et al. 2005).

Table 38. Summary of Annualized Excess Events and Relative Risks for Health Indicators in Racial and Ethnic Group Compared to White Residents, Connecticut^{a, b}, Various Years

Indicator	Year(s)	Black or African American		Hispanic ^c		Asian or Pacific Islander		American Indian or Alaska Native	
		Relative Risk	Excess (Fewer) Events	Relative Risk	Excess (Fewer) Events	Relative Risk	Excess (Fewer) Events	Relative Risk	Excess (Fewer) Events
Mortality									
All Causes ^y	2000-2004	1.2	376	0.8	(232)	0.4	(176)	0.8	(8)
Cancer ^y	2000-2004	1.1	56	0.6	(93)	0.4	(53)	0.6	(5)
Diabetes ^y	2000-2004	2.5	49	1.5	11	†	†	†	†
Heart Disease ^y	2000-2004	1.2	70	0.7	(73)	0.4	(41)	1.0	0
HIV/AIDS ^{a, v, †}	2000-2004	14.9	74	9.8	44	†	†	†	†
Homicide ^y	2000-2004	10.4	38	4.6	16	†	†	†	†
Stroke ^y	2000-2004	1.4	28	0.8	(10)	0.5	(9)	†	†
Suicide ^y	2000-2004	0.5	(13)	0.7	(8)	†	†	†	†
Unintentional injuries ^y	2000-2004	1.0	3	1.0	(3)	0.3	(12)	†	†
Infectious Disease/STD Incidence									
Acute Hepatitis B ^{a, v, †}	2001-2005	1.9	4	--	--	3.0	3	--	--
Chlamydia ^{§, //, †}	2001-2005	18.1	2,788	9.4	1,486	1.1	3	3.2	10
Gonorrhea ^{§, //, †}	2001-2005	28.8	1,219	7.7	317	0.8	(3)	†	†
HIV/AIDS ^{a, †, †}	2001-2005	6.6	205	7.4	253	0.3	(8)	†	†
Invasive pneumococcal infection ^{a, v}	2001-2005	1.8	34	1.1	5	0.2	(11)	--	--
P & S syphilis ^{§, //, †}	2001-2005	4.9	8	2.2	3	†	†	--	--
Tuberculosis ^{a, †, †}	2001-2005	8.6	24	8.0	24	23.0	23	--	--
Pregnancy and Birth Outcomes									
Infant deaths ^{a, v, †}	2001-2005	3.3	44	1.7	20	0.6	(3)	0.7	0
Late or no prenatal care ^{a, v, †}	2002-2006	2.8	665	3.0	1,206	1.6	91	1.8	12
Low birthweight ^{a, v, †}	2002-2006	1.9	299	1.3	139	1.2	31	1.2	3

^a For Whites for all indicators relative risk = 1.0 and excess events = 0.

^b Racial groupings (Black or African American, Asian or Pacific Islander, American Indian or Alaska Native) exclude persons of Hispanic ethnicity for the following indicators: all mortality, pregnancy and birth outcomes, hospitalization indicators, and asthma emergency department visits. Racial groupings exclude persons of Hispanic ethnicity for all infectious diseases and STDs with the exception of acute hepatitis B.

^c Hispanic category includes any race.

^d "Relative risk" is the ratio of the minority group rate to the White rate.

^e "Excess events are the events that would not have occurred if the minority group had the same rate as the White population, and are presented on an annualized or per year basis. Parentheses indicate fewer events.

† Statistic not calculated due to small numbers.

-- Data not available.

^a Black
[§] African American

[†] Asian & Pacific Islander
^v Asian/Pacific Islander
^{//} Asian American/PI
^δ Asian

[‡] American Indian/Alaska Native
^ε Native American
[#] American Indian

Table 38 (continued). Summary of Annualized Excess Events and Relative Risks for Health Indicators in Racial and Ethnic Group Compared to White Residents, Connecticut^{a, b}, Various Years

Indicator	Year(s)	Black or African American		Hispanic ^c		Asian or Pacific Islander		American Indian or Alaska Native	
		Relative Risk	Excess (Fewer) Events	Relative Risk	Excess (Fewer) Events	Relative Risk	Excess (Fewer) Events	Relative Risk	Excess (Fewer) Events
Hospitalizations									
Asthma ^{a, f, #}	2005	3.7	761	3.9	736	0.3	(53)	0.8	(2)
Circulatory conditions ^{a, f, #}	2005	1.4	1,369	1.0	12	0.3	(613)	0.4	(67)
Diabetes ^{a, f, #}	2005	3.8	753	2.3	309	‡	‡	‡	‡
Diabetes with lower extremity amputation ^{a, f, #}	2005	3.8	137	3.1	80	‡	‡	‡	‡
Other									
Asthma Emergency Department Visits ^a	2004	4.6	1,130	5.2	1,716	--	--	--	--

^a For Whites for all indicators relative risk = 1.0 and excess events = 0.

^b Racial groupings (Black or African American, Asian or Pacific Islander, American Indian or Alaska Native) exclude persons of Hispanic ethnicity for the following indicators: all mortality, pregnancy and birth outcomes, hospitalization indicators, and asthma emergency department visits. Racial groupings exclude persons of Hispanic ethnicity for all infectious diseases and STDs with the exception of acute hepatitis B.

^c Hispanic category includes any race.

^d "Relative risk" is the ratio of the minority group rate to the White rate.

^e "Excess events are the events that would not have occurred if the minority group had the same rate as the White population, and are presented on an annualized or per year basis. Parentheses indicate fewer events.

‡ Statistic not calculated due to small numbers.

-- Data not available.

^a Black

[§] African American

[¶] Asian & Pacific Islander

[∇] Asian/Pacific Islander

^{//} Asian American/PI

^δ Asian

[≠] American Indian/Alaska Native

^ε Native American

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MORTALITY (2000–2004)

Racial or ethnic disparities in all-cause mortality and the top three leading causes of death for Connecticut residents (heart disease, cancer, stroke) were presented in this report. Other leading causes of death that were presented—diabetes, HIV/AIDS, and homicide—were selected based on their disproportionate impact on one or more racial or ethnic subgroups. Deaths caused by unintentional injury and suicide were also included. While there did not appear to be a racial or ethnic minority disparity in either unintentional injury or suicide deaths for the 2000–2004 period, there appears to be a large *gender* disparity, with males having significantly higher mortality rates from both causes relative to females. It is also worth noting that in an earlier time period (1993–1997) there *were* racial or ethnic minority disparities in unintentional injury Connecticut resident deaths (Hynes et al. 1999). See Appendix IX for the Leading Cause of Death Tables by Gender and Race or Ethnicity of Connecticut Residents.

Of all the racial and ethnic groups considered in this report, Blacks or African American Connecticut residents had the highest relative risk for and excess deaths from all causes. Compared with White residents, Blacks or African Americans had an estimated total of 376 excess deaths per year from 2000 to 2004. Blacks or African Americans had the highest death rates and risk relative to White residents for HIV/AIDS (an estimated 74 excess deaths per year), heart disease (70 excess deaths), cancer (56 excess deaths), diabetes (49 excess deaths), homicide (38 excess deaths), and stroke (28 excess deaths). Blacks or African Americans had similar unintentional injury death rates to Whites, and lower suicide death rates (approximately 50% lower with an estimated 13 fewer deaths).

Numerous research studies have documented the link between lower socioeconomic status and higher mortality (Kitagawa and Hauser 1973; Adler et al. 1994). Higher mortality among Blacks or African Americans relative to Whites has been connected to their lower socioeconomic profile (Sorlie, Rogot, Anderson et al. 1992; Howard, Anderson, Russell, et al. 2000) and residential segregation in urban areas (Polednak 1997; Collins and Williams 1999). Closer consideration of the role of poverty, residential segregation, and low-income environments on the mortality of Black or African American residents of Connecticut is warranted.

From 2000 to 2004, relative to the White population, Hispanic residents of Connecticut had lower age-adjusted mortality rates for the following: all causes, the chronic conditions of heart disease, stroke, and cancer, and suicide. Hispanics had an estimated total of 232 fewer deaths per year compared with Whites, including 73 fewer heart disease deaths, ten fewer stroke deaths, 93 fewer cancer deaths, and eight fewer suicide deaths. Hispanic residents had higher age-adjusted death rates for diabetes (11 excess deaths), HIV/AIDS (44 excess deaths), and homicide (16 excess deaths) compared with White residents. Hispanics had similar unintentional injury death rates as Whites.

In general, these findings are consistent with both national statistics and previous analyses for Connecticut (Hynes, Mueller, and Amadeo 2004; Hynes et al. 2005). National studies have documented lower age-adjusted, and income-adjusted mortality rates due to heart disease, stroke, and cancer among Hispanics relative to non-Hispanic Whites, which is contrary to expectation given Hispanics' lower socioeconomic profile. This phenomenon has been termed the "Latino or Hispanic mortality paradox." Various explanations have been advanced to account for it, including that Hispanics may have better health practices and social support relative to Whites, and thus are at lower risk of death despite their lower socioeconomic position (Abraido-Lanza et al. 1999). These two protective factors (health practices and social support) are mentioned in the context of a "mortality paradox," but they likely play a role in other health status comparisons as well. Nevertheless, in terms of mortality, protective factors are hypothesized to positively influence health status and mortality outcomes among Hispanics.

A contrasting explanation is that the phenomenon of lower mortality among Hispanics relative to Whites is not real, but rather an artifact of undercounting of Hispanics on death certificates. A study of mortality in Texas suggested that when decedent names were matched to a Hispanic surname list, numbers of Hispanic deaths and death rates increased substantially. The authors thereby concluded that the Hispanic paradox as described in research studies is not real; it is the result of inconsistencies in counts of Hispanic-origin decedents and populations (Smith and Bradshaw 2006). Because Hispanics are a large, diverse, and rapidly growing subgroup in Connecticut, the continued monitoring of trends in the leading causes of death is especially important regardless of the underlying explanation for Hispanics' lower mortality rates compared with Whites.

Asian/Pacific Islander Connecticut residents had lower age-adjusted all-cause mortality rates relative to the White resident population, with an estimated 176 fewer total

deaths per year. Asians/Pacific Islanders had fewer deaths per year due to cancer (53 fewer deaths), heart disease (41 fewer deaths), stroke (nine fewer deaths), and unintentional injury (12 fewer deaths) compared with the White population. There were too few deaths due to diabetes, HIV/AIDS, homicide, and suicide reported among Asians/Pacific Islanders in Connecticut from 2000 to 2004 to calculate reliable rates.

As noted previously, Asian/Pacific Islanders are a heterogeneous group, in national origin, cultural practices, and socioeconomic status. While some Asians are recent immigrants, others have been here for generations. While some Asian immigrants are highly educated, high-income earners who speak English fluently, others are recent refugees from war, unrest, and social upheaval, and are less educated, and more likely to live in poverty. These varied experiences may appear as differences in the mortality of Asian/Pacific Islander subgroups; however, analyses of these data are not possible due to small numbers of reported deaths.

Mortality data for American Indian or Alaska Native residents of Connecticut are extremely limited due to the small numbers of this population. Between 2000 and 2004, American Indian or Alaska Native residents had lower all-cause mortality rates compared with Whites with an estimated eight fewer deaths per year. The only other causes of death with sufficient numbers for which to calculate reliable mortality rates for this subgroup were heart disease and cancer. American Indian or Alaska Native residents had similar heart disease mortality rates as Whites, and slightly lower estimated cancer mortality with an estimated five fewer deaths per year. National studies suggest that, historically, there has been substantial misclassification of American Indians or Alaska Natives on death certificates, and that this has not improved much over time (Arias et al. 2008).

INFECTIOUS DISEASE AND STD INCIDENCE (2001–2005)

Compared with Whites, Blacks or African Americans in Connecticut were disproportionately affected by all infectious and sexually transmitted diseases considered in this report for the 2001–2005 period. The rate of acute hepatitis B infection was 1.9 times with an estimated four excess events; invasive pneumococcal infection 1.8 times with 34 estimated excess events; tuberculosis 8.6 times with 24 estimated excess events; and HIV/AIDS 6.6 times that of Whites with 205 excess events. Blacks or African Americans were also disproportionately affected by high rates of sexually transmitted diseases with rates of chlamydia 18.1 times (2,788 estimated excess events), gonorrhea 28.8 times

(1,219 estimated excess events), and primary and secondary syphilis about 4.9 times (eight estimated excess events) that of White residents.

Hispanics had higher relative risks among all infectious diseases considered (acute hepatitis B statistics were not calculated because Hispanic ethnicity was counted separate from race). The rate of invasive pneumococcal infection was 1.1 times (5 estimated excess events), tuberculosis 8.0 times (24 estimated excess events), and HIV/AIDS 7.4 times (253 estimated excess events) that of Whites. Hispanics were also disproportionately affected by high rates of sexually transmitted diseases with rates of chlamydia 9.4 times (1,486 estimated excess events), gonorrhea 7.7 times (317 estimated excess events), and primary and secondary syphilis 2.2 times (3 estimated excess events) that of White residents.

Asian/Pacific Islanders had higher risks relative to the White population in Connecticut for tuberculosis (23 times higher with 23 excess events estimated), acute hepatitis B infection (3.0 times higher with three excess events estimated), and chlamydia (1.1 times higher with three excess events estimated). Relative to the White population, Asian/Pacific Islander residents had lower risk due to invasive pneumococcal infection, HIV/AIDS, and gonorrhea, and consequently, fewer estimated events or cases.

There were too few cases for six of the seven infectious and sexually transmitted disease conditions among American Indian or Alaska Native residents to calculate reliable statistics. Chlamydia was the one condition for which sufficient cases exist—Native American residents had 3.2 times the risk of White Connecticut residents with an estimated excess of 10 events per year.

Epidemiological studies suggest that geographical location and social networks in a given community, rather than race or ethnicity per se, are the salient factors to consider in understanding the dynamics of infectious and sexually transmitted diseases (Aral and Wasserheit 1998; Fullilove 1998). For example, while not all Black or African American and Hispanic Connecticut residents are at high risk for infectious and sexually transmitted diseases, they are more likely to live in high poverty neighborhoods where a core of high risk individuals live. Detailed analyses of risk factors, including place of residence, income level, and social networks, may help identify higher risk subgroups within Connecticut.

Earlier and more recent analyses suggest that the completeness of reported race and ethnicity data for chlamydia and gonorrhea may be higher in urban rather than suburban areas of Connecticut (see Hynes, et al. 1999, and Appendix III of this report). This would create a potential bias toward reporting race and ethnicity status more often for Black or African Americans and Hispanics, given their overrepresentation in urban areas of the state. Thus, the relative risks and excess events for Black or African Americans and Hispanics may be overestimated for chlamydia and gonorrhea.

PREGNANCY AND BIRTH OUTCOMES (2000–2005; 2002–2006)

The infant death (or mortality) rate is a key measure of the health of populations. For 2001 to 2005, the infant mortality rate for Black Connecticut residents was 3.3 times higher than that for White residents, with an estimated 44 excess deaths per year. Late or no prenatal care (no care within the first trimester of pregnancy) for Black mothers in 2002–2006 was 2.8 times that of White mothers, with an estimated annual excess of 665 Black mothers with late or no prenatal care. Low birth weight, a major contributor to infant mortality and long-term health problems, was 1.9 times higher among Black mothers compared with White mothers from 2002 to 2006, with an estimated 299 annual excess low birth weight births.

Hispanics in Connecticut experienced an infant mortality rate 1.7 times higher than that of White residents in 2001–2005, with an estimated 20 excess deaths per year. Late or no prenatal care for Hispanic mothers (2002–2006) was three times that of White mothers, with an estimated annual excess of 1,206 Hispanic mothers with late or no prenatal care. Low birth weight was 1.3 times higher among Hispanic mothers compared with White mothers (2002–2006), with an estimated 139 annual excess low birth weight births.

During 2001–2005, the infant mortality rate for Asians/Pacific Islanders in Connecticut was 60% of that for White residents, with an estimated three fewer deaths per year. Late or no prenatal for Asian/Pacific Islander mothers (2002–2006) was 1.6 times that of White mothers, with an estimated annual excess of 91 Asian/Pacific Islander mothers with late or no prenatal care. Low birth weight was 1.2 times higher among Asian/Pacific Islander mothers compared with White mothers (2002–2006), with an estimated 31 annual excess low birth weight births.

American Indians/Alaska Natives in Connecticut had an infant mortality rate that was similar to that of White residents (2001–2005). Late or no prenatal for American Indian/Alaska Native mothers (2002–2006) was 1.8 times that of White mothers, with an estimated annual excess of 12 American Indian/Alaska Native mothers with late or no prenatal care. Low birth weight was 1.2 times higher among American Indian/Alaska Native mothers compared with White mothers (2002–2006), with an estimated three annual excess low birth weight births.

HOSPITALIZATIONS (2005) AND EMERGENCY DEPARTMENT VISITS (2004)

Black Connecticut residents had higher hospitalization and emergency department visit rates for asthma, and all other conditions considered in this report (hospitalization rates for all circulatory conditions, diabetes, and diabetes with lower extremity amputations) relative to White residents. Blacks had 3.7 times the asthma hospitalization rate with 761 annual excess events in 2005, and 4.6 times the asthma emergency department visit rate in 2004 with 1,130 annual excess events. In 2005, Black residents had 1.4 times the hospitalization rate for circulatory conditions (1,369 annual excess events), and 3.8 times the diabetes and diabetes-related lower extremity amputation rates (753 and 137 annual excess events, respectively) of White residents.

Similarly, Hispanic Connecticut residents had higher hospitalization and emergency department visit rates for asthma, and higher hospitalization rates for diabetes and diabetes with lower extremity amputations relative to White residents. Hispanics had 3.9 times the asthma hospitalization rate with 736 annual excess events in 2005; 5.2 times the asthma emergency department visit rate in 2004 with 1,716 annual excess events; 2.3 times the diabetes hospitalization rate with 309 annual excess events in 2005; and 3.1 times the diabetes-related lower extremity amputation rate with 80 annual excess events relative to White residents in 2005. Hispanic residents had a similar rate of hospitalizations for circulatory diseases as Whites.

Asian/Pacific Islander Connecticut residents had lower hospitalization rates for asthma and all circulatory conditions relative to the White population in 2005, with an estimated 53 fewer asthma hospitalizations and 613 fewer hospitalizations for circulatory conditions per year. There were too few reported hospitalizations of Asian/Pacific Islander Connecticut residents for diabetes and diabetes with lower extremity amputation (2005) and asthma emergency department visits (2004) to calculate reliable rates.

American Indian or Alaska Native Connecticut residents had a lower hospitalization rate for all circulatory conditions relative to the White population in 2005, with an estimated 67 fewer hospitalizations per year for circulatory conditions. Asthma hospitalization rates for American Indian or Alaska Native Connecticut residents were similar to those of Whites. There were too few reported hospitalizations of American Indian or Alaska Native Connecticut residents for diabetes and diabetes with lower extremity amputation (2005) and asthma emergency department visits (2004) to calculate reliable rates.

FUTURE DIRECTIONS

Current state data provide a limited picture of the health status of various Connecticut population subgroups. In particular, although Asians are the fastest growing subgroup in Connecticut, there is still little known about their risk factors for major chronic diseases and ability to access care. More detailed data on this exceedingly socioeconomically and ethnically diverse population is needed.

Compared with other population subgroups, there is relatively more health information collected and available about Hispanics in Connecticut. However, because the Connecticut Hispanic or Latino population is rapidly increasing in both size and diversity, more detailed information, particularly on issues related to access to quality health care and language barriers, is needed.

Mortality data show that Blacks or African Americans suffer disproportionately more than other racial and ethnic subgroups in Connecticut from the major chronic diseases of 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 on the influences of poverty, low-income neighborhood environments, residential segregation, and discrimination on health outcomes.

Available health and social data are generally good for the White 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.

It is important to note that certain racial and ethnic minority populations may fare better than the White population on a given indicator (e.g., age-adjusted suicide rates). It has been observed that protective factors such as social support, social networks, and other health practices may have positive influences on health outcomes for certain minority subgroups (e.g., Abraido-Lanza, et al. 1999). Additional investigation of such factors may offer insight into protective aspects of cultural practices on health outcomes.

This report has described other vulnerable populations in Connecticut, for which limited information is available. Such populations include residents of rural areas, sexual and gender minorities, persons with disabilities, immigrants and refugees, limited English proficiency populations, and homeless persons. While available national data show that each of these population groups have specific health needs and concerns, little systematically-collected health data are available on these populations in Connecticut.

CONCLUSION

This report has presented the contexts and descriptions of health disparities experienced by various populations in Connecticut. First, social context was provided by presenting the definition of “health disparities,” and outlining selected sociodemographic characteristics of Connecticut residents. Social factors implicated in health disparities, such as socioeconomic position, behaviors, social support, stress, discrimination, and environmental exposures, were also discussed. Health outcomes for populations based on characteristics such as race, ethnicity, gender, educational attainment and income level were presented, as was the dearth of consistently-collected data on various vulnerable populations (i.e., older or younger persons, those living in rural areas, sexual and gender minorities, persons with disabilities, immigrants and refugees, limited English proficiency populations, and homeless persons).

Second, using available data from the state of Connecticut and the U.S. Census, this report has documented and described some disparities in the health status of Connecticut racial and ethnic minority groups relative to the White population. A few disparities by household income and education were also documented. The patterns of disparities documented here are generally consistent with previous analyses for Connecticut and with those observed nationally. With adequate resources and attention, a number of documented gaps in health status can be narrowed. Improvements in the quality of data

collected will further increase our statewide capacity to accurately monitor and devise plans to reduce health disparities. Improvements in data quality involve several tasks including: consistent collection of race and ethnicity according to current federal standards; improved collection of other sociodemographic information, such as educational attainment, employment status, and preferred language, which are known to influence health outcomes; and enhanced use of geographic information system (GIS) management and routine performance of spatial analysis using residential address information, so that health outcomes can be reported for smaller geographic areas of the state.

In 2007, the Connecticut Department of Public Health (DPH) outlined a series of recommendations to enhance data collection and reporting and information technology, as well as increasing the knowledge of data users and reporters (Nepaul, Hynes, and Stratton 2007). In 2008, DPH set forth a *Policy on Collecting Sociodemographic Data* (DPH 2008x). Implementation of the recommendations of the 2007 report, in concert with the system-wide adoption of the DPH data collection policy, should greatly improve data quality and efforts related to monitoring and reporting of health disparities.

A more detailed and clearer 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 as increased use of geographic information systems (GIS) technology so that accurate and vivid depictions of the health status and needs of small neighborhoods are captured.

In 2010, the U.S. decennial census will provide an updated picture of the Connecticut population, and the *Healthy People 2020* health objectives for the nation will be released. These enterprises, together with this report, will provide Connecticut with important new information. This knowledge will be invaluable to public health practitioners, state and local leaders, academic researchers, and others engaged in identifying health priorities and objectives for the next decade that can help assure the conditions in which all people can be healthy.