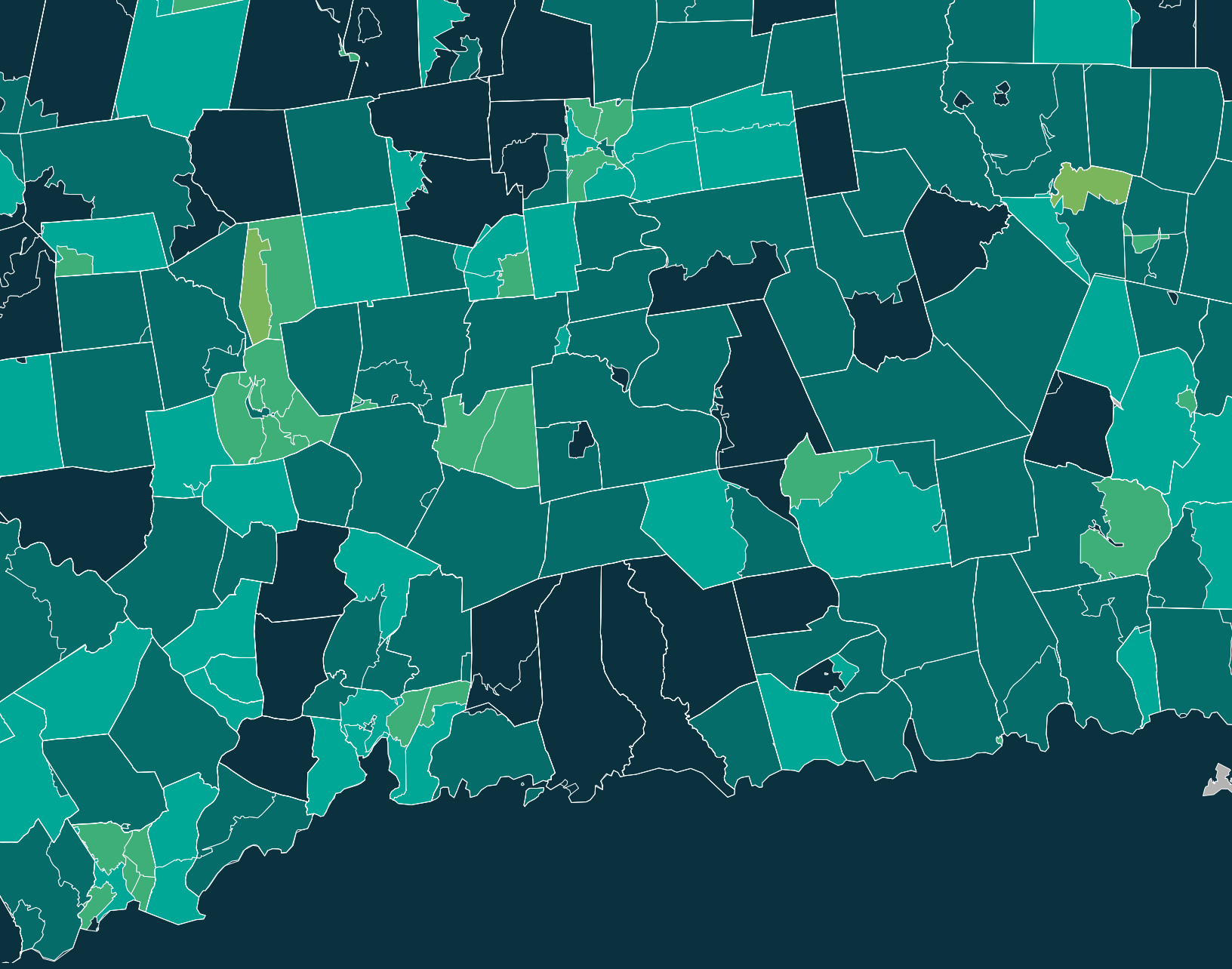

Towards Health Equity in Connecticut

The Role of Social Inequality and the Impact of COVID-19

DataHaven

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Towards Health Equity in Connecticut:
The Role of Social Inequality and the Impact of COVID-19

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Cover Image Share of adults that say they are satisfied with the area where they live by ZIP code. DataHaven analysis (2020) of 2015 & 2018 DataHaven Community Wellbeing Survey.

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Preface: COVID-19 Exposes Health Inequities

In January, 2020, the first confirmed case of coronavirus infection (COVID-19) was reported in the United States, and by March 8, the first infection was recorded in Connecticut. As of the time of writing, tens of thousands of Connecticut residents have tested positive for the illness and thousands have died. The true number of those affected is likely many times greater than reported.[1,2] Early data from across the country suggest that Black, Latino, and indigenous communities are experiencing disproportionately higher rates of infection and serious complications. In Connecticut, Black and Latino individuals have died at higher age-adjusted rates than white individuals.[3] Nursing home residents currently represent more than half of all deaths across the state.[4]

Disasters like the COVID-19 pandemic expose and exacerbate existing social inequities. Prior to the pandemic, communities of color endured disproportionately worse health outcomes and increased mortality as a consequence of decades of structural inequality. The pandemic has made these disparities only more obvious.[5]

Although most of the data in this report were collected before the pandemic, we feel this analysis would be incomplete without acknowledging how COVID-19 has magnified the extent to which health inequity is predicated by social inequity. Throughout, we provide context for understanding how the social forces that contribute to disparate health outcomes influence how communities are affected by this unprecedented public health emergency.

1 Holshue, M. L., DeBolt, C., Lindquist, S., Lofy, K. H. (2020). First Case of Novel Coronavirus in the United States. *New England Journal of Medicine,* 383: 929–936. https://dx.doi.org/10.1056/NEJMoa2001191

2 FT Visual & Data Journalism team. (2020). Coronavirus tracked: the latest figures as the pandemic spreads. *Financial Times*. Retrieved from https://www.ft.com/coronavirus-latest. See also Dong, E., Du, H., Gardner, L. (2020). An interactive web-based dashboard to track COVID-19 in real time. *The Lancet Infectious Diseases.* Retrieved from https://doi.org/10.1016/S1473-3099(20)30120-1.

3 For COVID-19 statistics for Connecticut, see https://www.ctdatahaven.org/reports/covid-19-connecticut-data-analysis.

4 Carlesso, J., and Thomas, J. R. (2020, May 24). As Connecticut nursing home deaths mounted, months passed without broad testing. *CT Mirror.* Retrieved from https://ctmirror.org/2020/05/24/as-nursing-home-deaths-mounted-months-passed-without-broad-testing/.

5 Risher, M., Bubola, E. (2020, March 15). As Coronavirus Deepens Inequality, Inequality Worsens Its Spread. *The New York Times.* Retrieved from https://www.nytimes.com/2020/03/15/world/europe/coronavirus-inequality.html.

Health Disparities are Rooted in Social Inequality

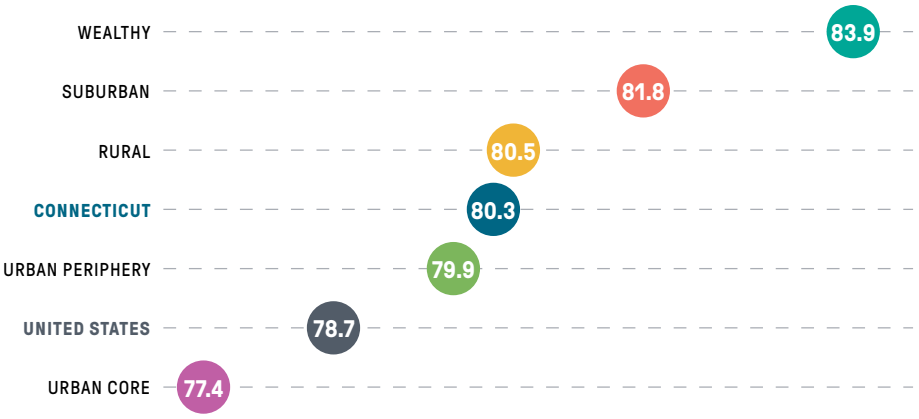
When compared to other states, Connecticut ranks highly in many aspects of quality of life, but those statistics often reflect the wealth and well-being of a majority-white population. For other residents, opportunities are more limited and barriers to good health are numerous. The consequences of social disparity are often evident in utero, well-established in youth, and can persist throughout the course of an individual's life.

Stark differences in quality of life are apparent both locally and regionally. Just 10 miles but almost 19 years separate the life expectancy of a child born in Bridgeport from a child born in Westport.[6] We see a similar trend within cities: two children born in New Haven may have such vastly different health determinants that one child can expect to live 14 fewer years than another born to a family just three miles away.[7] These differences are highly correlated with socioeconomic conditions.

FIG 1

Children born in wealthy towns can expect to live six years longer than children born in Connecticut's cities

LIFE EXPECTANCY (YEARS), BY FIVE CONNECTICUTS GROUP, 2015



The forces that contribute to health inequity are intrinsic to discrimination-based social inequality. For many, the greatest barrier to overall good health is the legacy of racism, structural deprivation, and limited integration into the systems that help people achieve a better quality of life. Historically, people who have had unequal access to the resources needed to become and remain healthy have included people of color, especially Black people; specific ethnic groups—in Connecticut, especially people of Puerto Rican ancestry; immigrants, especially those who are undocumented; people with low incomes; people who identify as lesbian, gay, bisexual, transgender, queer, or as sexual/gender minorities (henceforth, LGBTQ); and people with disabilities. Too often, this marginalization is the result of intentional disenfranchisement by the most advantaged groups.

In this report, we summarize five broad social determinants of health[8] and discuss how various groups of people are affected by their opportunities in each category. Each section begins with general comparisons of many groups across several indicators, and ends with an example of how those social circumstances relate to a specific health prospect. Throughout, we also include how the COVID-19 pandemic has magnified the social forces that influence health and well-being.

In addition to common disaggregations by race and sex, we also disaggregate when possible by ethnicity and/or ancestry,[9] income level, educational attainment, and other specific demographic features. This allows us to demonstrate that using statewide

6 Life expectancy is 70.4 years in tract 09001070900 in Bridgeport, and 89.1 years in tract 09001050100 in Westport. DataHaven analysis (2019) of National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015.

7 The New Haven census tract with the lowest life expectancy (71.0 years) is 09009140200 in the Hill; the tract with the highest (85.1 years) is 09009141100, in Westville. DataHaven analysis (2019) USALEEP.

8 Social determinants are the social and environmental circumstances that affect an individual's health outcomes and quality of life.

9 For the purposes of this report, the American Community Survey's data on ancestry is used, which is defined as "a person's ethnic origin or descent, 'roots,' or heritage, or the place of birth of the person or the person's parents or ancestors before their arrival in the United States." See https://www.census.gov/topics/population/ancestry.html.

averages to track health and well-being masks dramatic disparities between groups. It also allows us to present a more nuanced discussion of differential access to resources. Our goal in taking this approach is to encourage policymakers, social service organizations, and health care providers to consider the upstream factors contributing to health inequities in our state, and to take a more holistic approach to resolving disparities by reducing health and social inequities among our residents.

Given the current crisis, local officials and policymakers are poised to make decisions that could widen or help bridge the gap in health outcomes driven by the social factors described below. Improving social and health equity will help communities start toward a path of resiliency in the face of public health disasters like the COVID-19 pandemic.

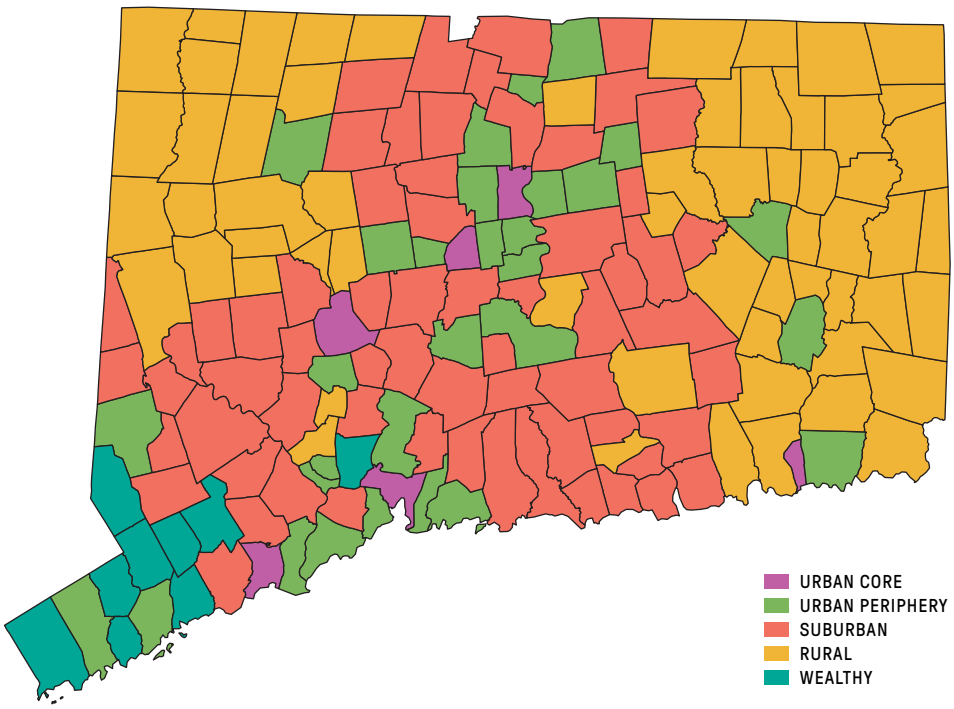
TABLE 1

Towns by Five Connecticuts Grouping

GROUP	TOWNS
Urban Core	Bridgeport, Hartford, New Britain, New Haven, New London, Waterbury
Urban Periphery	Ansonia, Bloomfield, Branford, Bristol, Danbury, Derby, East Hartford, East Haven, Enfield, Groton, Hamden, Manchester, Meriden, Middletown, Milford, Naugatuck, Newington, Norwalk, Norwich, Plainville, Rocky Hill, Stamford, Stratford, Torrington, Vernon, West Hartford, West Haven, Wethersfield, Windham, Windsor Locks
Suburban	Avon, Barkhamsted, Berlin, Bethany, Bethel, Bolton, Bridgewater, Brookfield, Burlington, Canton, Cheshire, Chester, Clinton, Colchester, Columbia, Cromwell, Durham, East Granby, East Hampton, Ellington, Essex, Fairfield, Farmington, Glastonbury, Granby, Guilford, Haddam, Hebron, Killingworth, Lyme, Madison, Marlborough, Middlebury, Middlefield, Monroe, New Fairfield, New Hartford, Newtown, North Branford, North Haven, Old Lyme, Old Saybrook, Orange, Oxford, Prospect, Redding, Roxbury, Salem, Shelton, Sherman, Simsbury, Somers, South Windsor, Southbury, Southington, Suffield, Tolland, Trumbull, Wallingford, Watertown, Westbrook, Windsor, Wolcott, Woodbury
Rural	Andover, Ashford, Beacon Falls, Bethlehem, Bozrah, Brooklyn, Canaan, Canterbury, Chaplin, Colebrook, Cornwall, Coventry, Deep River, East Haddam, East Lyme, East Windsor, Eastford, Franklin, Goshen, Griswold, Hampton, Hartland, Harwinton, Kent, Killingly, Lebanon, Ledyard, Lisbon, Litchfield, Mansfield, Montville, Morris, New Milford, Norfolk, North Canaan, North Stonington, Plainfield, Plymouth, Pomfret, Portland, Preston, Putnam, Salisbury, Scotland, Seymour, Sharon, Sprague, Stafford, Sterling, Stonington, Thomaston, Thompson, Union, Voluntown, Warren, Washington, Waterford, Willington, Winchester, Woodstock
Wealthy	Darien, Easton, Greenwich, New Canaan, Ridgefield, Weston, Westport, Wilton, Woodbridge

FIG 2

The Five Connecticuts



Throughout this report, we refer to groups of towns using the following terms: Urban Core, Urban Periphery, Suburban, Rural, and Wealthy.[10] These groupings can be helpful to understand how access to opportunity often varies by geography. For reference, the map color-codes each Connecticut town by its designation.

10 See notes for Figure 1 and Table 1.

Education and Economic Stability

Youth Education

Educational indicators related to youth academic performance, disciplinary actions, and other factors underlie socioeconomic outcomes in adulthood. Disparate disciplinary and academic outcomes become apparent as early as preschool and often persist through a child's school years, resulting in wide achievement gaps by the time students graduate from high school. These gaps in turn correlate with health outcomes, suggesting that improving academic measures for youth has positive effects on health and well-being later in life—and that the negative effects of the achievement gap can be detrimental to health in adulthood.

Overall, four-year public high school graduation rates were high for students in the class of 2017 in Connecticut (88 percent) compared to the national average of public school graduates in the same cohort (85 percent),[11] but these rates vary between groups of students.[12] Statewide, white students in the class of 2017 had a graduation rate of 93 percent compared to just 80 percent for Black students and 78 percent for Latino students.[13] Female students have higher graduation rates than male students, and while rates for both males and females appear to be improving, the gap between them has not narrowed since 2011.[14]

The widest gaps are measured for high-needs students, which include students with English Language Learner (ELL) or Special Education (SPED) designations. While non-SPED students have seen a slight improvement in their overall graduation rates since 2011, students with SPED designations have had a near-steady graduation rate around 65 percent—about 25 percentage points lower than non-SPED students in 2017. Similarly, the graduation rate for ELL students in the class of 2017 was 21 percentage points lower than for students who are proficient in English, despite having risen 10 percentage points since 2011.[15]

Students who qualify for free or reduced-price meals (FRPM)—as measured against their family's income and federal poverty guidelines—also have demonstrably lower graduation rates than students from higher-income families. Graduation rates for non-FRPM students generally exceed 90 percent, and as of 2017, stood at 95 percent. Meanwhile, only 78 percent of FRPM students in the class of 2017 had graduated within four years, although that rate has improved nearly 16 percentage points since 2011.[16] Low graduation rates among low-income students further reduce the potential for improving their socioeconomic outcomes later in life.

An uneven transition to remote learning prompted by school closures in the wake of the COVID-19 pandemic may worsen the yawning student achievement gap.[17] Access to a home computer and broadband varies widely across Connecticut towns. In urban areas, with more low-income families and comparatively under-resourced school districts, students are more likely to lack the technology needed for distance learning.[18] Higher-needs students, such as those with learning disabilities, may lose access to their educational support system and risk falling behind academically and socially.[19]

11 National Center for Education Statistics. (2019). Public High School Graduation Rates. Retrieved from https://nces.ed.gov/programs/coe/indicator_coi.asp.

12 See notes for Figure 3.

13 Throughout this report, unless otherwise noted, "white" and "Black" refer to non-Hispanic white and non-Hispanic Black groups.

14 See notes for Figure 3.

15 Ibid.

16 Ibid.

17 Thomas, J. R. (2020, March 19). Two districts, two very different plans for students while school is out indefinitely. *CT Mirror.* Retrieved from https://ctmirror.org/2020/03/19/two-districts-two-very-different-plans-for-students-while-school-is-out-indefinitely/.

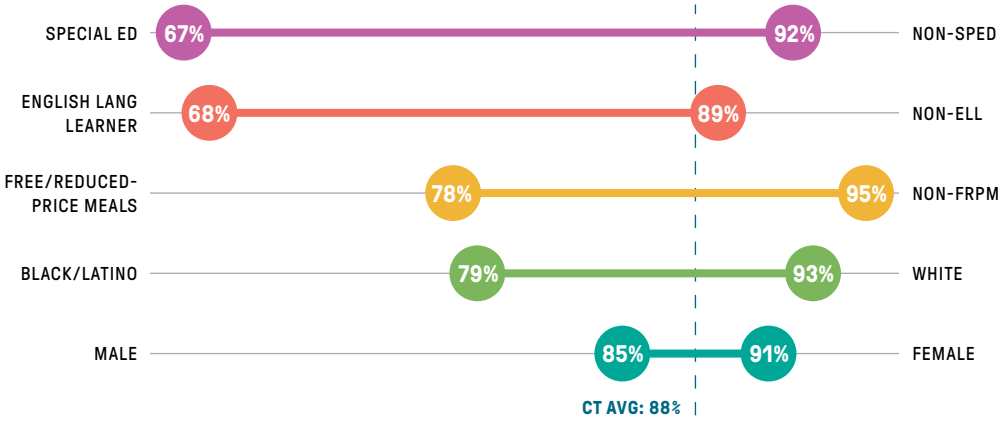
18 See Connecticut Wellbeing and Equity Data App. https://www.ctdatahaven.org/data-dashboard. In New Canaan, 6 percent of households have no computer, compared to 32 percent in Bridgeport.

19 United States Department of Education. (2020, March). Questions and answers on providing services to children with disabilities during the coronavirus disease 2019 outbreak. Retrieved from https://www2.ed.gov/policy/speced/guid/idea/memosdcltrs/qa-covid-19-03-12-2020.pdf.

FIG 3

Graduation gaps are widest for high-needs students

FOUR-YEAR HIGH SCHOOL GRADUATION RATES, CONNECTICUT PUBLIC SCHOOL DISTRICTS, CLASS OF 2017



Adult Educational Attainment

Similar to youth outcomes, adult educational attainment statewide is high, but varied. As of 2018, just 10 percent of Connecticut adults ages 25 and older lacked a high school diploma or equivalent, compared to 13 percent of adults nationwide. The share of Connecticut adults with a bachelor's degree or more—39 percent—is 7 percentage points higher than the national average.[20]

Just as Latino students are about three times as likely as white students not to graduate high school within four years in Connecticut, Latino adults are almost five times as likely as white adults to lack a high school diploma. This includes about a quarter of adults of Puerto Rican ancestry and more than half of adults of Guatemalan ancestry. About two-thirds of adults who speak Spanish at home have a high school diploma or less.[21] As more employers in the region expect workers to have at least a high school diploma or equivalent, the economic consequences of having a large share of the population effectively underqualified for jobs becomes an important consideration for statewide workforce development.

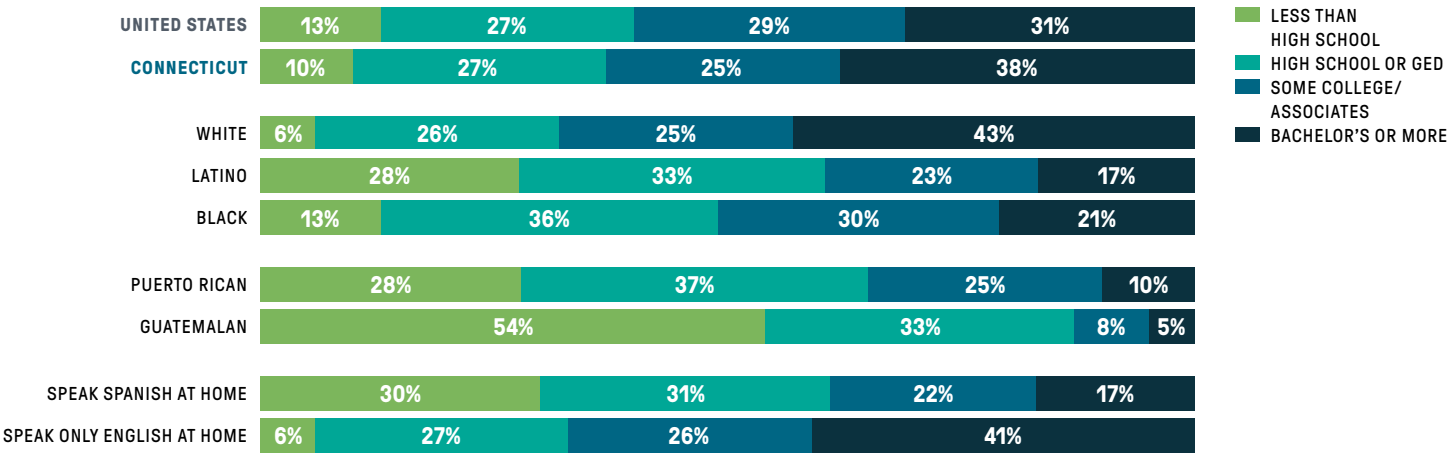
20 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B15003, Educational Attainment for the Population 25 Years and Over. Available at https://data.census.gov.

21 See notes for Figure 4.

FIG 4

Less than half of the state's Latino and Spanish-speaking adults have more than a high school diploma

EDUCATIONAL ATTAINMENT FOR ADULTS (AGES 25+), CONNECTICUT, 2018



Employment

The economic impact of COVID-19 is evident as whole sectors of the economy constrict in an effort to prevent the virus from spreading. While the most privileged have begun to adjust to working at home, the ripples of economic collateral damage are beginning to emerge. The outcome, so far, has included thousands of business closures and tens of millions of new unemployment claims nationwide, including hundreds of thousands in Connecticut.[22]

The following data reflect the situation before the onset of the pandemic. They do not capture the staggering growth in unemployment claims, nor do they reflect the sudden loss of income for many households. Commonly reported statistics like unemployment and poverty rates will dramatically change as the economy adapts and recovers. However, the data below expose the gaps in wealth and economic opportunity which are likely to grow as the most vulnerable workers face the worst of the economic fallout.

According to the American Community Survey, the unemployment rate in Connecticut was 7 percent in 2018, down from 9 percent in 2012.[23] By race, this ranged from 6 percent for white workers to 12 percent for Black workers and 10 percent for Latino workers. People of Central American and Caribbean ancestry were more likely to be unemployed than people of other ancestry groups.[24]

Underemployment includes those who are unemployed and looking for work as well as those who are employed part-time but would like to work full-time. According to the 2018 DataHaven Community Wellbeing Survey, Black and Latino adults were twice as likely to be underemployed as white adults. Adults with a high school diploma or less were more than twice as likely to be underemployed than adults with at least a bachelor's degree (26 percent versus 10 percent).[25]

Industries considered high-risk for job loss—deemed "non-essential" prior to the early phases of reopening—include most retail, food service, personal care (such as barber shops), and similar services. Individuals with jobs in those industries, who are at higher-risk for unemployment or underemployment and who are less able to work from home, are often immigrants or people of color, whereas people in lower-risk occupations, such as management, are predominantly white.[26]

22 Connecticut Department of Labor. Initial claims profile. Retrieved from https://www1.ctdol.state.ct.us/lmi/claimsdata.asp.

23 U.S. Census Bureau American Community Survey 2012 and 2018 5-year estimates, Table B23025, Employment Status for the Population 16 Years and Over. Available at https://data.census.gov.

24 DataHaven analysis (2020) of Ruggles, S., Flood, S., Goeken, R., Grover, J., Meyer, E., Pacas, J., and Sobek, M. IPUMS USA: Version 10.0 2018 5-year Census microdata. Minneapolis, MN: IPUMS, 2020. https://doi.org/10.18128/D010.V10.0

25 See notes for Table 2.

26 DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata using methodology developed by the NYU Furman Center.

TABLE 2

Unemployment and underemployment by group

CONNECTICUT, 2018

GROUP	UNEMPLOYMENT RATE	UNDEREMPLOYMENT RATE
Total	7%	15%
Male	7%	14%
Female	6%	17%
White	5%	13%
Black	11%	25%
Latino	10%	26%
Puerto Rican	12%	23%
High school or less	9%	26%
Some college/Associates	6%	19%
Bachelors or more	3%	10%

Many employers require workers to have at least a high school diploma or GED, with higher-wage jobs usually demanding even more education. Higher-wage jobs are often located in urban areas, but in Connecticut's six largest cities, 20 percent of adults lack a high school diploma or equivalent.[27] This indicates that many adults who live in those cities are not qualified for the jobs concentrated there and implies a spatial mismatch of workers and jobs. In fact, the trend of higher-wage workers living in the suburbs and commuting into the city while some lower-wage workers who live in urban areas reverse-commute to jobs in the suburbs is seen statewide.[28] The cost of a long commute coupled with the higher cost of housing in urban areas can financially constrain city-dwelling workers in lower-wage jobs.

In 2018, about 5 percent of workers in Connecticut used public transit to commute to work, but the majority relied on a personal vehicle.[29] About 20 percent of Black and Latino households had no vehicle available, and another 40 percent had only one vehicle. Meanwhile, only 6 percent of white households had no vehicle, but more than 60 percent had at least two.[30] Long commute times—either because of distance to work or reliance on public transit—can have a detrimental effect on well-being.[31] However, this varies by mode—walking or bicycling to work is perceived as less stressful than driving alone,[32] and those active modes are associated with improved productivity at work.[33]

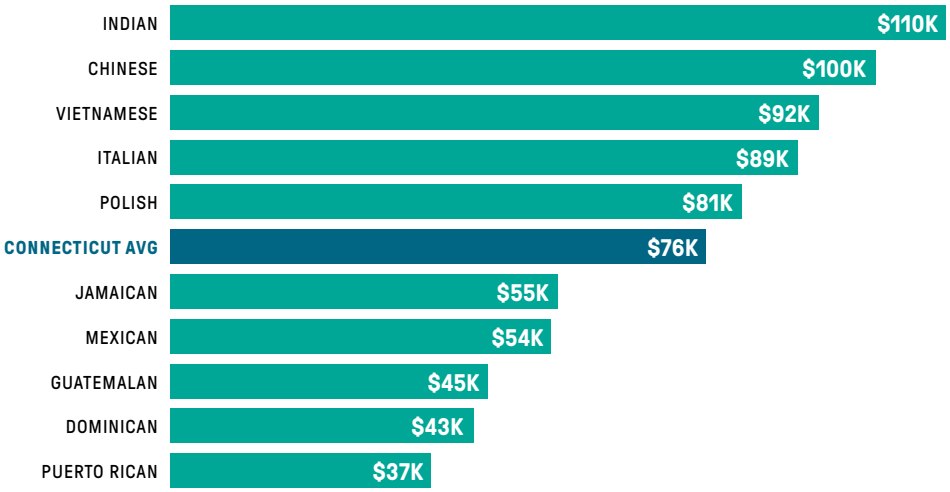
Income & Poverty

In 2018, the median household income in Connecticut was approximately $76,000.[34] In that year, the average household headed by a white person had a median income of about $89,000 while the average Black or Latino-led household had a median income less than $50,000. The average household headed by a person of Puerto Rican ancestry had an income of just $37,000 per year, less than half the state average and the lowest household income among the largest ancestry groups in Connecticut.[35]

FIG 5

Household income is much lower than the state average for Central American and Caribbean groups

MEDIAN HOUSEHOLD INCOME BY ANCESTRY OF HEAD OF HOUSEHOLD, CONNECTICUT, 2018



Statewide in 2018, the median personal income for men was $69,000, and for women, $54,000. Men out-earn women across all major racial and ethnic groups.[36] This holds true after controlling for age, hours worked, and educational attainment.[37]

27 Adults here include people ages 25 and over. DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B15003. Available at https://data.census.gov.

28 For a more thorough discussion of spatial mismatch in Connecticut's large metropolitan regions, see chapter 2 of the 2019 DataHaven Community Wellbeing Indexes, available at http://ctdatahaven.org/reports.

29 U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B08006, Sex of Workers by Means of Transportation to Work. Available at https://data.census.gov.

30 DataHaven analysis (2019) of U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics (LODES). For more detail, see chapter 2 of the DataHaven Community Wellbeing Index at ctdatahaven.org/reports.

31 Clark, B., Chatterjee, K., Martin, A. et al. (2019). How commuting affects subjective well-being. *Transportation*. https://doi.org/10.1007/s11116-019-09983-9.

32 Legrain, A., Eluru, N., & El-Geneidy, A. (2015). Am stressed, must travel: The relationship between mode choice and commuting stress. *Transportation Research Part F: Traffic Psychology and Behaviour,* 34: 141–151. https://doi.org/10.1016/j.trf.2015.08.001.

33 Ma, L. & Ye, R. (2019). Does daily commuting behavior matter to employee productivity? Journal of *Transport Geography,* 76: 130–141.

34 U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B19013, Median Income in the Past 12 Months (in 2018 Inflation-Adjusted Dollars). Available at https://data.census.gov.

35 See notes for Figure 5.

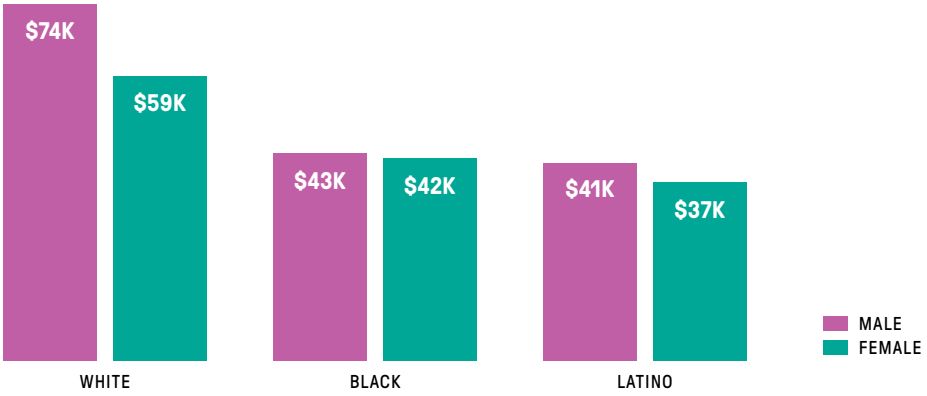
36 See notes for Figure 6.

37 For additional information on wage gaps in Connecticut, see chapter 2 of the 2019 DataHaven Community Wellbeing Indexes, available at http://ctdatahaven.org/reports.

FIG 6

Men out-earn women across major race/ethnicity categories

MEDIAN PERSONAL INCOME BY RACE/ETHNICITY AND SEX, CONNECTICUT, 2018



In 2018, about 10 percent of the population, or roughly 361,000 people in Connecticut, lived in poverty—the equivalent of a family of four earning less than $25,100 per year. An additional 449,000 people lived in households earning between one and two times the federal poverty limit. By race, 19 percent of Black, 23 percent of Latino, and just 6 percent of white residents lived in poverty.[38] The poverty rate has undoubtedly risen with the loss of thousands of jobs this Spring, and the people most affected by job loss are more likely to be Black or Latino than white.[39]

People under 18, especially children under 5 years old, are the most likely of all age groups to experience poverty. Statewide in 2018, 13 percent of children under 18 lived in poverty, but the disproportionate impact among communities of color is clear: 29 percent of Latino children and 25 percent of Black children lived in poverty compared to just 5 percent of white children. Poverty rates typically decline as a cohort ages, but this is not the case for Latinos, for whom poverty is highest in youth, drops off, then rises again in older age. About one in four Latinos over age 65 lives in poverty. For white seniors, that rate is one in 20.[40]

38 See notes for Figure 7.

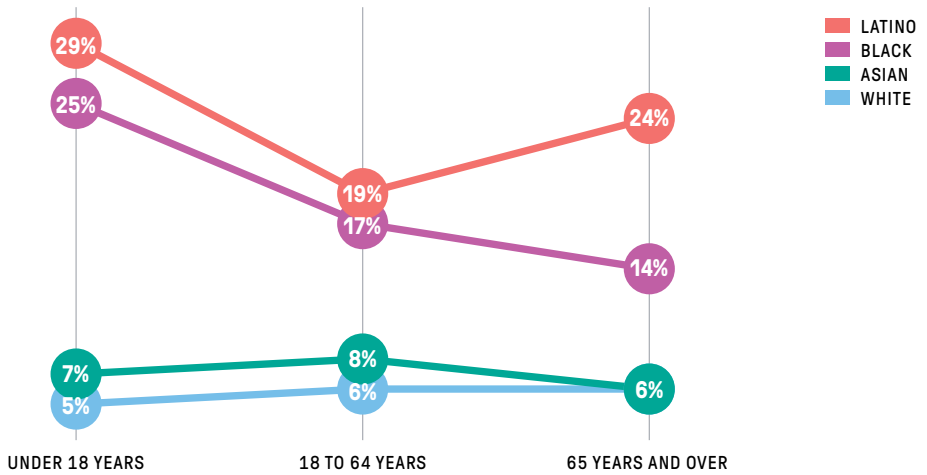
39 DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata using methodology developed by the NYU Furman Center.

40 See notes for Figure 7.

FIG 7

Unlike other groups, poverty rates for Latinos increase in their senior years

POVERTY RATE BY AGE GROUP AND RACE/ETHNICITY, CONNECTICUT, 2018



FOCUS: SOCIOECONOMIC STATUS PLAYS A ROLE IN INFLUENZA TRANSMISSION & SMOKING

Poverty and other poor economic outcomes, and the corresponding health inequities arising from a lack of resources, are partially responsible for elevated COVID-19 infection rates in Black and Latino communities. Trends in seasonal influenza cases may serve as a model for understanding this connection. Since influenza viruses and the novel coronavirus responsible for COVID-19 are similar in how they are transmitted from person to person,[41] conditions that facilitate transmission and severe complications related to influenza are also associated with increased transmission and serious complications related to COVID-19.

Influenza-related hospitalizations, cases requiring ventilator care, and influenza-related deaths are associated with patients who live in overcrowded households and areas of concentrated poverty (where at least 20 percent of households fall below the poverty threshold).[42] Overcrowded housing increases the chance of viral transmissions between household members. Areas of high poverty are associated with social factors that underlie chronic conditions, such as asthma and diabetes, which may lead to increased susceptibility to respiratory illnesses like influenza, and compromised immune response to fighting the disease. Analyses of data from New Haven County suggest that despite a population-wide increase in influenza vaccination, higher rates of severe influenza cases were still observed in areas of concentrated poverty compared to areas with low rates of poverty.[43,44]

Emerging studies suggest that COVID-19 patients who smoke have a higher chance of experiencing severe symptoms or death than non-smoking patients because smoking often leads to severe respiratory afflictions and is detrimental to the immune system.[45] Cigarette smoking is highly correlated with lower socioeconomic status and has numerous negative and potentially deadly health consequences, including cancer. Fourteen percent of adults in Connecticut smoke cigarettes, but adults who earn $30,000 per year or less and adults who have less than a high school diploma have smoking rates three times higher than adults earning more than $100,000 per year or who have a bachelor's degree or more. Smoking rates are also elevated among Latino and Black adults compared to white adults.[46]

The emergence of e-cigarette usage, or vaping, is also a rising concern, with many users across the country recently hospitalized with serious respiratory complications, although the long-term health effects of vaping remain to be seen. Statewide, 19 percent of adults had tried e-cigarettes as of 2018, and 8 percent used them at least once in the past month. Vaping is more common among younger adults—36 percent of adults ages 18 to 34 had tried e-cigarettes, and 18 percent were regular users.[47]

41 Johns Hopkins Medicine. (2020). Coronavirus disease 2019 vs. the flu. Retrieved from https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-disease-2019-vs-the-flu.

42 Hadler J.L., Yousey-Hindes K., Pérez A., et al. (2016, February 12). Influenza-related hospitalizations and poverty levels—United States, 2010–2012. *MMWR Morbidity Mortality Weekly Report,* 65:101–105. Retrieved from http://dx.doi.org/10.15585/mmwr.mm6505a1.

43 Yousey-Hindes, K. M., and Hadler, J. L. (2011, March 11). Neighborhood socioeconomic status and influenza hospitalizations among children: New Haven County, Connecticut, 2003–2010. *American Journal of Public Health,* 101, 1785–1789. https://doi.org/10.2105/AJPH.2011.300224.

44 Tam et al. (2014) Influenza-related hospitalization of adults associated with low census tract socioeconomic status and female sex in New Haven County, Connecticut, 2007-2011. *Influenza and Other Respiratory Viruses,* 8(3), 274–281. https://onlinelibrary.wiley.com/doi/pdf/10.1111/irv.12231.

45 Vardavas, C. I., NIkitara, K. (2020). COVID-19 and smoking: A systematic review of the evidence. *Tobacco Induced Diseases,* 18: 20. https://doi.org/10.18332/tid/119324.

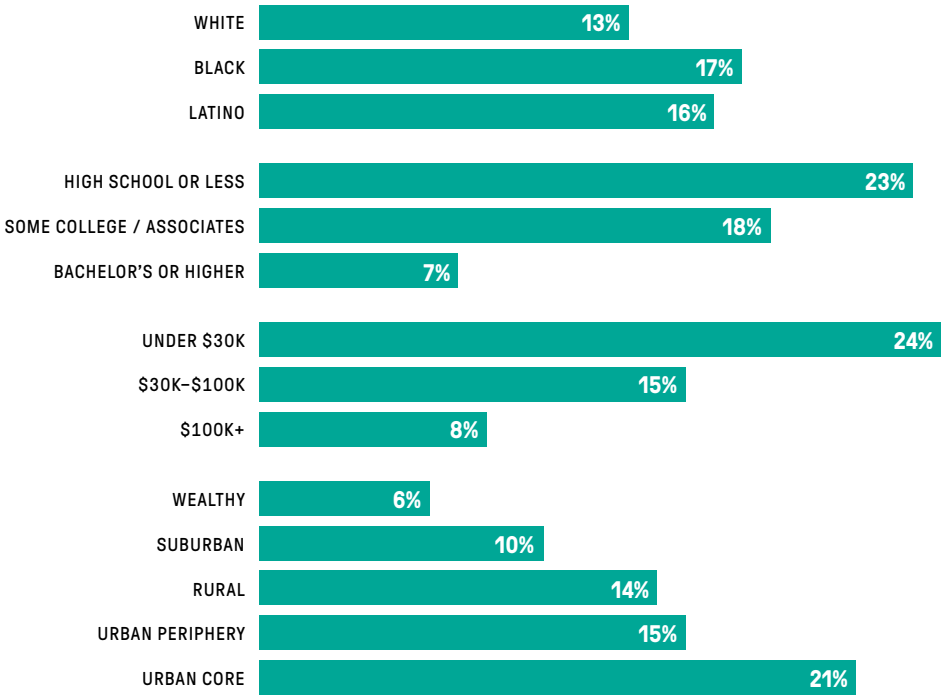
46 See notes for Figure 8.

47 DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Regular users reported using e-cigarettes or vaping at least once per month.

FIG 8

Smoking rates are elevated among adults with low income and low educational attainment

SHARE OF ADULTS WHO CURRENTLY SMOKE, CONNECTICUT, 2018



Nutrition and Hunger

Food insecurity disproportionately affects people with lower incomes, and access to food remains a challenge for many people in Connecticut. The city of Hartford, for example, has very low food access coupled with financial constraints that contribute to food insecurity.[48] The additional, widespread loss of income due to the COVID-19 outbreak has exacerbated long standing conditions of food insecurity in the state, straining the limited existing resources for public support.[49] Many families in Connecticut rely on the meals provided to their children in school—often at no cost to the family—and now face difficulty in accessing free food while schools are closed. Districts throughout the state have organized alternative meal and grocery pickup and delivery services, but this change is yet another hurdle for many families.[50] Food banks and pantries in the state are also seeing unprecedented demand as families lose income and await federal benefits.

In 2018, one-third of Connecticut adults who earned less than $30,000 reported being food insecure—unable to afford food at least once in the past 12 months. By comparison, 13 percent of those earning between $30,000 and $100,000 and only 3 percent of adults earning more than $100,000 reported being food insecure. Black and Latino adults were more than twice as likely to have experienced food insecurity (23 and 28 percent, respectively) than white adults (10 percent). Other groups more likely to report being unable to afford food included adults living with children (17 percent) and women (15 percent).[51]

48 Zhang, M. (2017). *A geographical analysis of food access in the Greater Hartford area of Connecticut* (Publication number 1473). [Doctoral dissertation, University of Connecticut]. Open Commons @ UConn.

49 Radleat, A. (2020, April 3). CT enrollment in food stamps soars, but there's a wait for benefits. *CT Mirror.* Retrieved from https://ctmirror.org/2020/04/03/ct-enrollment-in-food-stamps-soars-but-theres-a-wait-for-benefits/.

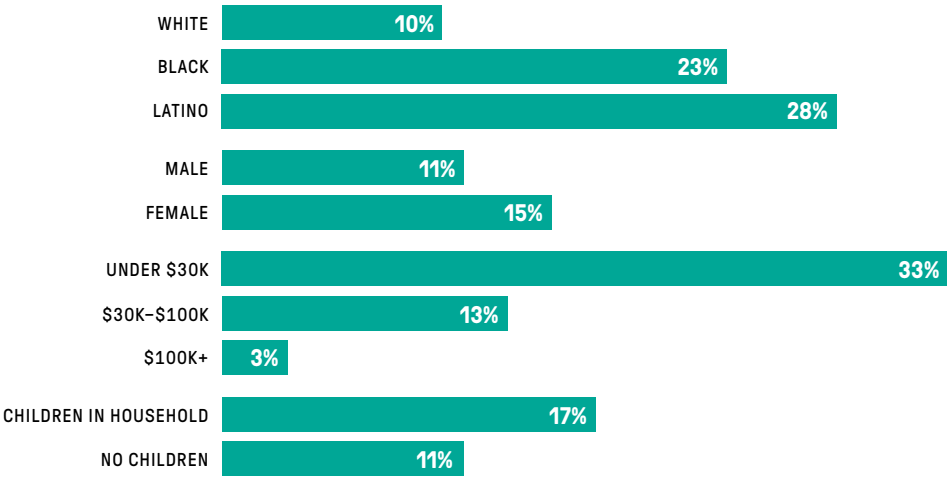
50 Spiegel, J. E., (2020, May 26). Connecticut public schools are out, but their kitchens are busier than ever. *CT Mirror.* Retrieved from https://ctmirror.org/2020/05/26/connecticut-public-schools-are-out-but-their-kitchens-are-busier-than-ever/.

51 See notes for Figure 9.

FIG 9

Food insecurity disproportionately affects low-income and non-white adults

SHARE OF ADULTS WHO SAID THEY COULD NOT AFFORD FOOD AT SOME POINT IN THE PAST YEAR, CONNECTICUT, 2018



Reducing food insecurity helps individuals invest in higher quality foods and improve their overall nutrition, which in turn helps them dedicate energy to heal from illness, manage chronic disease, and strengthen their body's immune response, thereby improving their overall health and reducing health care costs in the long term.[52] For very low-income households the Supplemental Nutrition Assistance Program (SNAP, or food stamps) covers some of the cost of food, although SNAP benefits—estimated at $1.86 per meal—fall short of the actual cost of food in all but a handful of counties nationwide, including every county in Connecticut. According to the Urban Institute, the

52 Carlson, S., & Keith-Jennings, Brynne. (2018, January 17). SNAP is linked with improved nutritional outcomes and lower health care costs. Center on Budget and Policy Priorities. Retrieved from https://www.cbpp.org/sites/default/files/atoms/files/1-17-18fa.pdf.

estimated cost of a meal in Connecticut was 40 to 50 percent higher than the SNAP per-meal benefit in 2015.[53]

Statewide, more than 235,000 households received SNAP benefits in 2018. The share of households utilizing SNAP is highest in urban areas, although this is due in part to eligibility waivers that take into account the area unemployment rate, which is higher in cities.[54] New SNAP guidance that was set to take effect on April 1, 2020, would have reduced the number of people eligible for benefits by eliminating area unemployment waivers. If enacted, that rule could push more than 25,000 recipients in Connecticut out of the program, according to the Department of Social Services.[55] As of the time of this writing, a temporary injunction prevents the enforcement of these new guidelines due to the COVID-19 pandemic.[56] While income restrictions remain in place for SNAP eligibility, benefits have increased under the CARES Act for households that qualify. Tens of thousands of new SNAP applications have flooded the Department of Social Services since March.[57]

FOCUS: SOCIAL FACTORS IN OBESITY, DIABETES, AND STROKE

Several hypotheses attempt to explain the co-occurrence of food scarcity and obesity, particularly relating to irregular food consumption[58] and consumption of meals of lower nutritional quality.[59] The role of poverty, chronic stress, and behavioral factors have also been explored.[60] While 29 percent of adults in Connecticut have a body mass index qualifying them as obese, rates are elevated in Urban Core cities (37 percent compared to 17 percent in Wealthy towns). Rates are also elevated among Black (35 percent) and Latino (36 percent) adults compared to white adults (28 percent), and adults whose incomes are less than $30,000 per year (36 percent) compared to adults earning $100,000 or more (25 percent).[61] When adjusting these rates to be age-specific, the disparity is more pronounced. Among adults ages 50 and over, 41 percent of Latino adults and 40 percent of Black adults are obese compared to 28 percent of white adults.

Research indicates that being obese increases one's chances of developing type 2 diabetes.[62] Ten percent of adults reported that they had diabetes of any kind, but like obesity, this rate is elevated among some groups. Sixteen percent of adults earning less than $30,000 per year reported having diabetes, compared to 5 percent of adults earning more than $100,000 per year. The rate was also elevated among Black adults (14 percent) compared to white or Latino adults (10 and 9 percent, respectively). These disparities are more evident in age-specific rates. Among adults ages 50 and over, diabetes rates are 27 percent among Black adults and 24 percent among Latino adults, compared to just 15 percent among white adults.[63]

Obesity and diabetes are risk factors for stroke. Adults in the lower-income Urban Core cities are twice as likely to have had diabetes as adults in Wealthy towns (12 percent compared to 5 percent).[64] Likewise, between 2010 and 2014, age-adjusted deaths caused by stroke were two to three times as common in Urban Core cities (834 deaths per 100,000 residents) compared to Suburban (432) and Wealthy (279) towns.[65]

The socioeconomic forces that push vulnerable communities into food insecurity have also invited the circumstances for serious complications related to COVID-19. Because elevated blood sugar can affect an individual's vascular and immune systems, people with diabetes are more likely to experience serious complications from COVID-19, especially if their diabetes is not well-managed.[66] Similarly, obesity is associated with a weakened immune system, high blood pressure, and vascular damage.[67] It too has emerged as a comorbidity in serious COVID-19 cases.[68]

53 Waxman, E., Gundersen, C., & Thompson, M. (2018). Does SNAP cover the cost of a meal in your county? Retrieved from https://www.urban.org/does-snap-cover-cost-meal-your-county.

54 Work requirements and exemptions can be found at https://portal.ct.gov/DSS/SNAP/Able-Bodied-Adults-Without-Dependents-or-ABAWDs.

55 Office of the Attorney General of the State of Connecticut. (2020, January 16). Connecticut sues to block federal plan to eliminate food assistance for nearly 700,000 struggling Americans. Retrieved from https://portal.ct.gov/AG/Press-Releases/2020-Press-Releases/CONNECTICUT-SUES-TO-BLOCK-FEDERAL-PLAN-TO-ELIMINATE-FOOD-ASSISTANCE-FOR-STRUGGLING-AMERICANS.

56 Office of the Attorney General for the District of Columbia. (2020, March 13). AG Racine announces federal court blocks Trump administration from cutting food benefits. Retrieved from https://oag.dc.gov/release/ag-racine-announces-federal-court-blocks-trump.

57 Spiegel, J. E., (2020, April 23). Coronavirus is breaking the food supply chain. *CT Mirror.* Retrieved from https://ctmirror.org/2020/04/23/coronavirus-is-breaking-the-food-supply-chain/.

58 Pan, L., Sherry, B., Njai, R., & Blanck, H. (2012). Food insecurity is associated with obesity among U.S. adults in 12 states. *Journal of the Academy of Nutrition and Dietetics,* 112(9): 1403–1409. https://doi.org/10.1016/j.jand.2012.06.011.

59 Galobardes, B., Moraibia, A., & Bernstein, M.S. (2001). Diet and socioeconomic position: does the use of different indicators matter? *International Journal of Epidemiology,* 30(2): 334–340. https://academic.oup.com/ije/article/30/2/334/713793.

60 Levine, J. L. (2011). Poverty and Obesity in the U.S. *Diabetes,* 60(11): 2667–2668. https://doi.org/10.2337/db11-1118

61 See notes for Table 3.

62 Although genetics play a role in the development of type 2 diabetes (the most common form of diabetes in the United States), behavioral factors contributing to obesity also contribute to insulin resistance and diabetes.

63 See notes for Table 3.

64 Ibid.

65 Ibid.

66 American Diabetes Association. COVID-19 FAQ. Retrieved from https://www.diabetes.org/covid-19-faq.

67 De Heredia, F.P., Gomez-Martinez, S., Marcos, A. (2012). Obesity, inflammation and the immune system. *Proceedings of the Nutrition Society,* 71(2): 332–338. https://www.ncbi.nlm.nih.gov/pubmed/22429824.

68 Centers for Disease Control and Prevention. (2020). COVID-19: Groups at Higher Risk for Severe Illness. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html.

TABLE 3

Rates of obesity, diabetes, and stroke, by group

CONNECTICUT, † 2018, ‡ 2010–2014 AGE-ADJUSTED RATE

GROUP	OBESITY, ADULTS 18+ †	OBESITY, ADULTS 50+ †	DIABETES, ADULTS 18+ †	DIABETES, ADULTS 50+ †	DEATHS FROM STROKE (PER 100K) ‡
Total	29%	30%	10%	16%	548
White	28%	28%	10%	15%	N/A
Black	35%	40%	14%	27%	N/A
Latino	36%	41%	9%	24%	N/A
Under $30K	36%	36%	16%	28%	N/A
$30K–$100K	31%	32%	10%	16%	N/A
$100K+	25%	27%	5%	9%	N/A
Wealthy	17%	21%	5%	5%	279
Suburban	25%	27%	13%	13%	402
Rural	29%	31%	15%	15%	672
Urban Periphery	30%	31%	11%	19%	581
Urban Core	37%	39%	12%	23%	834

Housing and the Physical Environment

Housing insecurity is a perennial challenge facing low-income households. Barriers to safe and affordable housing can have negative effects on health by exposing inhabitants to harmful environmental conditions in the home or surrounding neighborhood, and by limiting available resources to put towards other needs such as food, health care, or education.

As a result of lost income due to business closures during the COVID-19 pandemic, housing insecurity is a growing concern. Fewer protections are currently afforded to renters—who are more likely to be Black, Latino, or female—than to people who own their homes.[69] Renters also face adverse housing conditions, including higher rates of overcrowding, that can facilitate transmission of the disease if an infected person is asked to home-quarantine during the course of their illness.

Housing Affordability

Housing affordability involves a complex interrelationship of regional housing demand on heavily localized housing supply. There are many tools available to help regions achieve an adequate supply of affordable housing, but zoning is perhaps the most effective way of organizing new developments such that a diverse supply of housing is achieved. However, many towns have effectively blocked subsidized and affordable housing developments despite evident demand for more units or greater affordability.[70] Consequently, subsidized housing is concentrated in specific areas—primarily in the poorest neighborhoods in Connecticut's cities—which exacerbates underlying economic segregation. These de facto housing policies prevent market-based corrections in the regional housing supply, further driving the need for policy reform that emphasizes a regional, rather than town-level, approach to housing development.

The process of purchasing a home is entrenched with structures that help groups who are already at an advantage. Due to changing housing markets since the Great Recession, structural barriers including racist brokerages curtailing access to homes in some neighborhoods for people of color,[71] and lending algorithms imbued with bias limiting financial resources,[72] homeownership is simply not attainable for all residents.[73] In Connecticut, 76 percent of white heads-of-household own their home, about twice the share of Black (39 percent) and Latino (33 percent) heads-of-household.[74]

As demand and cost for rental housing increases while incomes stagnate, especially in urban areas, renters are more likely than homeowners to be housing cost-burdened (spending more than 30 percent of income on housing). People who are more likely to rent—Black and Latino households and households headed by women—are most likely to experience that burden. Roughly two-thirds of Black women and Latina renters are cost-burdened.[75]

The high cost of the average home in Connecticut, coupled with the low supply of single-family homes in urban areas,[76] leaves some would-be homeowners unable to afford to buy a home in the city where they live. Those who can afford to buy homes often do so in wealthier suburban areas where the prevailing housing stock is single-family.[77] The broader impact of this lopsided housing supply means that larger cities, as well as some rural areas, have greater municipal funding challenges than suburban communities. Municipal governments with lower shares of owner-occupied housing, lower assessed home values, and fewer taxable properties on their grand lists rely on slim budgets to support their residents and workers commuting from other towns with services such as police and public works. This contributes to growing economic segregation in the state; in fact, the number of people living—often renting—in the poorest neighborhoods in Connecticut, many of which are in urban areas, has doubled since 1980.[78]

69 Thomas, J. R., Poisson, C. (2020, April 3). Homeowners get 90-day pass on mortgage bills. Renters still owe rent. *CT Mirror.* Retrieved from https://ctmirror.org/2020/04/03/homeowners-get-90-day-pass-on-mortgage-bills-renters-still-owe-rent/.

70 Thomas, J. R. (2019, May 22). Separated by design: How some of America's richest towns fight affordable housing. *ProPublica.* Retrieved from https://www.propublica.org.

71 For example, see Choi, A., Dedman, B., Herbert, K., & Winslow, O. (2019, November 17).Long Island divided. *Newsday.* Retrieved from https://projects.newsday.com/long-island/real-estate-agents-investigation/.

72 Although algorithms may reduce overt prejudice in lending compared to a human, evidence suggests low-income, Black, and Latino residents are unfairly targeted and overcharged compared to white consumers with similar creditworthiness. See Bartlett, R., Morse, A., Stanton, R., & Wallace, N. (2019). Consumer-lending discrimination in the fin-tech era. National Bureau of Economic Research. https://doi.org/10.3386/w25943.

73 Although mortgage practices have tightened since the housing crisis and Great Recession, many of the current barriers to homeownership for people of color date back to federally-sanctioned New Deal programs that promoted racially-based mortgage approval and lending, which in turn were influenced by prejudice in banking and lending. Coupled with less access to credit, fewer liquid assets, and algorithms based on the aforementioned prevailing schemes in lending, mortgage assistance and availability is lower in general for people of color.

74 DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata.

75 See notes for Figure 10.

76 As of 2018, 19 percent of all housing units in Hartford, 23 percent in New Haven, and 31 percent in Bridgeport were single-family homes—but 64 percent of all housing units in Connecticut are single-family homes. DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B25024, Units in Structure.

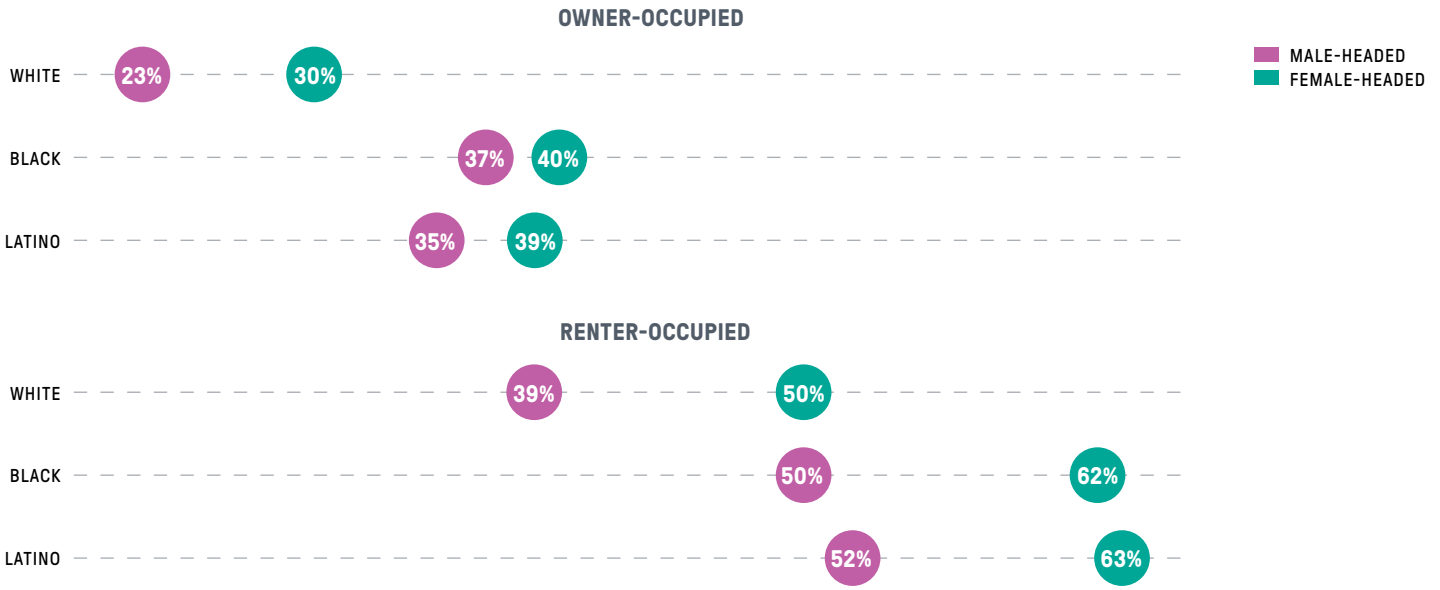
77 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B25003, Tenure. Available at https://data.census.gov.

78 DataHaven analysis (2019) of household income and population data by census tract. 1980, 1990, and 2000 figures from the U.S. Census Bureau Decennial Census are provided by Neighborhood Change Database (NCDB) created by GeoLytics and the Urban Institute. 2018 values are calculated from U.S. Census Bureau American Community Survey 2018 5-year estimates Tables B01003, Total Population; B19101, Family Income in the Past 12 Months (in 2018 Inflation-Adjusted Dollars); and B19127, Aggregate Family Income in the Past 12 Months (in 2018 Inflation-Adjusted Dollars). Available at https://data.census.gov.

FIG 10

Black and Latino households—especially those headed by women—are more often cost-burdened

SHARE OF COST-BURDENED HOUSEHOLDS BY RACE/ETHNICITY AND GENDER OF HEAD OF HOUSEHOLD, CONNECTICUT, 2018



Income-based segregation contributes to fewer educational and job opportunities for residents in those areas, leading to increased health risks and reduced access to community resources.[79] With revenues limited or reduced as a result of the COVID-19 emergency, the gulf in municipal funding between towns is likely to widen.

Housing Insecurity and Eviction

The loss of income due to the COVID-19 pandemic has put renters in precarious circumstances. By one estimate, about 70 percent of renters paid rent on time in April, 2020, compared to 81 percent in March.[80] A statewide grace period (a rent-deferral, not a waiver or cancellation) may provide relief for some renters in the short term,[81] but it is entirely possible that rent will again be due before household income returns. Although formal evictions through a court process are temporarily prohibited,[82] as of the time of writing there is currently no guarantee that households with lost income as a result of COVID-19 will not be evicted or informally asked to leave their home as a result of past due rent.

In 2018, 8 percent of adults said they did not have money to pay for housing at some point in the past year, but that rate was twice as high among Black and Latino adults (13 percent each) as for white adults (6 percent), and nearly three times as high for young adults ages 18 to 34 (11 percent) as for adults 65 and older (4 percent). Adults with children at home were also more likely to report they were unable to pay for housing (10 percent) compared to adults without children at home (7 percent).[83]

At its worst, chronic inability to pay rent can lead to eviction. In 2018, 7 percent of renters who had moved in the past three years reported being evicted, but this measure was about twice as high for Black and Latino adults (8 percent and 10 percent, respectively) as white adults (5 percent), twice as high for adults with children (10 percent) as without (5 percent), and more than five times higher for adults with a high school diploma or less education (11 percent) compared to adults with a bachelor's degree or more (2 percent).[84]

79 Chetty, R., Friedman, J., Hendren, N., & Porter, S. (2018). The Opportunity Atlas: Mapping the childhood roots of social mobility. Available at http://opportunityatlas.org.

80 National Multifamily Housing Council (NMHC). (2020). NMHC Rent Payment Tracker. Retrieved from https://www.nmhc.org/research-insight/nmhc-rent-payment-tracker/.

81 Putterman, A., Blair, R., and Fawcett, E. (2020, April 10). Hartford Courant. Retrieved from https://www.courant.com/coronavirus/hc-news-coronavirus-updates-0410-20200410-bzxojexxy5fxpolmppsb6uieuy-story.html.

82 Putterman, A., Blair, R., and Fawcett, E. (2020, April 10). *Hartford Courant*. Retrieved from https://www.courant.com/coronavirus/hc-news-coronavirus-updates-0410-20200410-bzxojexxy5fxpolmppsb6uieuy-story.html.

83 See notes for Figure 11.

84 Ibid.

Once evicted, households immediately and repeatedly face the stress and anxiety of finding shelter. From that point forward, they will have a much more difficult time finding a safe, healthy, affordable, and stable place to call home.[85] Children and adults often experience long-term, negative socioeconomic outcomes as a result of eviction. If job loss was not a cause for eviction, evicted adults will often suffer loss of employment.[86] Children whose families were evicted and who are unstably housed may stop attending school and see their academic performance decline, leading to an increased likelihood of low educational attainment and lower income later in life.[87]

85 National Law Center on Homelessness and Poverty. (2018).Protect Tenants, Prevent Homelessness. Retrieved from https://nlchp.org/wp-content/uploads/2018/10/ProtectTenants2018.pdf.

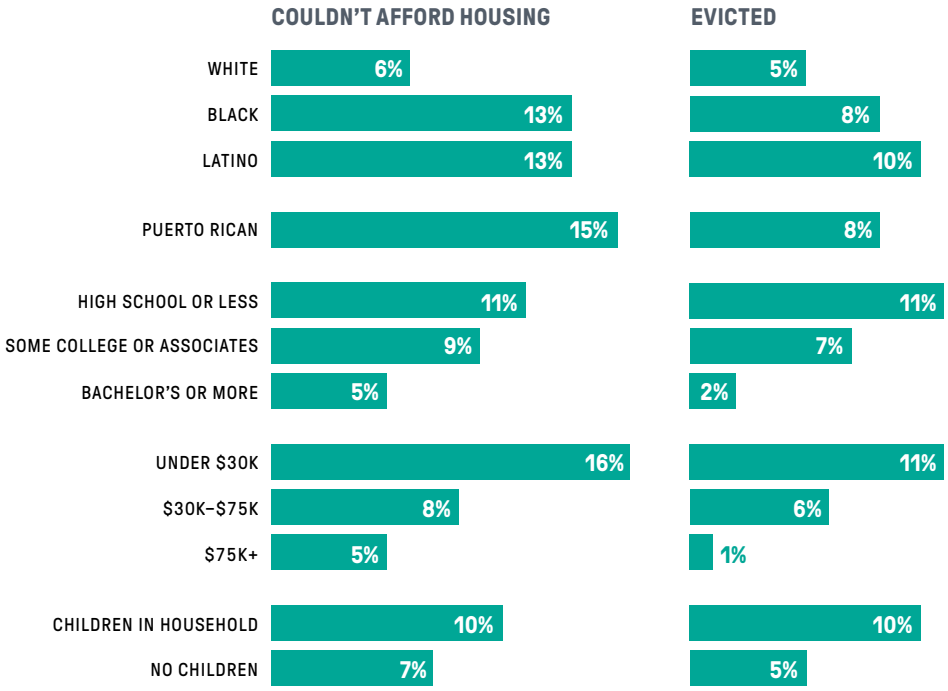
86 Desmond, M. & Gershenson, C. (2016). Who gets evicted? Assessing individual, neighborhood, and network factors. *Social Science Research.* https://doi.org/10.1016/j.ssresearch.2016.08.017.

87 Desmond, M. & Tolbert Kimbro, R. (2015). Eviction's fallout: housing, hardship, and health. *Social Forces.* http://doi.org/10.1093/sf/sov044.

FIG 11

Housing insecurity affects low-income and non-white groups most

COULDN'T AFFORD HOUSING: SHARE OF ADULTS; EVICTED: SHARE OF RENTERS WHO MOVED IN PAST THREE YEARS; CONNECTICUT, 2018



FOCUS: HIGH-QUALITY NEIGHBORHOOD ASSETS CONTRIBUTE TO OVERALL GOOD HEALTH

Neighborhood amenities can have a direct impact on residents' health and well-being. In 2018 about two-thirds of Connecticut adults reported having recreational facilities and safe bicycling facilities in their area; on both measures, however, residents of rural areas were less likely to report access to these resources. Overall, the most privileged groups—white adults, residents of suburban or wealthy towns, and adults with more income and education—were more likely to report that nearby parks and other public facilities were in good condition, but less likely to report that their neighborhood had safe sidewalks and crosswalks. Black and Latino adults were less likely than other groups to feel that parks in their neighborhood were well-maintained. Access to recreational facilities and quality parks create opportunities to improve physical and mental health, and can improve residents' perception of their neighborhood and sense of belonging.[88]

Safe and well-connected streets also improve access to transportation and recreation. In urbanized areas, well-maintained sidewalks and bicycle infrastructure can promote economic opportunity.[89] These amenities contribute to greater social cohesion, and even modest improvements to the built environment provide measurable health benefits to residents.[90] In a time of extended home-isolation and social distancing, neighborhood amenities are important assets for improving mental health and allowing room for many people to safely engage in physical activity. Cities around the country, including New Haven, have closed some streets to motor vehicle traffic to create more space for outdoor recreation. When planning if and where to close streets, officials should consider which neighbors stand to benefit and who may be underserved.

88 White, M. P., Alcock, I., Wheeler, B. W., Depledge, M. H. (2013). Would you be happier living in a greener urban area? A fixed-effects analysis of panel data. *Psychological Science*, 24(6): 920–928. Would You Be Happier Living in a Greener Urban Area? A Fixed-Effects Analysis of Panel Data. https://doi.org/10.1177/0956797612464659.

89 Litman, T. A. (2014). Economic value of walkability. Victoria Transport Policy Institute. Retrieved from http://newmobilitywest.org/wp-content/uploads/2014/06/Economic-Value-of-Walkability.pdf.

90 Oakes, J.M., Forsyth, A. & Schmitz, K.H. (2007). The effects of neighborhood density and street connectivity on walking behavior: the Twin Cities walking study. *Epidemiological Perspectives & Innovations*, 4(16). https://doi.org/10.1186/1742-5573-4-16.

TABLE 4

Select housing conditions and neighborhood assets

†SHARE OF HOUSEHOLDS; ǂ SHARE OF ADULTS; CONNECTICUT, 2018

GROUP	OVERCROWDED HOUSEHOLDS	GOOD CONDITION OF PARKS	SAFE SIDEWALKS	SAFE BIKING	PARKS AND REC. FACILITIES NEARBY
Total	2%	75%	61%	63%	70%
White	<1%	79%	56%	62%	68%
Black	3%	59%	79%	66%	72%
Latino	6%	64%	73%	64%	75%
High school or less	N/A	66%	67%	61%	66%
Some college/Associates	N/A	71%	61%	63%	70%
Bachelors or higher	N/A	80%	56%	63%	71%
Under $30K	N/A	64%	68%	61%	64%
$30K–$100K	N/A	74%	63%	63%	71%
$100K+	N/A	82%	52%	65%	72%
Wealthy	<1%	89%	48%	56%	73%
Suburban	<1%	88%	46%	65%	70%
Rural	<1%	76%	37%	56%	58%
Urban Periphery	2%	72%	73%	66%	72%
Urban Core	4%	52%	77%	61%	70%

FOCUS: THE CONDITION AND GOOD REPAIR OF HOMES HAS A DIRECT IMPACT ON HEALTH AND WELL-BEING

Overcrowded housing (households with more than one person per room) can facilitate the transmission of viral diseases like influenza and COVID-19.[91] In Connecticut, 6 percent of Latino households and 3 percent of Black households are considered overcrowded, compared to about 0.7 percent of white households. Renter-households are five times as likely to be overcrowded—4 percent, compared to about 0.8 percent of owner-occupied households. Households in Urban Core and Urban Periphery areas are more likely to be overcrowded than households in Suburban, Rural, or Wealthy towns. All told, about 25,000 households in Connecticut are overcrowded.[92]

Renters can be at a disadvantage when it comes to the safe and sanitary conditions of the homes they rent. Twenty percent of renters in Connecticut reported having difficulty getting a landlord to respond to issues they encountered in their home, such as broken plumbing, pest infestations, or chipping paint. Nearly a quarter of Latino and Black renters (23 and 25 percent, respectively) said that they reported problems and had difficulty getting them fixed, compared to 14 percent of white renters.[93]

The use of toxic lead in building materials was officially banned in 1978, and homes built before 1950 are very likely to contain lead-based materials. Because of rapid neurological development during early childhood, the dangers of lead poisoning are particularly grave for children. Children living in and around older buildings are at elevated risk of lead poisoning. In 2016, the lead poisoning rate among all children in Connecticut was 2.7 percent, but was more than six times higher in Urban Core areas (with an average rate of 4.9 percent) than in Suburban towns (0.8 percent) where housing stock is newer.[94] Although these disparities are still extreme, programs that remediate lead-based paint and lead hazards in buildings and help to rally public awareness have helped to significantly reduce lead poisoning rates in Connecticut in recent decades.

91 World Health Organization. (2018). "Household Crowding." *WHO Housing and Health Guidelines*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK535289/.

92 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B25014, Tenure by Occupants Per Room. Available at https://data.census.gov.

93 DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey

94 Connecticut Department of Public Health, Lead and Healthy Homes Program. (2016). Annual lead surveillance report. Available at https://portal.ct.gov/DPH/Environmental-Health/Lead-Poisoning-Prevention-and-Control/Screening--Surveillance-Data.

Health Care Coverage and Affordability

Health insurance coverage is particularly urgent during this public health crisis. So-called "essential" workers—including grocery store clerks, food preparers, on-demand delivery drivers, health care providers, and emergency medical personnel—are interacting with potentially sick people, and many do not have employer-provided health care benefits or adequate protective equipment.[95] Our understanding of the disease is changing rapidly, but we know that it has the potential to wreak havoc on the body. While the CARES Act covers the cost of COVID-19 tests,[96] many people who become sick will require costly but life-saving treatment.

As of the time of writing, hard data are not available on the number of individuals who lost their health insurance as a result of the pandemic. The Urban Institute estimates that, at 15 percent unemployment during a COVID-19 related recession, 64,000 people in Connecticut may become newly uninsured. At 20 percent unemployment, that number rises to 92,000 people.[97] With new unemployment claims continuing to grow, it is certain that many fewer people than reported below are insured. Connecticut's health insurance marketplace, Access Health CT, opened a special enrollment period for individuals to purchase health insurance in early 2020,[98] but it is unclear how many individuals were able to enroll during that time.

As a result of lost or reduced income, or lost health insurance, many families may now be unable to afford their existing medical expenses, let alone critical treatment in the event they contract COVID-19 and endure serious complications.

95 Tomer, A., and Kane, J. W. (2020, March 31). How to protect essential workers during COVID-19. Retrieved from https://www.brookings.edu/research/how-to-protect-essential-workers-during-covid-19/.

96 Adler, L. (2020, April 9). How the CARES Act affects COVID-19 test pricing. Retrieved from https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/04/09/how-the-cares-act-affects-covid-19-test-pricing/.

97 Garret, B., and Gangopadhyaya, A. (2020, May 4). How the COVID-19 Recession Could Affect Health Insurance Coverage. Retrieved from https://www.urban.org/research/publication/how-covid-19-recession-could-affect-health-insurance-coverage/view/full_report.

98 Access Health CT. (2020). Access Health CT extends new special enrollment period for the uninsured. Retrieved from https://agency.accesshealthct.com/access-health-ct-extends-new-special-enrollment-period-for-the-uninsured.

Overall Insurance Coverage

According to the American Community Survey,[99] 94 percent of Connecticut residents had health insurance in 2018, although that rate was higher for citizens than noncitizens; only 70 percent of noncitizens were insured.[100] This is due in part to the fact that some legal and nearly all undocumented immigrants are ineligible for public insurance coverage. Otherwise, lower rates of coverage correspond to higher unemployment, higher rates of poverty, and lower incomes. As a result, in larger cities with higher rates of poverty and unemployment, and areas with higher concentrations of foreign-born residents, the overall insured rate is lower.

Due to more comprehensive public insurance programs, children and seniors have higher rates of insurance coverage than adults younger than 65. Overall, 97 percent of children and 99 percent of seniors ages 65 and over in Connecticut had health insurance in 2018. By contrast, 92 percent of adults younger than 65 were insured. Adults younger than 65 are at greater risk of losing health insurance due to the pandemic as they are more likely to have insurance through an employer.[101]

By race, insurance among children is fairly equitable compared to other age groups, with 98 percent of white children, 96 percent each of Black and Asian children, and 95 percent of Latino children insured in 2018. Latino adults between 19 and 64 years old had the lowest overall insurance coverage rate (80 percent) followed by Black adults (90 percent). For seniors, this rate also varied by race, with more than 99 percent of white seniors insured compared to 94 percent of Asian seniors.[102]

99 In this report, we use American Community Survey estimates of health insurance coverage, which will likely differ from other local estimates, including our own Community Wellbeing Survey data published elsewhere.

100 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B27020, Health Insurance Coverage Status and Type by Citizenship Status. Available at https://data.census.gov.

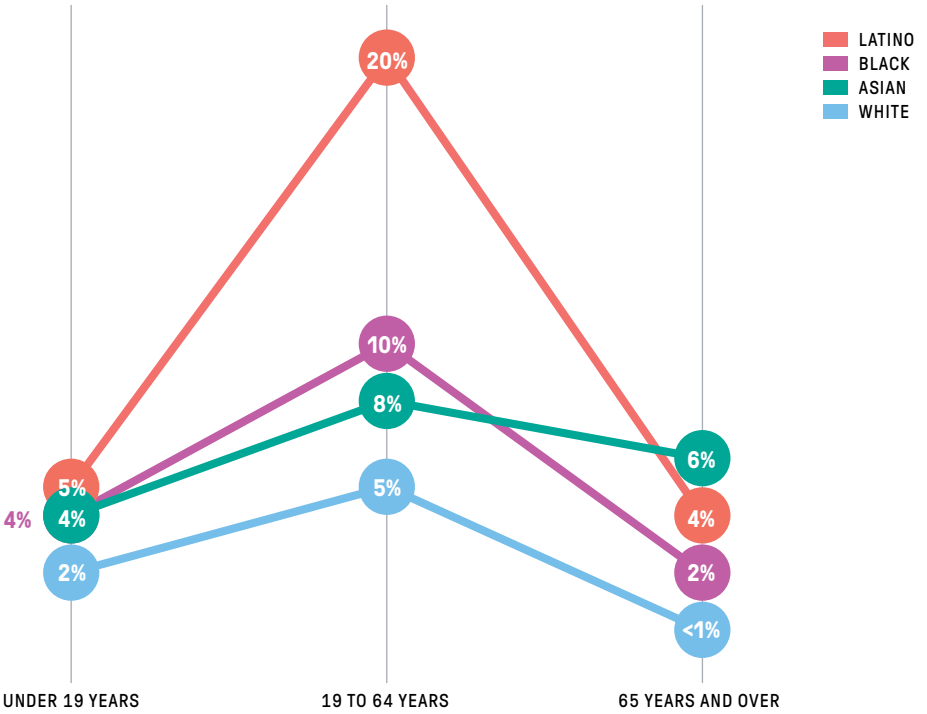
101 In 2018, of adults ages 19-64 who had insurance, 67 percent had it through their employer. DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table C27004, Employer Based Health Insurance by Sex by Age.

102 See notes for Figure 12.

FIG 12

Younger adults are more likely to be uninsured, especially Latinos

SHARE OF UNINSURED POPULATION BY AGE AND RACE/ETHNICITY GROUPS, CONNECTICUT, 2018



Public Health Insurance Coverage

Income is one of the primary criteria used to determine whether an individual qualifies for public insurance, such as Medicaid. Different means-tested insurance programs have different income thresholds, which are often higher for children than their parents or caregivers, pregnant people, and low-income adults.[103] Because of this complexity, individuals are encouraged to apply to the program and have the state determine whether they qualify for coverage. Those who are not aware of that process may remain uninsured. By one estimate, 25 percent of the uninsured population in Connecticut qualifies for public coverage. Another 26 percent of the uninsured are not income-eligible for public coverage, but may be eligible for subsidized direct-purchase insurance through Access Health CT.[104]

103 See notes for Table 5.

104 Kaiser Family Foundation estimates using Medicaid and American Community Survey data. Retrieved from https://www.kff.org/health-reform/state-indicator/distribution-of-eligibility-for-aca-coverage-among-the-remaining-uninsured/.

TABLE 5

Connecticut's means-tested insurance programs, with income limits

2019

PROGRAM	COVERAGE FOR	LOWER INCOME LIMIT	UPPER INCOME LIMIT
HUSKY A (Medicaid for children)	Children 0–18	No lower limit	201 percent FPG
HUSKY A (Medicaid for parents)	Parents and caregivers	No lower limit	160 percent FPG
HUSKY A (Medicaid for pregnant people)	Pregnant people	No lower limit	263 percent FPG
HUSKY B (CHIP)	Children 0–18	201 percent FPG	254 percent FPG
HUSKY B (CHIP) (level 2)	Children 0–18	254 percent FPG	323 percent FPG
HUSKY D (Medicaid for adults)	Adults 19+	No lower limit	138 percent FPG

In 2018, 79 percent of children in households earning up to twice the federal poverty guideline (FPG; for a family of four in 2018, the FPG was $25,100) were enrolled in Medicaid or the Children's Health Insurance Program (CHIP). That rate was 32 percent for children in households earning between two and four times the FPG, and just 6 percent for children in households earning more than four times the FPG.[105] Sixty percent of adults who were income-eligible for Medicaid (those earning 138 percent FPG or less) were enrolled in public coverage.[106]

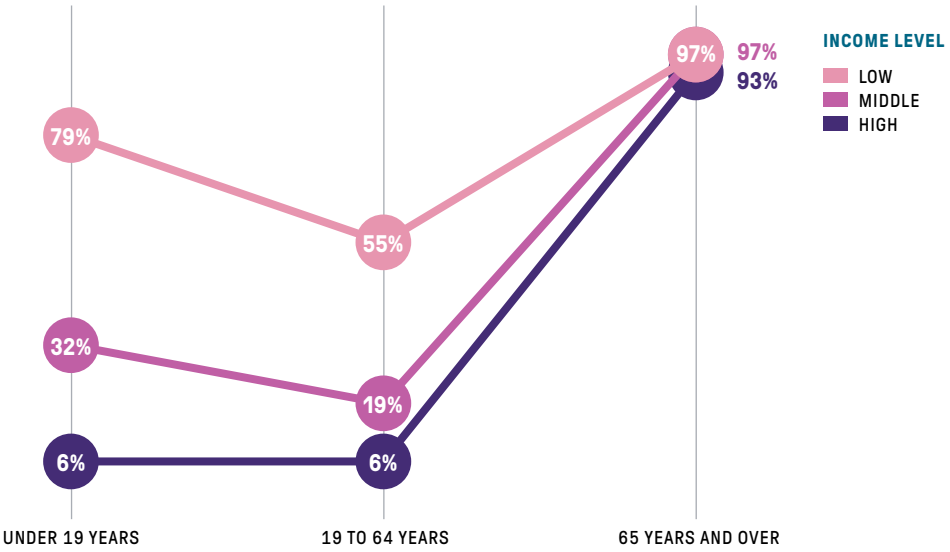
105 See notes for Figure 13.

106 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Tables C27017B, C27017D, C27017H, C27017I, Private Health Insurance by Ratio of Income to Poverty Level by Age; and C27018B, C27018D, C27018H, C27018I, Public Health Insurance by Ratio of Income to Poverty Level by Age.

FIG 13

For low-income individuals, public health insurance coverage declines in adulthood

SHARE WITH PUBLIC HEALTH INSURANCE BY AGE AND INCOME LEVEL, CONNECTICUT, 2018; LOW: LESS THAN 200% FPG; MIDDLE: 200% TO 399% FPG; HIGH: AT LEAST 400% FPG



Dental Care

Oral health affects overall well-being and intersects with other health issues, including heart disease, birth outcomes, and the rate and severity of infection.[107] For the purposes of this report, recent dentist visits serve as a proxy for adequate dental care. In 2018, 74 percent of adults reported going to the dentist in the past year, but only 57 percent of adults earning less than $30,000 saw a dentist compared to 86 percent of those earning more than $100,000.[108] The Centers for Disease Control and Prevention reports that Black and Latino children also have poorer oral health than other racial/ethnic groups.[109] Hospitalizations and emergency department encounters related to dental health are highest in Connecticut's Urban Core areas.[110]

Cost of Care

Simply having health insurance does not guarantee affordable health care. In fact, New England states have some of the highest per capita health care expenditures in the country. In 2014 (the year for which the latest data are available), per capita personal health care spending in Connecticut was 6th highest in the country at $9,859—slightly less than the New England average of $10,119. About one-third of per capita spending in Connecticut ($3,326) went towards hospital care. Spending on prescriptions and nondurable medical equipment has increased at an average annual rate of 7 percent since 1991—the biggest year-over-year increase of any spending category.[111]

107 California HealthCare Foundation. (2009). Snapshot: Emergency department visits for preventable dental conditions in California. Retrieved from https://www.chcf.org/wp-content/uploads/2017/12/PDFEDUseDentalConditions.pdf.

108 DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey.

109 Centers for Disease Control and Prevention. (2020). Disparities in oral health. Retrieved from https://www.cdc.gov/oralhealth/oral_health_disparities/index.htm.

110 DataHaven analysis (2019) of 2015–2017 CHIME data. For a more thorough discussion of differences in hospital encounter rates in Connecticut's large metropolitan regions, see the DataHaven Community Wellbeing Indexes, available at http://ctdatahaven.org/reports.

111 See notes for Figure 14.

FIG 14

Costs of hospital care, physician services, and prescription drugs are high and rising

PER-PERSON MEDICAL SPENDING BY CATEGORY, CONNECTICUT (IN 2014 DOLLARS)

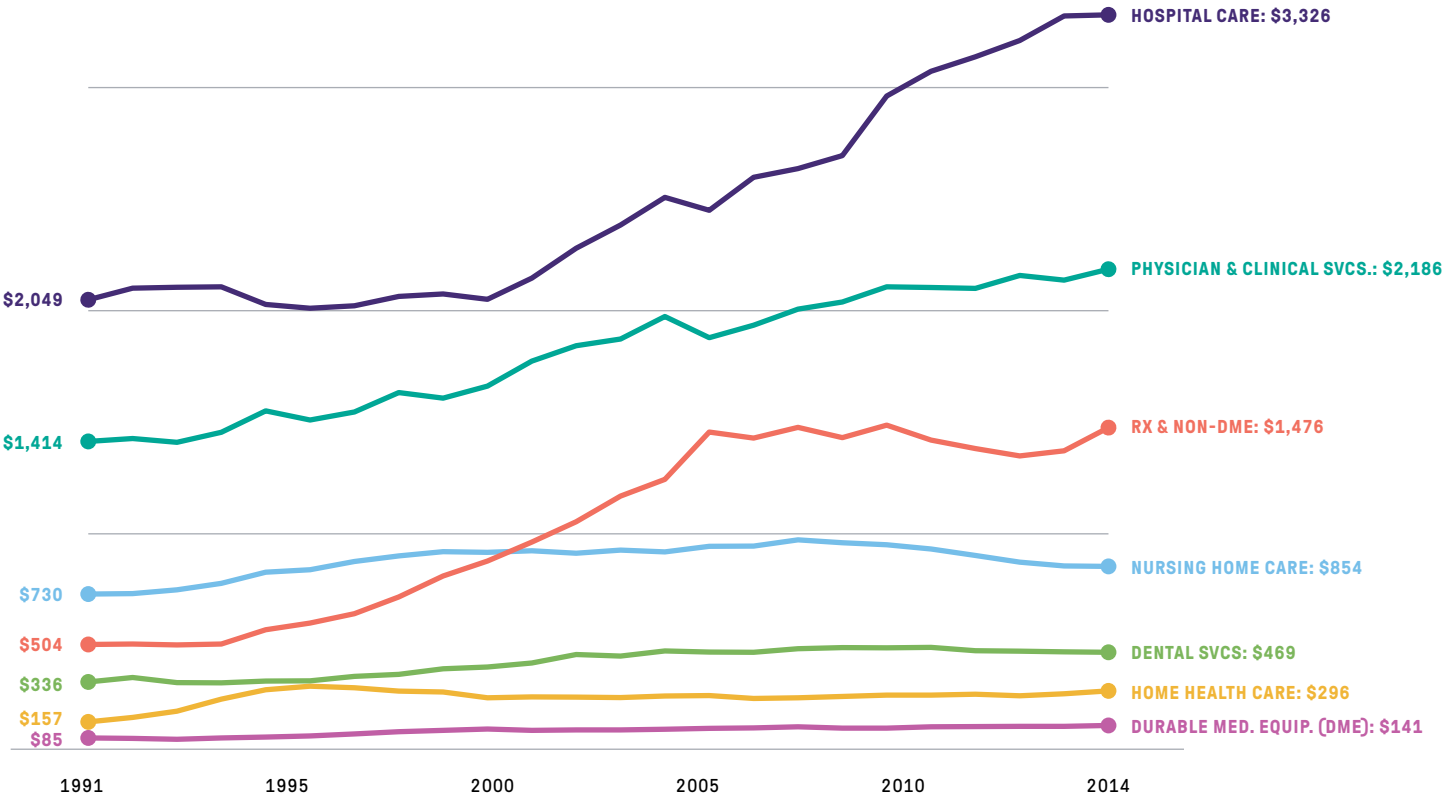


TABLE 6

Adults reporting altering or skipping prescriptions

CONNECTICUT, 2018

GROUP	COULD NOT AFFORD PRESCRIPTION IN PAST YEAR	ALTERED PRESCRIPTION IN PAST YEAR
Total	9%	7%
Female	10%	7%
Male	7%	6%
White	8%	6%
Black	11%	6%
Latino	18%	17%
Ages 18–34	12%	8%
Ages 35–49	10%	7%
Ages 50–64	9%	8%
Ages 65+	4%	3%
Under $30K	15%	11%
$30K–$100K	10%	8%
$100K+	5%	2%
High school or less	12%	11%
Some college or Associates	10%	8%
Bachelor's or higher	6%	4%

Due to the high cost of medications, some people are forced to go without them because they cannot afford the cost, and others reduce or skip dosages to extend prescriptions. According to our 2018 survey, 15 percent of adults earning $30,000 or less per year were unable to afford prescriptions as compared to 5 percent of adults earning $100,000 per year. Adults ages 18–34 were more likely than adults over 65 to alter or skip prescriptions. Adults with a high school diploma or less were twice as likely as adults with a bachelor's degree or more to be unable to afford a prescription (12 percent compared to 6 percent), and almost three times as likely to alter the way they took medicine (11 percent compared to 4 percent).[112] Altering or skipping prescriptions may further complicate an underlying health problem or render the medicine ineffective.

112 See notes for Table 6.

FOCUS: TREATMENT-RELATED DISCRIMINATION CONTRIBUTES TO PREVENTABLE DEATHS

The United States is the only prosperous country in the world where maternal mortality rates are not only alarmingly high by the standards suggested by our medical technology, but rising. The annual average maternal mortality rate between 2013 and 2017 in the U.S. was 29.6 per 100,000 births—a rate that has more than doubled in the past 30 years.[113] Pregnancy-related complications leading to death are elevated among some groups, particularly Black women and women over 40, but are not necessarily reduced by income, education level, or health insurance status. Rather, the risk of maternal mortality is linked to the way medical care is administered to pregnant people around the time they give birth. Pregnant patients may be further beset by discrimination if they are a person of color[114] or identify as LGBTQ.

The causes of maternal mortality are recognizable[115] and preventable[116] with awareness and timely response to early warning symptoms. But health care providers often miss the warning signs of serious complications due in part to the emphasis on infant health in pregnancy-related medical training and bias in the medical profession downplaying some patients' symptoms in clinical settings, especially women and people of color. To address this, California, for example, has implemented quality improvement protocols[117] to reduce mortality related to complications such as preeclampsia by treating the causes of maternal death as a failure to adequately respond in a medical situation.

While Connecticut has a lower maternal mortality rate than the nation—Connecticut's annual average is 19.0 deaths per 100,000 live births between 2013 and 2017, compared to the national rate of 29.6 per 100,000— when disaggregated by race, that rate is more than three times higher among Black women (48.0) than white women (14.8), and among women ages 35–44 (33.4) than women ages 25–34 (9.3).[118] While access to and quality of prenatal health care contribute to a healthy pregnancy, manageable precursors to maternal mortality are also rooted in stressors provoked by socioeconomic status and the treatment women and pregnant people (including transgender and gender-nonconforming people who wish to become or are pregnant) expect to receive from their health care providers. In particular, women of color are more likely to experience health issues which may remain unresolved during pregnancy, and are also more likely to experience postpartum depression.[119] While understudied, pregnancy among transgender men and gender-nonconforming people also presents considerations for complications in pregnancy related to hormones, dysphoria, and postpartum depression.[120]

113 Centers for Disease Control and Prevention. (2020). Pregnancy mortality surveillance system. Retrieved from https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

114 Martin, N., & Montagne, R. (2017, May 12). The last person you'd expect to die in childbirth. *ProPublica* & *NPR*. Retrieved from https://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system.

115 Council on Patient Safety in Women's Health Care. (2017). Maternal early warning criteria. Retrieved from https://safehealthcareforeverywoman.org/patient-safety-tools/maternal-early-warning-criteria/.

116 Main E.K., Cape V., Abreo A., et al. (2017). Reduction of severe maternal morbidity from hemorrhage using a state perinatal quality collaborative. *American Journal of Obstetrics & Gynecology,* 216(3): 216–298. https://doi.org/10.1016/j.ajog.2017.01.017.

117 E.g., California Maternal Quality Care Collaborative at https://www.cmqcc.org/.

118 See notes for Figure 15.

119 Ranji, U., Gomez, I., & Salganicoff, A. (2019). Expanding postpartum Medicaid coverage. Retrieved from https://www.kff.org/womens-health-policy/issue-brief/expanding-postpartum-medicaid-coverage/.

120 Obedin-Maliver, J., & Makadon, H. (2015). Transgender men and pregnancy. *Obstetric Medicine,* 9(1): 4–8. https://doi.org/10.1177/1753495X15612658.

Some of the same problems that increase the risk of maternal mortality also contribute to low-weight births. While 8 percent of all births in Connecticut between 2011 and 2016 were classified as low birthweight, this affected 7 percent of births to white women, 12 percent of births to Black women, and 8 percent of births to Latinas.[121] Inadequate prenatal care is also more common among Black women (28 percent of all births between 2011 and 2015) and Latinas (26 percent) than white women (20 percent).[122] Infant mortality was twice as high among babies born to Black mothers (10.6 per 1,000 live births) and elevated among babies born to Latinas (6.6) compared to babies born to white women (4.0) between 2011 and 2016, due in part to these inequities.[123]

Connecticut's HUSKY A/Medicaid plan covers a pregnant person whose household earns up to 263 percent of the federal poverty guideline during their pregnancy (about $44,474 for a family of two: pregnant person and unborn child). After birth, infants are automatically enrolled in coverage for an additional year. However, the parent giving birth is only covered 60 days postpartum; after this point, they may only remain eligible for Medicaid if their household earns less than 160 percent of the federal poverty guideline. For a family of two—parent and newborn—that amounts to less than $17,237 per year.

121 See notes for Table 7.

122 Ibid.

123 Ibid.

FIG 15

Maternal mortality is highest among Black women

ANNUAL AVERAGE DEATHS PER 100,000 LIVE BIRTHS, CONNECTICUT, 2013–2017

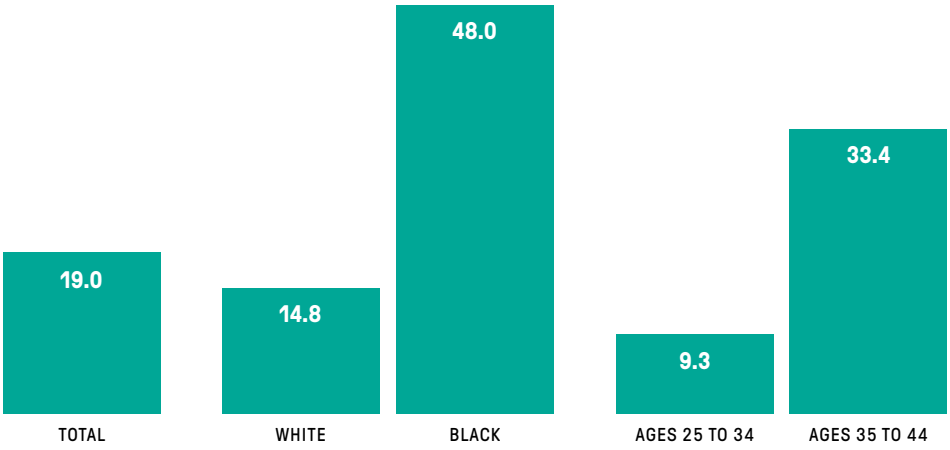


TABLE 7

Birth outcomes by race, annualized averages

Connecticut, † 2011–2015 AVERAGE; ‡ 2011–2016 AVERAGE

GROUP	NONADEQUATE PRENATAL CARE †	LOW BIRTHWEIGHT ‡	INFANT MORTALITY RATE PER 1,000 BIRTHS ‡
Total	23%	8%	5.1
White	20%	6%	4.0
Black	28%	12%	10.6
Latino	26%	8%	6.6
Other	23%	9%	2.5

Social Context of Health Care

The social and economic conditions in which a person lives affect how they access and perceive the quality of the health care available to them, as well as the outcomes of their health care encounters. These conditions are reflected in whether and when they choose to seek care, and in their choice of provider. A lack of high quality health care in underserved neighborhoods, perceived discrimination during clinical encounters, and difficulty accessing culturally competent care often prevent people with the greatest health need from accessing necessary care. The COVID-19 pandemic is bringing the effects of this disparity into focus—recent data indicate that Black and Latino populations are experiencing higher rates of infection and COVID-related death than their white counterparts in Connecticut and across the United States.[124]

Adverse experiences with health care providers are not uncommon for adults in Connecticut. In 2018, one in ten adults reported experiencing some form of discrimination while accessing health care within the past three years. Latino adults were the most likely to report this had happened to them (17 percent), followed by Black adults (14 percent), compared to just 9 percent of white adults. Lower-income adults also reported this more frequently than higher-income adults, and younger adults more often than older adults.[125]

Of all adults who had ever experienced discrimination while trying to access health care, 61 percent said it had happened multiple times in the past three years. The most commonly cited reason—mentioned by 26 percent of all respondents who gave a reason for discrimination—was health insurance status. Nearly 7 percent Black adults in Connecticut said race played a part. Black and Latino adults were more than ten times as likely as white adults to report racial discrimination in accessing health care. Four times as many women as men cited gender as a factor.[126]

Research indicates that providers might demonstrate implicit bias against gay and lesbian patients in a clinical setting.[127] Of Connecticut adults who reported experiencing discrimination in health care, 4 percent said their sexual orientation was a reason. Likewise, 6 percent of adults cited a physical disability as a reason for perceiving discrimination in a health care setting,[128] and research indicates that people with disabilities who perceived discrimination when accessing health care were less likely to seek care.[129] Additional studies suggest that people experiencing homelessness also feel less welcome during health care encounters.[130]

124 For COVID-19 statistics for Connecticut, see https://www.ctdatahaven.org/reports/covid-19-connecticut-data-analysis.

125 See notes for Figure 16.

126 Ibid.

127 Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health,* 105(9): 1831–1841. https://dx.doi.org/10.2105%2FAJPH.2015.302631.

128 DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey.

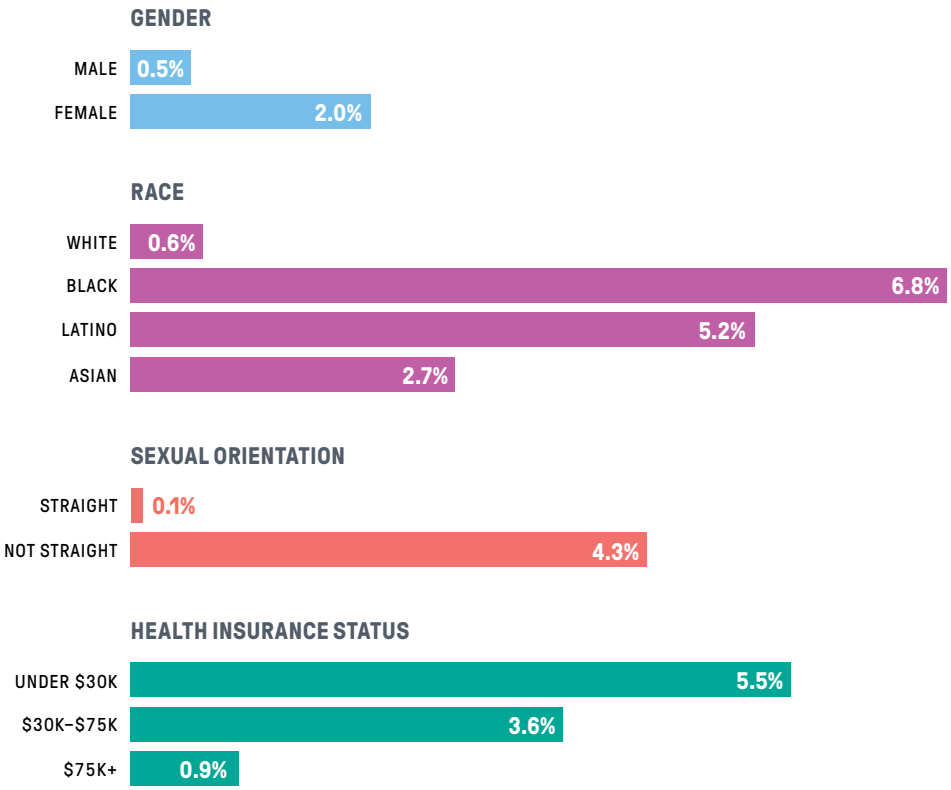
129 Moscoso-Porras, M. G. and Alvarado, G. F. (2018, January). Association between perceived discrimination and healthcare–seeking behavior in people with a disability. *Disability and Health Journal,* 11(1): 93–98. https://doi.org/10.1016/j.dhjo.2017.04.002.

130 Wen, C. K., Hudak, P. L., & Hwang, S. W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in health care encounters. *Journal of General Internal Medicine,* 22(7): 1011–1017. https://dx.doi.org/10.1007%2Fs11606-007-0183-7.

FIG 16

Race and insurance status are among the reasons for perceived discrimination in accessing health care

SHARE OF ADULTS, CONNECTICUT, 2018, EXPERIENCING DISCRIMINATION IN ACCESSING HEALTH CARE BASED ON THEIR...



According to our 2018 survey, there are about 20,400 adults in Connecticut (roughly 0.7 percent of the population), who identify as transgender. Of those, 57 percent say their primary care provider is trans-inclusive, but 44 percent said they did not seek health care in the past year when they needed it because they didn't think they would be treated well.[131]

The fear of discrimination influences patients' relationships with the broader health care system, leading some to postpone or go without care altogether. In 2018, 9 percent of adults reported that they missed medical care at some point in the past year, but low-income adults, Latinos, and young adults were more than twice as likely than their high-income, white, and older counterparts to report this.[132] Reasons for missing care varied by group, but being too busy and the cost of care were cited by at least half of respondents who gave a reason. Young adults were the most likely of all groups to say the reason for needing care was not serious enough or that care would be too costly. Adults with children at home were more than twice as likely to cite caregiving as a barrier than adults not living with children. Believing that insurance would not be accepted or that insurance would not pay for care were also common across groups, but especially elevated among Latino adults.[133]

131 DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey.

132 Ibid.

133 Ibid.

TABLE 8

Reasons given for going without health care

CONNECTICUT, 2018

GROUP	WENT WITHOUT HEALTH CARE (SHARE OF ALL ADULTS)	REASONS GIVEN FOR MISSING CARE (SHARE OF ADULTS WHO DIDN'T GET CARE)					
		TOO BUSY	TOO COSTLY	CAREGIVING	NOT SERIOUS ENOUGH	INSURANCE NOT ACCEPTED	INSURANCE WON'T PAY
Total	9%	53%	50%	22%	47%	18%	30%
Ages 18–34	13%	65%	57%	23%	57%	23%	30%
Ages 35–49	11%	53%	49%	28%	44%	16%	29%
Ages 50–64	8%	49%	51%	16%	43%	16%	34%
Ages 65+	5%	35%	28%	21%	41%	11%	22%
White	8%	55%	49%	23%	49%	17%	31%
Black	10%	48%	51%	17%	40%	14%	29%
Latino	16%	55%	57%	28%	46%	28%	36%
Under $30K	16%	47%	49%	24%	41%	25%	32%
$30K–$100K	9%	55%	56%	23%	47%	15%	32%
$100K+	5%	64%	42%	18%	56%	15%	24%
No children	8%	51%	50%	15%	47%	16%	31%
Children at home	11%	59%	48%	33%	48%	20%	30%

Some residents struggle to find a provider who speaks their language, and may rely on other family members (often children) to translate in medical settings. Linguistic isolation[134] affects about 5 percent of households in Connecticut overall, but more than 20 percent of the households where Spanish or an Asian or Pacific Island language is spoken. In urban areas, these rates are higher, but those households are more likely to be co-located near community members and health care providers who speak the same language. In Connecticut's rural areas, 31 percent of households where Asian or Pacific Island languages are spoken are linguistically isolated, and those residents may not live near others who speak the same language.[135]

Connecticut health care providers could do more to ensure that provision of care is equitably administered to patients regardless of race, ethnicity, language spoken, sexual orientation, gender identity, disability, or other factors by improving data collection and following up with patients to understand if they are satisfied with the care they received. Cultural competency and humility training are also research-supported strategies that can build empathy among health care practitioners.[136]

134 Households in which no inhabitant speaks English "very well."

135 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B16004, Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over. Available at https://data.census.gov.

136 County Health Rankings. (2020). Cultural competence training for health care professionals. Retrieved from https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/cultural-competence-training-for-health-care-professionals.

FOCUS: CONSIDER SOCIAL NEEDS WHEN COORDINATING PANDEMIC RESPONSE

In the midst of a public health emergency like the COVID-19 pandemic, officials are compelled to make decisions about testing and treatment quickly, perhaps without the opportunity to consider all options or recourse. What seems like the best approach for most patients—have a doctor order a test,[137] drive to a testing site, quarantine at home if symptomatic, reduce contact with others as much as possible—may not be actionable to all patients when considering the social inequities described in this report. These differences are only made more apparent as the virus establishes itself in our communities.

137 Although there is no longer a requirement that a doctor order a COVID-19 test before it is administered, the requirement did likely prevent many people from getting tested who had the disease but exhibited fewer or no symptoms.

Statewide, 12 percent of adults say they have no person or place they consider their health care provider, but that share is about 8 times higher among adults ages 18–34 than adults over 65, and twice as high among Latinos as white adults. When COVID-19 testing protocols required physicians to order tests for patients, individuals without a primary care provider may have had a more difficult time getting a test ordered. Even those who were able to see a doctor may not have received the same treatment based on their race or ethnicity. A recent multi-state review of patient records through March 20, 2020, indicated that Black patients exhibiting symptoms consistent with COVID-19 were less likely to receive orders for a COVID test than white patients.[138]

The location of the testing site and protocols for conducting tests can prohibit some patients from receiving one. Drive-through sites are among the most common testing facilities as of the time of this writing, and they are often located in large parking lots in commercial or industrial areas where long lines of vehicles can be efficiently organized. In Connecticut, 20 percent of Black and Latino households have no vehicle available, compared to just 6 percent of white households.[139] Patients without vehicles are often turned away.[140] Cities around Connecticut have organized walk-up COVID testing facilities and free, safe taxi services—in New Haven, these were placed in some of the city's predominantly Black and Latino neighborhoods—in an effort to improve access to tests for people without vehicles.[141]

Since it has become established that the virus travels to new hosts through respiratory droplets (among other means), the conditions for transmitting the virus are ideal when people live within close proximity to one another, as in overcrowded households with more than one person per room. Overcrowding affects 7 percent of Latino households and 3 percent of Black households, but less than 1 percent of white households.[142] This is partly due to the presence of multigenerational households, which are twice as common among Black and Latino households (7 and 8 percent, respectively) than white households (3 percent).[143] Overall, recent data indicate that Black and Latino populations in Connecticut have higher per-capita COVID-19 infection rates than white populations, and experience disproportionately higher rates of COVID-related death.[144]

Close-quarters living conditions among people experiencing homelessness also facilitate viral transmission, and people experiencing homelessness are unable to follow home-isolation orders. Local officials have been challenged to find shelter, supplies, medical personnel, and volunteers—effectively setting up satellite clinics and triage operations—for people experiencing homelessness to receive COVID-19 treatment or resources. While these facilities are necessary to prevent the spread of the disease and allow affected people to convalesce safely, their placement is often selected for political reasons rather than where they are needed most.[145] Such responses also need to respect the autonomy of people experiencing homelessness and recognize the underlying factors exacerbated by both lack of stable housing and the pandemic. Harm reduction models used to tackle issues such as addiction may translate well to addressing these overlapping needs.

Telemedicine has emerged as an alternative to in-person health care provider visits, but individuals without access to the appropriate technology (such as a broadband connection or device with a camera) or whose insurance does not cover telemedicine may remain unable to safely access health care for COVID-19 or other health issues. Telemedicine has other challenges that may further complicate access including legal issues, especially related to privacy, and linguistic or other communications barriers.

138 Rubix Life Sciences. (2020, March). COVID-19 and minority health access. Retrieved from https://rubixls.com/wp-content/uploads/2020/04/COVID-19-Minority-Health-Access-7-1.pdf. See also Basler, C. (2020, April 22). Son's death highlights COVID-19 testing barriers for black residents. *CT Mirror.* Retrieved from https://ctmirror.org/2020/04/22/sons-death-highlights-covid-19-testing-barriers-for-black-resdents/.

139 DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata.

140 Office of the Governor. (2020, April 17). Governor Lamont announces launch of Connecticut's first rapid COVID-19 testing center in New Haven. Retrieved from https://portal.ct.gov/Office-of-the-Governor/News/Press-Releases/2020/04-2020/Governor-Lamont-Announces-Launch-of-Connecticuts-First-Rapid-COVID19-Testing-Center-in-New-Haven.

141 Breen, T. (2020, April 22). City steps up food access efforts. *New Haven Independent.* Retrieved from https://www.newhavenindependent.org/index.php/archives/entry/422_covid/#When:22:27:15Z.

142 DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B25014, Tenure by Occupants Per Room. Available at https://data.census.gov.

143 DataHaven analysis (2020) of U.S. Census Bureau 2010 Decennial Census data, Table PCT14, Presence of Multigenerational Households. Available at https://data.census.gov.

144 For COVID-19 statistics for Connecticut, see https://www.ctdatahaven.org/reports/covid-19-connecticut-data-analysis.

145 E.g., Hawkins, M. (2020, April 21). Up close: COVID-19, homelessness and New Haven's response. *Yale Daily News.* Retrieved from http://features.yaledailynews.com/blog/2020/04/21/up-close-covid-19-homelessness-and-new-havens-response/.

FOCUS: UNDERSTANDING SOCIAL FACTORS IN THE OPIOID CRISIS

In 2019, drug overdoses reached an all time high in Connecticut with 1,200 deaths—an increase of nearly 20 percent from 2018.[146] The opioid crisis, which underlies this increase, is an onerous public health concern. Some of the highest overdose death rates occur in the northeastern United States. In 2016, Connecticut ranked 11th in the country for opioid overdose deaths per capita; other states in New England also consistently rank among the top ten. Overdoses are now common across all genders and major racial and ethnic groups.[147] From 2014 to 2019, the mortality rate per 100,000 residents due to opioid overdose doubled among white individuals (from 16 to 34), tripled among Latino individuals (from 10 to 30) and increased six-fold for Black individuals (from 5 to 31).[148]

The challenge in addressing this crisis is due to its complexity: opioid misuse affects people of many different backgrounds, who live in different social and physical environments. It is often instigated by different socioeconomic triggers. Preventing overdose deaths therefore must include a wide continuum of treatment and intervention plans catering to a diverse array of patients.

The age-adjusted opioid overdose death rate in Connecticut between 2015 and 2018 was 22.8 deaths per 100,000 residents. Both urban and rural areas had elevated rates, ranging from 23.7 in Rural towns to 37.1 in Urban Core cities and 23.9 in Urban Periphery towns.[149] Rural and urban regions represent two of the most widely studied environments where opioid misuse takes hold.

In urban areas, opioid overdose deaths are more commonly attributed to illicit drug use and the surge in the presence of fentanyl in the illegal drug supply. Yet rates are not uniform across urban areas. Hartford and New Britain (44.5 and 51.7 deaths per 100,000 residents) have overdose death rates that are notably higher than Bridgeport or New Haven (27.6 and 27.9, respectively), while rates in Stamford (7.0 per 100,000) are comparatively lower.[150] Reasons why people turn to illicit drugs, specifically opiates, are often related to an accumulation of social and economic factors, including adverse childhood experiences, experiences in the criminal justice system, inadequate health care, family history, and stress.[151] For some, seeking treatment for drug misuse becomes increasingly difficult due in part to mistrust of health care providers or fear of law enforcement. As a result, some individuals give up on seeking or receiving help.

Meanwhile, in rural areas, the prevailing hypothesis suggests that years of economic decline in formerly industrial areas, often with long histories of alcohol and drug misuse, have left residents both socially and economically isolated. Many who were dealing with workplace injuries or disability may at some point have received prescription opioids for legitimate medical reasons, then progressed toward opioid misuse over time.[152] For these individuals, access to treatment is often complicated by their distance from providers. In Connecticut, rural towns such as Griswold and North Canaan have much higher overdose death rates than the statewide average and the average of rural towns (64.1 and 46.6 per 100,000 residents, respectively).[153]

146 Altimari, D. (2020, February 14). Drug overdose deaths increased by nearly 20 percent in Connecticut in 2019, reaching a record-high 1,200. *Hartford Courant.* Retrieved from https://www.courant.com/news/connecticut/hc-news-drug-deaths-increase-20200214-gqxzdint6rbqxcyroi2n4a735y-story.html.

147 Ankrah, J. (2018, September 3). Connecticut's opioid epidemic: A glimpse of the past five years. *CT Mirror.* Retrieved from https://ctmirror.org.

148 Ungemack, Jane. (2020). Director, Center for Prevention Evaluation and Statistics (CPES), UCONN Health. Presentation to State Epidemiological Outcomes Workgroup (SEOW), April 29, 2020.

149 DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at https://data.ct.gov/resource/rybz-nyjw. The four towns with the highest overdose death rates are Griswold (Rural, 64.1), Essex (Suburban, 59.3), New Britain (Urban Core, 51.7), and Windham (Urban Periphery, 49.2).

150 Ibid.

151 U.S. Department of Health and Human Services, Office of the Surgeon General. (2018, September). Facing addiction in America: the Surgeon General's spotlight on opioids. Retrieved from https://addiction.surgeongeneral.gov/sites/default/files/Spotlight-on-Opioids_09192018.pdf.

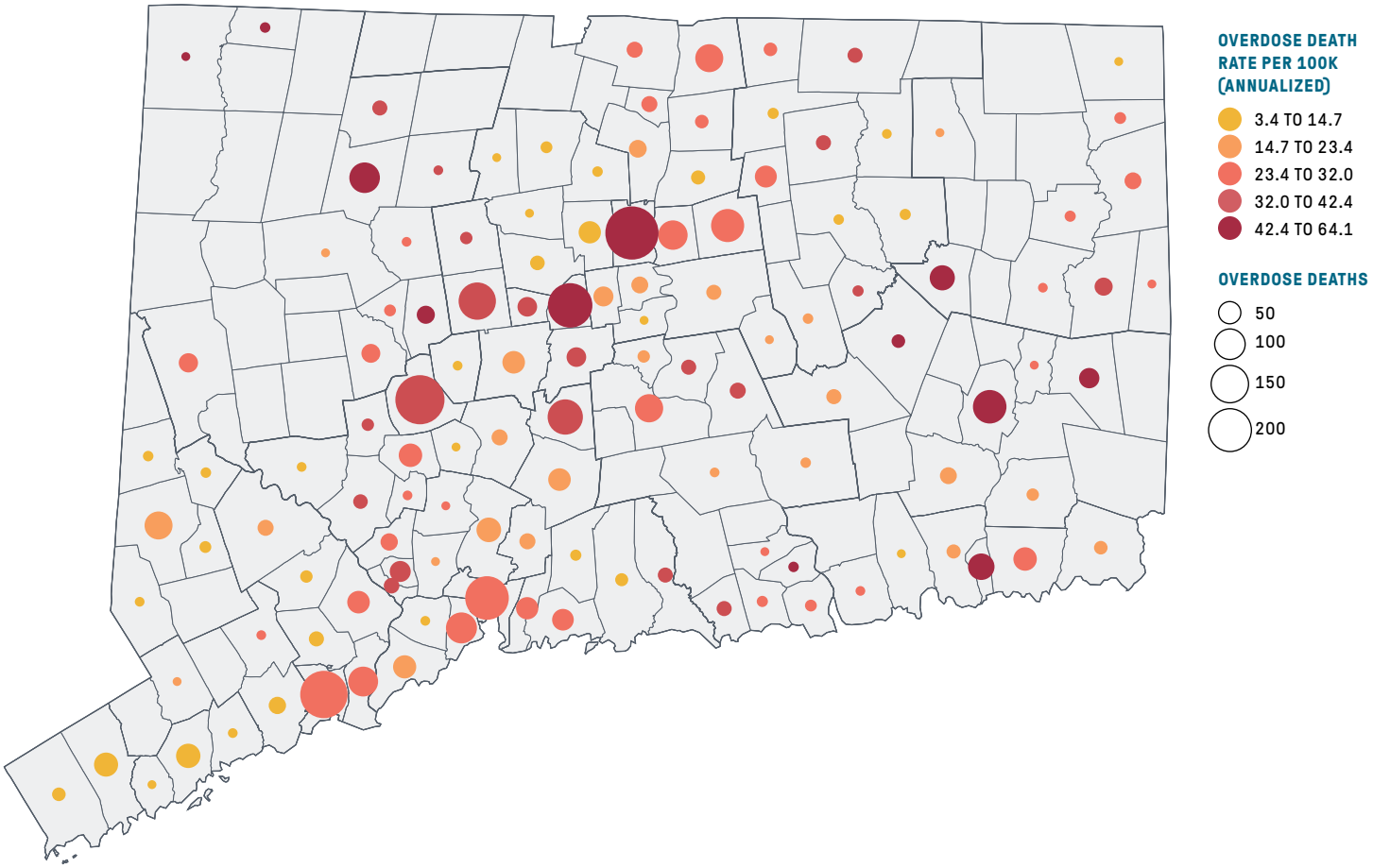
152 Peters, D. J., Monnat, S. M., Hochstetler, A. L., & Berg, M. T. (2019). The opioid hydra: understanding overdose mortality epidemics and syndemics across the rural-urban continuum. *Rural Sociology.* https://doi.org/10.1111/ruso.12307.

153 See notes for Figure 17.

FIG 17

High rates of opioid overdose deaths are seen throughout the state

RATE AND TOTAL NUMBER OF OPIOID-RELATED DEATHS BY TOWN, 2015–2018



Reducing Health Disparities Means Reducing Social Disparities

Taken together, the social determinants of health reveal an interrelated system of inequities that lead to disparate health outcomes in Connecticut. The legacy of racism has compounded these inequities especially for Black people, but also for other marginalized groups.

Addressing social needs—especially those related to basic necessities such as food and housing—can improve individual and public health.[154] When individuals spend less time and energy worrying about how to survive day to day, they can invest more time in improving their overall health and quality of life. During the current pandemic, the struggle to obtain food and pay for housing has become a reality for some who previously had only considered these needs in the abstract.

Research strongly indicates that financial insecurity—poverty in particular—is highly correlated with mental health issues, especially depression,[155] which in turn are associated with negative health outcomes including greater disease burden, longer duration of illness, disability, and suicide. While low-income adults often report they are financially insecure,[156] other groups—many of which we describe above as having worse economic outcomes, who struggle with housing and food insecurity, and who bear the burden of discrimination or social isolation—report similarly high levels of financial insecurity. These groups are much more likely to report that they feel depressed and are less likely to report they are in good health overall.[157] The cruel irony is that a lack of social and economic support and barriers to health care can make an individual feel depressed, and for those who are depressed, that lack of support also exacerbates feelings of hopelessness, instills false ideas that they deserve to suffer, and makes the prospect of seeking help unimaginably difficult.

People who are financially insecure are at greater risk of resource-based stress—including food and housing insecurity—and consequently have higher incidences of diabetes, cancer, and poor birth outcomes. Over time, this prolonged resource-based stress can lead to chronic emotional instability. For some, these health issues may go untreated, as low-income groups are also less likely to see a health care provider when they need medical care. Reasons for missing treatment include being unable to afford care, being unable to find transportation to receive care, having to work, providing care for another person, or believing they will be treated badly.

154 Artiga, S., & Hinton, E. (2018). Beyond health care: the role of social determinants in promoting health and health equity. Kaiser Family Foundation Disparities Policy. Retrieved from https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/.

155 Heflin, C. M., & Iceland, J. (2009). Poverty, material hardship, and depression. *Social Science Quarterly,* 90(5): 1051–1071. https://dx.doi.org/10.1111%2Fj.1540-6237.2009.00645.x.

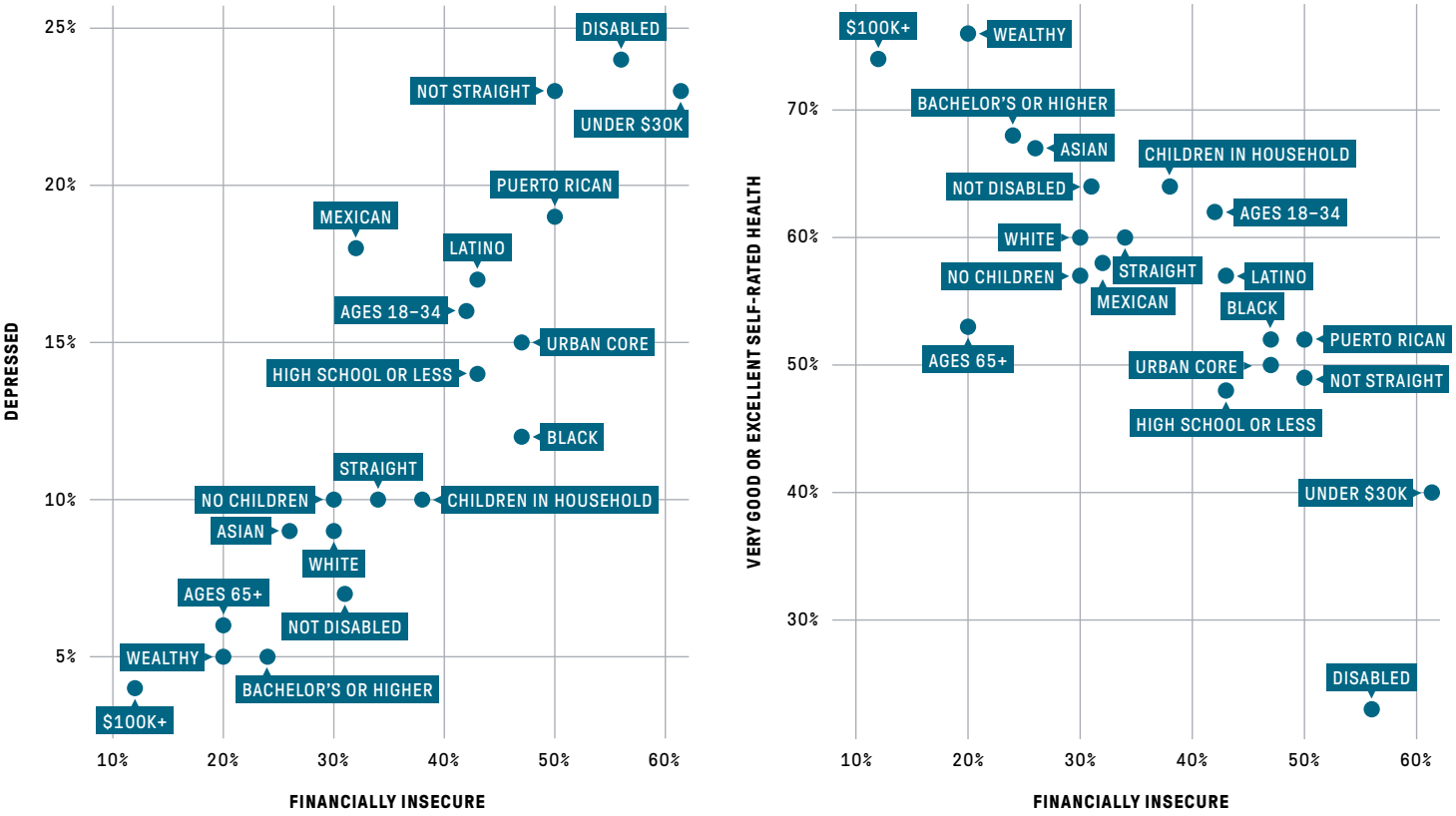
156 Individuals who are financially insecure report that they are just getting by or finding it difficult or very difficult to manage financially.

157 See notes for Figure 18.

FIG 18

Groups that are more financially insecure are more likely to report that they feel depressed and less likely to report they are in very good health

SHARE OF ADULTS, CONNECTICUT, 2018



When disparate access to social and economic resources results in limited access to health care and poor health outcomes, solutions must include improvements to the access and quality of health care alongside relief from social and economic anxiety. There are two major barriers to this approach. First, despite a broad awareness of social determinants, patient care in the United States tends to focus on the individual physically, exclusive of their broader social circumstances. Yet, as this report suggests, the quality of education starting in childhood, stable housing, a reliable source of income, and consistent access to nutritious food all play a part in keeping people healthy in the first place. Still, by design, these basic provisions are denied to the most vulnerable. Centuries of social and economic deprivation have given a false legitimacy to the idea that the conditions essential to a healthy life are not deserved by all people. While the medical establishment cannot by itself undo centuries of oppression, it can reckon with its role in facilitating it, and commit to actively advancing health equity by including approaches informed by social determinants of health in provider education, and expanding the roles of community health workers or other means of connecting patients with wraparound services outside of the clinic.[158]

The second barrier is the fact that health care in the United States is expensive by design. Economic models for administering care are not flexible enough to permit providers or individual institutions to administer high-quality, affordable care to patients with high need and low resources. Health insurance policies are byzantine, and having insurance does not guarantee that care or prescriptions are affordable or even available.

158 For an example of how hospitals are using technology to help address social determinants of health, see Carlesso, J. (2020, January 14). Hospitals, nonprofits tackle social determinants of health with digital network of providers. *CT Mirror.* Retrieved from https://ctmirror.org/2020/01/14/hospitals-nonprofits-tackle-social-determinants-of-health-with-digital-network-of-providers/.

Individuals are often hesitant to seek care because of the fear of being unable to afford it, even with health insurance. Many patients do not know the full cost of care until a bill arrives. Because health care services make up a significant portion of the national economy, systemic changes to improve coverage, quality, and affordability are enormously complex.

While the United States has exceptional medical expertise and technology, our health care system was not prepared for a pandemic. The downside of manufacturing protective gear and supplies "just in time" has become apparent as health care facilities nationwide have the same unprecedented and concurrent need for scarce resources. A system designed to provide a wide variety of treatment with local or regional specialization now confronts one single, deadly affliction, everywhere, all at once. The economic cost of this dramatic shift in medical labor and resources—let alone the cost of treatment for the more than two million affected people—is not yet clear.

As a society, we are now faced with an opportunity to acknowledge that resolving social inequities helps to improve health outcomes for everyone. By doing so, we can begin to dismantle some of the structures that contribute to disparate health outcomes. Policymakers may focus on removing barriers to accessing health insurance coverage (for example, by extending coverage to non-citizens) or advocating for universal coverage; advancing educational opportunities and closing achievement gaps starting in early childhood; expanding economic opportunity through community development; or increasing the affordability of food, housing, and social services while protecting those most vulnerable to losing those basic necessities. Community-based organizations may raise awareness of programs intended to improve outcomes for specific groups and advocate for new programs to help those with the greatest need. Collective action and cooperation with other community-based organizations may help extend programming for wraparound services. Grantmaking organizations and foundations should examine the extent to which philanthropic dollars are effectively used to reduce social and health inequities and increase support in promising initiatives.

The data in this report suggest that the slow drip of social and economic deprivation and oppression has eroded the opportunity for many people to achieve good health over generations. In a matter of weeks, it became a deluge. COVID-19 exposed how little we have contributed to our collective safety net and just how much effort we put into dismantling it; meanwhile, the number who are on the precipice of hardship is growing daily. With so many in precarious financial circumstances, now is the time to consider whether our solutions to address these crises will widen or bridge the gap.

Appendix A: Local Data by Race/Ethnicity for Connecticut Cities and Towns

We often find strong correlations between various measures of well-being and our Community Index. The index includes several socioeconomic indicators, disaggregated by race, factored into a single score that ranges from 0 (the worst outcome) to 1,000 (the best). The indicators include: unemployment, poverty, the share of adults with at least a high school diploma, the share of workers commuting less than 30 minutes, severe housing cost burden (spending more than 50 percent of household income on housing costs), youthful labor force (share of the population between 25 and 45), share without health insurance, and median household income.[159] We selected these indicators because, taken together, they can help us understand overall quality of life across groups. They also reflect key areas where between-group disparity can be significant, as we discuss at length in this report.

Index values for white and Asian residents are consistently higher than those for Latino and Black residents, although scores vary by area. Northwestern New Haven County (the area including Beacon Falls, Cheshire, Middlebury, Naugatuck, Oxford, Prospect, Southbury, and Wolcott) has similar index values for all four groups, and the lowest level of inequality across groups. The city of Hartford has the highest degree of inequality of any area, due to a very low score for Latino residents and relatively high score for Asian residents. Generally speaking, inequality is greater in Connecticut's cities because two people in a suburban area are more likely to have the same socioeconomic status than two people in an urban area. In other words, economic sorting in our cities and towns drives the inequality we see in these index scores.

The tables that follow summarize summarizes the index values for four major racial/ethnic groups for 26 geographic areas in Connecticut for which granular data are available, as well as the state and nation.

159 See notes for Table 9.

FIG 19

Connecticut PUMAs with county boundaries

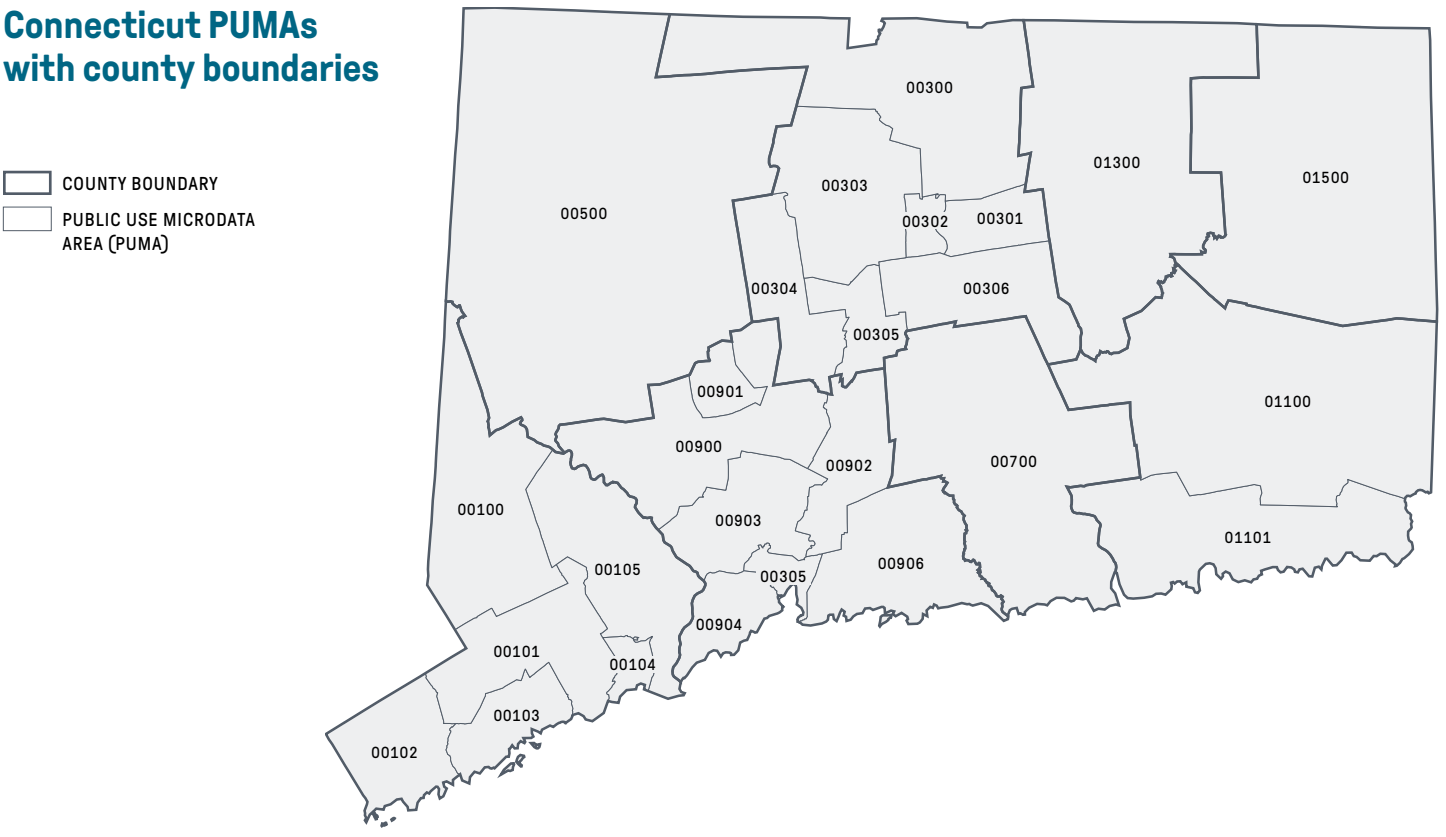


TABLE 9

DataHaven Community Index score by location (PUMA) and race/ethnicity

HIGH/LOW SCORES HIGHLIGHTED, 2018

REGION	WHITE	BLACK	LATINO	ASIAN	INEQUALITY RATIO
Hartford	530	386	245	693	2.83
New Haven	634	360	399	679	1.89
Waterbury	582	376	315	509	1.85
Manchester & East Hartford	696	586	440	794	1.80
Norwalk, Westport & Darien	749	438	426	738	1.76
New London County (South)	708	449	412	698	1.72
Connecticut	704	474	437	747	1.71
United States	654	403	443	670	1.66
Danbury, Ridgefield, Bethel, Brookfield, New Fairfield, Redding & Sherman	716	513	447	732	1.64
Windham County, Connecticut	648	416	398	608	1.63
Stamford & Greenwich	754	515	469	749	1.61
New Britain, Berlin & Plainville	670	508	419	657	1.60
Bridgeport	484	380	323	362	1.50
Litchfield County, Connecticut	674	489	539	717	1.47
Meriden, Wallingford & North Haven	732	557	540	785	1.45
Tolland County, Connecticut	690	484	607	682	1.43
West Haven, Milford & Orange	691	530	566	743	1.40
Stratford, Shelton, Trumbull, Newtown & Monroe	721	523	638	695	1.38
Fairfield, New Canaan, Wilton, Weston & Easton	747	558	548	701	1.36
Bristol, Southington & Burlington	690	557	522	709	1.36
New London County (North)	684	522	526	704	1.35
Glastonbury, Newington, Wethersfield, Rocky Hill & Marlborough	770	673	594	789	1.33
West Hartford, Farmington, Simsbury, Bloomfield, Avon & Canton	784	599	631	715	1.31
Middlesex County, Connecticut	710	558	557	694	1.27
Hamden, Ansonia, Seymour, Derby, Woodbridge & Bethany	683	539	544	669	1.27
Hartford County (North)	730	654	651	790	1.21
East Haven, Branford, Guilford, Madison & North Branford	714	610	649	715	1.17
New Haven County (Northwest)	701	606	674	683	1.16

TABLE 10.1

Community Index components by location and race/ethnicity

UNITED STATES, 2018

COMPONENTS	WHITE	BLACK	LATINO	ASIAN	TOTAL
Unemployment rate	5%	11%	7%	5%	6%
Percent HS grads	93%	85%	68%	87%	88%
Poverty rate	10%	24%	21%	12%	14%
Workers w/ short commute	64%	58%	59%	54%	62%
Severe housing cost burden	13%	25%	22%	18%	14%
Youthful labor force	24%	28%	30%	33%	26%
Percent w/o insurance	6%	11%	19%	8%	9%
Median household income	$65,912	$40,155	$49,225	$83,898	$60,293
Community Index score	654	403	443	670	581

TABLE 10.2

Community Index components by location and race/ethnicity

CONNECTICUT, 2018

COMPONENTS	WHITE	BLACK	LATINO	ASIAN	TOTAL
Unemployment rate	6%	12%	10%	5%	7%
Percent HS grads	94%	86%	72%	90%	91%
Poverty rate	6%	18%	23%	8%	10%
Workers w/ short commute	64%	65%	68%	65%	65%
Severe housing cost burden	14%	27%	27%	17%	16%
Youthful labor force	21%	28%	31%	37%	24%
Percent w/o insurance	3%	7%	14%	7%	6%
Median household income	$86,697	$47,856	$45,730	$93,665	$76,106
Community Index score	704	474	437	747	618

TABLE 10.3

CI components by location, Fairfield County

00100: DANBURY, RIDGEFIELD, BETHEL, BROOKFIELD, NEW FAIRFIELD, REDDING & SHERMAN

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	10%	7%	5%
Percent HS grads	95%	87%	67%	89%
Poverty rate	4%	17%	16%	5%
Workers w/ short commute	53%	56%	63%	64%
Severe housing cost burden	15%	22%	25%	13%
Youthful labor force	20%	27%	35%	37%
Percent w/o insurance	5%	16%	28%	7%
Median household income	$102,415	$69,281	$57,973	$107,337
Community Index score	716	513	447	732

TABLE 10.4

CI components by location, Fairfield County

00101: FAIRFIELD, NEW CANAAN, WILTON, WESTON & EASTON

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	7%	8%	8%
Percent HS grads	97%	89%	93%	90%
Poverty rate	4%	14%	10%	6%
Workers w/ short commute	53%	63%	48%	47%
Severe housing cost burden	17%	22%	31%	17%
Youthful labor force	16%	20%	20%	31%
Percent w/o insurance	3%	3%	10%	8%
Median household income	$158,013	$72,000	$114,359	$193,885
Community Index score	747	558	548	701

TABLE 10.5

CI components by location, Fairfield County

00102: STAMFORD & GREENWICH

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	11%	8%	6%
Percent HS grads	97%	89%	71%	95%
Poverty rate	5%	14%	15%	6%
Workers w/ short commute	62%	61%	69%	58%
Severe housing cost burden	17%	33%	36%	19%
Youthful labor force	24%	29%	32%	44%
Percent w/o insurance	4%	11%	24%	5%
Median household income	$130,150	$48,555	$53,596	$128,765
Community Index score	754	515	469	749

TABLE 10.6

CI components by location, Fairfield County

00103: NORWALK, WESTPORT, & DARIEN

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	12%	11%	8%
Percent HS grads	97%	88%	69%	93%
Poverty rate	4%	12%	17%	4%
Workers w/ short commute	58%	67%	64%	59%
Severe housing cost burden	17%	30%	30%	16%
Youthful labor force	20%	24%	34%	37%
Percent w/o insurance	6%	17%	32%	8%
Median household income	$133,014	$52,355	$58,298	$137,434
Community Index score	749	438	426	738

TABLE 10.7

CI components by location, Fairfield County

00104: BRIDGEPORT

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	10%	16%	14%	15%
Percent HS grads	86%	84%	63%	78%
Poverty rate	14%	19%	27%	26%
Workers w/ short commute	62%	57%	63%	80%
Severe housing cost burden	25%	31%	30%	35%
Youthful labor force	25%	29%	32%	31%
Percent w/o insurance	12%	9%	19%	14%
Median household income	$53,030	$45,938	$39,908	$54,048
Community Index score	484	380	323	362

TABLE 10.8

CI components by location, Fairfield County

00105: STRATFORD, SHELTON, TRUMBULL, NEWTOWN & MONROE

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	10%	8%	5%
Percent HS grads	95%	90%	86%	85%
Poverty rate	4%	13%	8%	8%
Workers w/ short commute	58%	58%	59%	57%
Severe housing cost burden	14%	26%	16%	14%
Youthful labor force	19%	25%	27%	32%
Percent w/o insurance	2%	4%	8%	3%
Median household income	$102,138	$72,990	$81,268	$123,206
Community Index score	721	523	638	695

TABLE 10.9

CI components by location, Hartford County

00300: HARTFORD COUNTY (NORTH): EAST GRANBY, EAST WINDSOR, ENFIELD, GRANBY, HARTLAND, SOUTH WINDSOR, SUFFIELD, WINDSOR, & WINDSOR LOCKS

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	10%	8%	5%
Percent HS grads	95%	88%	81%	92%
Poverty rate	4%	9%	16%	4%
Workers w/ short commute	68%	69%	70%	70%
Severe housing cost burden	12%	16%	11%	11%
Youthful labor force	22%	28%	35%	40%
Percent w/o insurance	2%	4%	6%	4%
Median household income	$88,490	$79,844	$79,635	$99,735
Community Index score	730	654	651	790

TABLE 10.10

CI components by location, Hartford County

00301: MANCHESTER & EAST HARTFORD

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	10%	11%	7%
Percent HS grads	93%	90%	74%	89%
Poverty rate	8%	11%	21%	6%
Workers w/ short commute	72%	72%	73%	73%
Severe housing cost burden	13%	19%	27%	10%
Youthful labor force	24%	32%	33%	48%
Percent w/o insurance	4%	5%	9%	4%
Median household income	$70,033	$54,581	$43,611	$82,729
Community Index score	696	586	440	794

TABLE 10.11

CI components by location, Hartford County

00302: HARTFORD

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	8%	15%	16%	7%
Percent HS grads	88%	82%	60%	80%
Poverty rate	19%	27%	37%	13%
Workers w/ short commute	71%	68%	73%	74%
Severe housing cost burden	20%	31%	36%	21%
Youthful labor force	25%	28%	28%	49%
Percent w/o insurance	7%	10%	11%	7%
Median household income	$50,357	$37,015	$26,747	$71,667
Community Index score	530	386	245	693

TABLE 10.12

CI components by location, Hartford County

00303: WEST HARTFORD, FARMINGTON, SIMSBURY, BLOOMFIELD, AVON & CANTON

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	4%	12%	6%	5%
Percent HS grads	98%	88%	83%	90%
Poverty rate	4%	11%	13%	7%
Workers w/ short commute	66%	69%	72%	62%
Severe housing cost burden	13%	18%	17%	14%
Youthful labor force	20%	25%	29%	34%
Percent w/o insurance	2%	3%	4%	4%
Median household income	$107,318	$66,656	$85,783	$98,241
Community Index score	784	599	631	715

TABLE 10.13

CI components by location, Hartford County

00304: BRISTOL, SOUTHINGTON, & BURLINGTON

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	7%	7%	2%
Percent HS grads	93%	86%	84%	85%
Poverty rate	5%	18%	21%	4%
Workers w/ short commute	65%	62%	67%	71%
Severe housing cost burden	13%	13%	23%	14%
Youthful labor force	22%	31%	33%	36%
Percent w/o insurance	2%	3%	6%	18%
Median household income	$83,014	$43,500	$51,418	$78,634
Community Index score	690	557	522	709

TABLE 10.14

CI components by location, Hartford County

00305: NEW BRITAIN, BERLIN, & PLAINVILLE

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	12%	8%	7%
Percent HS grads	89%	89%	69%	90%
Poverty rate	8%	14%	32%	13%
Workers w/ short commute	73%	78%	84%	81%
Severe housing cost burden	17%	21%	28%	31%
Youthful labor force	25%	27%	30%	45%
Percent w/o insurance	5%	5%	6%	9%
Median household income	$64,904	$45,240	$36,464	$63,608
Community Index score	670	508	419	657

TABLE 10.15

CI components by location, Hartford County

00306: GLASTONBURY, NEWINGTON, WETHERSFIELD, ROCKY HILL, & MARLBOROUGH

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	4%	14%	10%	3%
Percent HS grads	95%	97%	84%	92%
Poverty rate	4%	10%	12%	4%
Workers w/ short commute	73%	77%	74%	67%
Severe housing cost burden	10%	11%	18%	10%
Youthful labor force	21%	26%	30%	36%
Percent w/o insurance	2%	1%	8%	6%
Median household income	$92,032	$55,227	$68,654	$104,534
Community Index score	770	673	594	789

TABLE 10.16

CI components by location, Litchfield County

00500: LITCHFIELD COUNTY

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	8%	10%	3%
Percent HS grads	93%	78%	79%	92%
Poverty rate	6%	14%	17%	6%
Workers w/ short commute	61%	46%	59%	73%
Severe housing cost burden	13%	12%	19%	12%
Youthful labor force	20%	23%	30%	29%
Percent w/o insurance	4%	14%	11%	11%
Median household income	$79,615	$58,380	$62,727	$79,355
Community Index score	674	489	539	717

TABLE 10.17

CI components by location, Middlesex County

00700: MIDDLESEX COUNTY

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	7%	4%	5%
Percent HS grads	95%	90%	86%	93%
Poverty rate	6%	17%	19%	9%
Workers w/ short commute	60%	67%	72%	65%
Severe housing cost burden	14%	22%	27%	21%
Youthful labor force	21%	28%	32%	33%
Percent w/o insurance	3%	6%	8%	7%
Median household income	$87,923	$52,500	$68,558	$86,509
Community Index score	710	558	557	694

TABLE 10.18

CI components by location, New Haven County

00900: NEW HAVEN COUNTY (NORTHWEST): BEACON FALLS, CHESHIRE, MIDDLEBURY, NAUGATUCK, OXFORD, PROSPECT, SOUTHBURY, AND WOLCOTT

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	7%	5%	6%
Percent HS grads	94%	90%	86%	92%
Poverty rate	5%	5%	6%	6%
Workers w/ short commute	55%	38%	42%	37%
Severe housing cost burden	12%	19%	8%	9%
Youthful labor force	19%	36%	33%	33%
Percent w/o insurance	3%	10%	6%	5%
Median household income	$94,005	$61,576	$87,845	$137,448
Community Index score	701	606	674	683

TABLE 10.19

CI components by location, New Haven County

00901: WATERBURY

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	9%	16%	12%	5%
Percent HS grads	88%	84%	66%	70%
Poverty rate	13%	26%	33%	15%
Workers w/ short commute	68%	62%	70%	58%
Severe housing cost burden	21%	28%	36%	19%
Youthful labor force	25%	28%	29%	32%
Percent w/o insurance	7%	8%	11%	24%
Median household income	$53,631	$39,213	$29,119	$52,634
Community Index score	582	376	315	509

TABLE 10.20

CI components by location, New Haven County

00902: MERIDEN, WALLINGFORD, & NORTH HAVEN

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	11%	7%	2%
Percent HS grads	94%	89%	74%	90%
Poverty rate	5%	20%	17%	4%
Workers w/ short commute	70%	67%	64%	64%
Severe housing cost burden	11%	12%	18%	5%
Youthful labor force	23%	33%	30%	35%
Percent w/o insurance	2%	3%	6%	4%
Median household income	$77,564	$52,917	$48,219	$104,902
Community Index score	732	557	540	785

TABLE 10.21

CI components by location, New Haven County

00903: HAMDEN, ANSONIA, SEYMOUR, DERBY, WOODBRIDGE & BETHANY

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	9%	7%	6%
Percent HS grads	94%	92%	83%	86%
Poverty rate	6%	13%	12%	6%
Workers w/ short commute	63%	65%	65%	57%
Severe housing cost burden	15%	28%	28%	16%
Youthful labor force	22%	26%	29%	39%
Percent w/o insurance	3%	5%	8%	7%
Median household income	$80,511	$54,246	$54,056	$87,250
Community Index score	683	539	544	669

TABLE 10.22

CI components by location, New Haven County

00904: WEST HAVEN, MILFORD & ORANGE

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	7%	9%	9%	3%
Percent HS grads	93%	89%	82%	95%
Poverty rate	6%	13%	14%	11%
Workers w/ short commute	69%	67%	75%	65%
Severe housing cost burden	18%	25%	21%	15%
Youthful labor force	22%	28%	32%	36%
Percent w/o insurance	3%	4%	13%	7%
Median household income	$81,285	$58,585	$54,584	$103,899
Community Index score	691	530	566	743

TABLE 10.23

CI components by location, New Haven County

00905: NEW HAVEN

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	14%	12%	4%
Percent HS grads	93%	85%	72%	96%
Poverty rate	21%	28%	30%	21%
Workers w/ short commute	74%	70%	74%	79%
Severe housing cost burden	23%	34%	32%	34%
Youthful labor force	35%	26%	32%	49%
Percent w/o insurance	5%	5%	17%	9%
Median household income	$57,317	$31,839	$37,348	$57,606
Community Index score	634	360	399	679

TABLE 10.24

CI components by location, New Haven County

00906: EAST HAVEN, BRANFORD, GUILFORD, MADISON & NORTH BRANFORD

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	11%	8%	5%
Percent HS grads	95%	92%	88%	91%
Poverty rate	5%	13%	10%	2%
Workers w/ short commute	68%	59%	77%	62%
Severe housing cost burden	14%	6%	16%	14%
Youthful labor force	19%	33%	33%	20%
Percent w/o insurance	2%	18%	9%	3%
Median household income	$86,914	$56,750	$63,166	$109,375
Community Index score	714	610	649	715

TABLE 10.25

CI components by location, New London County

01100: NEW LONDON COUNTY (NORTH): BOZRAH, COLCHESTER, FRANKLIN, GRISWOLD, LEBANON, LEDYARD, LISBON, MONTVILLE, NORTH STONINGTON, NORWICH, PRESTON, SALEM, SPRAGUE & VOLUNTOWN

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	13%	9%	4%
Percent HS grads	93%	82%	83%	80%
Poverty rate	7%	22%	14%	6%
Workers w/ short commute	63%	70%	58%	74%
Severe housing cost burden	13%	20%	21%	13%
Youthful labor force	24%	32%	34%	28%
Percent w/o insurance	4%	5%	8%	6%
Median household income	$76,754	$55,083	$53,075	$70,100
Community Index score	684	522	526	704

TABLE 10.26

CI components by location, New London County

01101: NEW LONDON COUNTY (SOUTH): NEW LONDON, EAST LYME, GROTON, LYME, OLD LYME, STONINGTON & WATERFORD

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	12%	12%	6%
Percent HS grads	95%	85%	73%	93%
Poverty rate	7%	25%	31%	10%
Workers w/ short commute	80%	81%	80%	71%
Severe housing cost burden	13%	26%	25%	14%
Youthful labor force	20%	32%	30%	32%
Percent w/o insurance	3%	7%	13%	5%
Median household income	$75,935	$42,054	$40,354	$85,402
Community Index score	708	449	412	698

TABLE 10.27

CI components by location, Tolland County

01300: TOLLAND COUNTY

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	5%	7%	8%	4%
Percent HS grads	96%	90%	78%	93%
Poverty rate	6%	19%	16%	10%
Workers w/ short commute	57%	51%	62%	66%
Severe housing cost burden	13%	27%	15%	28%
Youthful labor force	19%	30%	30%	33%
Percent w/o insurance	3%	7%	8%	3%
Median household income	$86,839	$38,281	$77,167	$85,864
Community Index score	690	484	607	682

TABLE 10.28

CI components by location, Windham County

01500: WINDHAM COUNTY

COMPONENTS	WHITE	BLACK	LATINO	ASIAN
Unemployment rate	6%	11%	12%	3%
Percent HS grads	91%	74%	70%	84%
Poverty rate	8%	21%	28%	22%
Workers w/ short commute	60%	62%	66%	71%
Severe housing cost burden	12%	35%	13%	20%
Youthful labor force	24%	24%	31%	29%
Percent w/o insurance	3%	4%	8%	6%
Median household income	$68,163	$40,000	$40,429	$33,725
Community Index score	648	416	398	608

Figure and Table Notes

GENERAL NOTE ON DATAHAVEN COMMUNITY WELLBEING SURVEY

One of the major sources used in this report is the DataHaven Community Wellbeing Survey (CWS). This survey was most recently carried out from March to November 2018, during which 16,000 randomly-selected adults were interviewed, including residents from all 169 towns in Connecticut; the 2015 iteration had a similar sample size and scope. Questions on the CWS are compiled from local, national, and international sources and best practices, and are developed with input from an advisory committee of leading experts in survey research. All reported CWS estimates are weighted in order to accurately represent the underlying adult population within each region, town, or neighborhood. For more information and crosstabs of data, see https://ctdatahaven.org/reports/datahavencommunity-wellbeing-survey.

FIGURE 1. LIFE EXPECTANCY BY FIVE CONNECTICUTS GROUPINGS, 2015

DataHaven analysis (2019) of National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. USALEEP data available at https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html.

Life expectancy is a prediction of the number of years a person born today might expect to live given the mortality rate among all age groups in the area in which they are born. Because of the interrelated nature of health and socioeconomic status, life expectancy can be understood as a measure of health and a measure of social well-being. Regional averages were calculated as population weighted means of available Census tract values.

FIGURE 2. THE FIVE CONNECTICUTS

See notes for Table 1.

FIGURE 3. FOUR-YEAR HIGH SCHOOL GRADUATION RATE, CLASS OF 2017

DataHaven analysis (2019) of enrollment data from the Connecticut State Department of Education, accessed via EdSight at http://edsight.ct.gov.

FIGURE 4. EDUCATIONAL ATTAINMENT, 2018

DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Tables B15003, Educational Attainment for the Population 25 Years and Over; B16010, Educational Attainment and Employment Status by Language Spoken at Home for the Population 25 Years and Over. Available at https://data.census.gov.

DataHaven analysis (2020) of data accessed via IPUMS. Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. IPUMS USA: Version 9.0 2014–2018 ACS 5-year Census microdata. Minneapolis, MN: IPUMS, 2020. https://doi.org/10.18128/D010.V9.0.

FIGURE 5. MEDIAN HOUSEHOLD INCOME BY ANCESTRY OF HEAD OF HOUSEHOLD, 2018

DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata.

FIGURE 6. MEDIAN PERSONAL INCOME BY RACE/ETHNICITY AND SEX, 2018

DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata.

FIGURE 7. POVERTY RATE BY AGE AND RACE, 2018

DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Tables B17020B, B17020D, B17020H, and B17020I, Poverty Status in the Past 12 Months by Age. Available at https://data.census.gov.

FIGURE 8. ADULT SMOKING RATE, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Smoking rates were calculated based on the number of participants who estimated having smoked at least 100 cigarettes in their entire lives; those who said they had were then asked whether they smoked every day, some days, or not at all. Smoking prevalence for the entire population was then extrapolated from these two figures. See Community Wellbeing Survey note at the beginning of this section.

FIGURE 9. FOOD INSECURITY, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Food insecurity is defined as the share of participants reporting that at some point in the past 12 months, they were unable to afford to buy food they needed. See Community Wellbeing Survey note at the beginning of this section.

FIGURE 10. COST-BURDEN BY RACE AND GENDER OF HEAD OF HOUSEHOLD, 2018

DataHaven analysis (2020) of Ruggles et al. American Community Survey 2018 5-year Census microdata.

FIGURE 11. HOUSING INSECURITY AND EVICTIONS, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey respondents were asked whether in the past 12 months, they have not had enough money to provide adequate shelter or housing for themselves or their family. An eviction is when a landlord forces one to move against their will. The eviction question was asked to respondents who did not own a home, previously rented a home, and reported moving residences since 2016. Respondents were asked whether they or a person they were staying with was evicted from the home they moved from. See Community Wellbeing Survey note at the beginning of this section.

FIGURE 12. UNINSURED RATE BY AGE AND RACE/ETHNICITY, 2018

DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Tables C27001B, C27001D, C27001H, C27001I, Health Insurance Coverage by Sex by Age.

FIGURE 13. PUBLIC HEALTH INSURANCE RATE BY AGE AND INCOME, 2018

DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Tables C27017B, C27017D, C27017H, C27017I, Private Health Insurance by Ratio of Income to Poverty Level by Age; and C27018B, C27018D, C27018H, C27018I, Public Health Insurance by Ratio of Income to Poverty Level by Age.

FIGURE 14. PER-PERSON MEDICAL SPENDING, 1991–2014

DataHaven analysis (2019) of Centers for Medicare & Medicaid Services (2017). Health Expenditures by State of Residence. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/resident-state-estimates.zip.

FIGURE 15. MATERNAL MORTALITY RATE BY RACE, 2013–2017

America's Health Rankings analysis of CDC WONDER Online Database, Mortality files, United Health Foundation. Retrieved from https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/maternal_mortality_a/state/CT. These figures represent race without regard to ethnicity, meaning "Black" may include both Non-Hispanic and Hispanic Black individuals.

FIGURE 16. DISCRIMINATION IN HEALTHCARE, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked questions on experiences of discrimination with quality of health care services. If respondents answered that they had been discriminated against, they were then asked to identify the reasons why they thought this happened. Note that respondents were allowed to identify more than one issue. See Community Wellbeing Survey note at the beginning of this section.

FIGURE 17. RATE AND COUNT OF OPIOID-RELATED DEATHS, 2015–2018

DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at https://data.ct.gov/resource/rybz-nyjw.

FIGURE 18. DEPRESSION AND SELF-RATED HEALTH VS. FINANCIAL INSECURITY, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Adult respondents were asked to rate their overall health and report recent levels of depression.

FIGURE 19. CONNECTICUT PUMAS

The Community Index that follows is adapted from the DataHaven Community Index reports (available at ctdatahaven.org/reports), disaggregated to show disparity by race. However, several indicators in the Community Index are not available at the town level disaggregated by race/ethnicity. Therefore, the Community Index here uses an analysis of U.S. Census Bureau public use microdata sample (PUMS) data at the public use microdata areas (PUMAs), the smallest geographic unit for which PUMS data is available. Public use microdata areas (PUMAs) used here are set by the Census Bureau based on population (approximately 100,000 people). The state's largest cities each constitute their own PUMAs, while smaller towns within a county are clustered together to form one PUMA. For more sparsely populated counties, the entire county is one PUMA.

TABLE 1. TOWNS BY FIVE CONNECTICUTS GROUPINGS

The Five Connecticuts is a system used to classify individual towns into one of five categories (Wealthy, Suburban, Rural, Urban Periphery, and Urban Core) based on the median household income, population density, and poverty rate of each town using 2010 Census data. In many cases, results for any individual town in Connecticut will be similar to other towns within its grouping. The original classification system for the Five Connecticuts was developed in: Levy, Don, Orlando Rodriguez, and Wayne Villemez. 2004. The Changing Demographics of Connecticut - 1990 to 2000. Part 2: The Five Connecticuts. Storrs, Connecticut: University of Connecticut, The Connecticut State Data Center, Series, no. OP 2004-01.

TABLE 2. UNEMPLOYMENT AND UNDEREMPLOYMENT, 2018

DataHaven analysis (2020). National and statewide rates are from the U.S. Census Bureau American Community Survey 2012 and 2018 5-year estimates, Table B23025, Employment Status for the Population 16 Years and Over. Available at https://data.census.gov. Data on racial and ancestry groups are from Ruggles et al. American Community Survey 2018 5-year Census microdata. Civilians 16 years old and over are classified as unemployed if they (1) were neither "at work" nor "with a job but not at work" during the reference week, and (2) were actively looking for work during the last 4 weeks, and (3) were available to accept a job. Also included as unemployed are civilians who did not work at all during the reference week, were waiting to be called back to a job from which they had been laid off, and were available for work except for temporary illness.

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Underemployment is calculated as the share of participants not working within the past 30 days but wanting to work, plus the share working part-time but preferring full-time work. See Community Wellbeing Survey note at the beginning of this section.

TABLE 3. OBESITY, DIABETES, AND STROKE RATES

DataHaven analysis (2019). Obesity and diabetes data are from the 2018 DataHaven Community Wellbeing Survey. Participants reported their height and weight, from which their body mass index (BMI) was calculated; obesity in adults is defined as a BMI of 30 or higher. Adult respondents were asked to report whether they had even been told by a doctor or medical professional that they had diabetes. See Community Wellbeing Survey note at the beginning of this section. Data on deaths from stroke are from a DataHaven analysis (2019) of data from the Connecticut Department of Public Health.

TABLE 4. HOUSING AND NEIGHBORHOOD ASSETS, 2018

DataHaven analysis (2020) of U.S. Census Bureau American Community Survey 2018 5-year estimates, Table B25014, Tenure by Occupants Per Room. Available at https://data.census.gov; and DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Participants were asked to give ratings on the condition of local parks, availability of recreation facilities, presence of safe places to bike and safe sidewalks and crosswalks. See Community Wellbeing Survey note at the beginning of this section.

TABLE 5. MEANS-TESTED INSURANCE PROGRAMS, 2019

Summary of eligibility according to Connecticut Medicaid and CHIP Services. Retrieved from https://portal.ct.gov/HUSKY/How-to-Qualify.

TABLE 6. PRESCRIPTION AFFORDABILITY, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey respondents were asked whether in the past 12 months there was any time they needed prescription medicines but did not get them because they could not afford them, and whether altered the way they took prescriptions, because they could not afford to get more. See Community Wellbeing Survey note at the beginning of this section.

TABLE 7. BIRTH OUTCOMES BY RACE

DataHaven analysis (2019) of data from the Connecticut Department of Public Health Vital Statistics, available at https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports. Low birthweight is defined as 2,500 grams (roughly 5.5 pounds). Inadequate prenatal care is defined as attending fewer than 80 percent of scheduled visits or starting prenatal care visits in the second trimester or later.

TABLE 8. REASONS FOR MISSING HEALTH CARE, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked several questions about their access to and use of medical care, including whether at any point in the previous 12 months they postponed or did not receive medical care they needed. A panel of respondents were asked why they postponed or did not receive care. See Community Wellbeing Survey note at the beginning of this section.

TABLE 9. DATAHAVEN COMMUNITY INDEX SCORE BY LOCATION AND RACE/ETHNICITY

DataHaven analysis (2020) of American Community Survey 2018 5-year estimates, Tables B01001, Sex by Age; B08303, Travel Time to Work; B15001, Sex by Age by Educational Attainment for the Population 18 Years and Over; B17001, Poverty Status in the Past 12 Months by Sex by Age; B18135, Age by Disability Status by Health Insurance Coverage Status; B19013, Median Household Income in the Past 12 Months (in 2018 Inflation-Adjusted Dollars); B23025, Employment Status for the Population 16 Years and Over; B25070, Gross Rent as a Percentage of Household Income in the Past 12 Months; B25091, Mortgage Status by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months. Available at https://data.census.gov.

TABLES 10.1–10.28. COMMUNITY INDEX COMPONENTS BY LOCATION

See notes for Table 9 for data references and Figure 19 for geographic references.

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DataHaven is a non-profit organization with a 25-year history of public service to Connecticut. Our mission is to empower people to create thriving communities by collecting and ensuring access to data on well-being, equity, and quality of life. DataHaven is a formal partner of the National Neighborhood Indicators Partnership of the Urban Institute in Washington, DC.

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