# Health Equity in Connecticut 2023

**DataHaven**

# DataHaven
## The Thirtieth Year

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[†] This type of review does not suffice to represent the position of the state concerning the views expressed in this report.

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# Health Equity in Connecticut 2023

**Contents**

# Introduction

This report updates Towards Health Equity in Connecticut: The Role of Social Inequality and the Impact of COVID-19, which DataHaven released in June 2020,[1] during the first wave of data issued relating to the pandemic and its effects. Since then, more information has become available. We now have the latest data from the 2021 and 2022 DataHaven Community Wellbeing Surveys and other datasets, such as the American Community Survey and the 2020 Decennial Census from the United States Census Bureau. New information derived from mortality records in Connecticut and nationwide also help us understand the pandemic's profound public health, social, and economic effects.

The pandemic laid bare the many structural inequalities that lead to poor health and well-being for Black, Latino, urban-dwelling, and low-income populations in Connecticut. These groups were also more likely to hold jobs considered "essential," and therefore less likely to be able to work from home to avoid potentially contracting the coronavirus. The isolation during lockdown and beyond, which took a particular toll on youth and those living alone, renewed focus on the importance of mental health on overall well-being.

This summary report contains a curated list of indicators for audiences to quickly assess major health and related inequities in Connecticut. Many more social and systemic factors contribute to poor health-related, financial, educational, and other outcomes for Black, Latino, low-income, and urban-dwelling populations. For data on inequities in each of the 169 towns in Connecticut, and for broader regions within the state, reports are available for download at ctdatahaven.org/equityreports. **DH**

## Notes on Demographics

In this report, when we refer to Black, white, Asian, or Native American people, we mean non-Latino people. Latino refers to anyone who self-identifies as Latino, regardless of race.

"Vulnerable" or "disadvantaged" groups are defined as those who are potentially subject to higher levels of racism, discrimination, stigma, community disenfranchisement, social isolation, and economic stress, both historically and today. These include Black, Latino, and Native American populations, older adults, women, the LGBTQ+ community, and many other groups. People with intersecting identities within these groups experience compounded structural barriers that have a major influence on their lived experiences.

Standardized data-collection methodologies, smaller population sizes, divergent levels of trust between institutions and communities, and limited resources for data collection make it difficult to find information about these groups. However, we acknowledge that a significant amount of community-held knowledge exists about these groups within Connecticut.

To address these data gaps, several surveys of residents, including the statewide DataHaven Community Wellbeing Survey, now include more questions relating to detailed racial and ethnic identity, place of birth, languages spoken, sexuality and gender identity, disability, experiences of incarceration, and other topics.[2] Although we did not include a complete analysis of conditions impacting each of these groups in this publication, we provide summaries of those data in our other reports. We also provide specific information for grants and programs that focus on supporting these populations, and advocate for data collection improvements that can help paint a more complete picture of the diversity of our state. For more information, visit ctdatahaven.org.

1   Davila, K., Abraham, M., & Seaberry, C. (2020, June 6). *Towards Health Equity in Connecticut*. DataHaven. https://ctdatahaven.org/reports/towards-health-equity-connecticut.

2   See https://ctdatahaven.org/reports/datahaven-community-wellbeing-survey.

# The Rising Cost of Healthcare

Since 2020, a number of factors have contributed to rising costs (inflation), including Russia's invasion of Ukraine, supply chain disruptions, raw material scarcity, and fluctuations in employment. As a result, the Consumer Price Index, a commonly used cost-of-living proxy in the United States, increased by about 17 percent from March 2020 to March 2023.

Healthcare costs are high in Connecticut compared to the United States, and have risen in the past few decades. New England is among the most expensive regions for healthcare in the nation, and Connecticut is frequently in the top 10 states in per capita healthcare expenditures, with costs averaging 25 percent more per person in compared to the national average. In 2020, hospital and physician/clinic visits together comprised more than half of an individual's average annual healthcare spending in Connecticut (SEE FIGURE 1). DH

**FIG 1**

## Hospital, clinic, and doctor visit costs continue to rise while prescription costs stabilize

SELECT PERSONAL HEALTH CARE COSTS IN 2020 DOLLARS, PER CAPITA, CONNECTICUT, 1991–2020
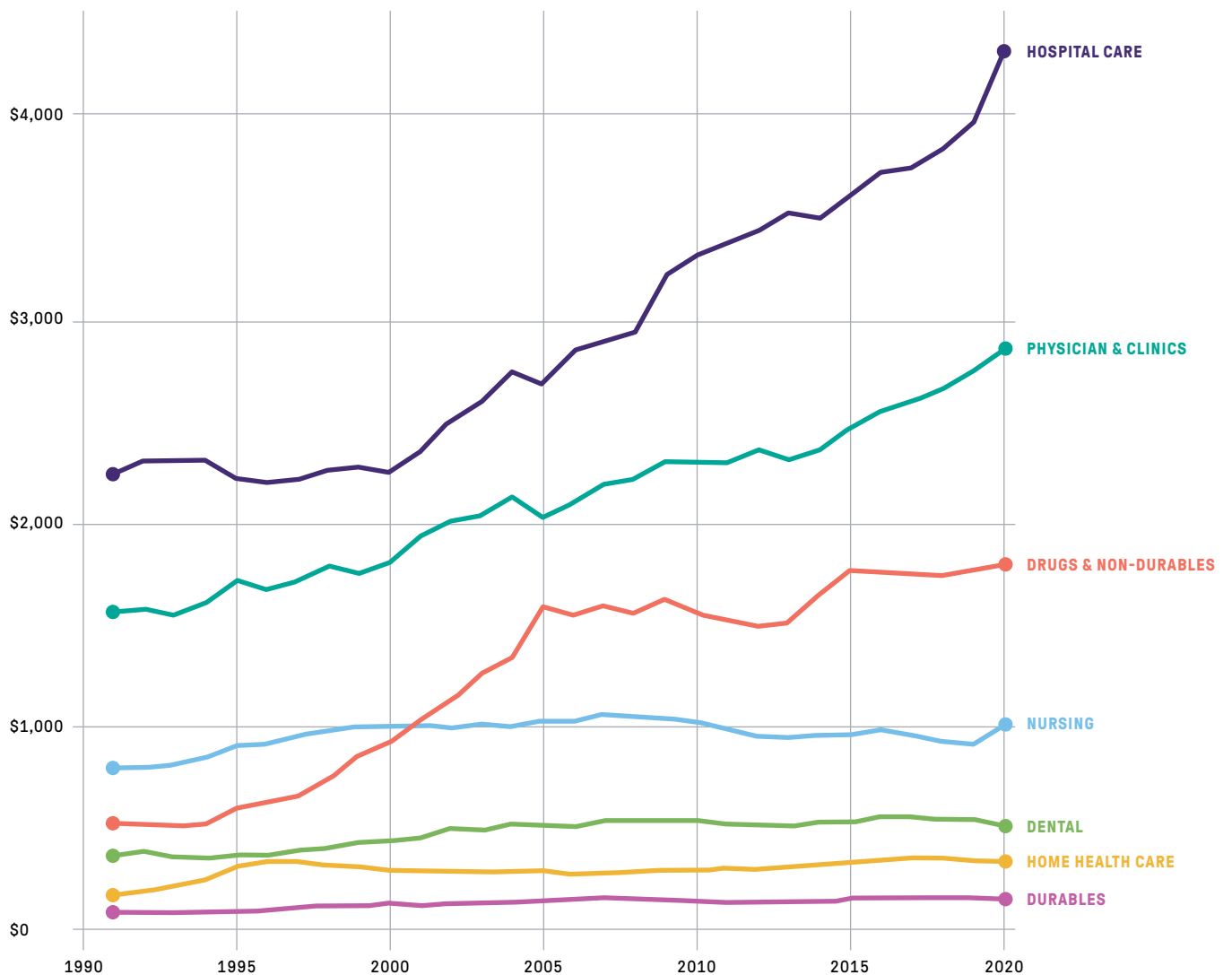
# Barriers to Healthcare

One of the provisions the federal government passed during the pandemic ensured that individuals would not be removed from Medicaid for the duration of the COVID-19 public health emergency. The emergency was allowed to expire at the end of March 2023. Beginning in April 2023, states could disenroll individuals for many factors, including changes to income or employment and out-of-date contact information or paperwork. An estimated 5 million to 14 million people nationwide are expected to be disenrolled in the coming months, including potentially thousands in Connecticut once the process is completed.[3,4]

Lack of health insurance is one of many structural barriers that prevent individuals from seeking timely or preventive healthcare, especially for low-income adults, adults ages 18 to 64, those with limited English proficiency, immigrants, and Black and Latino residents. Many preventable factors can create barriers to financial stability and reliable access to resources, such as high unemployment, legacies of exclusionary regulations, and complex bureaucratic processes required to apply for and receive resource assistance. As a result, we also find elevated rates of financial and food insecurity among these groups.

Barriers to resources are often treated as problems with meeting personal needs—for example, an individual in need of Medicaid, food stamps, or rental assistance. However, these issues reflect problems at the social scale. A body of new scholarship calls for reorienting health barriers as social rather than individual challenges.[5] By implementing broad public policies that ameliorate these problems— such as expanding and simplifying subsidies for health insurance premiums, adequately funding food and nutrition assistance programs, and raising minimum wages to livable levels while also maintaining those wage increases along with inflation—health policy can be refocused as a truly public practice.

In addition to facing the high costs of healthcare (SEE FIGURE 1), some individuals feel like they are not treated as well as others or that their concerns are not taken seriously in healthcare settings. Several reasons are offered for this, including a person's race, gender identity, age, or insurance status. Between 15 and 20 percent of Black adults, low-income adults, and adults living in Hartford and New Haven have experienced some sort of discrimination in a healthcare setting recently. Poor experiences with providers are linked to a lower willingness to seek medical care, potentially leading those who need care to delay or skip necessary treatments altogether. These experiences are often compounded with other preventable barriers to access, such as a lack of transportation. About one in five low-income and Latino adults reported that they didn't get the medical care they needed at some point in the past year. More than 40 percent of low-income adults, as well as adults living in Waterbury, said they had not seen a dentist in a year or more (SEE FIGURE 2). **DH**

3    Tolbert, J. & Ammula, M. (2023, April 5). *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*. Kaiser Family Foundation. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision.

4    Srinivasan, S. (2023, February 7). *Thousands in Connecticut are expected to lose Medicaid coverage unless they act soon*. Connecticut Public Radio. https://www.ctpublic.org/news/2023-02-07/thousands-in-connecticut-are-expected-to-lose-medicaid-coverage-unless-they-act-soon.

5    Brown, T.H. & Homan, P. (2022, May 6). The future of social determinants of health: Looking upstream to structural drivers. *The Milbank Quarterly, 101*(S1), 36-60. https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.12641.

## How To Understand Table Color Coding In This Report

MUCH BETTER THAN STATE AVG.

BETTER THAN STATE AVG.

SIMILAR TO STATE AVG.

WORSE THAN STATE AVG.

MUCH WORSE THAN STATE AVG.

Many tables in this report are presented with color coding, from dark blue to orange. Each color corresponds to standard deviations from the state average. Additionally, a dashed vertical line in each column represents the state average for a given indicator.

## Black, Latino, and low-income adults face greater than average barriers to good health and healthcare

SHARE OF ADULTS, 2021

| | JUST GETTING BY | FOOD INSECURE | TREATED UNFAIRLY IN HEALTHCARE SETTING | DIDN'T GET NECESSARY CARE IN PAST YEAR | NO DENTIST VISIT IN PAST YEAR |
|---|---|---|---|---|---|
| Connecticut | 26% | 11% | 10% | 11% | 28% |
| Male | 23% | 8% | 8% | 10% | 31% |
| Female | 30% | 14% | 13% | 12% | 29% |
| Age 18–34 | 31% | 17% | 14% | 15% | 35% |
| Age 35–49 | 28% | 13% | 13% | 12% | 29% |
| Age 50–64 | 29% | 11% | 11% | 11% | 27% |
| Age 65+ | 19% | 4% | 4% | 7% | 26% |
| White | 22% | 8% | 8% | 9% | 27% |
| Black | 41% | 20% | 18% | 11% | 35% |
| Latino | 38% | 22% | 14% | 19% | 33% |
| Under $30K | 57% | 28% | 16% | 18% | 44% |
| $30K-$100K | 29% | 12% | 12% | 12% | 31% |
| $100K+ | 9% | 2% | 6% | 8% | 19% |
| Suburban | 19% | 8% | 8% | 11% | 24% |
| Rural | 23% | 8% | 9% | 10% | 29% |
| Bridgeport | 48% | 26% | 12% | 13% | 36% |
| Hartford | 42% | 26% | 17% | 16% | 29% |
| New Haven | 34% | 15% | 15% | 13% | 39% |
| Stamford | 29% | 16% | 11% | 16% | 28% |
| Waterbury | 45% | 18% | 12% | 14% | 41% |

LEGEND

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# Health Risks

Health risks are medical, environmental, or behavioral complications that contribute to other health concerns. These are often preventable. Asthma, for example, can be environmentally induced by pollutants, contaminants, or poor housing conditions. Once asthma develops, respiratory issues like bronchitis and even minor issues such as allergies can become more severe, requiring more intensive healthcare. In Connecticut, residents in areas with older housing stock, and especially people of color in those areas, are more likely to be exposed to conditions that result in developing asthma.[6] Adults in Hartford are nearly twice as likely as adults in suburban areas to say they currently have asthma. As the global climate changes, and with it local weather patterns, rates of asthma are likely to remain high.

Tobacco use, is a risky behavior with a well-established connection to reduced immune response, heart and lung disease, cancer, and premature death. Great strides have been made in reducing the smoking rate in the overall population, but smoking remains concentrated among lower-income and urban-dwelling populations. In Connecticut, adults earning less than $30,000 per year are three times more likely to be smokers than adults earning $100,000 or more. This is partially due to a legacy of tobacco companies concentrating advertisements and discounting products in low-income communities, as well as policymakers failing to adequately regulate these practices.[7] Since low-income populations are less likely to receive healthcare when they need to (SEE FIGURE 2), and in many cases also lack a primary care physician, they may not have access to therapeutics that help tobacco users quit.

Unlike smoking, obesity in the United States and Connecticut has worsened over time.[8] The reasons for this are various, vague, and complex, attributable to genetic, behavioral, and medical reasons. To be clear, body mass index (BMI) alone does not indicate whether a person is healthy or unhealthy, but BMI over 30 is often associated with poor health outcomes, especially related to heart and kidney health.[9,10] Several factors are also believed to contribute to obesity. These include subsidies on less nutritious food, pesticides and contaminants used in commercial farming, ultra processing of food products, and the prevalence of fast food and lack of grocery stores in low-income areas.[11] Black, Latino, and Native American residents, and people living in urban areas, are more often affected by these conditions than wealthier, white, suburban and rural residents. Statewide, 73 percent of adults feel there is good availability of affordable, high-quality produce in their area, but this share ranges from 90 percent in many wealthy suburbs to less than 50 percent in urban cities such as Hartford.[12]

Finally, depression and anxiety create risks for developing other health conditions. These factors have been linked to lower immune response, cardiovascular episodes like stroke and heart attack, diabetes, asthma, and risk for suicide, especially gun-related suicide.[13,14,15] It is normal to occasionally feel depressed or anxious. But chronically experiencing these feelings can indicate underlying health issues that may be caused by unresolved trauma, discrimination, or environmental quality, or the prolonged stress that accompanies unemployment, unstable housing, or financial insecurity. Statewide, low-income adults report feeling chronically depressed at five times the rate of high-income adults; Black and Latino adults report chronic depressive symptoms at more than 1.3 times the rate of white adults; and adults under 35 at twice the rate of adults 65 and older. Nearly one in five adults in Hartford reported feeling depressed or anxious, double the rate of adults living in rural areas of Connecticut (SEE FIGURE 3). DH

6    Samuels, E.A., Taylor, R.A., Pendyal, A., Shojaee, A., Mainardi, A.S., Lemire, E.R., Venkatesh, A.K., Bernstein, S.L., & Haber, A.L. (2022, August 18). Mapping emergency department asthma visits to identify poor-quality housing in New Haven, CT, USA: A retrospective cohort study. *Lancet Public Health 7*(8), e694-e704. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9387147/.

7    *Tobacco Industry Marketing.* (2021, May 14). Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm.

8    Fryar, C.D., Carroll, M.D., & Afful, J. (2020, December). *Prevalence of overweight, obesity, and severe obesity among adults aged 20 and over: United States, 1960–1962 through 2017–2018.* National Center for Health Statistics. https://www.cdc.gov/nchs/data/hestat/obesity-adult-17-18/overweight-obesity-adults-H.pdf.

9    Held, C., Hadziosmanovic, N., Aylward, P. E., Hagstrom, E., Hochman, J. S., Stewart, R. A. H., White, H. D., & Wallentin, L. (2022, January 22). Body mass index and association with cardiovascular outcomes in patients with stable coronary heart disease – A STABILITY substudy. *Journal of the American Heart Association, 11*(3). https://www.ahajournals.org/doi/10.1161/JAHA.121.023667.

10   Herrington, W.G., Smith, M., Bankhead, C., Matsushita, K., Stevens, S., Holt, T., Hobbs, F.D., Coresh, J., & Woodward M. (2017, March 8). Body-mass index and risk of advanced chronic kidney disease: Prospective analyses from a primary care cohort of 1.4 million adults in England. *PLoS One.* https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0173515. Notably, people with BMI under 20 are also at risk.

11   *What Causes Obesity?* (2023, January 25). Cancer Research UK. https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/obesity-weight-and-cancer/what-causes-obesity
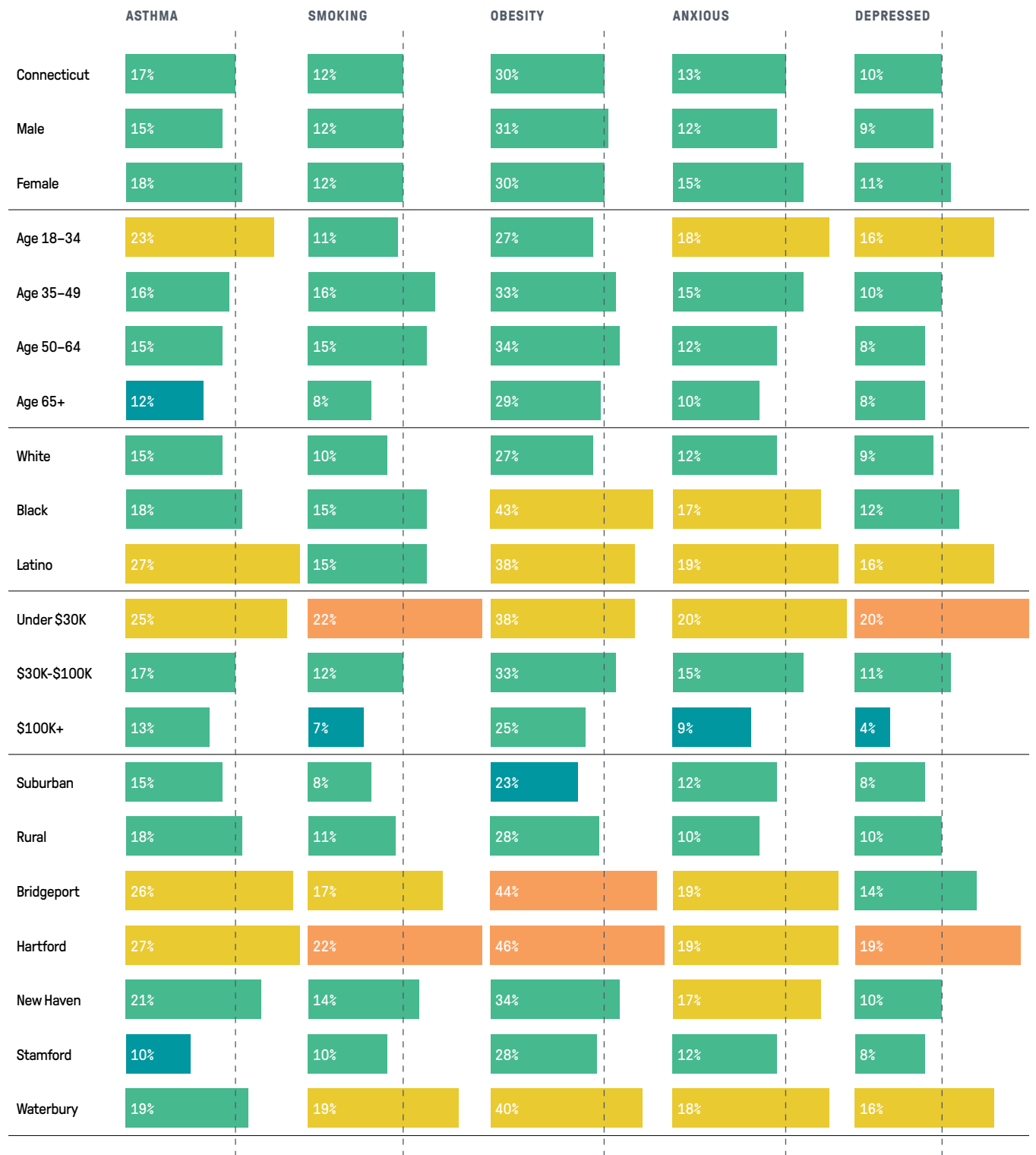
12   DataHaven analysis (2023) of data from the 2022 DataHaven Community Wellbeing Survey.

## Adults in Bridgeport and Hartford may be at elevated risk for poor health outcomes

SHARE OF ADULTS, 2021

| | ASTHMA | SMOKING | OBESITY | ANXIOUS | DEPRESSED |
|---|---|---|---|---|---|
| Connecticut | 17% | 12% | 30% | 13% | 10% |
| Male | 15% | 12% | 31% | 12% | 9% |
| Female | 18% | 12% | 30% | 15% | 11% |
| Age 18–34 | 23% | 11% | 27% | 18% | 16% |
| Age 35–49 | 16% | 16% | 33% | 15% | 10% |
| Age 50–64 | 15% | 15% | 34% | 12% | 8% |
| Age 65+ | 12% | 8% | 29% | 10% | 8% |
| White | 15% | 10% | 27% | 12% | 9% |
| Black | 18% | 15% | 43% | 17% | 12% |
| Latino | 27% | 15% | 38% | 19% | 16% |
| Under $30K | 25% | 22% | 38% | 20% | 20% |
| $30K-$100K | 17% | 12% | 33% | 15% | 11% |
| $100K+ | 13% | 7% | 25% | 9% | 4% |
| Suburban | 15% | 8% | 23% | 12% | 8% |
| Rural | 18% | 11% | 28% | 10% | 10% |
| Bridgeport | 26% | 17% | 44% | 19% | 14% |
| Hartford | 27% | 22% | 46% | 19% | 19% |
| New Haven | 21% | 14% | 34% | 17% | 10% |
| Stamford | 10% | 10% | 28% | 12% | 8% |
| Waterbury | 19% | 19% | 40% | 18% | 16% |

LEGEND

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# Birth Outcomes

A society's wellness is often reflected in birth outcomes, and unfortunately the United States lags woefully behind peer nations in terms of maternal and infant health. As with many health outcomes, averages in these measures obscure disparities by race, ethnicity, and geography—and excess and disparate mortality in this regard are largely preventable.

Prenatal care is an important head start for every baby's health and is crucial for monitoring the health of every parent giving birth, yet babies born to white or suburban parents are more likely to receive timely, adequate prenatal care than babies born to Black, Latino, or urban parents. While this disparity is caused in part by discrimination, lack of financial or healthcare resources, or inability to keep appointments due to work or other commitments, it also reflects a failure on behalf of healthcare systems to make this care affordable, accessible, and equitably administered across all pregnancies. Incomplete prenatal care can result in a number of complications, including low-weight births (which require additional specialized and intensive medical care) and higher mortality for fetuses, infants, and parents giving birth.

Fetal mortality is more than twice as high—and infant mortality three times as high—for Black babies than white babies in Connecticut. Similarly, nationwide, maternal mortality is 2.6 times higher for Black parents than white parents (52.0 deaths per 100,000 live births compared to 20.1).[16] In Connecticut, the overall maternal mortality rate is 24.9 per 100,000 live births and has risen in the past several years.[17,18]

Regarding maternal mortality, data have demonstrated a failure of the healthcare system to treat patients with equal levels of care and compassion, and Black women in particular bear the worst outcomes as a result. For decades, anecdotal stories shared between families and friends have revealed how the structural and intersectional subordination of being both Black and a woman have affected birthing experiences and outcomes,[19] and new research has provided more evidence for these claims. Recent analysis has discovered through linked administrative datasets that wealthy Black women have worse birth outcomes than poor white women.[20] This means that money and access to medical care alone are not the only drivers of healthy birth outcomes; race also plays a critical role. Reasons for this include entrenched legacies of racism present in factors ranging from neighborhood development, employment, and environmental determinants to the stress of ongoing and generational racism. Together, these factors contribute to poor health outcomes for Black women and babies nationally and in Connecticut (SEE FIGURE 4). DH
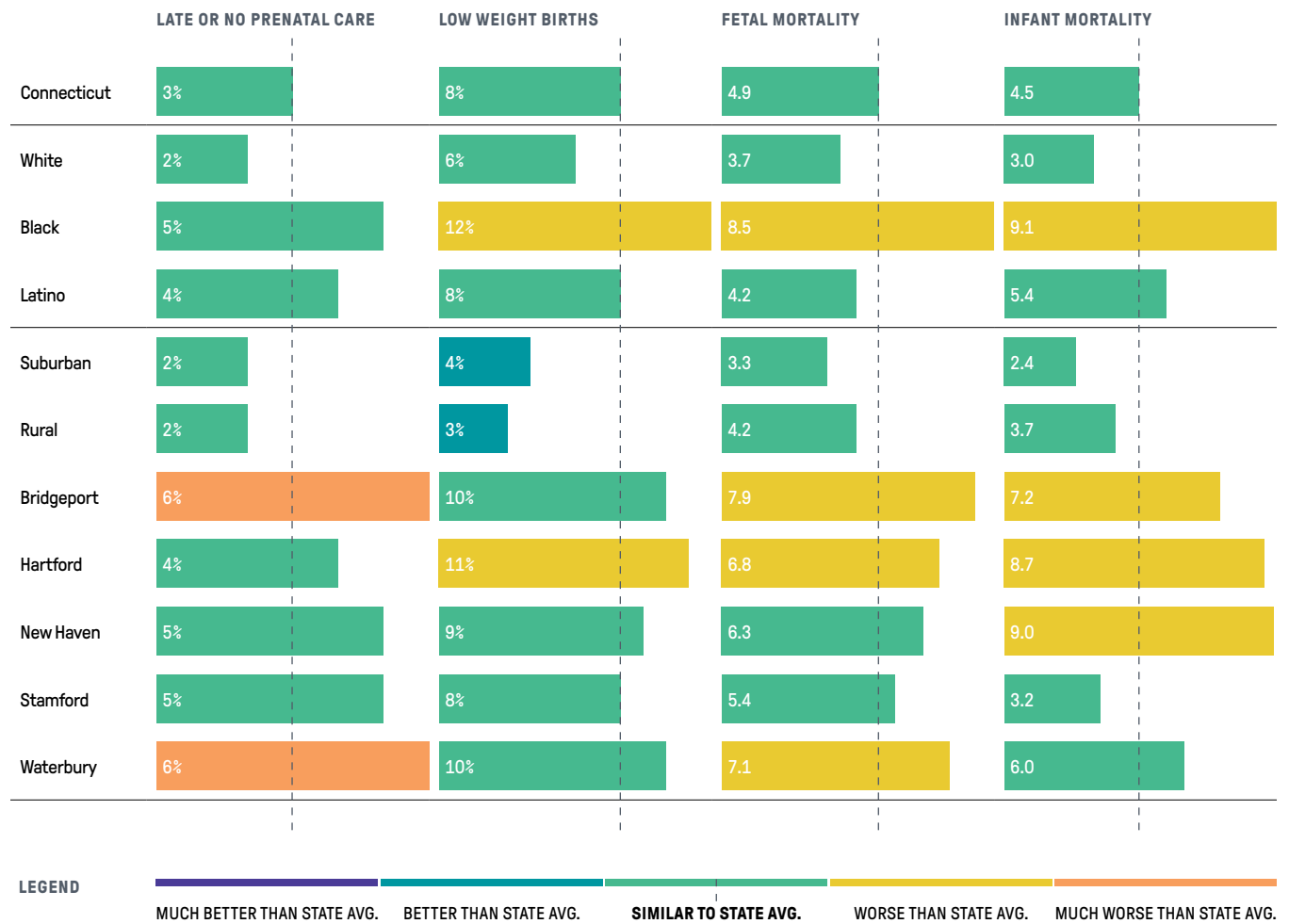
13   Cañas-González, B., Fernández-Nistal, A., Ramírez, J.M., & Martínez-Ferenández, V. influence of stress and depression on the immune system in patients evaluated in an anti-aging unit. *Frontiers in Psychology, 11*, 1844. https://doi.org/10.3389/fpsyg.2020.01844.

14   Scott, K.M., Lim, C., Al-Hamzawi, A., Alonso, J., Bruffaerts, R., Caldas-de-Almeida, J. M., Florescu, S., de Girolamo, G., Hu, C., de Jonge, P., Kawakami, N., Medina-Mora, M. E., Moskalewicz, J., Navarro-Mateu, F., O'Neill, S., Piazza, M., Posada-Villa, J., Torres, Y., & Kessler, R. C. (2016). Association of mental disorders with subsequent chronic physical conditions: World mental health surveys from 17 countries. *JAMA Psychiatry, 73*(2),150–158. https://doi.org/10.1001/ jamapsychiatry.2015.2688.

15   Li, Z., Page, A., Martin, G., & Taylor, R. (2010, November 24). Attributable risk of psychiatric and socio-economic factors for suicide from individual- level, population-based studies: a systematic review. Zhuoyang Li, Andrew Page, Graham Martin, Richard Taylor. (2010, November 24). *Social science & medicine (1982), 72*(4), 608–616. https://doi.org/10.1016/j.socscimed.2010.11.008.

16   *Maternal Mortality in the United States*. America's Health Rankings. Retrieved July 3, 2023. https://www.americashealthrankings.org/explore/measures/maternal_mortality_c?population=mmr_black.

17   Disaggregations by race/ethnicity for Connecticut are not available due to low counts for non-white parents. This may be due to underreporting or incorrect reporting. See Fleszar, L.G., Bryant, A.S., & Johnson, C.O. (2023, July 3). Trends in state-level maternal mortality by racial and ethnic group in the United States. *Journal of the American Medical Association, 330*(1), 52-61. https://jamanetwork.com/journals/jama/article-abstract/2806661.

18   Hoyert, D.L. (2023, March 16). *Maternal Mortality Rates in the United States, 2021*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/hestat/maternal-mortality/2021/maternal-mortality-rates-2021.htm.

19   Villarosa, L. (2018, April 11). *Why America's Black mothers and babies are in a life-or-death crisis*. New York Times Magazine. https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

20   Kennedy-Moulton, K., Miller, S., Persson, P., Rossin-Slater, M., Wherry, L. & Aldana, G. (2022, November). Maternal and infant health inequality: new evidence from linked administrative data. *National Bureau of Economic Research*. https://www.nber.org/system/files/working_papers/w30693/w30693.pdf.

**FIG 4**

## Black parents have worse outcomes in pregnancy and childbirth

PERCENTAGES: SHARE OF LIVE BIRTHS. RATES: PER THOUSAND LIVE BIRTHS. 2017-2021, POOLED.

| | LATE OR NO PRENATAL CARE | LOW WEIGHT BIRTHS | FETAL MORTALITY | INFANT MORTALITY |
|---|---|---|---|---|
| Connecticut | 3% | 8% | 4.9 | 4.5 |
| White | 2% | 6% | 3.7 | 3.0 |
| Black | 5% | 12% | 8.5 | 9.1 |
| Latino | 4% | 8% | 4.2 | 5.4 |
| Suburban | 2% | 4% | 3.3 | 2.4 |
| Rural | 2% | 3% | 4.2 | 3.7 |
| Bridgeport | 6% | 10% | 7.9 | 7.2 |
| Hartford | 4% | 11% | 6.8 | 8.7 |
| New Haven | 5% | 9% | 6.3 | 9.0 |
| Stamford | 5% | 8% | 5.4 | 3.2 |
| Waterbury | 6% | 10% | 7.1 | 6.0 |

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# Age-Adjusted Mortality

Mortality rates measure deaths by a certain cause, or overall (SEE FIGURE 11), per population. Individual mortality records can be summarized for specific demographic categories and geographic areas, allowing us to compare how the occurrence of deaths varies across groups after adjusting for population size and age distributions. Figure 5 summarizes some of the major causes of death in Connecticut, including those with disparate effects on particular populations.

Heart disease and cancer are two of the leading causes of death statewide and nationwide.[21] These are often attributed to preventable risks related to smoking and low levels of physical activity; prior cardiovascular, respiratory, or other medical complications; and limited access to healthcare or health resources. For example, Black adults ages 50 to 64 are twice as likely to report having hypertension compared to white adults in the same age range.[22] Black people have elevated mortality rates due to heart disease and cancer compared to white people, as do people in urban areas compared to the state average. Chronic kidney disease (CKD) also disproportionately affects the Black population in Connecticut, whose mortality rate from CKD is more than twice the rate of the white population. More than a quarter of Black adults ages 50 to 64 report having diabetes, compared to about one in ten white adults in the same age range.[23]

COVID-19 was one of the leading causes of death nationally in 2020 and 2021.[24] Research has shown that Black and Latino populations were disproportionately affected nationwide and in Connecticut for a number of reasons, ranging from higher initial risk of exposure and lower vaccine uptake to prior underlying medical conditions that were severely complicated by contracting the coronavirus.[25,26,27] Mortality due to COVID-19 was more than twice as high for Black residents of Connecticut compared to white residents, and about twice as high for residents of urban areas compared to suburban areas. Within urban areas of Connecticut, even white residents had worse COVID-related mortality than the statewide white population. COVID-related mortality rates for white Bridgeport residents were 1.6 times higher and for white Hartford residents 2.4 times higher than statewide white population rates.[28]

Fatal overdoses also hit an historic high statewide and nationwide in 2021.[29] Although fatal overdoses happen in every town in Connecticut, many are concentrated in urban areas, with overdose mortality rates about 2.5 times higher in Hartford and Waterbury compared to the state average, and nearly 7 times higher than the average in Stamford (SEE FIGURE 5). Fentanyl is a major driver of increasing overdose fatality in the state. In 2014, fentanyl was present in about 14 percent of fatal overdoses statewide. By 2022, that share was 85 percent.[30] **DH**

21 *Leading causes of death*. (2023, January 23). Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm.

22 DataHaven analysis of data from the DataHaven Community Wellbeing Surveys 2015, 2018, and 2021, pooled.

23 Ibid.

24 Shiels, M.S. (2022, July 5). *COVID-19 was the third leading cause of death in the United States in both 2020 and 2021*. U.S Department of Health & Human Services. https://www.nih.gov/news-events/news-releases/COVID-19-was-third-leading-cause-death-united-states-both-2020-2021.

25 Ndugga, N., Hill, L., & Artiga, S. (2022, November 17). *COVID-19 cases and deaths, vaccinations, and treatments by race/ethnicity as of 2022*. Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/issue-brief/COVID-19-cases-and-deaths-vaccinations-and-treatments-by-race-ethnicity-as-of-fall-2022/.

26 For analysis in the three major regions of Connecticut (Fairfield County, Greater Hartford, and Greater New Haven), see the 2023 Community Wellbeing Index reports for those areas at https://ctdatahaven.org/reports. For analysis on other Connecticut regions, contact DataHaven.

27 DataHaven analysis (2023) of data from the Connecticut Department of Public Health.
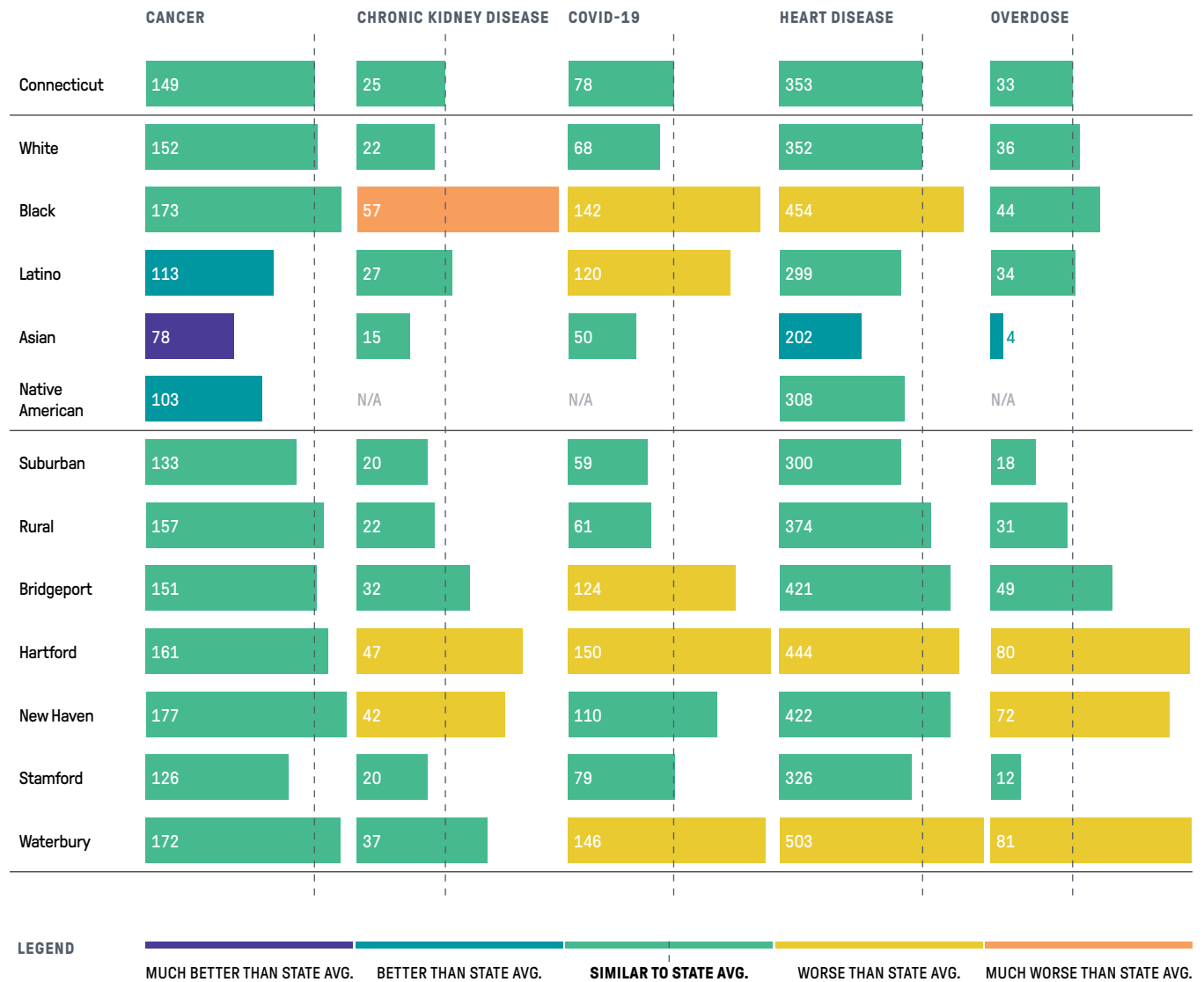
28 See footnote 25.

29 DataHaven analysis (2022) of data from the Centers for Disease Control and Prevention (2022). Provisional drug overdose death counts. Retrieved July 3, 2023 form https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm.

30 See notes for Figure 5

**FIG 5**

# Black residents have much higher than average mortality due to chronic kidney disease, while residents of urban areas suffer higher mortality across a variety of causes.

ANNUAL AVERAGE, AGE-ADJUSTED RATES PER 100,000, 2017-2022. COVID-19 IS ANNUALIZED SINCE 2020.

| | CANCER | CHRONIC KIDNEY DISEASE | COVID-19 | HEART DISEASE | OVERDOSE |
|---|---|---|---|---|---|
| Connecticut | 149 | 25 | 78 | 353 | 33 |
| White | 152 | 22 | 68 | 352 | 36 |
| Black | 173 | 57 | 142 | 454 | 44 |
| Latino | 113 | 27 | 120 | 299 | 34 |
| Asian | 78 | 15 | 50 | 202 | 4 |
| Native American | 103 | N/A | N/A | 308 | N/A |
| Suburban | 133 | 20 | 59 | 300 | 18 |
| Rural | 157 | 22 | 61 | 374 | 31 |
| Bridgeport | 151 | 32 | 124 | 421 | 49 |
| Hartford | 161 | 47 | 150 | 444 | 80 |
| New Haven | 177 | 42 | 110 | 422 | 72 |
| Stamford | 126 | 20 | 79 | 326 | 12 |
| Waterbury | 172 | 37 | 146 | 503 | 81 |

**LEGEND**

MUCH BETTER THAN STATE AVG.    BETTER THAN STATE AVG.    **SIMILAR TO STATE AVG.**    WORSE THAN STATE AVG.    MUCH WORSE THAN STATE AVG.

# Focus: Gun-Related Deaths

Gun-related deaths and gun violence have roots in several factors, but the mortality and injury burden are only a part of the massive effect on our state's overall health. In 2022, 15 percent of adults in Connecticut reported being afraid of gun violence, but these values ranged from 5 percent in suburban areas to 42 percent in the state's large cities.[31]

Where a person lives and grows up, including housing and environmental quality, can be affected by the presence of gun violence.[32] The ways individuals cope with these external factors have a complex interrelationship with other aspects of their physical and mental health, as well as their relationships with guns and gun violence later in life.

The economic impact of gun violence in the United States has been estimated at hundreds of billions of dollars per year, of which the government—and thereby the public—takes on as much as half the costs, which begin with first responders and proceed through medical treatments and ongoing social support intended to help survivors of gun violence.[33,34] Experiencing gun-related trauma, including being present at a shooting, or having a family member hurt by a firearm, is linked with a higher likelihood of complications from depression, anxiety, and post-traumatic stress disorder, especially among children.[35] One study found that teens who lived within a few blocks of the site of a shooting were more likely to utilize an emergency department for a mental health-related reason.[36] Another found a connection between the proximity of a police-involved shooting and diminished educational outcomes among high school students of color in what is believed to be a post-traumatic response to police brutality.[37]

31  DataHaven analysis (2023) of data from the 2022 DataHaven Community Wellbeing Survey.

32  South, E.C., Macdonald, J.M., & Tam, V.W. (2022, October 5). Effect of abandoned housing interventions on gun violence, perceptions of safety, and substance use in black neighborhoods. *JAMA Internal Medicine, 183*(1), 31-39. https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2799226. A study assessing this phenomenon in New Haven is planned. See Otte, E. (2023, February 27). *Researchers target housing in pilot program to reduce gun violence.* Connecticut Examiner. https://ctexaminer.com/2023/02/27/researchers-target-housing-in-pilot-program-to-reduce-gun-violence/.

33  *The economic cost of gun violence.* (2022, July 19). Everytown Support Fund. https://everytownresearch.org/report/the-economic-cost-of-gun-violence/.

34  Hansen, A.J (2019, January 23). *Costs of gun-related hospitalizations, readmissions examined in study.* Scope. https://scopeblog.stanford.edu/2019/01/23/costs-of-gun-related-hospitalizations-readmissions-examined-in-study/.

35  Ranney, M., Kard, R., Ehrlich, P., Bromwich, K., Cunningham, R., & Beidas, R.S. (2019, August 1). What are the long-term consequences of youth exposure to firearm injury, and how do we prevent them? A scoping review. *Journal of Behavioral Medicine 42*(4), 724-740. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8321509/

36  Vasan A., Mitchell H.K., Fein J.A., Buckler D.G., Wiebe D.J., & South E.C. (2021, September 20). Association of neighborhood gun violence with mental health–related pediatric emergency department utilization. *JAMA Pediatrics 175*(12), 1244-1251. https://jamanetwork.com/journals/jamapediatrics/article-abstract/2784065.

37  Ang, D (2021, February). The effects of police violence on inner-city students. *Quarterly Journal of Economics 136*(1), 115-168. https://scholar.harvard.edu/files/ang/files/PoliceViolence_Ang.pdf.

**FIG 6**

## Generally, gun-related suicides outpace homicides in Connecticut

NUMBER OF GUN-RELATED DEATHS BY TYPE, 2010-2022
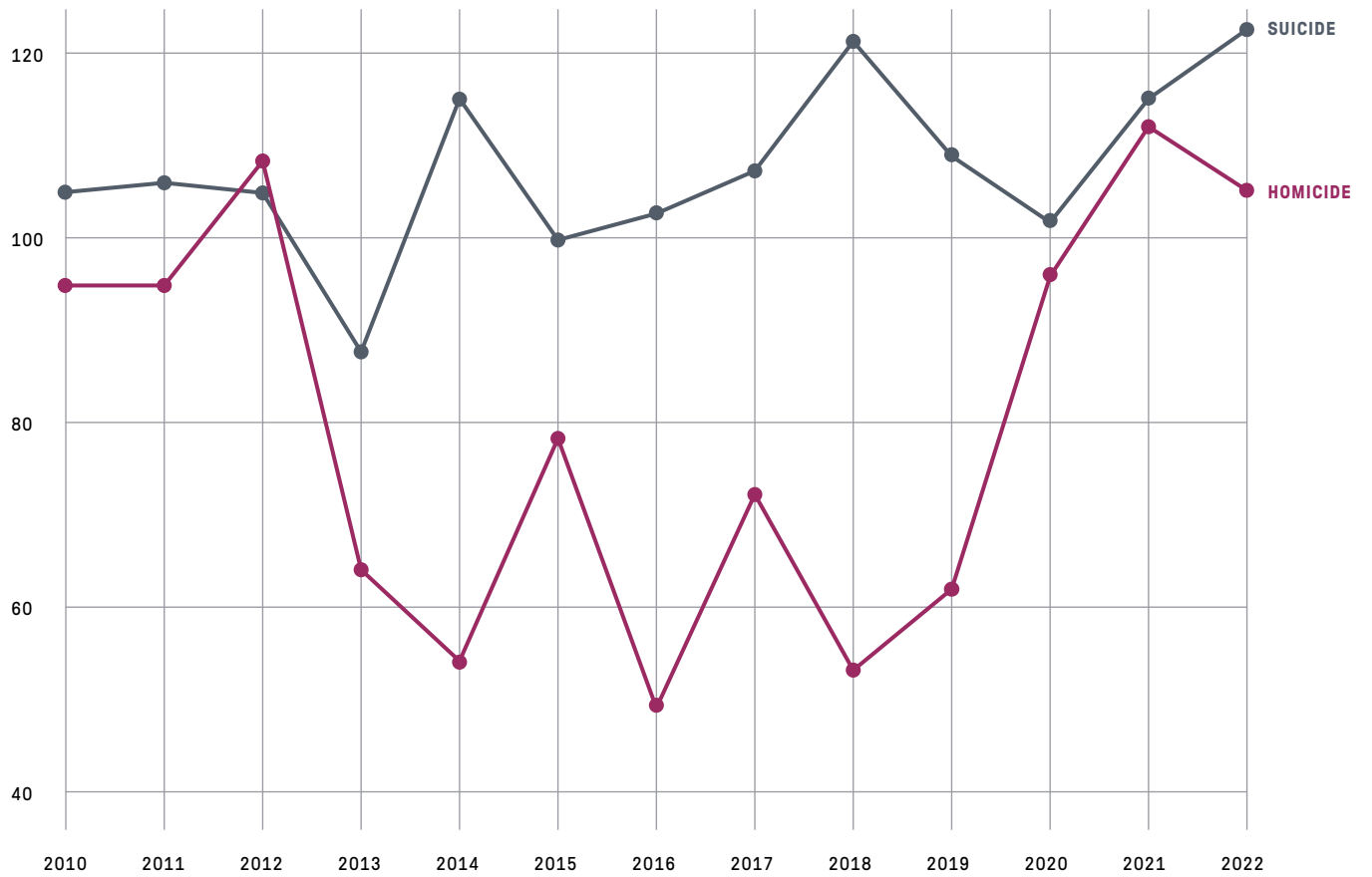
Mass shootings in particular make up a small portion of gun violence nationwide, but they have an enormous impact on society in the form of media coverage, political climate, and—most notably—mental health. Reported motivations for mass shootings have included racism, anti-LQBTQ+ sentiment, anti-semitism, and other violent intolerance. This has led members of these targeted groups to experience increases in anxiety and declines in perceived safety.

Increasingly, schools are the sites of mass shootings. This includes one of the deadliest school shootings in United States history at Sandy Hook Elementary in Newtown, Connecticut in 2012. Dozens more school shootings have occurred nationwide. A national poll conducted in 2019 found that a majority of teens and parents of students were worried about school shootings.[38] A 2019 survey found that 71 percent of adults in the United States reported mass shootings as their top source of stress.[39] A review of literature on mass shootings identified a trend in the incidence of adverse psychological outcomes (including post-traumatic stress and depression) in the wake of mass shootings in America.[40] When these events are covered in the media, even people who are not directly affected by mass shootings but who follow reporting on them feel increasing distress—an example of collective trauma.[41]

Access to firearms is linked to higher firearm-related injury and death.[42,43] Gun restrictions enacted after Sandy Hook led to Connecticut having some of the most stringent gun laws in the nation. Despite these restrictions, the distributions of gun deaths by type are nearly the same as those in the United States (SEE FIGURE 7), with just over half of all gun deaths attributed to suicide, 40 percent to homicide, and under 5 percent attributed to other causes including police shootings and gun-related accidents.

Gun-related deaths are now the top cause of death among children in the United States, eclipsing motor vehicle crashes and pediatric cancers.[44] The same holds true in Connecticut. However, gun-related mortality rates in Connecticut—including areas in Connecticut with the highest gun-related mortality—are still lower than the rate for the United States (SEE FIGURES 9 AND 10).

38  Graf, N. (2018, Apr. 18). *A majority of U.S. teens fear a shooting could happen at their school, and most parents share their concern.* Pew Research Center. https://www.pewresearch.org/short-reads/2018/04/18/a-majority-of-u-s-teens-fear-a-shooting-could-happen-at-their-school-and-most-parents-share-their-concern/.

39  American Psychological Association. (2019). Stress in America: *Stress and current events.*

40  Lowe, S. R., & Galea, S. (2016, Jun. 21). The mental health consequences of mass shootings. *Trauma, Violence, & Abuse, 18*(1), 62–82. https://doi.org/10.1177/1524838015591572.

41  Thompson, R.R., Jones, N.M., Holman, E.A., and Silver, R.C. (2019, Apr. 17). Media exposure to mass violence events can fuel a cycle of distress. *Science Advances, 5*(4). https://www.science.org/doi/10.1126/sciadv.aav3502.

42  Saunders, H. (2022, July 18). *Do states with easier access to guns have more suicide deaths by firearm?* Kaiser Family Foundation. https://www.kff.org/other/issue-brief/do-states-with-easier-access-to-guns-have-more-suicide-deaths-by-firearm/.

43  Kang, M., & Rasich, E. (2023, May 19). *Extending firearm suicide proxy for household gun ownership.* Social Science Research Network. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4453698.

44  Choi, A. (2023, March 29). *Children and teens are more likely to die by guns than anything else.* CNN. https://www.cnn.com/2023/03/29/health/us-children-gun-deaths-dg/index.html.

FIG 7

# Gun deaths by type

## TOTAL NUMBER AND SHARE OF DEATHS, CONNECTICUT AND UNITED STATES, 2018–2021

| AREA | HOMICIDE | SUICIDE | OTHER | TOTAL FIREARM DEATHS |
|---|---|---|---|---|
| United States | 68,714 | 98,993 | 5,792 | 173,499 |
| | 40% | 57% | 3% | 100% |
| Connecticut | 323 | 447 | 24 | 794 |
| | 41% | 56% | 3% | 100% |

The majority of gun deaths are suicides, not homicides (SEE FIGURE 6). White men comprise a significant majority of the victims of gun-related suicide, while Black men are usually the victims of gun-related homicide. In Connecticut, the median age at death for homicides is 29, while for suicides it is 57. As a result, many more life years are lost to homicide than suicide, and more Black residents are losing more years of life to guns than white residents.

Between 2012 and 2018, gun homicides dropped statewide and then rose again, spiking from 2020 into 2022. Researchers believe that the increases in gun-related homicide beginning in 2020 may be a reflection of social changes and stress related to the COVID-19 pandemic (SEE FIGURE 6).[45]

Between 2018 and 2021, 323 firearm homicides, 447 firearm suicides, and 24 other firearm deaths (including unintentional and police-related shootings) occurred in Connecticut, for a total of 794 firearm-related deaths, or an average of 199 per year.

45  Houry D.E., Simon T.R., & Crosby A.E. (2022, May 10). Firearm homicide and suicide during the COVID-19 pandemic: Implications for clinicians and health care systems. *JAMA 327*(19), 1867-1868. https://jamanetwork.com/journals/jama/fullarticle/2792080.

**FIG 8**

## A significant majority of gun suicide victims are white males

SHARE OF GUN-RELATED DEATHS FOR MALES BY RACE, CONNECTICUT, 2018-2021



- WHITE
- BLACK
- LATINO
- OTHER

HOMICIDE: 8%, 55%, 21%, 2%

SUICIDE: 82%, 7%, 3%, <1%
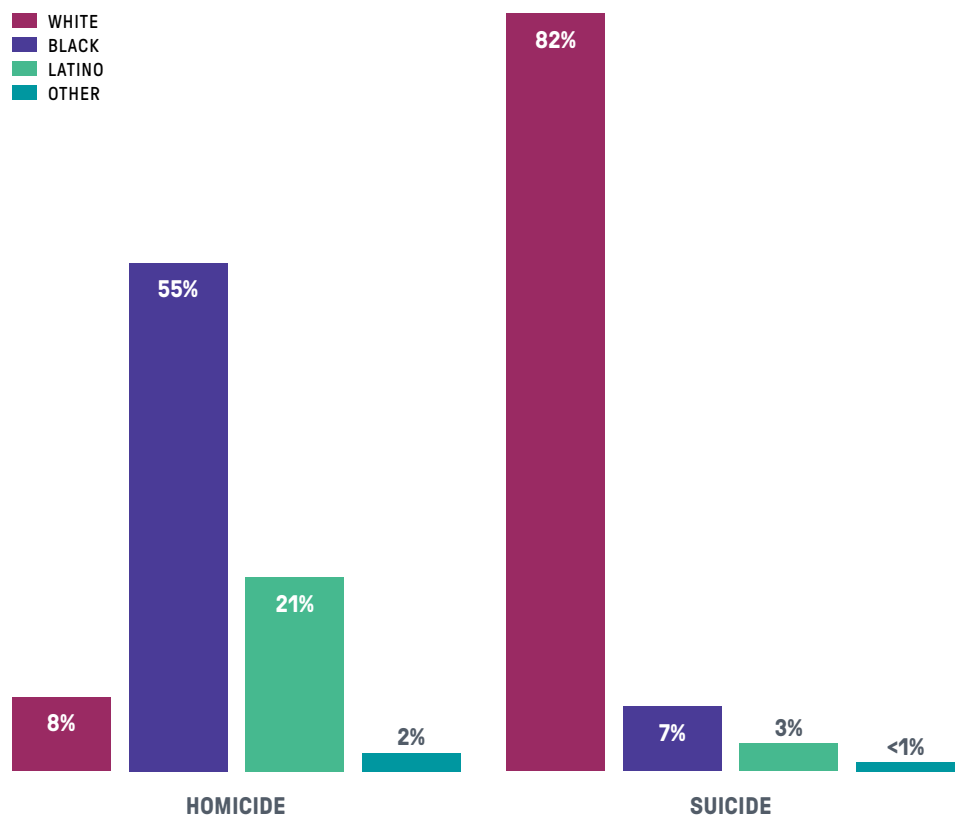
Scholarship has shown that the legacies of racist housing practices have led to higher shares of Black residents living in neighborhoods where there is concentrated poverty, lower formal educational attainment among adults, and high unemployment rates. These neighborhoods also see higher rates of gun violence. The racist outcomes of redlining and disinvestment are interrelated with high rates of gun-related mortality.[46]

Black boys and young men bear a high burden of premature death due to gun homicide. Between 2018 and 2021, 37 percent of gun homicide victims in Connecticut were Black men and boys between ages 15 and 24, yet this race-age group comprises only 3 percent of the state population (SEE FIGURE 8). The economic and social impacts of this disparity in mortality ripple through generations, and bearing witness to this loss of life further inhibits Black communities from the social and economic security afforded to white communities. DH

46  Poulson, M., Neufeld, M.Y., Dechert, T., Allee, L., Kenzik, K.M. (2021, August 20). Historic redlining, structural racism, and firearm violence: A structural equation modeling approach. *The Lancet Regional Health–Americas 3*. https://www.thelancet.com/pdfs/journals/lanam/PIIS2667-193X(21)00044-2.pdf.

**FIG 9**

## Gun-related mortality in Connecticut's major cities is lower than the national average

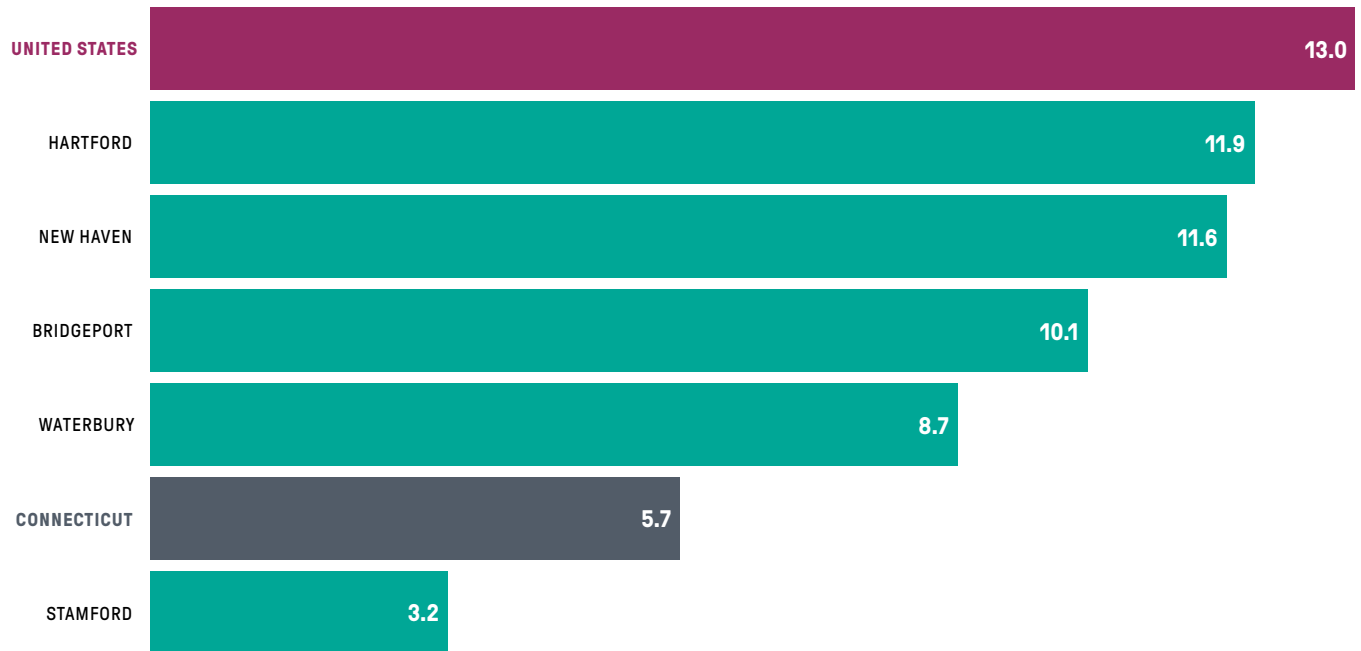AGE-ADJUSTED GUN-RELATED MORTALITY PER 100,000, 2018-2021

| Area | Value |
|------|-------|
| UNITED STATES | 13.0 |
| HARTFORD | 11.9 |
| NEW HAVEN | 11.6 |
| BRIDGEPORT | 10.1 |
| WATERBURY | 8.7 |
| CONNECTICUT | 5.7 |
| STAMFORD | 3.2 |

**FIG 10**

## Gun deaths by city

TOTAL COUNTS OF GUN-RELATED DEATHS (INCL. HOMICIDE, SUICIDE, AND OTHER), 2018–2021

| AREA | UNITED STATES | CONNECTICUT | BRIDGEPORT | HARTFORD | NEW HAVEN | STAMFORD | WATERBURY |
|------|---------------|-------------|------------|----------|-----------|----------|-----------|
| Gun deaths, 2018-2021 | 173,499 | 794 | 63 | 64 | 65 | 16 | 38 |
| Population, 2020 | 331,449,281 | 3,605,944 | 148,654 | 124,775 | 134,023 | 135,470 | 114,403 |

# Conclusion

Across issues ranging from food insecurity to discrimination, risks from asthma to depression, and poor birth outcomes to premature and elevated mortality, Black populations fare measurably worse than white populations in Connecticut. Low-income, Latino, and urban populations also experience significant disadvantages compared to white populations in the state, at different magnitudes.

Life expectancy is one measure used to describe disparities in health for a population, but the latest available values by race at the state level are pre-COVID-19.[47] To account for some COVID-related impact, we instead look to the age-adjusted all-cause mortality rate (ACMR), a measure that takes into account excess death and life-years lost.

While all demographic groups in Connecticut fare better than those same groups nationally, the ACMR for Black people in Connecticut is 21 percent higher than it is for white people. This means that Connecticut on the whole is healthier than the national average, but both statewide and nationwide, poor health outcomes are disparately experienced by Black populations (SEE FIGURE 11).

If Black people in Connecticut had the same mortality rates as white people, we estimate that there would have been about 14,000 fewer deaths in the Black community between 2017 and 2022. In other words, there were 14,000 excess deaths in the Black population in this time period. We estimate that 1,300 of those deaths were due to COVID-19 alone. Those 14,000 deaths translate to about 150,000 life years lost in the Black community over a six-year period.[48]

If white people died at the same rate as Black people in Connecticut, in that same six-year window, an additional 226,000 white people statewide would have died, amounting to 3.1 million additional life years lost.

This report offers a small glimpse into the ways historical legacies rooted in racism have negatively affected marginalized communities—especially Black communities—and how those legacies continue to shape well-being. While this is not a comprehensive look at all of the structural factors leading to poor health outcomes, we believe the information in this report can help policymakers develop long-term strategies that promote health equity.

Nearly all of the health barriers, risks, and outcomes discussed in this report are preventable, but some prevention strategies will take more work than others. The effects of racism and discrimination will not be solved overnight or with any single policy, but access to healthcare, housing, healthy foods, and recreational opportunities, along with gun reform, can and should be public health priorities. Inaction will lead only to the continuation or worsening of the existing gaps in health and well-being. The process will not be easy, but it is not too late to start. **DH**

47  Life expectancy as of 2019 in Connecticut was 81.2 years for white people, 79.0 years for Black people, and 82.6 years for Latinos. DataHaven analysis (2022) of data from the Institute for Health Metrics and Evaluation. (2022). United States mortality rates and life expectancy by county, race, and ethnicity, 2000-2019. Retrieved December 6, 2022 from https://ghdx. healthdata.org/record/ ihme-data/ united-states-life-expectancyby-county-race-ethnicity-2000-2019.

48  For methodological direction and a sobering look at the national analysis in this framework, see Caraballo, C., Massey, D.S., Ndumele, C.D. (2023, May 16). Excess mortality and years of potential life lost among the Black population in the United States, 1999-2020. JAMA 329(19), 1662-1670. https:// jamanetwork.com/journals/jama/ article-abstract/2804822.

**FIG 11**

## Mortality is highest for Connecticut's Black residents, but populations in the state fare better than nationwide

AGE-ADJUSTED ALL-CAUSE MORTALITY PER 100,000, BY RACE/ ETHNICITY, 2018-2021



| ASIAN | LATINO | NATIVE AMERICAN | WHITE | BLACK |
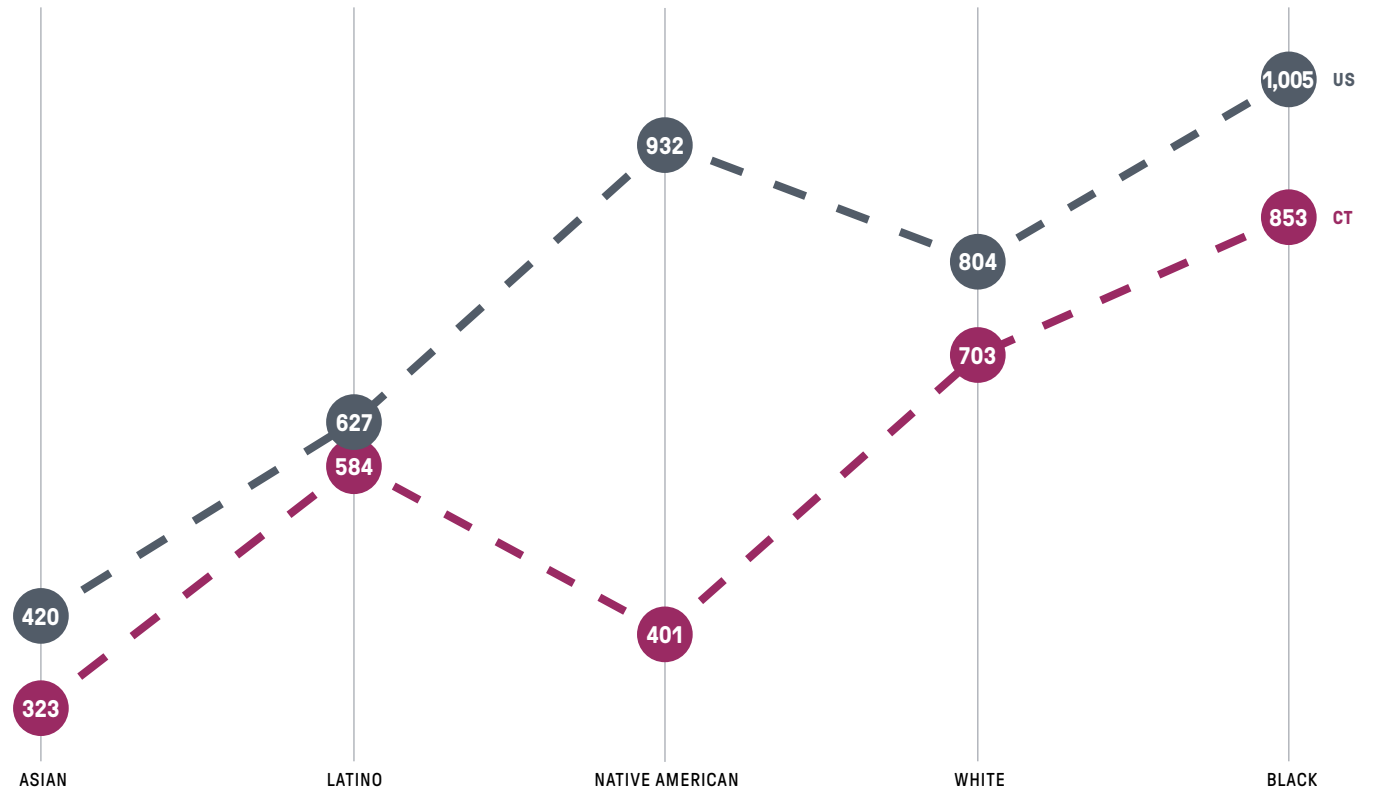
# Figure and Table Notes

Several tables use "Rural" and "Suburban'' in comparison to the state and five largest cities in Connecticut. This is based on the Five-Connecticuts classification, published in Levy, D. & DataHaven. (2015): Five Connecticuts 2010 update. https://www.ctdatahaven.org/data-resources/datahaven-five-connecticuts-5ct-ct-data-and-town-groups-2010. Produced for Siena College Research Institute and DataHaven based on the original method of assigning designations used in Levy, D., Rodriguez, O., & Villemez, W. (2004). The changing demographics of Connecticut–1990 to 2000. Part 2: The Five Connecticuts. University of Connecticut SDC Series, no. OP 2004-01. Published by DataHaven. A map of these regions and list of each town is provided on page 4 of Davila, K., Abraham, M., and Seaberry, C. (2020, June 6). Towards Health Equity in Connecticut. https://ctdatahaven.org/reports/towards-health-equity-connecticut. For the purposes of this report, we have combined the "Wealthy" and "Suburban'' classifications into one group entitled "Suburban."

**FIGURE 1: AVERAGE ANNUAL HEALTH CARE SPENDING PER CAPITA IN CONNECTICUT, 1991-2020**

Datahaven analysis (2023) of data from the Centers for Medicare and Medicaid Services (2022). Health expenditures by state of residence. Retrieved April 3, 2023 from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsstatehealthaccountsresidence.

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: BARRIERS TO HEALTHCARE, 2021**

DataHaven analysis (2023) of questions from the DataHaven Community Wellbeing Survey 2021. **Just getting by:** When surveyed, adults were asked how they were doing financially. The share in this table aggregates those who responded they are "just getting by," "finding it difficult," or "finding it very difficult." **Food insecure:** Share of adults who had trouble paying for food for their families at some point in the past year. **Treated unfairly in a healthcare setting:** Share of adults who said they felt like they were treated poorly

or provided with services not as good as what other people received when accessing healthcare in the past three years. **Didn't get necessary care in past year:** Share of adults who went without getting medical care for any reason. **No dentist visit in past year:** Share of adults who had not seen a dentist in at least 12 months.

**FIGURE 3: HEALTH RISKS, 2021**

DataHaven analysis (2023) of questions from the DataHaven Community Wellbeing Survey 2021. **Asthma:** Share of adults who have diagnosed asthma. **Smoking:** Share of adults who have smoked at least 100 who currently smoke. **Obesity:** share calculated from respondent-offered height and weight. **Anxious:** Share of adults who said they were "mostly" or "completely" anxious yesterday. **Depressed:** Share of adults who said they were depressed at least half of the time in the past two weeks.

**FIGURE 4: BIRTH OUTCOMES, 2017-2021**

DataHaven analysis (2023) of data from the Connecticut Department of Public Health Vital Statistics. Retrieved April 6, 2023 from https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports. **Late or no prenatal care:** share of births where the birthing parent attended fewer than 80 percent of expected prenatal visits or did not start prenatal care until the second trimester. **Low weight births:** share of live births where the infant was born weighing 2.5 kilograms or less (roughly 5.5 pounds). **Fetal and infant mortality:** Fetal deaths occur between 8 weeks of conception through live birth. Infant deaths occur between live birth and 365 days postpartum. Rates are given per 1,000 live births. Due to low occurrences, several years of data are pooled.

**FIGURE 5: ANNUALIZED AGE-ADJUSTED MORTALITY BY CAUSE, MULTIPLE YEARS**

DataHaven analysis (2023) of data from the Connecticut Department of Public Health Occurrent Deaths file, by request. **Cancer, Chronic Kidney Disease, COVID, Heart Disease:** Rates are weighted to the CDC standard United States million based on the 2000 Census (the latest available standard estimation file). **Overdose:** DataHaven analysis (2023) of data from the Connecticut Office of the Chief Medical Examiner (2023). Retrieved June 25, 2023 from https://portal.ct.gov/OCME/Statistics and age-adjusted using the CDC standard 2010 United States million.

**FIGURE 6: GUN-RELATED DEATHS, 2010-2022**

DataHaven analysis (2023) of data from the Connecticut Department of Public Health Occurrent Deaths file, by request. Intent and mechanism of death was derived from ICD-10 codes.

**FIGURE 7: SHARE OF GUN DEATHS BY TYPE, CONNECTICUT AND UNITED STATES, 2018-2021**

See notes for Figure 6. For United States summaries, data retrieved from CDC WONDER on June 25, 2023.

**FIGURE 8: DEMOGRAPHICS OF GUN DEATHS IN CONNECTICUT, 2018-2021**

See notes for Figure 6.

**FIGURE 9: GUN-RELATED MORTALITY, 2018-2021**

See notes for Figure 7.

**FIGURE 10: COUNTS OF GUN-RELATED DEATHS (INCL. HOMICIDE, SUICIDE AND OTHER), 2018-2021**

See notes for Figure 7.

**FIGURE 11: ALL-CAUSE MORTALITY PER 100,000, BY RACE/ETHNICITY, UNITED STATES AND CONNECTICUT, 2018-2022**

See notes for Figure 7. Native American populations in Connecticut are smaller compared to other racial/ethnic groups, and therefore the trend in mortality among this group looks quite different from the national average. The CDC compiles mortality records from each state with preferences for reporting race based on previous self-identification used by the deceased, although sometimes visual assessment is used instead. As a result, many Native Americans may not be correctly identified in mortality records as Native American. Furthermore, a significant proportion of Native Americans in Connecticut identify as two or more races (for example, Black and Native American), which we cannot disaggregate for the purposes of this analysis.

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