CHAPTER 9:

Navigating Towards Health Equity

IN CONCLUSION

There is much uncovered from this assessment. For one thing, Connecticut is aging. The data reveals that there has been a 28% increase between 2000 and 2017 in the number of people over the age of 65 living in Connecticut. Connecticut has also grown more diverse; over the past two decades persons of color have grown from 21% of our residents to 32%. We also learned that poverty affects many of our Connecticut residents. One in ten people in Connecticut live below 100% of the Federal Poverty Guidelines (FPG) and 23% of our state population lives below 200% of the FPG. With Connecticut's high cost of living, residents earning below 200% of the FPG are at risk for the same poor health outcomes associated with poverty.

In Connecticut, 29% of homeowners and 49% of renters are cost burdened, meaning they spend more than 30% of their gross income on housing. Being cost burdened indicates that people are less able to afford fresh foods and healthcare, and are at high risk for housing instability, which has been associated with poor physical health among children.

While Connecticut compares favorably to the entire United States regarding many health indicators, the data in this State Health Assessment illustrates that persons of color (anyone other than Non-Hispanic White) experience a greater share of adverse health events. For example, the data show a disproportionate number of children of color were found to have a blood lead level that meets the definition for lead poisoning; Hispanic and non-Hispanic Black workers are at a higher risk of work-related injuries; and the low birthweight rate for non-Hispanic Black mothers was double that of non-Hispanic White mothers. While there has been some progress, disparities still clearly exist.

DPH has committed to emphasize health equity in the work we do through our mission statement, established values and our reaffirmed strategic priorities, which can be found in our **Strategic Plan**. We recognize that achieving health equity is dependent on the Social Determinants of Health (SDOH), or as defined by the Centers for Disease Control and Prevention, the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes." This place-based framework for health outcomes reflects five key areas that include economic stability; health and healthcare; education; social and community context; and neighborhood and built environment.[1]

As we move from assessment to planning, we will build on the previous efforts and input from partners who have been contributing to the work of the *Healthy Connecticut 2020: State Health Improvement Plan* (SHIP). Together, we will look at the common upstream factors of SDOH as cross-cutting themes to identify systemic inequities that impact prioritized health issues. By focusing on these determinants of health, engaging cross-sector partners, identifying alignment of efforts and collaboratively exploring strategic opportunities, we will create the *Healthy Connecticut 2025: State Health Improvement Plan*. This plan will serve as a roadmap for collaborative health improvement activities over the next five years and will prioritize the equal enjoyment of the highest attainable standard of health for all our residents, which is a human right and a priority.

[1] *Centers for Disease Control and Prevention. (2017, December 14).* CDC Research on SDOH. *Retrieved from www.cdc.gov/socialdeterminants/research/index.htm.*