GREATER HARTFORD

Community Wellbeing Index 2019

QUALITY OF LIFE

RACIAL EQUITY

DEMOGRAPHICS

ECONOMY

EDUCATION

LIFE EXPECTANCY

HEALTH OUTCOMES

RISK FACTORS

COMMUNITY TRUST

PARTICIPATION

PUBLIC REALM

Indicators of social progress, economic opportunity, and population well-being in Greater Hartford neighborhoods

A CORE PROGRAM OF

DataHaven

In collaboration with **Hartford Foundation for Public Giving,** and a **Community Health Needs Assessment** for Hartford and other Capitol Region towns and cities served by Saint Francis Hospital, Hartford HealthCare, and Eastern Connecticut Health Network

25

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GREATER HARTFORD

Community Wellbeing Index 2019

Indicators of social progress, economic opportunity, and population well-being in Greater Hartford neighborhoods

Visual Appendix

50 figures, 35 tables, 1 report — here's a preview of what we learned about Greater Hartford

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CHAPTER 1

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★ QUALITY OF LIFE
DataHaven Community Index
DataHaven Personal Wellbeing Index

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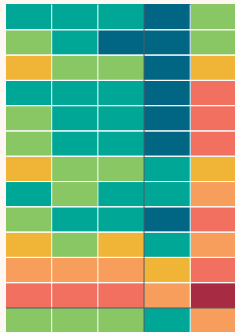
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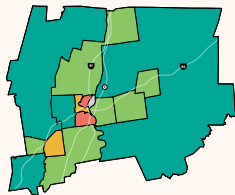
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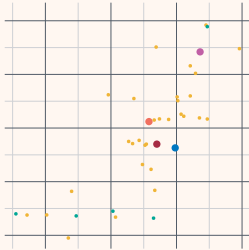
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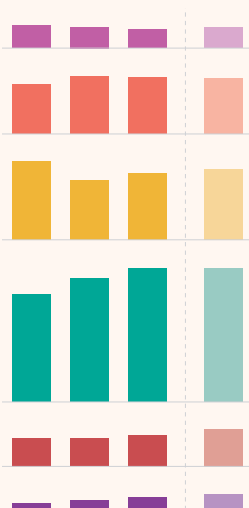
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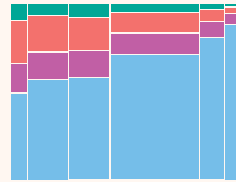
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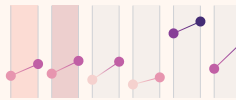
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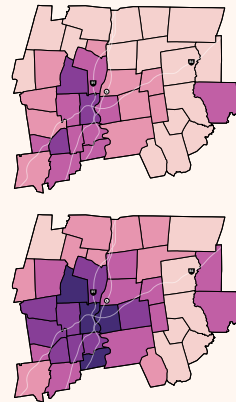
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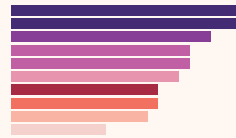
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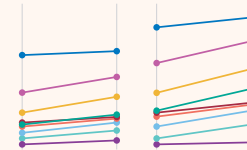
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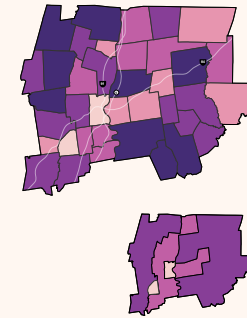
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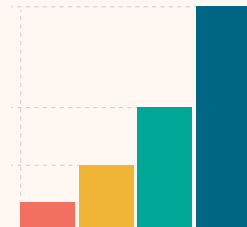
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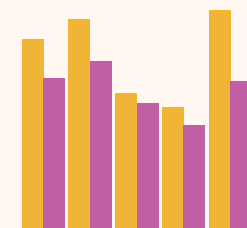
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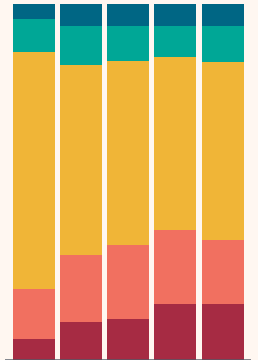
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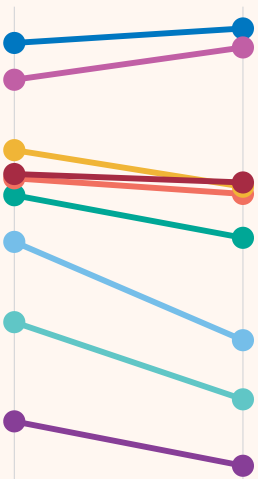
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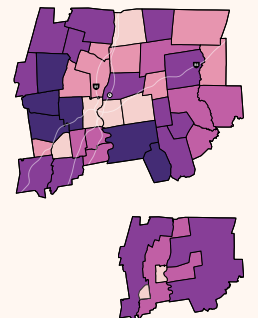
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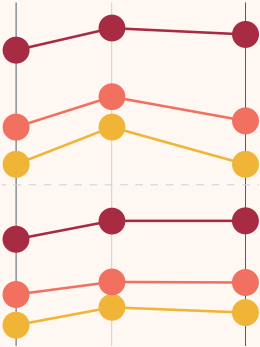
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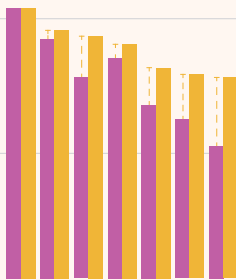
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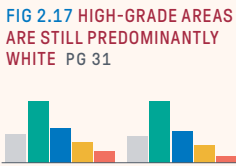
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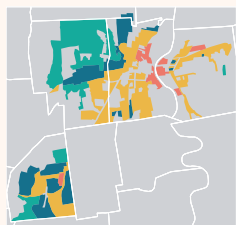
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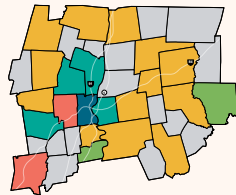
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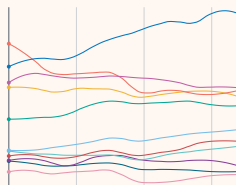
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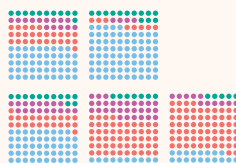
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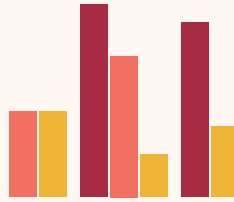
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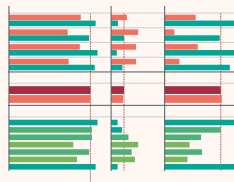
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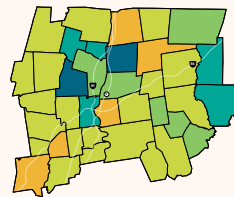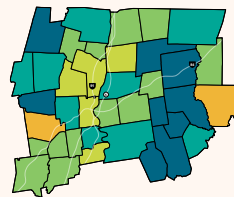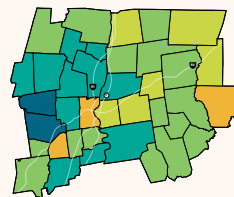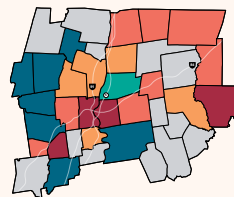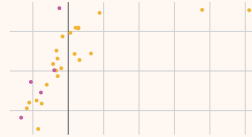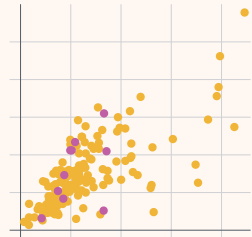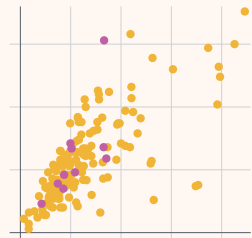
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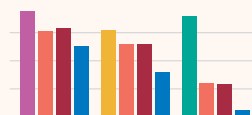
What matters more, having a job or having food on your plate?

Can money really buy happiness? Is it really true that if you haven't got your health, you haven't got anything?

As federal, state, and local agencies wrestle with one tough budget season after another, and have to decide how to help the greatest number of people with limited government funds, these questions matter—a lot.

Understanding what people need across our regions and neighborhoods helps answer these questions.

This report, *The Greater Hartford Community Wellbeing Index 2019*, collects and analyzes over 100 sources of national, state, and local data that pertain to these questions. But we have supplemented that information by conducting live, in-depth interviews with tens of thousands of randomly-selected adults statewide—over 32,000 in 2015 and 2018, including conversations with 7,000 representative adults in the Greater Hartford area. The DataHaven Community Wellbeing Survey (DCWS), believed to be the largest of its type in the United States, produces reliable data about life satisfaction, physical and mental health, neighborhood conditions, economic opportunity, and civic engagement that are not available at the local level from any of the other public data sources we work with. We use the latest data from the 2018 DCWS throughout this report.

Working with DataHaven, researchers Jan Wollenberg and Chris Barrington-Leigh of McGill University used this survey data to construct a model that could predict individuals' levels of life satisfaction.[1] The model accounted for household income, household size, self-reported physical and mental health, and personal experiences including food security, employment, and neighborhood conditions. Using these variables, Wollenberg and Barrington-Leigh created a life satisfaction score ranging from 0 to 100. Among the key findings:

> Addressing food insecurity would be more likely to increase overall life satisfaction than addressing unemployment.

Some might think that, after health, employment matters above all else. Indeed, for adults in the workforce, having employment improved life satisfaction as much as a nearly six-fold increase in household income did, whereas food security resulted in a 4.2-fold increase. However, there are approximately 400,000 food-insecure Connecticut adults, compared to about 200,000 Connecticut adults who are unemployed, according to the DataHaven survey.

> Money can buy happiness—but only up to a point.

Underscoring the importance of food security, the researchers found that having enough money to consistently buy food for themselves and their families improved adults' life satisfaction as much as if they quadrupled their household income. Meanwhile, about 680,000, or 19 percent of adults, say they live in neighborhoods with low walkability. The researchers' analysis of life satisfaction data shows that improving quality of life issues such as the built environment, trust in neighbors, and interactions with local government would make life better for many residents.

> The old saying about health turned out to be somewhat true, but not for the reasons we might expect.

Having excellent rather than poor physical and mental health improved life satisfaction scores by 18 and 26 points, respectively. The sizeable effect of improving mental health and the number of adults who face challenges in this area is consistent with other research suggesting that preventing depression would translate into enormous gains in life satisfaction. Meanwhile, a lack of health insurance had just a modest effect on the entire population. This is not because health insurance is unimportant—having insurance improved life

satisfaction by four points on the scale. But in recent years, Connecticut has done a relatively good job making sure that all people can get health insurance, whether through work, state-sponsored insurance, or AccessHealthCT (the state's insurance marketplace under the Affordable Care Act). Currently, only about 5 percent of adults in Connecticut are uninsured. If uninsurance rates were to rise back to where they were before the Affordable Care Act, the model suggests that the effect on people's well-being would be quite significant.

What does all this mean for local and state agencies looking to do the best they can with what they have? The survey's insights—whether at the level of the entire population or a single program—suggest more cost-effective ways to improve the lives of the widest range of people. Increasing families' incomes across the board would be a costly endeavor. Thus, improving access to nutritious food and health care, strengthening neighborhood assets and walkability, and deepening people's relationships with different levels of government are both more attainable and, perhaps, more effective.

About this Community Indicators Program and Community Health Needs Assessment

The Greater Hartford Community Wellbeing Index 2019 is part of a comprehensive community indicators program that collects, shares, and evaluates quality-of-life data on an ongoing basis at the state, regional, and neighborhood levels. This work builds upon the primary mission of DataHaven, a formal partner of the National Neighborhood Indicators Partnership, and is consistent with our focus since we released our first printed book of social indicator maps nearly 25 years ago in New Haven.

This report was made possible by contributions from more than 100 funders. A list of funders in this region can be found inside the front cover. We have also consulted extensively with other community partners and subject matter experts throughout the state and beyond, and are profoundly grateful for their guidance and support.

We are particularly grateful to the **Hartford Foundation for Public Giving** for their grants to support the DataHaven Community Wellbeing Survey in 2015 and 2018, and for underwriting the production costs associated with this report. The Foundation will use the report in several ways, and will help ensure that community leaders, agencies, and non-profits in the Greater Hartford region can access and analyze the data contained in this report.

Because it covers health and several other issues that relate to it, the *Community Wellbeing Index* is designed to help meet the requirements for **Community Health Needs Assessments (CHNA)** for Saint Francis Hospital–Trinity Health of New England, Eastern Connecticut Health Network, and other hospitals in the region, as laid out in Internal Revenue Service Form 990 Schedule H and Notice 2011-52. The CHNA also serves the City of Hartford Department of Health and Human Services and other local health departments participating in national accreditation processes. Chapter 3 of the *Community Wellbeing Index* is intended to document key health needs in communities served by all hospitals, while using a unified approach to reach the broadest possible audience. To complement this report with further context and locally-specific analysis, **additional CHNA sections and documents** have been created within each hospital's primary service area. Whereas the entire region is of interest to every hospital, these additional sections provide further documentation of the community needs identified within the geographic area on which each hospital plans to focus. They also outline the processes used by

each hospital to develop CHNAs and **Community Health Improvement Plans** within each hospital's primary service area. Like this report, the additional sections have benefited from input from dozens of local public health experts. They will be found on the individual hospital websites when they are finalized this year. This report includes a brief appendix, **2019 Community Conversations in Greater Hartford,** that summarizes a portion of the resident input that DataHaven and area stakeholders collected as a part of this process. SEE CHAPTER 5

The topics included in this report have been the subject of other studies, but to our knowledge there has never been a program that has synthesized them into a single report. Over the past decade, we have worked with partners to publish several *Community Wellbeing Index* reports that serve the Fairfield County, Naugatuck Valley, and Greater New Haven areas, and have been encouraged by how they have been used by local residents, agencies, and institutions. We envision that this report will serve as a platform to further the availability of neighborhood-level data and address gaps in disaggregated data related to age, gender, race, ethnicity, national origin, sexual orientation, disability, and other demographic characteristics. Since 2016, we have improved the quality of available data in several ways, including working diligently to ensure that all persons are represented in the information sources used in the report. Doing so allows the program to highlight areas where the region is and is not doing well, and also lets community leaders find data that are relevant to their interests and see how the work they do across different sectors contributes to the broader whole.

We recognize that most of the potential demographic or neighborhood data breakdowns do not fit within the practical confines of this report. We have published some of these on the DataHaven website (**ctdatahaven.org**), and we plan to release additional regional and statewide publications on health equity and other subject-specific topics in the near future. We encourage community partners to submit requests for the data that they need, using the instructions on our website: **ctdatahaven.org/ask-mark**.

Geography

In this report, Greater Hartford is generally defined as the area served by the Capitol Region Council of Governments, which consists of 38 cities and towns: Hartford, the state capital; the city of New Britain; the 13 Inner Ring towns (Berlin, Bloomfield, East Hartford, Enfield, Manchester, Newington, Plainville, Rocky Hill, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks); and the 23 Outer Ring suburbs (Andover, Avon, Bolton, Canton, Columbia, Coventry, East Granby, East Windsor, Ellington, Farmington, Glastonbury, Granby, Hebron, Mansfield, Marlborough, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, and Willington). Data for West Hartford, Manchester, and East Hartford, which are the largest towns within Greater Hartford's Inner Ring, are sometimes presented in addition to the combined Inner Ring data. In some cases, we also present information for specific neighborhoods or groups of neighborhoods within Hartford. In 2019, we have also worked with partner organizations to publish separate reports that cover all other areas of Connecticut. SEE OUR WEBSITE FOR DETAILS **DH**

DataHaven Community Index and Personal Wellbeing Index

Gross Domestic Product or
Gross Domestic Happiness?

Why should we measure well-being, happiness, and life satisfaction directly?

IN THIS CHAPTER

→ Greater Hartford has relatively high well-being compared to other areas nationwide. On our Community Index, the region would score 9th nationally among the 107 largest U.S. metropolitan areas.

→ But well-being varies by demographic factors like race, income, and hometown.

Asking residents about how they are doing on a daily basis is the most democratic approach to evaluating the extent to which a region's communities are flourishing. Measures of subjective well-being do not presuppose that any given resident needs a set of specific material goods, such as a paycheck of a certain size or a car, in order to be content with life. The greatest hopes and concerns of residents may lie within social aspects such as supportive friendships; access to fresh air, water, parks, and safe streets; or how they generally perceive their lives and their communities.

Traditional economic measures such as gross domestic product—the monetary value of all goods and services produced within the area—often show that Connecticut's metropolitan regions are among the wealthiest and most productive in the world. However, they do not necessarily account for how that affluence is distributed or how residents experience it. The many processes and policies that lead to social and economic inequalities, and the impacts that these inequalities can have on children and adults over time, are fundamental to understanding our current and future levels of well-being. Countries such as the United Kingdom and New Zealand have already begun to harness the power of a population well-being framework to inform public policy decisions.[2, 3]

When integrated with other data, measures of well-being also help illuminate the deep connections among financial stress, health, and happiness in a way that economic statistics, on their own, do not. For example, 1 in 7 Greater Hartford adults experience food insecurity. Our analysis suggests that reducing food insecurity would lead to a dramatic increase in the overall well-being of the region. The same data suggest that boosting incomes universally would lead to a much smaller gain.

To summarize and draw connections across these measures, we begin the report by introducing indexes of the region: the DataHaven Community Index and Personal Wellbeing Index. Additionally, a Neighborhood Assets Index is defined later in this report. SEE TABLE 4B Each index is a blend of indicators that capture the physical and social environments in which people live in Greater Hartford—including measures of community-wide health, infrastructure, education, and economics.

Executive Summary

The DataHaven Community Index incorporates 12 indicators into a single factored score that can be compared across multiple geographies. The indicators range from common economic measures, including poverty and unemployment rates, to educational attainment, life expectancy, and other general measures of quality of life. Greater Hartford would rank 9th among 107 large U.S. metropolitan areas, but the relatively high standard of living is divided; the region includes some of the highest- and lowest-scoring areas in our analysis.

Between 2012 and 2017 (the latest year for which these data are available), many Community Index scores improved, due in large part to economic recovery and expansion after the Great Recession. Despite this apparent progress, substantial regional and racial inequalities remain.

DataHaven's Personal Wellbeing Index—consisting of measures of self-reported life satisfaction, happiness, anxiety, and health—also reveals a high degree of inequality by geography, race and ethnicity, and household income level. Greater Hartford's score on the Personal Wellbeing Index is lower than the state average. **DH**

FIG 1.1

Community well-being comes from a number of different factors

COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX, 2017

INDEX COMPONENTS	U.S.	CONNECTICUT	GREATER HARTFORD	BEST	WORST
OPPORTUNITY YOUTH	7%	5%	5%	HARTFORD, CENTRAL/WEST 2%	EAST HARTFORD 13%
HEALTH INSURANCE	90%	94%	95%	WEST HARTFORD 97%	HARTFORD, SOUTHSIDE/SOUTH END 88%
WORKERS WITH SHORT COMMUTE	63%	65%	69%	NEW BRITAIN 80%	GH OUTER RING 63%
UNEMPLOYMENT	7%	7%	7%	GH OUTER RING 5%	NORTH HARTFORD PROMISE ZONE 24%
HIGH SCHOOL GRADUATES	87%	90%	90%	GH OUTER RING 95%	HARTFORD, SOUTHSIDE/SOUTH END 67%
YOUNG CHILD POVERTY	22%	15%	15%	GH OUTER RING 3%	NORTH HARTFORD PROMISE ZONE 51%
PRESCHOOL ENROLLMENT	48%	64%	65%	NORTH HARTFORD PROMISE ZONE 78%	HARTFORD, SOUTHSIDE/SOUTH END 51%
SEVERE HOUSING COST BURDEN	15%	16%	15%	GH OUTER RING 11%	NORTH HARTFORD PROMISE ZONE 32%
POVERTY	15%	10%	11%	GH OUTER RING 5%	NORTH HARTFORD PROMISE ZONE 37%
LIFE EXPECTANCY	78.7 yrs	80.3 yrs	79.9 yrs	WEST HARTFORD 82.4 yrs	NORTH HARTFORD PROMISE ZONE 76.1 yrs
YOUTHFUL LABOR FORCE	26%	24%	24%	MANCHESTER 31%	GH OUTER RING 21%
MEDIAN HOUSEHOLD INCOME	$58K	$74K	$76K	GH OUTER RING $98K	NORTH HARTFORD PROMISE ZONE $27K
COMMUNITY INDEX OVERALL (0–1,000)	594	657	668	WEST HARTFORD 746	NORTH HARTFORD PROMISE ZONE 393

NOTE: Please refer to text (Chapter 1) and endnotes (Chapter 5) for definitions of indicators used in this Index.

FIG 1.2

Compared to the U.S. and other metros, well-being is high but varied

COMPOSITE SCORE OF THE DATAHAVEN COMMUNITY INDEX, BY TOWN & NEIGHBORHOOD WITH NEARBY METROS, GREATER HARTFORD, 2017

RELATIVE RANK

- BETTER
-
-
- AVERAGE
-
- WORSE
- NOT AVAILABLE

Note: Index ranges from 0 (worse) to 1,000 (better).

United States
594

New York, NY
586

Connecticut
657

Springfield, MA
618

Greater Hartford
668

Boston, MA
666

Providence / Warwick, RI / MA
617

Worcester, MA / CT
649

GREATER HARTFORD INNER RING
698

NORTH HARTFORD PROMISE ZONE
393

GREATER HARTFORD OUTER RING
736

MANCHESTER
665

EAST HARTFORD
603

HARTFORD, SOUTHSIDE/ SOUTH END
418

NEW BRITAIN
548

HARTFORD, CENTRAL/WEST
567

WEST HARTFORD
746

FIG 1.3

White and Asian residents rank well above Black and Latino residents on well-being measures

COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX BY RACE/ETHNICITY, GREATER HARTFORD, 2017

	HEALTH INSURANCE	SEVERE HOUSING COST BURDEN	HIGH SCHOOL GRADUATES	YOUNG CHILD POVERTY	POVERTY	WORKERS W/ SHORT COMMUTE	OPPORTUNITY YOUTH	LIFE EXPECTANCY	UN-EMPLOYMENT	YOUTHFUL LABOR FORCE	MEDIAN HOUSEHOLD INCOME
WHITE	97%	12%	94%	4%	6%	67%	5%	81 yrs	6%	22%	$83K
BLACK	92%	19%	86%	28%	18%	69%	8%	78 yrs	14%	28%	$50K
LATINO	91%	29%	70%	35%	27%	74%	14%	77 yrs	12%	30%	$42K
ASIAN	94%	15%	90%	3%	8%	68%	13%	83 yrs	6%	38%	$88K

Residents are happier and healthier in places that score high on community well-being...

PERSONAL WELLBEING INDEX VS DATAHAVEN COMMUNITY INDEX

NOTE: Each index is scaled from 0 (worse) to 1,000 (better).

...as well as those with strong neighborhood assets

PERSONAL WELLBEING INDEX VS DATAHAVEN NEIGHBORHOOD ASSET INDEX
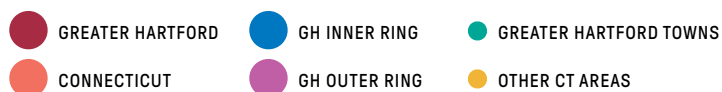
NOTE: Each index is scaled from 0 (worse) to 1,000 (better).

TABLE 1A

DataHaven Community Index

SCORES FOR LARGE U.S. METROPOLITAN AREAS AND LOCAL CITIES, TOWNS, AND NEIGHBORHOODS, 2012 AND 2017

RANK	LOCATION	2017 COMM. INX.	2012 COMM. INX.	PERCENT CHANGE	RANK	LOCATION	2017 COMM. INX.	2012 COMM. INX.	PERCENT CHANGE
	West Hartford	746	678	⬆10%	25	Santa Rosa, CA ◊	643	545	⬆18%
	GH Outer Ring	736	673	⬆9%	26	Milwaukee, WI ◊	642	563	⬆14%
1	Madison, WI	706	631	⬆12%	27	Buffalo, NY	640	581	⬆10%
	GH Inner Ring	698	635	⬆10%	28	Pittsburgh, PA	640	580	⬆10%
2	Des Moines, IA	691	635	⬆9%	29	Kansas City, MO	638	576	⬆11%
3	San Jose, CA ◊	688	595	⬆16%	30	Syracuse, NY	638	582	⬆10%
4	Minneapolis-St. Paul, MN ◊	683	607	⬆13%	31	New Haven, CT metro (incl. Waterbury)	637	568	⬆12%
5	Ogden, UT	683	612	⬆12%	32	Portland, OR ◊	634	547	⬆16%
6	Portland, ME ◊	675	590	⬆14%	33	Boise, ID ◊	629	540	⬆16%
7	Hartford, CT metro area (incl. Middlesex County)	671	604	⬆11%	34	Ventura, CA ◊	628	550	⬆14%
8	Albany, NY	669	606	⬆10%	35	Columbus, OH	628	570	⬆10%
	Greater Hartford	**668**	**600**	**⬆11%**	45	Springfield, MA	618	561	⬆10%
9	Provo, UT ◊	667	592	⬆13%	46	Providence, RI	617	554	⬆11%
10	Boston, MA	666	598	⬆11%		East Hartford ◊	603	529	⬆14%
11	Omaha, NE	665	612	⬆9%		United States (national avg.)	594	529	⬆12%
	Manchester	665	622	⬆7%	74	New York, NY ◊	586	512	⬆14%
12	Grand Rapids, MI ◊	663	557	⬆19%		Hartford, Central/West ◊	567	466	⬆22%
	Connecticut (state avg.)	**657**	**593**	**⬆11%**		New Britain ◊	548	473	⬆16%
13	San Francisco, CA ◊	656	566	⬆16%	100	Lakeland, FL ◊	537	469	⬆14%
14	Salt Lake City, UT ◊	656	574	⬆14%	101	Stockton, CA ◊	536	459	⬆17%
15	Bridgeport-Stamford-Norwalk, CT (Fairfield County)	655	593	⬆10%	102	Memphis, TN	532	495	⬆7%
16	Honolulu, HI ◊	653	580	⬆13%	103	Riverside, CA ◊	522	447	⬆17%
17	Colorado Springs, CO ◊	652	574	⬆14%	104	El Paso, TX ◊	517	445	⬆16%
18	Raleigh, NC	651	586	⬆11%	105	Bakersfield, CA ◊	504	436	⬆16%
19	Worcester, MA	649	594	⬆9%	106	Fresno, CA ◊	500	437	⬆14%
20	Harrisburg, PA	647	598	⬆8%		Hartford ◊	454	376	⬆21%
21	Washington, DC	647	584	⬆11%	107	McAllen, TX ◊	434	364	⬆19%
22	Rochester, NY	647	587	⬆10%		Hartford, Southside/South End ◊	418	361	⬆16%
23	Denver, CO ◊	644	556	⬆16%		North Hartford Promise Zone ◊	393	274	⬆43%
24	Seattle, WA ◊	643	565	⬆14%					

Connecticut cities, towns, and neighborhoods

◊ Community Index Score improvement at or above the national average.

★ DATAHAVEN COMMUNITY INDEX

Greater Hartford Ranks 9th Nationally

The Community Index integrates 12 individual and household indicators into a single factored score ranging from 0 to 1,000.[4] Distilling this information into a single score allows us to make relative comparisons of multiple geographies ranging from the national level to large metropolitan regions to individual neighborhoods within cities.[5] These measures incorporate the latest available Census American Community Survey (ACS) data with life expectancy data from the Centers for Disease Control and Prevention.[6] SEE FIG 1.1, 1.2, 1.3 / SEE TABLE 1A, 1B

With an overall Community Index score of 671, the Hartford metropolitan area (which includes Hartford, Tolland, and Middlesex Counties) ranks 7th among 107 U.S. metropolitan areas with a population of at least 500,000. Greater Hartford, as defined in this report, would rank 9th with a score of 668. Both the region and metro area improved by roughly 70 points or 11 percent from 2012. Nationwide and in Greater Hartford, the average Community Index score has improved as the result of continued economic recovery after the Great Recession, including improvements in economic outcomes such as unemployment as well as the expansion of health insurance coverage.[7] The Hartford Inner and Outer Ring regions[8] each improved by more than 60 points from 2012, or more than 9 percent, with some localized variation. Hartford and New Britain improved by more than 70 points each (21 and 16 percent, respectively), while the North Hartford Promise Zone saw the greatest improvement (43 percent, or 119 points). The Central/West areas of Hartford and the North Hartford Promise Zone each improved by more than 100 points from 2012 due in part to reductions in the youth poverty rate (from 61 percent in 2012 to 51 percent in 2017 in the North Hartford Promise Zone and 46 percent to 31 percent in the Central/West areas of Hartford).[9] However, the North Hartford Promise Zone still has the highest rate of youth poverty in the region. SEE TABLE 1B / SEE FIG 1.1

While the improvement in Greater Hartford's Community Index score is not itself significant given the overall improvement nationwide, the change was driven in part by significant decreases in the regional unemployment rate and childhood poverty,

and significant increases in adult educational attainment and health insurance coverage.

Greater Hartford includes areas that, by themselves, would rank among both the highest- and lowest-scoring regions in the nation. The Outer Ring and West Hartford scored higher than the highest-ranking metro area, while Hartford ranks just above the lowest-raking metro area. Two Hartford neighborhoods scored lower than the lowest-ranked metro area.

This inequality is associated with interrelated economic indicators—specifically unemployment and income—and the resulting burden of low income. The average unemployment rate from 2013 to 2017 ranged from 5 percent in the Outer Ring towns to 16 percent in Hartford and 24 percent in the North Hartford Promise Zone.[10] Median household income was nearly three times greater in the Outer Ring towns than in Hartford.[11] As a result, the overall poverty rate in Hartford was six times greater than the Outer Ring towns, and poverty among young children was more than 14 times greater.[12] Severe housing cost burden, or the share of households spending at least half of their income on housing, affected 28 percent of households in Hartford in 2017 compared to 11 percent of households in Outer Ring towns.[13]

There are other significant differences by geography, including a six-year difference in average life expectancy, a 30-percentage-point difference in preschool enrollment,[14] and a 28-percentage-point difference in adult educational attainment.[15] SEE TABLE 1B

GREATER HARTFORD'S 19-YEAR DIFFERENCE IN LIFE EXPECTANCY

While Greater Hartford's average life expectancy of 79.9 years is above average, it masks a dramatic difference within the region. Life expectancy in one part of Northeast Hartford is just 68.9 years—more than 19 years lower than that of the neighborhood with the highest life expectancy (88.1 years, in Avon).[16] Town-wide averages range from a maximum of 85.2 years in Andover to a minimum of 76.6 years in New Britain, a difference of nearly nine years. SEE CHAPTER 3 FOR MORE DETAILS

TABLE 1B

DataHaven Community Index and its components by area and neighborhood

LOCAL DATA VALUES AND SCORES, 2017

LOCATION	OPPORT- UNITY YOUTH	POV- ERTY	HIGH SCHOOL GRAD- UATES	YOUNG CHILD POVERTY	HEALTH INSUR- ANCE COVERAGE	PRE- SCHOOL ENROLL- MENT	UNEMPL- OYMENT RATE	LIFE EXPECT- ANCY	SEVERE HOUSING COST BURDEN	YOUTH- FUL LABOR FORCE	WORKERS WITH SHORT COMMUTE	MEDIAN HOUSE- HOLD INCOME	2017 COMM. INX.
United States	7%	15%	87%	22%	90%	48%	7%	78.7	15%	26%	63%	$57,652	594
Connecticut	5%	10%	90%	15%	94%	64%	7%	80.3	16%	24%	65%	$73,781	657
Greater Hartford	5%	11%	90%	15%	95%	65%	7%	79.9	15%	24%	69%	$75,531	668
Hartford	8%	30%	73%	43%	89%	62%	16%	77.1	28%	28%	71%	$33,841	454
Hartford, Central/ West	2%	23%	84%	31%	90%	67%	11%	77.8	21%	29%	70%	$41,111	567
Hartford, Southside/ South End	11%	31%	67%	42%	88%	51%	16%	77.2	32%	27%	72%	$34,437	418
N. Hartford Promise Zone	10%	37%	72%	51%	90%	78%	24%	76.1	32%	26%	69%	$27,463	393
New Britain	11%	23%	81%	37%	93%	53%	9%	76.6	21%	29%	80%	$43,611	548
GH Inner Ring	6%	8%	92%	10%	96%	68%	7%	80.1	14%	26%	72%	$74,833	698
East Hartford	13%	13%	83%	17%	92%	64%	10%	77.7	18%	29%	76%	$52,049	603
Manchester	8%	11%	93%	16%	95%	65%	8%	79.5	16%	31%	68%	$67,325	665
West Hartford	4%	8%	94%	8%	97%	69%	5%	82.4	14%	24%	75%	$95,298	746
GH Outer Ring	2%	5%	95%	3%	97%	67%	5%	81.5	11%	21%	63%	$98,077	736

Community Index by Race/Ethnicity

To further reveal the extent to which these measures vary across the population, we disaggregated the Community Index indicators by four racial/ethnic groups.[17] SEE FIG 1.3

White and Asian residents are generally more economically advantaged than Black and Latino residents. The median household income in white and Asian households was well above $80,000 in 2017 (greater than the Greater Hartford, state, and national averages). In Black and Latino households, median income was $50,000 or less.[18] Consequently, poverty rates were three times greater among Black residents and more than four times greater among Latino residents compared to white residents. This inequality is more severe among children: poverty was seven times greater for Black children and nearly nine times greater for Latino children compared to white children.[19] Severe housing cost burden affected nearly one in every three Latino households, compared to one in eight white households.[20] When families allocate half or more of their income to housing costs, they must then stretch their remaining income to cover other necessities like food, utilities, health care, and educational expenses.

Average unemployment from 2013 to 2017 in Latino communities in Greater Hartford was double (12 percent) the rate of white communities (6 percent),[21] and 14 percent of Latino youth between 16 and 19 years old were neither in school nor working (sometimes referred to as "opportunity youth" or "disconnected youth") compared to 5 percent of white youth.[22] These young people who become "disconnected" from school and the labor force often find it difficult to reconnect, which may further complicate their ability to pursue higher education or ultimately secure a living-wage job. These outcomes can significantly limit lifetime economic mobility and, in the worst cases, may perpetuate intergenerational poverty.[23]

TABLE 1C

DataHaven Index scores
GREATER HARTFORD WITH DEMOGRAPHIC GROUPS

LOCATION	COMMUNITY INDEX	PERSONAL WELLBEING INDEX	NEIGHBORHOOD ASSETS INDEX
Connecticut	657	612	556
Greater Hartford	668	570	580
BY DEMOGRAPHIC WITHIN GREATER HARTFORD			
Male	N/A	612	577
Female	N/A	565	595
Age 18–34	N/A	389	536
Age 35–49	N/A	487	537
Age 50–64	N/A	620	633
Age 65+	N/A	871	720
White	716	612	652
Black	549	483	351
Latino	437	390	371
<$15K	N/A	39	401
$15K–$30K	N/A	389	516
$30K–$50K	N/A	571	530
$50K–$75K	N/A	484	568
$75K–$100K	N/A	609	597
$100K–$200K	N/A	745	671
$200K+	N/A	1,000	851
BY REGION			
Hartford	454	440	195
New Britain	548	436	419
GH Inner Ring	698	563	529
East Hartford	603	445	356
Manchester	665	432	511
West Hartford	746	789	884
GH Outer Ring	736	742	788

Note: All indices scaled from 0 (worse) to 1,000 (better).

⭐ DATAHAVEN PERSONAL WELLBEING INDEX

As discussed above, the DataHaven Community Wellbeing Survey's questions on health, happiness, anxiety, and life satisfaction help us understand how people evaluate and experience their day-to-day life across multiple dimensions. Designed by a panel of local and national survey research experts, these questions are regularly used to evaluate personal well-being. For this report, we integrate the following four items into a Personal Wellbeing Index score from 0 to 1,000:

→ How would you rate your overall health?
→ Overall, how satisfied are you with your life nowadays?
→ Overall, how happy did you feel yesterday?
→ Overall, how anxious did you feel yesterday?

Greater Hartford's score on the Personal Wellbeing Index is lower than the state average. Further, throughout most of the state and in Greater Hartford, personal well-being has worsened slightly since 2015, with the measure of life satisfaction declining the most. In Greater Hartford, 65 percent of all adults reported being mostly or completely satisfied with life in 2018, compared to 72 percent in 2015. Further analysis is needed to identify and address this decline in life satisfaction, which has been steepest among adults under 50. SEE TABLE 1C

The DataHaven survey also includes questions on topics such as social support, meaning and purpose in life, and having time to enjoy life. The results from these measures are also essential for understanding quality of life, and detailed data may be found on the DataHaven website. However, they are not included in this report's Personal Wellbeing Index score.

We often find strong correlations between the Community Index, Personal Wellbeing Index, and other community-level outcomes, suggesting that continuing to improve community health and quality of life in Greater Hartford requires a comprehensive, multi-sectoral approach. The aspiration of this report is that these data will reveal both assets and opportunities, and provide a starting point for action by community leaders. SEE FIG 1.4 DH

Demographic Change and an Inclusive Economy

Before we can begin to understand what life is like in Greater Hartford, we need to understand who lives here.

Greater Hartford is a region comprised of 38 cities and towns.

IN THIS CHAPTER

→ Greater Hartford's older population is expanding, while its younger residents are becoming more racially and ethnically diverse.

→ Population growth is accompanied by increasing income and wealth disparities and a widening gap between higher- and lower-income households.

→ As jobs move away from the manufacturing sector, the service industry is growing but offers lower wages.

→ Achievement gaps within the education system, socioeconomic inequities, and the changing availability of jobs in specific sectors restrict opportunities for economic mobility.

Executive Summary

Greater Hartford is a region comprised of 38 cities and towns—the urban hubs of Hartford and New Britain, an inner ring of 13 towns surrounding the urban core, and an outer ring of 23 suburbs. Area residents are growing both older and more diverse. Diversity is increasingly concentrated in urban areas—including the region's Inner Ring towns—and is highest amongst residents under 35.

Since 1990, the number of households in Greater Hartford increased by 10 percent. While there was a significant decrease in the number of married-couple households with children during this time, this was offset by larger increases in the number of single-person and non-family households. In 2017, most housing units in Greater Hartford were single-family, although housing construction permits have shifted toward multi-family buildings in recent years.

Greater Hartford's median household income is similar to Connecticut as a whole, but the region is home to significant income inequality. In 2017, the city of Hartford had the lowest median household income in the state, while the median household income is nearly three times as high in the Outer Ring towns. In addition to the geographic concentration of wealth, multiple significant wage gaps can be seen when looking at gender, race, and education level. Likely related, at least in part, to this income inequality, Greater Hartford's neighborhoods are growing more segregated as middle-class neighborhoods shrink and neighborhoods at both income extremes grow. Further compounding these economic challenges, inflation-adjusted median household incomes grew modestly between 1990 and 2017 in Outer Ring towns, while decreasing in the Inner Ring and urban core.

Affordability is a significant barrier to homeownership in Greater Hartford, with one-third of households being housing cost-burdened, or spending more than 30 percent of their income on housing. Further, homeownership is considerably less accessible to Black and Latino residents compared to white residents.

Jobs are shifting from manufacturing toward service industries, including health care and social assistance. In 2017, Hartford County wages were slightly lower than the state as a whole. However, wage growth between 2000 and 2017 was highest in very high-paying sectors, while the number of jobs in lower-paying sectors continued to grow. This combination will likely further exacerbate income inequality in the region.

Data point to a significant shortage in childcare options for infants and toddlers, but nearly 65 percent of Greater Hartford's three- and four-year-olds were enrolled in preschool in 2017. Just five of the region's largest school districts serve well over half of the region's students of color and high-needs students. The wealthier Outer Ring school districts are less diverse and have fewer high-needs students. Greater Hartford's minority students and those with higher needs face several significant challenges: lower standardized testing pass rates, lower graduation rates, higher chronic absence rates, and higher discipline rates. **DH**

FIG 2.1

Greater Hartford's older population is projected to continue growing

POPULATION AND CHANGE BY AGE GROUP, GREATER HARTFORD, 1990–2035

	1990	2000	2015	2035 PROJECTION	1990–2015	2015–2035 PROJECTION
AGE 0–4	61,718	58,362	51,978	56,086	↓ -16% 9,740 PEOPLE	↑ +8% 4,108 PEOPLE
AGE 5–17	143,570	167,056	162,974	161,674	↑ +14% 19,404 PEOPLE	↓ -1% 1,300 PEOPLE
AGE 18–34	263,217	199,554	223,232	237,258	↓ -15% 39,985 PEOPLE	↑ +6% 14,026 PEOPLE
AGE 35–64	319,591	367,940	398,876	396,203	↑ +25% 79,285 PEOPLE	↓ -1% 2,673 PEOPLE
AGE 65–79	94,099	91,779	103,288	121,789	↑ +10% 9,189 PEOPLE	↑ +18% 18,501 PEOPLE
AGE 80+	28,143	37,899	43,668	52,345	↑ +55% 15,525 PEOPLE	↑ +20% 8,677 PEOPLE
TOTAL POPULATION	910,338	922,590	984,016	1,025,355	↑ +8% 73,678 PEOPLE	↑ +4% 41,339 PEOPLE

FIG 2.2

Children and younger adults are much more racially diverse

POPULATION BY AGE AND RACE, GREATER HARTFORD, 2010

Legend:
- OTHER RACE
- LATINO
- BLACK
- WHITE

AGE 0–4 · AGE 5–17 · AGE 18–34 · AGE 35–64 · AGE 65–79 · AGE 80+

Data labels by age group:

AGE 0–4: Other Race 4,789; Latino 13,286; Black 8,504; White 27,068

AGE 5–17: Other Race 10,345; Latino 33,281; Black 24,772; White 96,751

AGE 18–34: Other Race 15,736; Latino 39,853; Black 31,890; White 127,098

AGE 35–64: Other Race 17,989; Latino 43,982; Black 46,427; White 294,267

AGE 65–79: Other Race 2,429; Latino 5,604; Black 7,913; White 77,254

AGE 80+: Other Race 539; Latino 1,260; Black 2,300; White 40,622

FIG 2.3

The region is diversifying, some places more than others

NON-WHITE SHARE OF POPULATION, 1990–2017

	1990	2017
CONNECTICUT	16%	32%
GREATER HARTFORD	19%	35%
GH INNER RING	11%	34%
GH OUTER RING	5%	14%
HARTFORD	70%	85%
NEW BRITAIN	25%	58%
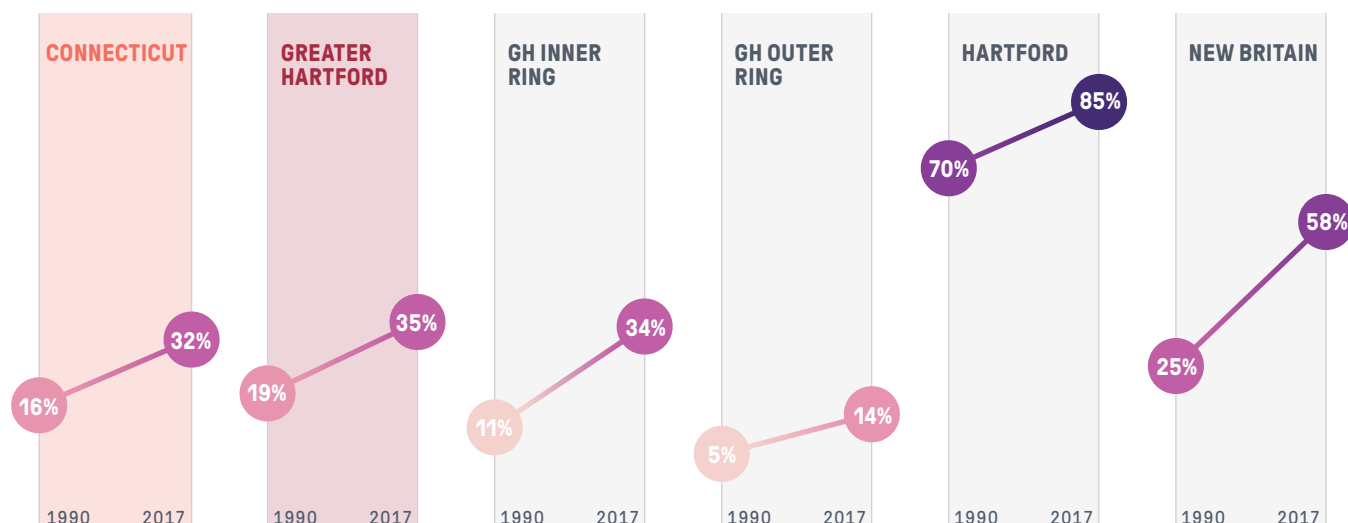
FIG 2.4

Immigrants make up a growing share of the region's population

FOREIGN-BORN SHARE OF POPULATION, GREATER HARTFORD, 1990 AND 2017

1990

2017

- 2 TO 5%
- 5 TO 8%
- 8 TO 13%
- 13 TO 19%
- 19 TO 24%
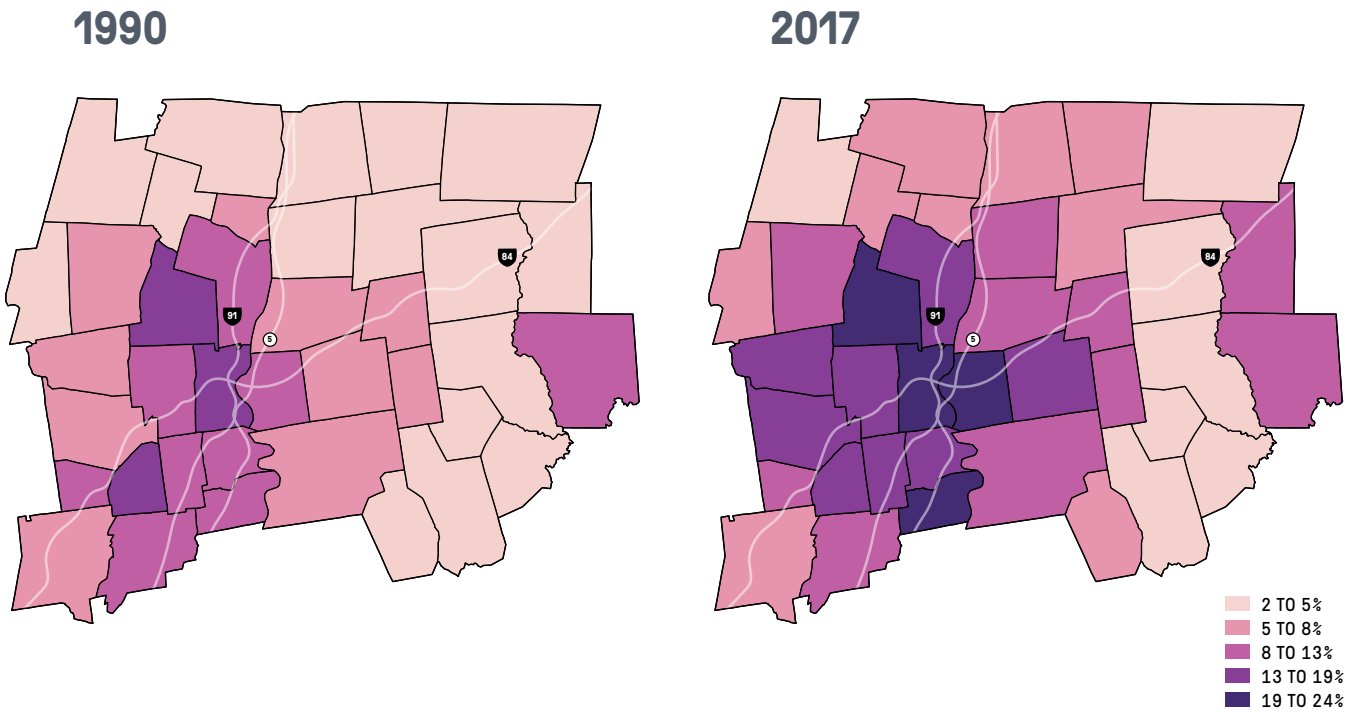
FIG 2.5

Greater Hartford's cities have sizeable immigrant populations

FOREIGN-BORN PERCENTAGE OF POPULATION, 2017

HARTFORD	22%
EAST HARTFORD	22%
NEW BRITAIN	19%
WEST HARTFORD	17%
MANCHESTER	17%
GH INNER RING	16%
GREATER HARTFORD	14%
CONNECTICUT	14%
UNITED STATES	13%
GH OUTER RING	9%
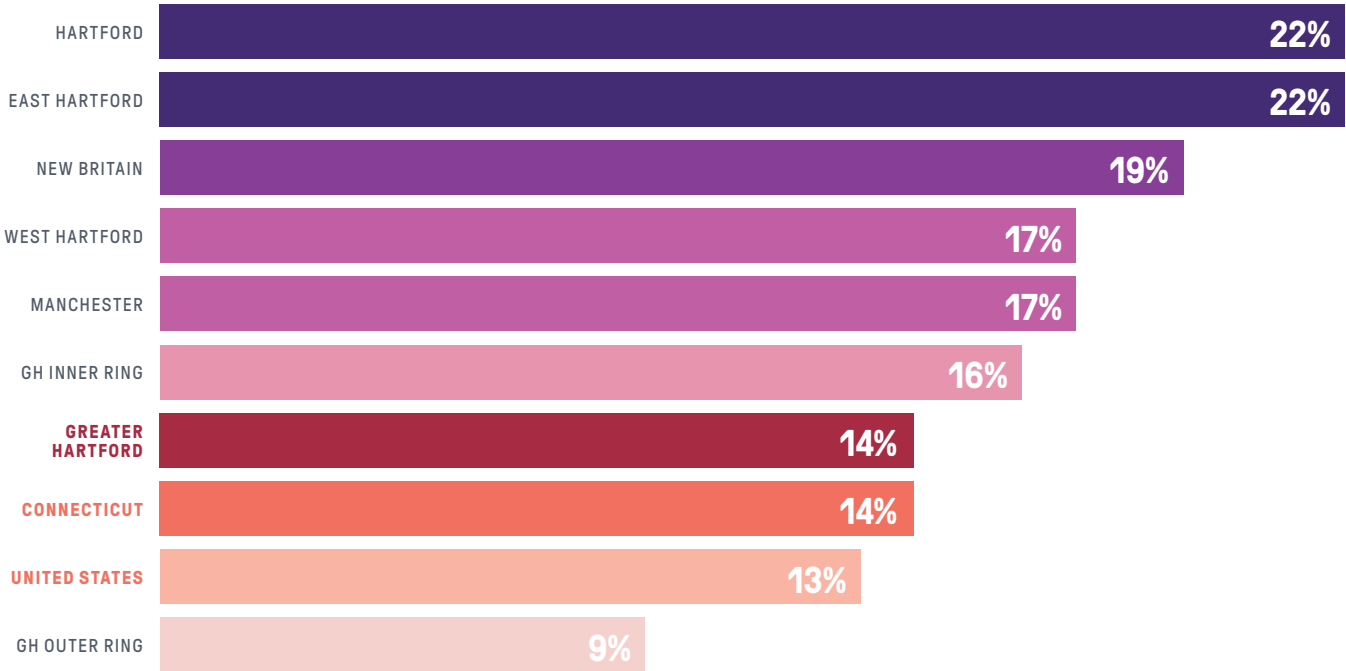
FIG 2.6

Shares of married-couple households have declined slightly

HOUSEHOLDS BY TYPE, GREATER HARTFORD, 1990–2017

	OTHER HOUSEHOLDS
	LIVING ALONE
	SINGLE, WITH CHILDREN
	MARRIED, NO CHILDREN
	MARRIED, WITH CHILDREN

1990 — 341,866
- 13% 44,015
- 24% 83,728
- 9% 29,954
- 30% 102,481
- 24% 81,688

2000 — 355,811
- 13% 46,481
- 27% 97,461
- 9% 33,605
- 28% 99,550
- 22% 78,714

2010 — 372,872
- 14% 51,711
- 28% 104,147
- 10% 36,563
- 28% 103,105
- 21% 77,346

2017 — 374,482
- 15% 56,737
- 29% 107,091
- 9% 33,978
- 29% 107,721
- 18% 68,955
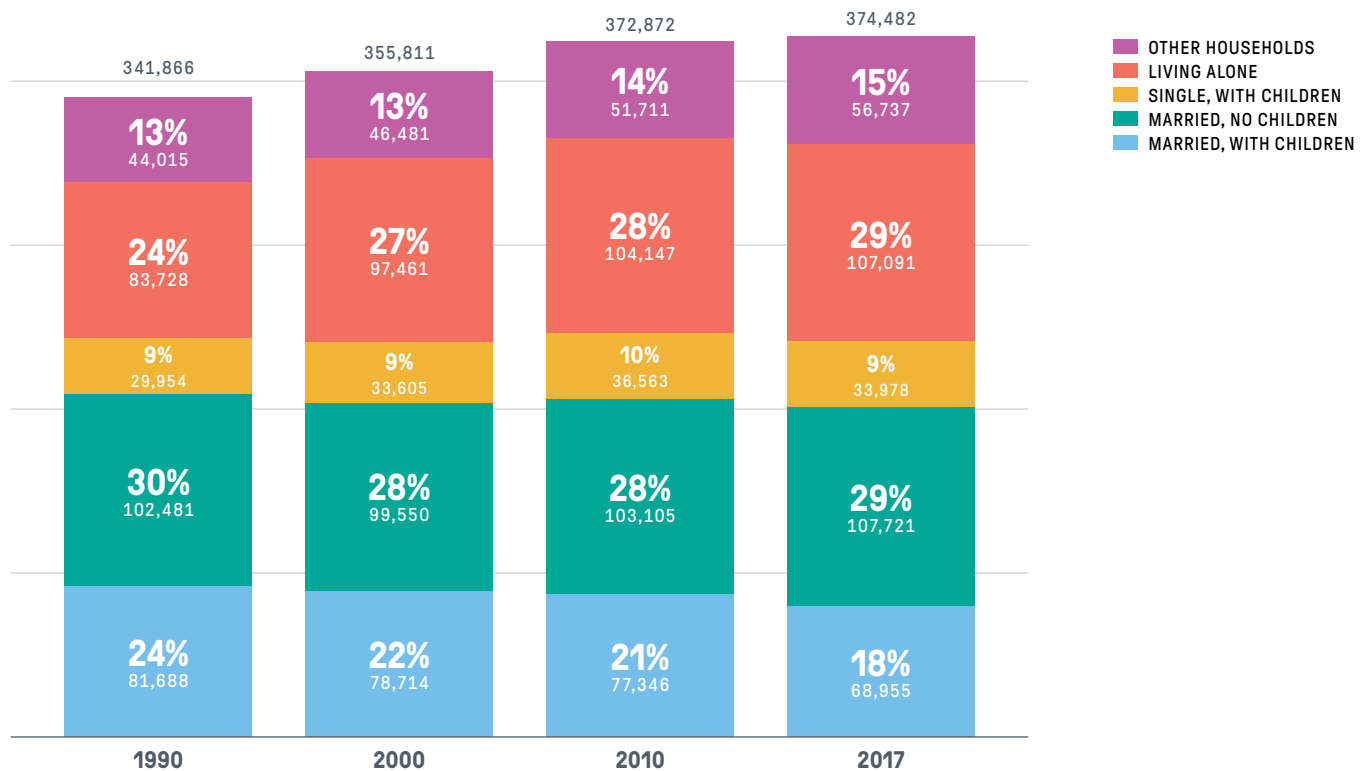
FIG 2.7

Low-income rates are rising, especially among children

LOW-INCOME RATE BY AGE, GREATER HARTFORD, 2000–2017

TOTAL POPULATION

2000 → 2017
- 55% → 57%
- 36% → 44%
- 26% → 34%
- 21% → 24%
- 20% → 23%
- 19% → 25%
- 16% → 21%
- 13% → 17%
- 10% → 12%

AGES 0–17

2000 → 2017
- 69% → 74% HARTFORD
- 51% → 62% NEW BRITAIN
- 36% → 48% EAST HARTFORD
- 27% → 38% MANCHESTER
- 26% → 31% GREATER HARTFORD
- 24% → 30% CONNECTICUT
- 19% → 27% GH INNER RING
- 13% → 20% WEST HARTFORD
- 10% → 11% GH OUTER RING
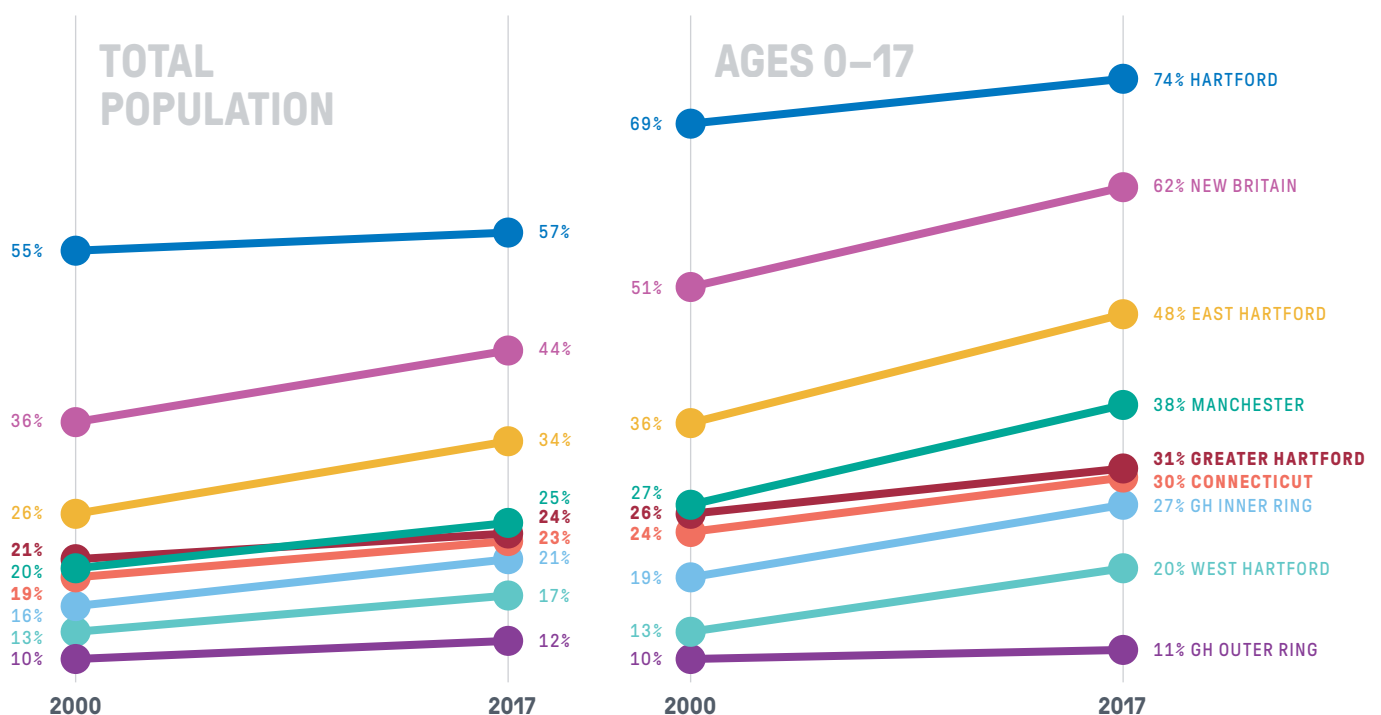
FIG 2.8

Greater Hartford has wide income disparities

MEDIAN HOUSEHOLD INCOME BY TOWN, GREATER HARTFORD, 2017

$34K TO $44K
$44K TO $69K
$69K TO $82K
$82K TO $102K
$102K TO $126K

SUFFIELD
$106K

SOMERS
$102K

EAST GRANBY
$93K

ENFIELD
$73K

ELLINGTON
$83K

WINDSOR
LOCKS
$67K

EAST
WINDSOR
$75K

STAFFORD
$69K

WILLINGTON
$76K

GRANBY
$111K

VERNON
$61K

TOLLAND
$113K

COVENTRY
$89K

WINDSOR
$90K

MANSFIELD
$59K

BLOOMFIELD
$74K

SIMSBURY
$116K

CANTON
$91K

HARTFORD
$34K

AVON
$126K

WEST
HARTFORD
$95K

FARMINGTON
$95K

NEWINGTON
$79K

NEW BRITAIN
$44K

COLUMBIA
$100K

PLAINVILLE
$62K

ANDOVER
$101K

BERLIN
$93K

BOLTON
$102K

EAST
HARTFORD
$52K

SOUTH WINDSOR
$106K

HEBRON
$105K

MANCHESTER
$67K

WETHERSFIELD
$81K

MARLBOROUGH
$110K

SOUTHINGTON
$91K

GLASTONBURY
$112K

ROCKY HILL
$79K

GH INNER RING
$75K

United States
$58K

Connecticut
$74K

Greater Hartford
$76K

GH OUTER RING
$98K

FIG 2.9

The highest-earning 5% makes almost 9x more money than the bottom 20%

MEDIAN HOUSEHOLD INCOME BY QUANTILE, GREATER HARTFORD, 2016, WITH RATIO TO BOTTOM 20% INCOME

8.8x
HIGHER THAN BOTTOM 20%

4.8x

2.5x

$245K

$134K

$70K

$28K

BOTTOM 20%   MEDIAN   TOP 20%   TOP 5%
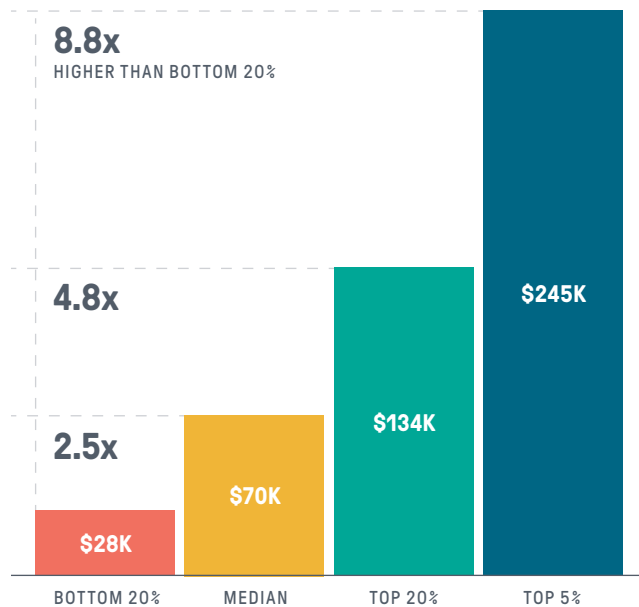
FIG 2.10

Greater Hartford has a wage gap by both gender and race

MEDIAN INCOME OF FULL-TIME ADULT WORKERS, GREATER HARTFORD, 2016

MALE
FEMALE

$63K $51K
$70K $55K
$46K $42K
$41K $36K
$73K $52K

ALL   WHITE   BLACK   LATINO   OTHER RACE
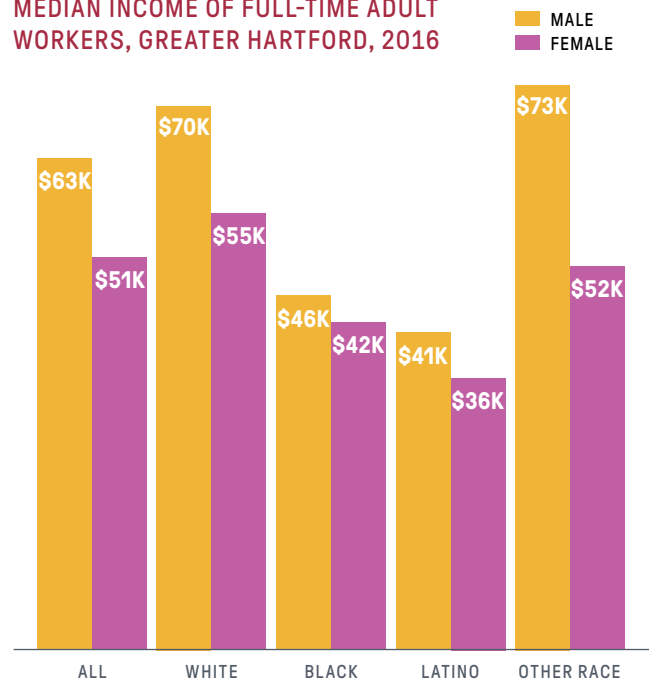
FIG 2.11

Greater Hartford's middle class has shrunk considerably

DISTRIBUTION OF POPULATION BY NEIGHBORHOOD INCOME LEVEL, GREATER HARTFORD, 1980–2017

AFFLUENT
HIGH INCOME
MIDDLE INCOME
LOW INCOME
POOR

	1980	1990	2000	2010	2017
Affluent	4%	6%	6%	6%	6%
High Income	9%	11%	10%	9%	10%
Middle Income	67%	54%	52%	49%	50%
Low Income	14%	19%	21%	21%	18%
Poor	6%	11%	12%	16%	16%
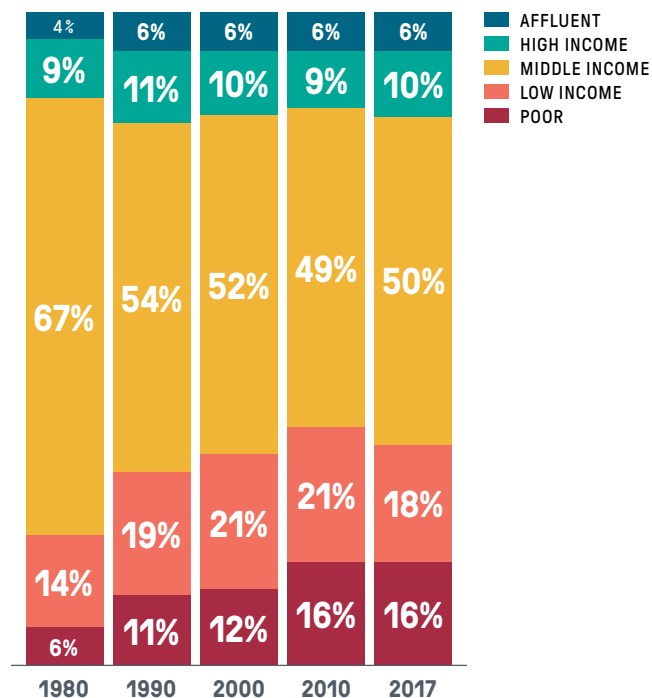
FIG 2.12

Average incomes have only risen in higher-income towns

MEDIAN HOUSHOLD INCOME, GREATER HARTFORD, 1990–2017, ADJUSTED TO 2017 DOLLARS

$96K
$91K

$80K
$77K
$76K
$73K

$67K

$55K

$40K

$98K GH OUTER RING
$95K WEST HARTFORD

$76K GREATER HARTFORD
$75K GH INNER RING
$74K CONNECTICUT

$67K MANCHESTER

$52K EAST HARTFORD

$44K NEW BRITAIN

$34K HARTFORD

1990   2017
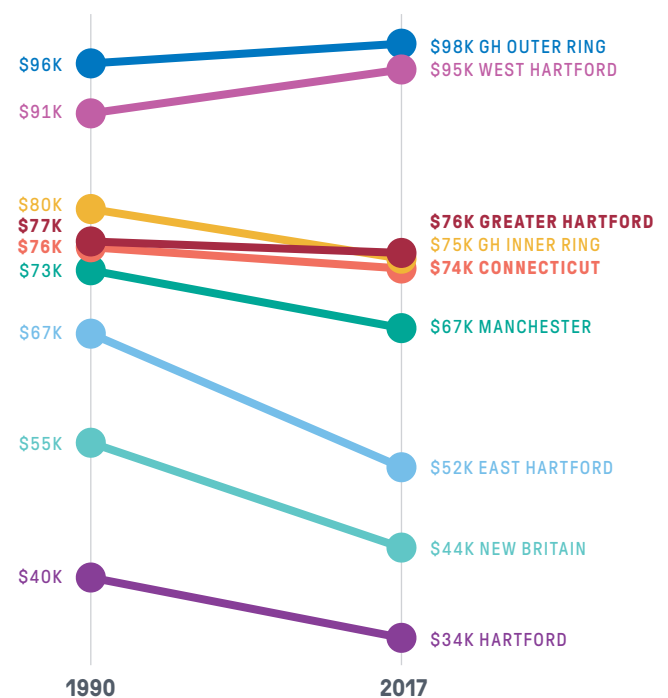
FIG 2.13

Housing values are very high in the Outer Ring towns

MEDIAN HOUSEHOLD VALUE BY TOWN, 2017

- $157K TO $185K
- $185K TO $220K
- $220K TO $264K
- $264K TO $308K
- $308K TO $378K

SUFFIELD
$293K

SOMERS
$309K

EAST GRANBY
$288K

ENFIELD
$185K

ELLINGTON
$250K

WINDSOR LOCKS
$190K

EAST WINDSOR
$204K

VERNON
$208K

STAFFORD
$190K

TOLLAND
$287K

WILLINGTON
$220K

GRANBY
$297K

COVENTRY
$244K

WINDSOR
$216K

BLOOMFIELD
$211K

MANSFIELD
$233K

SIMSBURY
$328K

CANTON
$301K

HARTFORD
$162K

AVON
$378K

WEST HARTFORD
$326K

FARMINGTON
$328K

NEWINGTON
$230K

NEW BRITAIN
$157K

PLAINVILLE
$205K

BERLIN
$281K

COLUMBIA
$243K

ANDOVER
$277K

BOLTON
$288K

EAST HARTFORD
$160K

SOUTH WINDSOR
$281K

HEBRON
$303K

MANCHESTER
$182K

WETHERSFIELD
$251K

MARLBOROUGH
$315K

GLASTONBURY
$344K

SOUTHINGTON
$272K

ROCKY HILL
$264K

United States

$194K

Connecticut

$270K

Greater Hartford

$249K

GH INNER RING
$228K

GH OUTER RING
$291K

FIG 2.14

Cost burden rates are back to pre-Recession levels, but are still high for renters

COST-BURDEN AND SEVERE COST-BURDEN RATES BY TENURE, HARTFORD & TOLLAND COUNTIES, 2005–2017
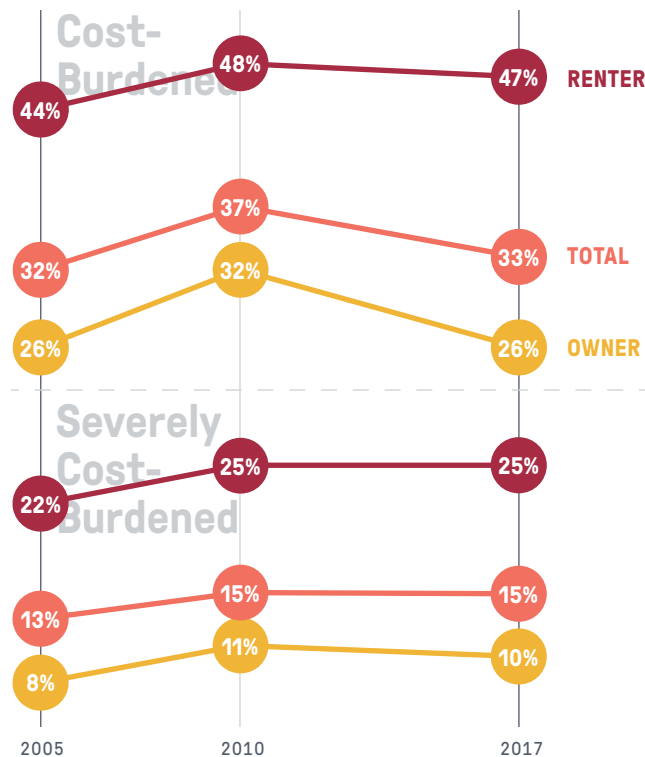
FIG 2.15

The average renter is $3,000 short of affording a 2 bedroom apartment

MEDIAN RENTER HOUSEHOLD INCOME AND MINIMUM HOUSEHOLD INCOME TO AFFORD 2BR HOUSING, GREATER HARTFORD, 2017, WITH SHORTFALL SHOWN

AVG. RENTER INCOME
MIN. AFFORDABLE INCOME

Based on HUD guideline of housing affordability as housing costs totaling no more than 30% of household income
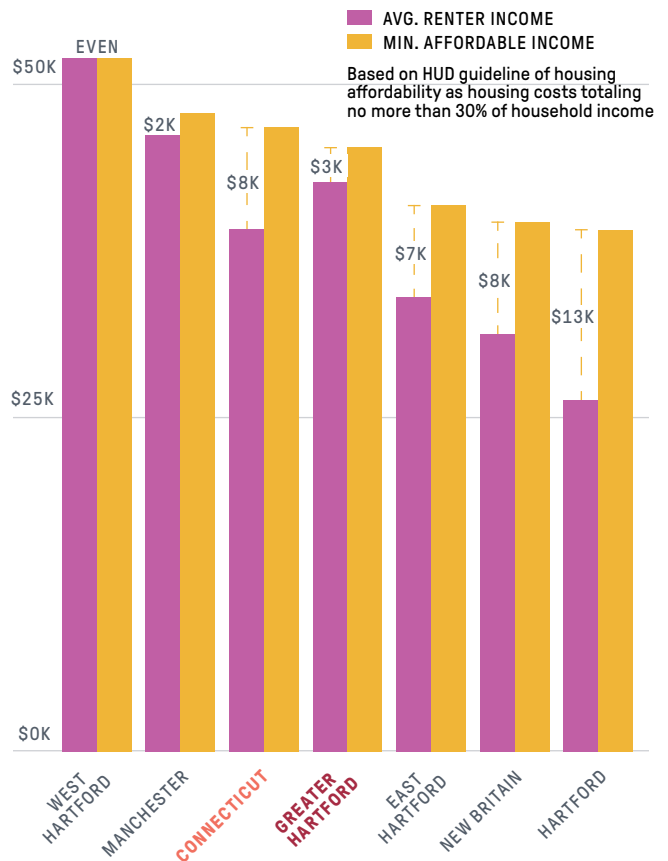
FIG 2.16

Homeownership is still low in lower-grade areas

HOMEOWNERSHIP RATE BY HISTORIC REDLINING GRADE, HOLC-MAPPED PARTS OF GREATER HARTFORD TOWNS, 2010
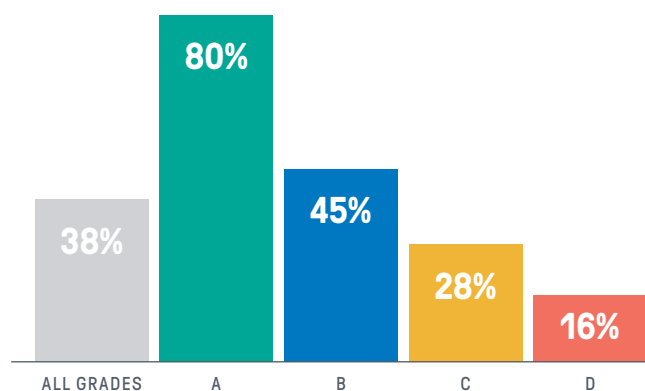
FIG 2.17

High-grade areas are still predominantly white

WHITE SHARE OF POPULATION BY HISTORIC REDLINING GRADE, HOLC-MAPPED PARTS OF GREATER HARTFORD TOWNS, 2010
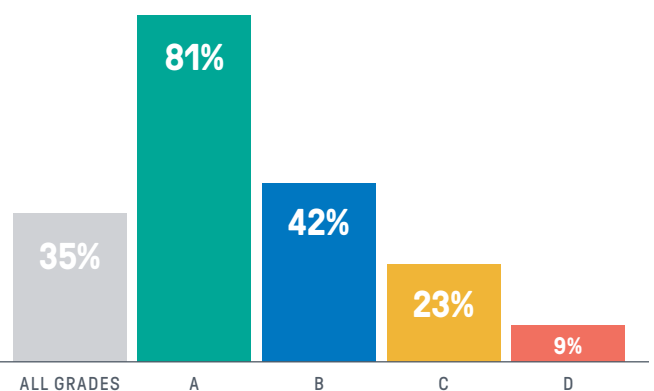
The patterns in 1930s redlining maps are still present today

HOLC REDLINED AREAS OF HARTFORD, NEW BRITAIN, AND NEIGHBORING TOWNS, 1937
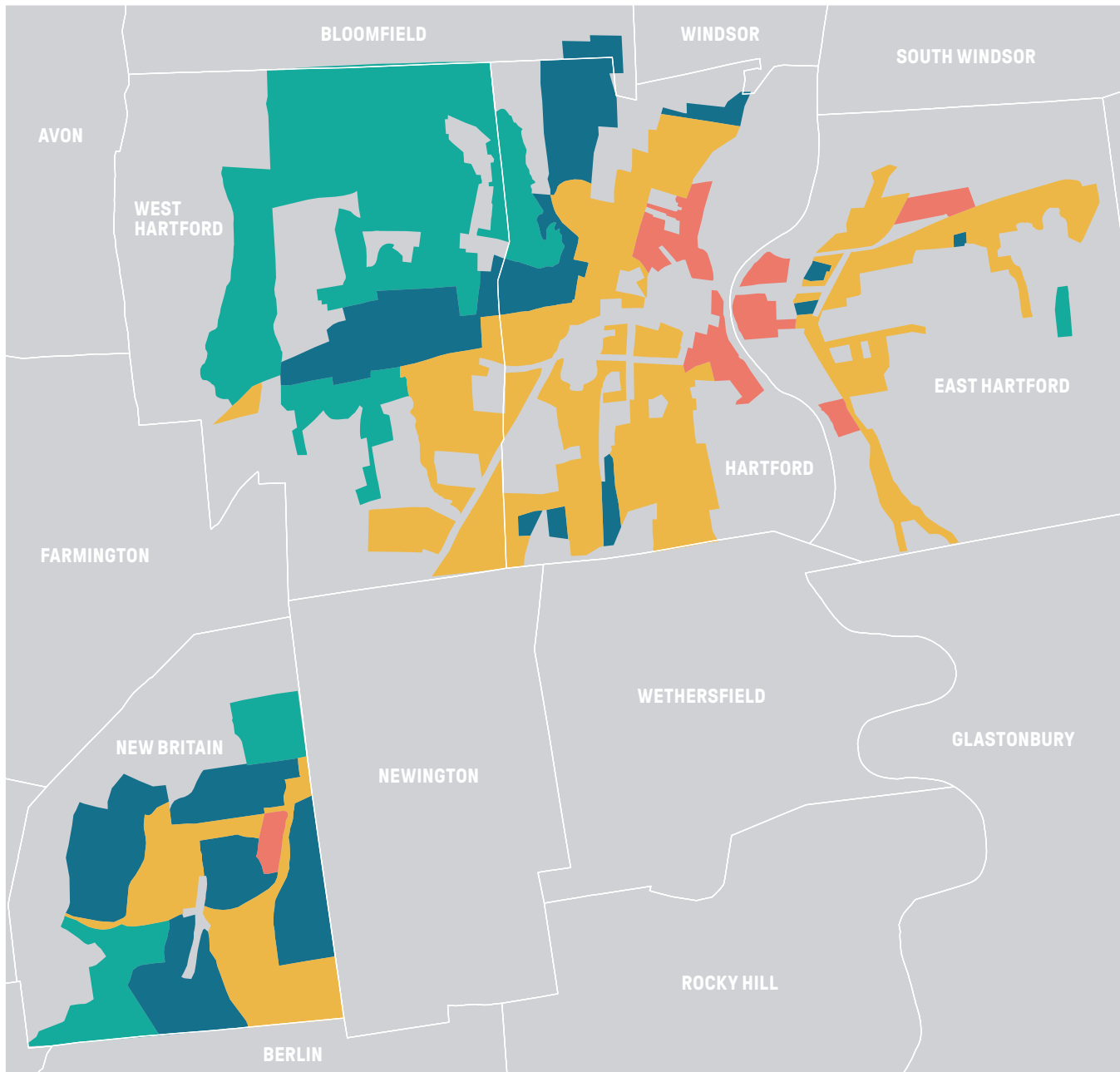
HOLC GRADE

- A — BEST
- B — STILL DESIRABLE
- C — DEFINITELY DECLINING
- D — HAZARDOUS

FIG 2.19

Hartford provides many high-paying jobs to the surrounding region

NET INFLOW OF WORKERS BY TOWN AND WAGE, 2015

Legend:
- 20K+ IN
- 6K TO 20K IN
- 2K TO 6K IN
- 2K OUT TO 2K IN
- 2K OUT TO 6K OUT
- 6K+ OUT

Note: Net inflow defined as number of workers commuting in minus number of workers commuting out. Areas with negative net inflow are those that lose more workers than they gain.

Higher-wage workers ($40K or higher)

MASSACHUSETTS +7.2K

RHODE ISLAND +400

PENNSYLVANIA +<100

NEW JERSEY -<100

NEW YORK +300

OTHER CT TOWNS +43K
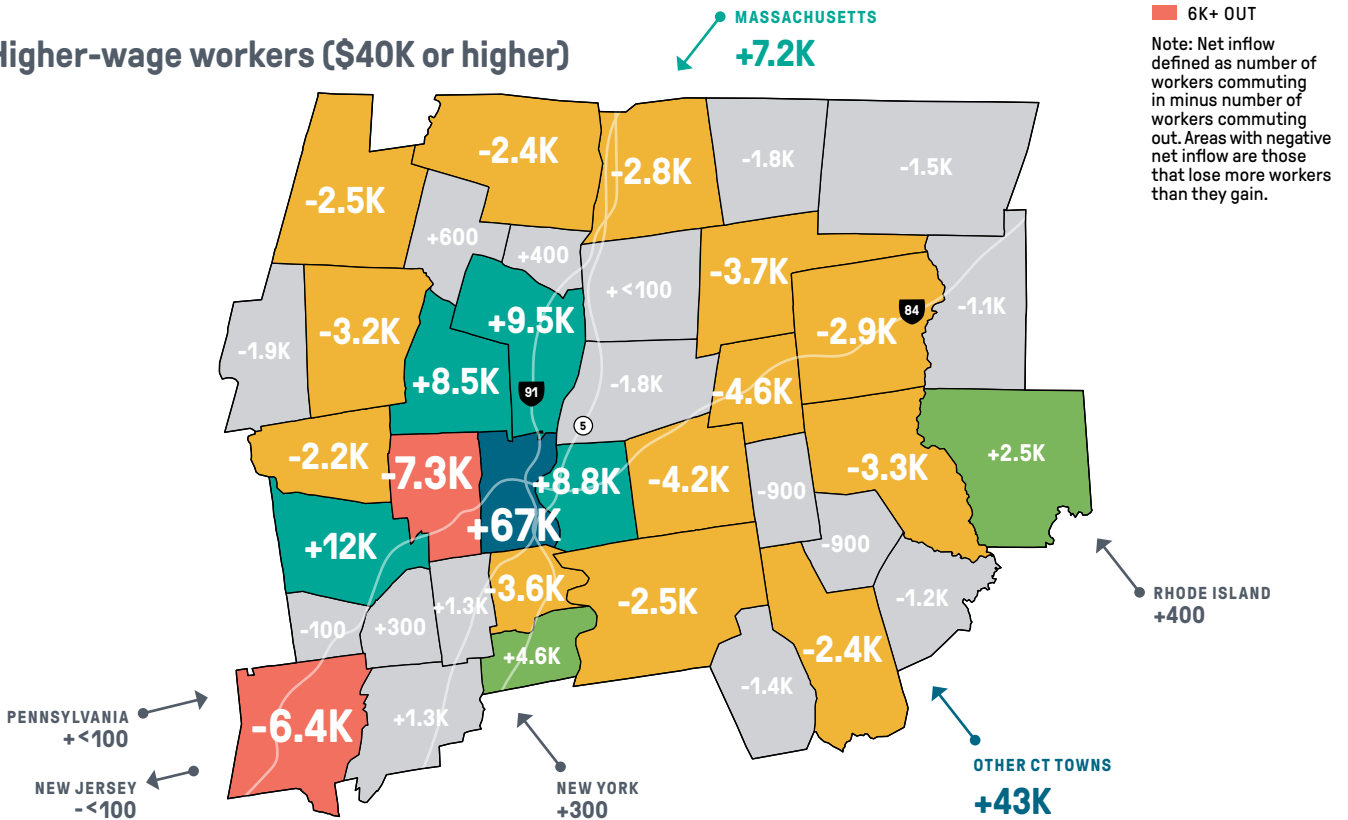
Lower-wage workers (under $40K)

MASSACHUSETTS +1.7K

RHODE ISLAND +<100

PENNSYLVANIA -<100

NEW JERSEY +<100

NEW YORK +700

OTHER CT TOWNS +23K
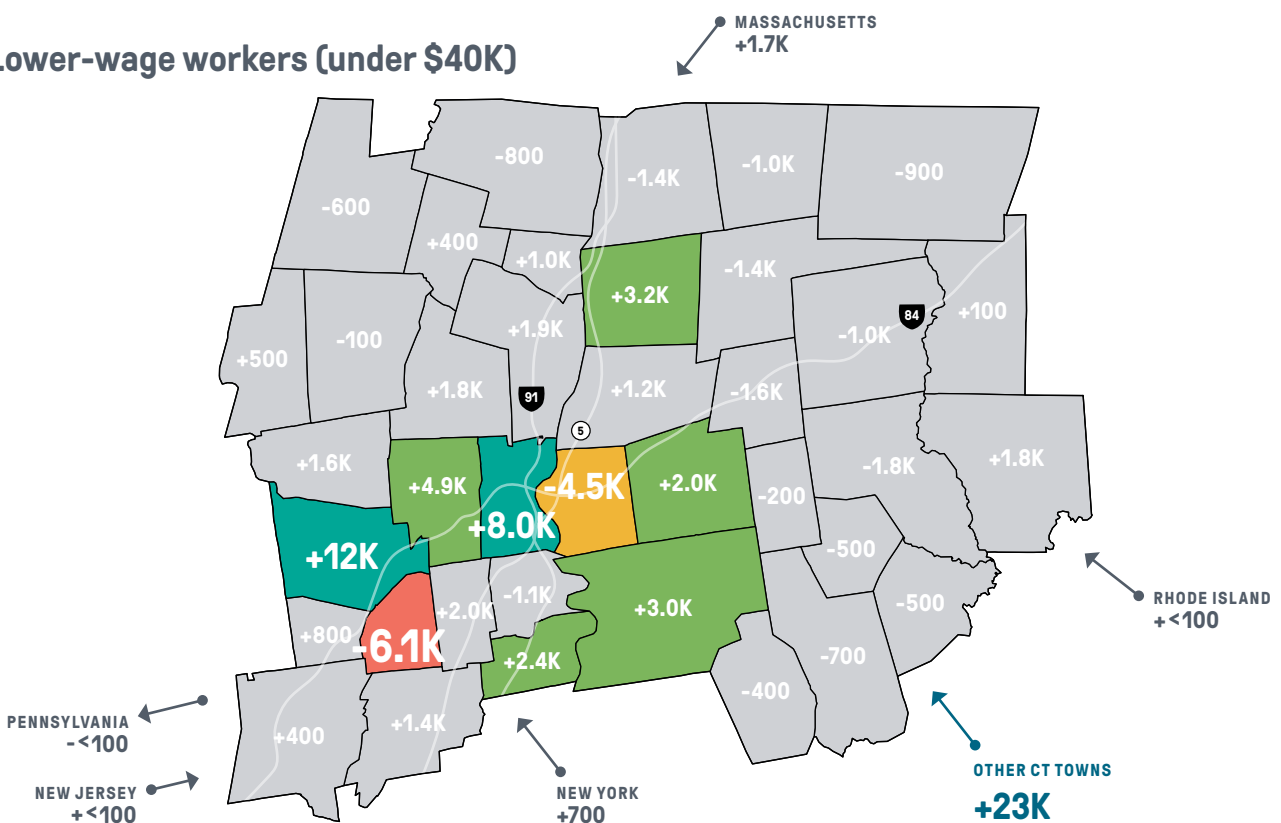
FIG 2.20

Greater Hartford's manufacturing sector has declined, while health care & social assistance jobs soar

NUMBER OF JOBS BY SECTOR, HARTFORD & TOLLAND COUNTIES, 2000–2017
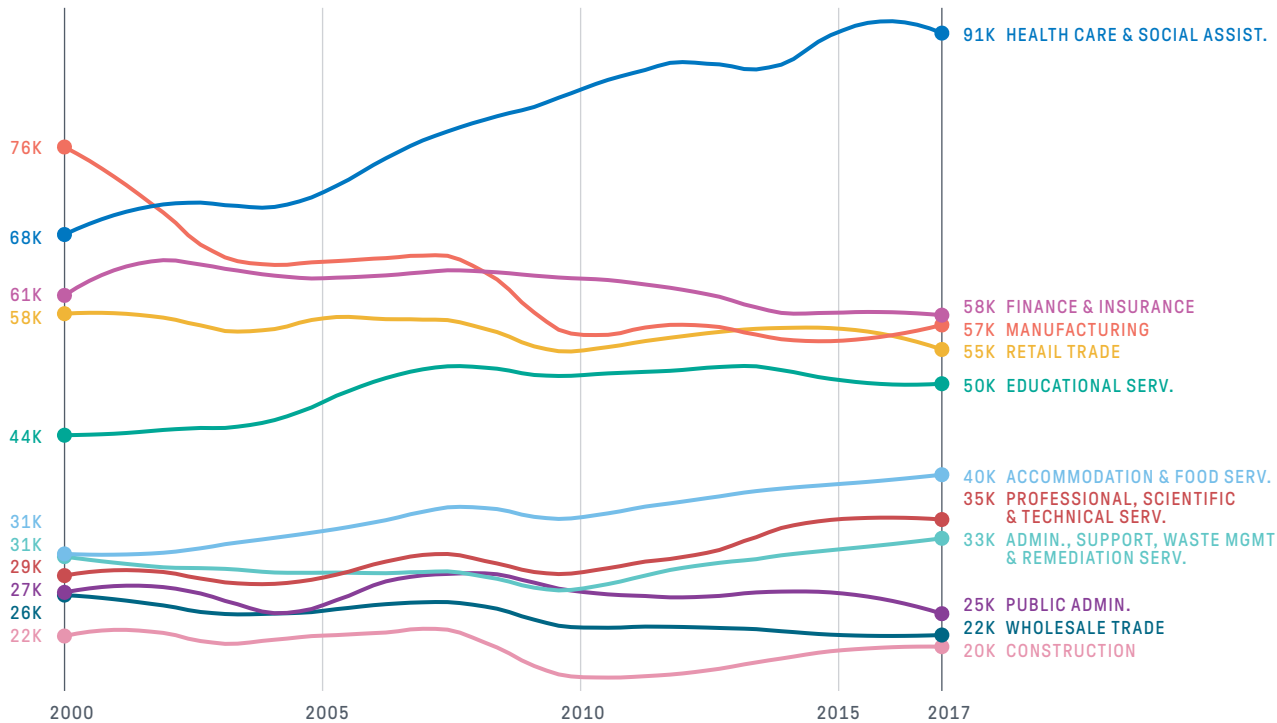
FIG 2.21

Hartford's Outer Ring school districts are much less diverse than the city's schools

COUNT OF K–12 STUDENTS BY RACE, PER 100 STUDENTS, 2018–2019
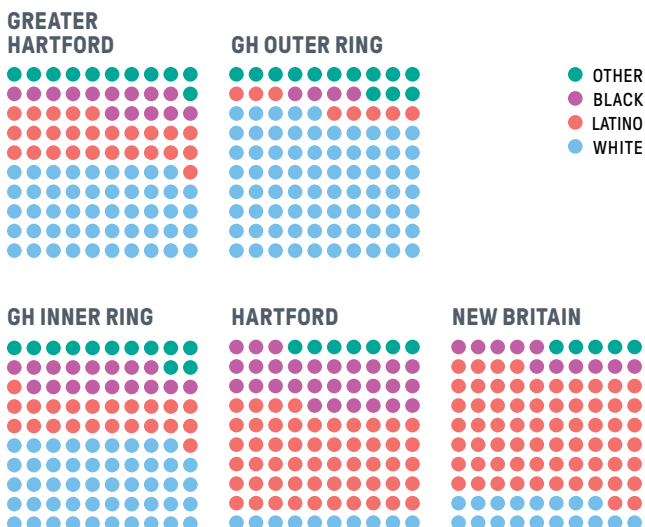
FIG 2.22

Black and special education students are suspended far more often than others

PERCENTAGE OF STUDENTS SUSPENDED OR EXPELLED AT LEAST ONCE DURING SCHOOL YEAR, GREATER HARTFORD K–12 DISTRICTS, 2017–2018
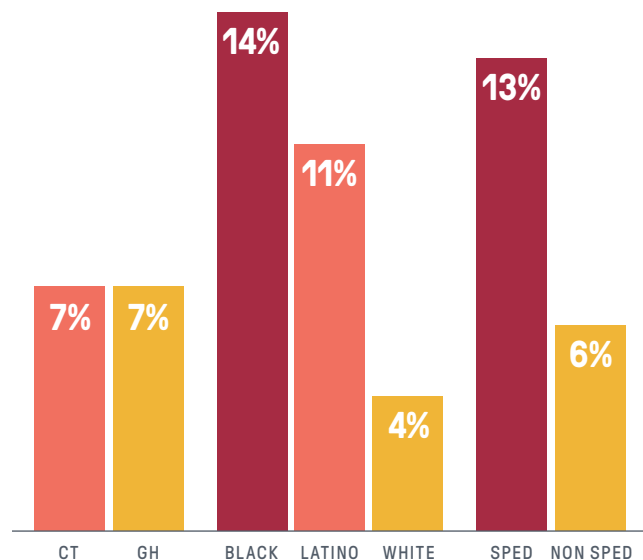
FIG 2.23

Greater Hartford schools have wide achievement gaps

PERCENT OF PUBLIC K–12 STUDENTS MEETING ACHIEVEMENT MEASURES, GREATER HARTFORD, 2017–2018

	4-year graduation rate[1]	Chronic absenteeism[2]	SBAC English proficiency rate[2]
			HIGH RISK / LOW RISK
BY GROUP			
NON-WHITE	78%	14%	30%
WHITE	93%	7%	69%
ELL	64%	24%	9%
NOT ELL	87%	12%	53%
FRPM	77%	22%	31%
NOT FRPM	95%	5%	70%
SPED	64%	22%	14%
NOT SPED	92%	10%	61%
REGION VS STATE			
GH	88%	12%	54%
CT	88%	11%	55%
BY DISTRICT			
GH OUTER RING	95%	6%	72%
GH INNER RING	89%	10%	54%
EAST HARTFORD	89%	16%	35%
HARTFORD	69%	25%	24%
MANCHESTER	86%	19%	36%
NEW BRITAIN	73%	22%	22%
WEST HARTFORD	93%	6%	70%

Note on school years: 1. Class of 2017 2. School year 2017–2018

GH Benchmark

FIG 2.24

Six years after graduating high school, only 51% of Greater Hartford public school students have a college degree

NUMBER AND PERCENTAGE OF STUDENTS ENROLLING IN, PERSISTING IN, AND GRADUATING FROM COLLEGE, OF GREATER HARTFORD HIGH SCHOOL GRADUATES
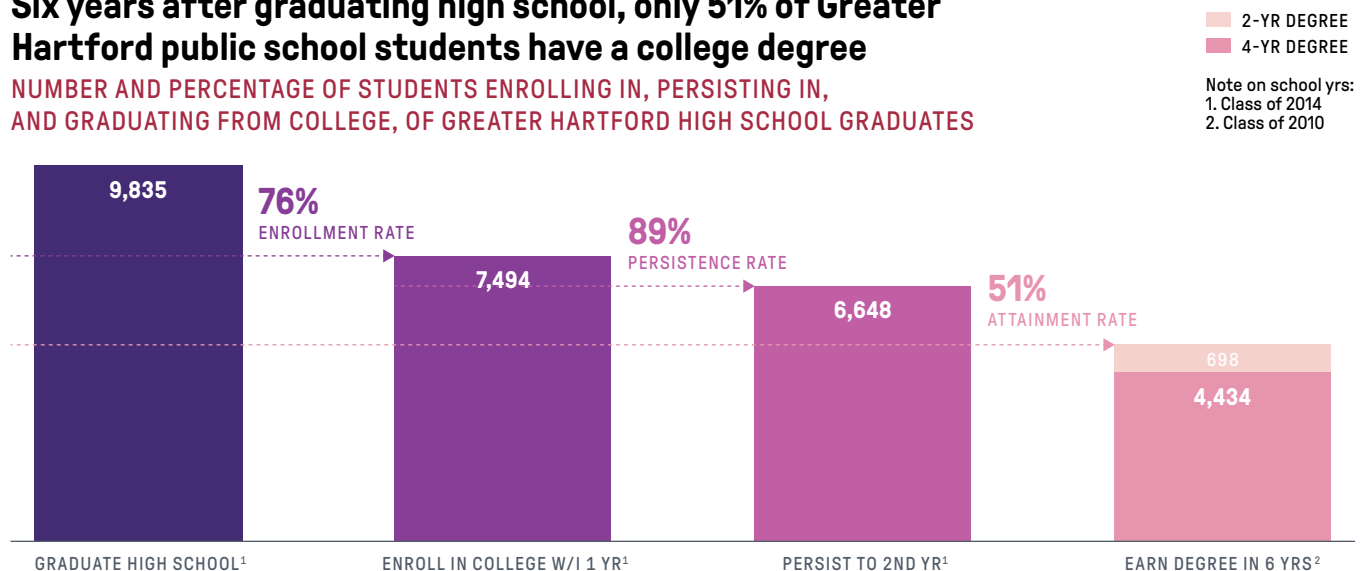
2-YR DEGREE
4-YR DEGREE

Note on school yrs:
1. Class of 2014
2. Class of 2010

9,835	7,494	6,648	698 / 4,434
	76% ENROLLMENT RATE	89% PERSISTENCE RATE	51% ATTAINMENT RATE
GRADUATE HIGH SCHOOL[1]	ENROLL IN COLLEGE W/I 1 YR[1]	PERSIST TO 2ND YR[1]	EARN DEGREE IN 6 YRS[2]

FIG 2.25

Greater Hartford residents have very different ideas of what young people experience

SHARE OF ADULTS RATING AS ALMOST CERTAIN OR VERY LIKELY THAT YOUNG PEOPLE IN THEIR AREA HAVE THE FOLLOWING EXPERIENCES, 2018

	GRADUATE FROM HIGH SCHOOL	GET A JOB WITH OPPORTUNITIES FOR ADVANCEMENT	GET ARRESTED FOR A FELONY
BY LOCATION ALL ADULTS			
CONNECTICUT	88%	59%	11%
GREATER HARTFORD	87%	60%	13%
HARTFORD	66%	42%	31%
GH INNER RING	88%	56%	12%
GH OUTER RING	93%	73%	5%
MANCHESTER	95%	60%	19%
NEW BRITAIN	70%	40%	31%
WEST HARTFORD	100%	87%	2%
GREATER HARTFORD BY RACE/ETHNICITY			
WHITE	91%	64%	8%
BLACK	80%	50%	25%
LATINO	75%	56%	29%
GREATER HARTFORD BY INCOME			
UNDER $30K	74%	48%	16%
$30K–$75K	81%	55%	16%
$75K–$100K	91%	62%	8%
$100K+	94%	76%	6%
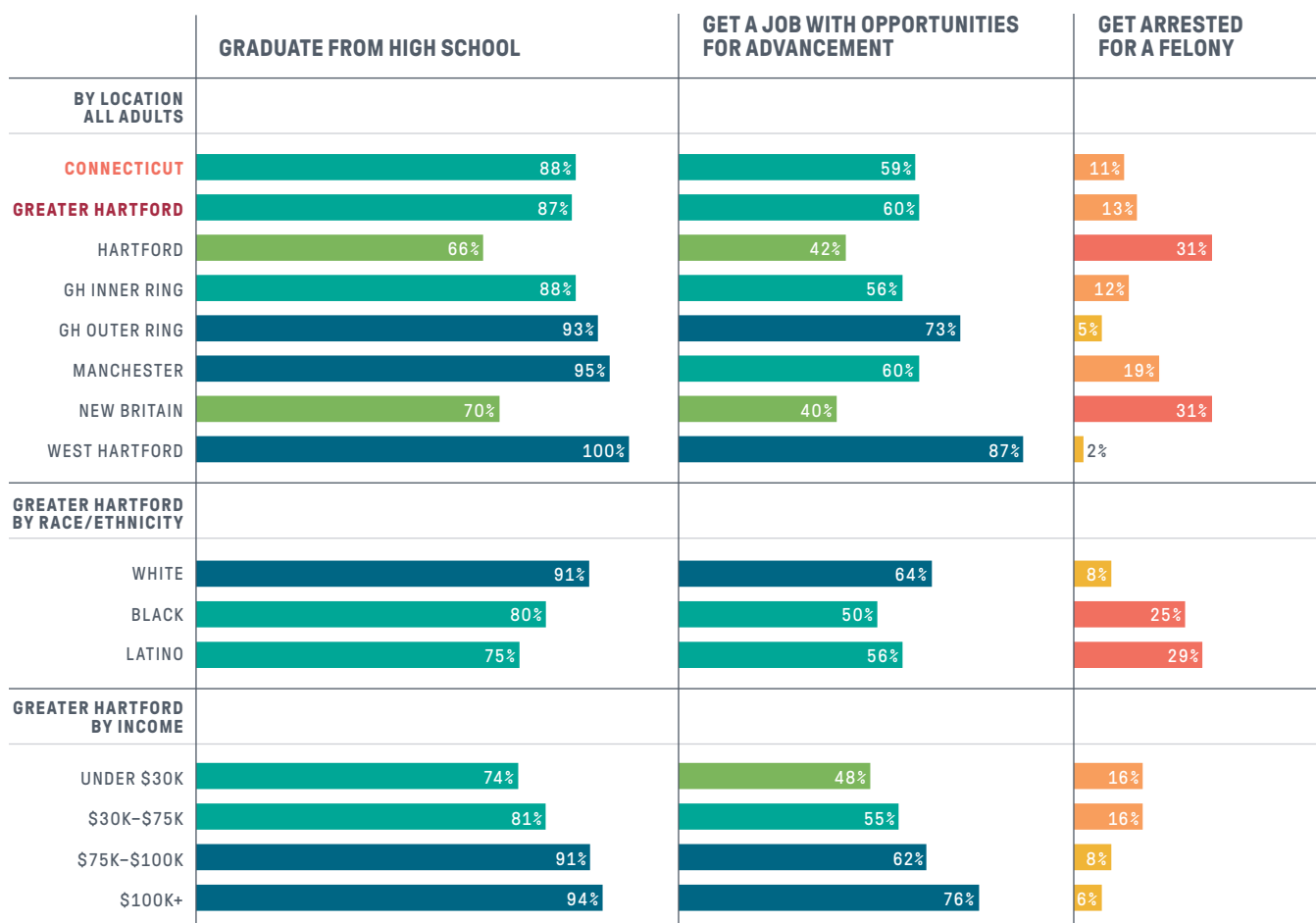
FIG 2.26

White children from low-income homes in Greater Hartford can expect greater upward economic mobility than Black children from high-income homes

PROBABILITY (%) OF REACHING TOP 20% OF HOUSEHOLD INCOMES AS ADULTS BY RACE AND CHILDHOOD HOUSEHOLD INCOME, HARTFORD & TOLLAND COUNTIES

BLACK
LATINO
WHITE

	LOW CHILDHOOD INCOME LEVEL	MIDDLE CHILDHOOD INCOME LEVEL	HIGH CHILDHOOD INCOME LEVEL
BLACK	5%	9%	13%
LATINO	6%	12%	22%
WHITE	18%	24%	33%
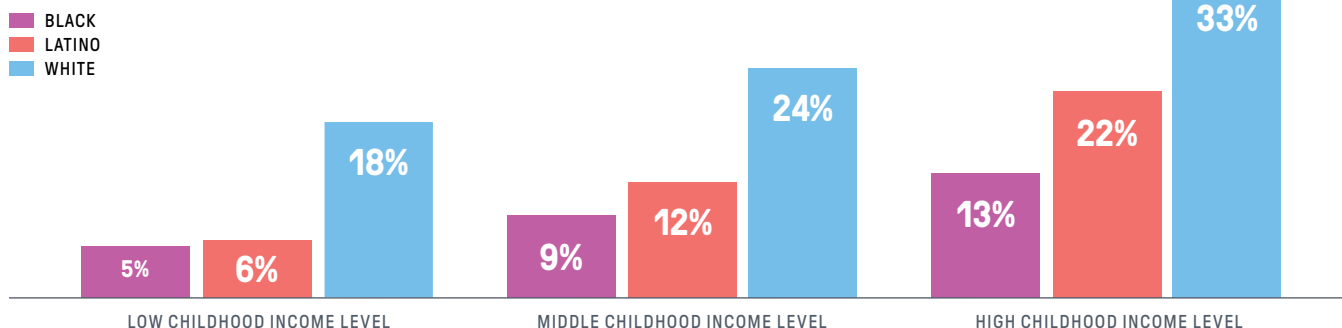
POPULATION CHANGE

A Growing Population

Greater Hartford (GH), as defined in this report, is the group of 38 Connecticut cities and towns served by the Capitol Region Council of Governments. The Greater Hartford region spans most of Hartford and Tolland Counties. It is similar to the Hartford-West Hartford-East Hartford metropolitan statistical area (MSA), a broader federal designation based on county boundaries that combines Hartford, Tolland, and Middlesex counties. The city of Hartford is by far the densest and most populous of Greater Hartford's municipalities, and is closely linked to many surrounding communities including the nearby city of New Britain, 13 GH Inner Ring towns (Berlin, Bloomfield, East Hartford, Enfield, Manchester, Newington, Plainville, Rocky Hill, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks), and 23 GH Outer Ring towns (Andover, Avon, Bolton, Canton, Columbia, Coventry, East Granby, East Windsor, Ellington, Farmington, Glastonbury, Granby, Hebron, Mansfield, Marlborough, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, and Willington).[24]

The total population of Greater Hartford's 38 towns and cities is 975,902, including 204,498 children. More than a third of the population lives in just five municipalities, however. The city of Hartford is the fourth-most populous municipality in the state with 124,390 residents, including 30,396 children. New Britain, West Hartford, Manchester, and East Hartford are among the 20 largest municipalities in the state with over 50,000 residents each. Since 1990, the regional population has increased by 7 percent, a growth rate slower than that of Connecticut overall (9 percent). The city of Hartford lost 11 percent of its population, or 15,349 people over this period. SEE TABLE 2A

An Aging Region

Between 2000 and 2017, the median age in Greater Hartford increased from 37.2 to 40.1.[25] This increase is in line with Connecticut's other urban counties, while the state's rural counties generally experienced steeper increases. Overall, the median age in Greater Hartford in 2017 was slightly younger than that of the state (40.8), but older than that of the U.S. (37.8).[26] The median age in Greater Hartford's largest cities—Hartford (30.9), New Britain (34.4), Manchester (35.4), and East Hartford (37.9)—are younger than that of the region overall, with the exception of West Hartford (41.1).[27]

From 1990 to 2015, Greater Hartford's population declined for two age groups: children under five years old decreased by 16 percent (9,740 children), and young adults ages 18 to 34 decreased by 15 percent (39,985 people).[28] Though older seniors ages 80 and over were the fastest-growing age group during this period, increasing by 55 percent (15,525 people), middle-aged adults ages 35 to 64 represented the largest segment of growth, increasing by 25 percent, or 79,285 people.[29]

Looking forward over the next two decades, Greater Hartford's total population is expected to increase 4 percent between 2015 and 2035, outpacing the 1 percent increase projected statewide.[30] However, this growth will not be evenly distributed. Greater Hartford's Inner Ring suburbs are expected to experience strong growth, increasing by 7 percent, or 28,937 people, while the population of the Outer Ring is expected to stay about the same.[31]

Greater Hartford's older population is projected to keep growing as the Baby Boomer generation ages. From 2015 to 2035, the region is expected to see an 18 percent increase in the senior population (ages 65 and over)—similar to the projected 20 percent statewide increase.[32] The transition of Baby Boomers into the senior age group is projected to contribute to a 1 percent decline in Greater Harford's middle-aged population, while children under five and young adult age groups are projected to grow.[33] The number of children under five is expected to increase by 8 percent, or 4,108 young children— partially offsetting the previous population decline of this age group between 1990 and 2015.[34] SEE FIG 2.1

Increased Diversity

Between 1990 and 2017, the share of people of color living in Greater Hartford increased from 19 percent of the population to 35 percent. In 2017, 65 percent of Greater Hartford residents were white, 12 percent were Black, 16 percent were Latino, 5 percent were Asian, and 2 percent were other races. Combined, the non-white population in the region doubled to 343,588 people between 1990 and 2017.[35] Meanwhile, the white population in Greater Hartford decreased by more than 105,000 between 1990 and 2017—a 14 percent reduction;

TABLE 2A

Population and growth

POPULATION IN GREATER HARTFORD AND TOWNS, 2017

LOCATION	POPULATION 1990	POPULATION 2017	POPULATION PERCENT CHANGE, 1990 TO 2017	DENSITY, 2017 POP. PER SQ. MI.	MEDIAN AGE 2000	MEDIAN AGE 2017	CHANGE IN MEDIAN AGE
United States	248,709,873	321,004,407	29%	91	35.3	37.8	2.5
Connecticut	3,287,116	3,594,478	9%	742	37.4	40.8	3.4
Greater Hartford	910,338	975,902	7%	950	37.2	40.1	2.9
Andover	2,540	3,179	25%	206	38.0	45.6	7.6
Avon	13,937	18,381	32%	792	42.0	45.1	3.1
Berlin	16,787	20,584	23%	783	41.0	48.6	7.6
Bloomfield	19,483	20,848	7%	799	43.9	50.2	6.3
Bolton	4,575	4,947	8%	344	40.5	47.0	6.5
Canton	8,268	10,339	25%	420	39.9	47.4	7.5
Columbia	4,510	5,442	21%	254	39.6	48.7	9.1
Coventry	10,063	12,458	24%	331	36.6	43.9	7.3
East Granby	4,302	5,220	21%	297	39.4	43.6	4.2
East Hartford	50,452	50,812	1%	2,823	37.4	37.9	0.5
East Windsor	10,081	11,409	13%	434	39.0	43.7	4.7
Ellington	11,197	15,948	42%	468	36.9	40.8	3.9
Enfield	45,532	44,608	-2%	1,340	37.3	41.0	3.7
Farmington	20,608	25,596	24%	911	40.4	43.8	3.4
Glastonbury	27,901	34,688	24%	676	39.8	45.8	6.0
Granby	9,369	11,323	21%	278	39.6	47.7	8.1
Hartford	139,739	124,390	-11%	7,149	29.7	30.9	1.2
Hebron	7,079	9,550	35%	259	36.8	44.5	7.7
Manchester	51,618	58,172	13%	2,123	36.5	35.4	-1.1
Mansfield	21,103	26,019	23%	583	22.0	21.1	-0.9
Marlborough	5,535	6,420	16%	274	39.0	44.3	5.3
New Britain	75,491	73,069	-3%	5,453	33.9	34.4	0.5
Newington	29,208	30,603	5%	2,336	41.9	44.9	3.0
Plainville	17,392	17,805	2%	1,836	39.6	43.4	3.8
Rocky Hill	16,554	20,015	21%	1,483	40.6	44.7	4.1
Simsbury	22,023	24,307	10%	717	39.6	44.7	5.1
Somers	9,108	11,284	24%	396	37.4	44.7	7.3
South Windsor	22,090	25,802	17%	918	39.0	43.5	4.5
Southington	38,518	43,817	14%	1,221	39.7	45.0	5.3
Stafford	11,091	11,901	7%	205	37.8	42.5	4.7
Suffield	11,427	15,675	37%	371	39.0	42.1	3.1
Tolland	11,001	14,838	35%	375	37.4	42.2	4.8
Vernon	29,841	29,182	-2%	1,649	37.7	39.2	1.5
West Hartford	60,110	63,360	5%	2,906	40.0	41.1	1.1
Wethersfield	25,651	26,395	3%	2,146	44.1	44.8	0.7
Willington	5,979	5,916	-1%	178	33.6	36.1	2.5
Windsor	27,817	29,037	4%	984	39.8	43.6	3.8
Windsor Locks	12,358	12,563	2%	1,396	38.9	44.0	5.1

TABLE 2B

Characteristics by race and origin

POPULATION OF GREATER HARTFORD BY RACE AND IMMIGRATION HISTORY, 2017

LOCATION	TOTAL POPULATION	PERCENT WHITE	PERCENT BLACK	PERCENT LATINO	PERCENT ASIAN	PERCENT OTHER RACE	FOREIGN-BORN POPULATION	PERCENT FOREIGN BORN
United States	321,004,407	62%	12%	18%	5%	3%	43,028,127	13%
Connecticut	3,594,478	68%	10%	15%	4%	3%	511,893	14%
Greater Hartford	975,902	65%	12%	16%	5%	2%	141,067	15%
Hartford	124,390	15%	35%	44%	3%	3%	27,154	22%
New Britain	73,069	42%	12%	41%	3%	2%	13,555	19%
GH Inner Ring	423,984	66%	13%	12%	6%	3%	67,544	16%
East Hartford	50,812	34%	25%	34%	4%	3%	11,094	22%
Manchester	58,172	58%	14%	14%	11%	4%	9,946	17%
West Hartford	63,360	73%	6%	11%	8%	3%	10,767	17%
GH Outer Ring	354,459	86%	2%	5%	5%	2%	32,814	9%

statewide, the white population decreased 11 percent.[36] SEE FIG 2.3

While the region's suburban towns have long been predominantly white, they are diversifying rapidly. Hartford's Inner Ring is 34 percent people of color, and its Outer Ring is only 14 percent, but these both represent non-white populations that have more than tripled in size since 1990. The region's largest cities are much more diverse than their surrounding towns: in 2017, 85 percent of Hartford residents and 58 percent of New Britain residents were people of color.[37] SEE TABLE 2B

Racial and ethnic diversity in Greater Hartford is highest among the population under 35, supporting the proposition that the region will continue to diversify over the coming decades.[38] Based on the 2010 decennial census figures, only 27 percent of middle-aged adults (ages 35 to 64), 17 percent of younger seniors (ages 65 to 79), and 9 percent of older seniors (ages 80 and up) in Greater Hartford were people of color; however, 50 percent of children under five and 41 percent of residents ages 5 to 34 identified as such.[39] SEE FIG 2.2

Greater Hartford's diverse population includes a substantial and growing immigrant community. In 2017, 15 percent of the region's residents, or 141,067 individuals, were foreign-born—a share similar to Connecticut overall (14 percent), and a 61 percent increase since 1990.[40] The region's immigrant population is most concentrated in the urban core and surrounding Inner Ring suburbs. In 2017, a larger share of Inner Ring residents was

foreign-born (16 percent) than Outer Ring (9 percent).[41] Immigrants comprised 22 percent of Hartford and East Hartford's populations, and slightly larger shares of Rocky Hill (24 percent) and Bloomfield (23 percent).[42] Additionally, large immigrant communities exist in New Britain (19 percent), West Hartford (17 percent) and Manchester (17 percent).[43] Immigrants from around the world call Greater Hartford home, including more than 5,000 residents each from Jamaica, India, Poland, China, and Peru.[44] Of particular note is the region's Polish population: 54 percent of the entire state's Poland-born population lives in the Greater Hartford region, and 22 percent live in New Britain alone.[45] SEE FIG 2.4, 2.5

In 2017, 54 percent of immigrants living in Greater Hartford were naturalized United States citizens—above the 50 percent naturalization rate for immigrants statewide.[46] Like other large cities in Connecticut, immigrants living in Hartford are less likely to be naturalized (41 percent) than in the Inner Ring (57 percent) or Outer Ring (61 percent).[47] Additionally, urban-dwelling immigrants are more likely to have arrived in the U.S. in 2000 or later.[48] Overall, 44 percent of immigrants residing in Greater Hartford arrived since 2000, with 18 percent arriving in 2010 or later. In Hartford, 41 percent of immigrants arrived since 2000, and 23 percent arrived in 2010 or later.[49]

As of 2016, 22 percent of Connecticut residents and 23 percent of Greater Hartford residents ages 5 and older lived in households

where English was not the primary language.[50] After English and Spanish, Polish, French, Portuguese, Italian, and Hindi are the most commonly spoken languages in the region.[51] In 2017, 8 percent of Greater Hartford residents ages 5 and older struggled with English proficiency, meaning they spoke English less than very well—equal to the state rate.[52] Low English proficiency is more common in Connecticut's large cities, as is the case in Hartford and New Britain (both 19 percent).[53]

Another aspect of diversity among Greater Hartford residents is in sexual orientation and gender identity. A 2016 Gallup poll found that 10 million Americans—4.6 percent—identify as lesbian, gay, bisexual, or transgender (LGBT), an increase of 1.75 million people since 2012.[54] The 2018 DataHaven Community Wellbeing Survey found that 8 percent of adults in Connecticut, and 7 percent in Greater Hartford, identify as not being straight. Additionally, 0.7 percent of adults in Connecticut and 0.8 percent of adults in Greater Hartford identify as transgender. Quantifying diversity in sexual orientation and gender identity is valuable in itself, but it also has important implications for other aspects of well-being, like health. LGBTQ individuals face specific health challenges, which are discussed in Chapter 3.

Changing Household Structure

In 2017, Greater Hartford had 374,482 total households, representing a 10 percent increase from 1990, or 33,910 additional households.[55, 56] The share of households headed by married couples has decreased, from 54 percent of the region's households in 1990 to 47 percent in 2017. The number of households composed of adults living alone or other non-family households has grown over this period.[57] SEE FIG 2.6

Compared to the state overall, Greater Hartford had a smaller share of married couple households (47 percent in Greater Hartford, 49 percent in Connecticut).[58] Connecticut's largest core cities generally had fewer married couple households and larger shares of less-traditional households compared to other towns and regions across the state. This is true in Hartford, where the share of households made up of an adult living alone (35 percent) was higher than that of the region overall (29 percent), while the city's share of married-couple households (21 percent) was less than half that of the region overall (47 percent).[59]

SEE TABLE 2C

TABLE 2C

Household structure

HOUSEHOLDS BY TYPE, GREATER HARTFORD, 2017

LOCATION	TOTAL HOUSEHOLDS COUNT	MARRIED, W/ CHLD. COUNT	MARRIED, W/ CHLD. SHARE	MARRIED, NO CHLD. COUNT	MARRIED, NO CHLD. SHARE	SINGLE, W/ CHLD. COUNT	SINGLE, W/ CHLD. SHARE	LIVING ALONE COUNT	LIVING ALONE SHARE	OTHER HOUSEHOLDS COUNT	OTHER HOUSEHOLDS SHARE
United States	118.8M	22.7M	19%	34.7M	29%	10.8M	9%	32.9M	28%	17.7M	15%
Connecticut	1,361,755	259,868	19%	404,743	30%	116,400	9%	383,275	28%	197,469	15%
Greater Hartford	374,482	68,955	18%	107,721	29%	33,978	9%	107,091	29%	56,737	15%
Hartford	45,822	3,753	8%	6,064	13%	9,053	20%	16,165	35%	10,787	24%
New Britain	28,531	3,211	11%	6,378	22%	4,261	15%	9,337	33%	5,344	19%
GH Inner Ring	169,750	30,836	18%	48,437	29%	13,421	8%	50,702	30%	26,354	16%
East Hartford	19,572	2,887	15%	4,343	22%	2,642	14%	5,701	29%	3,999	20%
Manchester	23,728	4,324	18%	5,898	25%	2,464	10%	7,152	30%	3,890	16%
West Hartford	24,470	5,780	24%	6,739	28%	1,670	7%	6,900	28%	3,381	14%
GH Outer Ring	130,379	31,155	24%	46,842	36%	7,243	6%	30,887	24%	14,252	11%

INCOME AND POVERTY

Median Income Disparities

Greater Hartford households had a median income of $75,531 in 2017—about $2,000 higher than Connecticut and $18,000 higher than the nation.[60] From 1990 to 2017, Connecticut's inflation-adjusted median household income decreased about 3 percent; Greater Hartford's median household income was stagnant during this period, decreasing by around 1.5 percent. The region's cities have fared even worse: adjusted for inflation, New Britain and East Hartford had among the steepest declines in the state, decreasing 21 percent and 22 percent, respectively. Hartford had the lowest median household income of any town in the state in both 1990 and 2017, and declined 16 percent since 1990. Meanwhile, the high-earning Outer Ring towns saw a modest 2.4 percent increase in inflation-adjusted median household income.[61]

Income inequality remains a significant issue in the region. In 2016, the Hartford MSA's level of income inequality ranked 29th of the 100 largest U.S. metros in 2016—a similar level of income inequality as the New Haven-Milford MSA (New Haven County), but lower than that of Fairfield County.[62] Median household income among Outer Ring towns was $98,077 in 2017—over $23,000 more than the Inner Ring ($74,833) and nearly three times that of Hartford ($33,841).[63] In 2016, the highest-earning 5 percent of households in Greater Hartford earned about $245,000 per year—almost 9 times more than the roughly $28,000 per year earned by the poorest 20 percent of households.[64] SEE FIG 2.8, 2.9

Wage Gaps and Wealth Gaps

While median household income is a useful indicator for analyzing inequality, it is critical to dig deeper into other underlying disparities, including differences in wages and wealth. Consider the wages of Greater Hartford's full-time, year-round workers ages 25 and older in 2016: when disaggregated by sex, men had median earnings of $62,766, compared to $50,597 for women. In other words, Greater Hartford's women earned 81 cents on the men's dollar—a smaller gender wage gap than Connecticut's overall (77 cents on the dollar), but still far from parity.[65]

Looking at full-time, year-round workers by both sex and race/ethnicity yields even starker discrepancies. The overall wage gap in Greater Hartford in 2016 can be largely attributed to the higher median earnings of white men; the intraracial wage gaps between Black men and Black women is 92 cents, and 86 cents between Latinos and Latinas. Statewide, the wage gap between men and women with graduate degrees was wider than within any other level of educational attainment.[66] In Greater Hartford, the median earnings for women with a graduate degree were $75,067, about $28,000 less than for men with a graduate degree, who earned $103,003.[67] Taking the analysis one step further, large wage gaps were apparent when disaggregating median earnings by sex, race/ethnicity, and educational attainment. For example, statewide, Latinas with bachelor's degrees earned about $4,600 less than white men with only high school diplomas; white men with bachelor's degrees made over $20,000 more than Black women with graduate or professional degrees, and about $22,000 more than Latinas with graduate or professional degrees.[68] SEE FIG 2.10

Beyond income is wealth—or the money, assets, and other financial resources that go beyond one's current paycheck. The racial wealth gap is a particular concern: nationally, white adults aged 60 to 70 have a median net worth about seven times greater than that of Black adults the same age. Differences in earnings are one important factor, but there are others: for instance, white families overall are about five times more likely than black families to receive the kind of large inheritance or cash transfer that might be used for the purchase of a home or vehicle, invested in business endeavors, or used toward education costs.[69] Discrimination also attenuates wealth accumulation for many Black homeowners; in 2016, the median home value in majority-Black neighborhoods in the Hartford-West Hartford-East Hartford MSA ($206,723) was estimated to be devalued by about 3 percent on average, or $6,097, after accounting for structural characteristics of homes and neighborhood amenities.[70] In Greater Hartford, 32 percent of Black and 27 percent of Latino adults report that they have a negative net worth, compared to 14 percent of white adults.[71] SEE TABLE 2F

Income Inequality

Income and wealth are perhaps the most important factors that influence where an individual or family lives, because of choice or the resources available to them. As is discussed later in this chapter, housing costs differ vastly—not only between municipalities, but also between neighborhoods. While gentrification has become a frequent topic of public debate, recent studies have found that the most common form of contemporary neighborhood change is the concentration of low-income populations. For example, one such study found that between 2000 and 2016, the low-income population of economically declining areas grew by 44 percent (5,369,000 people) in the 50 largest U.S. metropolitan areas.[72] According to this study, in 2016, 3.5 percent of residents in the Hartford MSA lived in economically expanding neighborhoods (those with a declining share of low-income population and growing number of non-low-income residents), while nearly 19 percent resided in economically declining neighborhoods (those with a growing share of low-income population and declining number of non-low-income residents).[73] Between 2000 and 2016, there was a 21 percent decline in the low-income population within Greater Hartford's economically expanding neighborhoods, and a 44 percent increase in low-income population within its economically declining neighborhoods, similar to trends in other large metropolitan areas.[74]

Analyzing population distribution by neighborhood income level paints a picture of the shrinking of the region's middle class, as increasing numbers of people are living in neighborhoods at the extremes.[75] Greater Hartford's middle-class neighborhoods—those where average family income is similar to that of the state overall—have progressively shrunk from housing 67 percent of the population in 1980 to only 50 percent in 2017. As the number of people living in these middle-class neighborhoods has declined and incomes have only increased in wealthier suburban areas, affluent neighborhoods have grown from being home to 4 percent of the region's population to 6 percent. Growth of neighborhoods considered poor compared to the state's average incomes has been even more stark. In 1980, about 49,000 people, or 6 percent of the region's population lived in poor neighborhoods; as of 2017, the population of these neighborhoods is more than 153,000, or 16 percent

Growing neighborhood income inequality

POPULATION AND DEFINITION BY NEIGHBORHOOD INCOME LEVEL, GREATER HARTFORD, 2017

INCOME BRACKET	DEFINITION BASED ON AVG FAMILY INCOME	POPULATION 1980	POPULATION 2017	CHANGE IN TOTAL POPULATION 1980–2017
Affluent	1.5x AFI or above	32,232	56,506	▲75%
High income	1.25 to 1.49x AFI	76,677	101,311	▲32%
Middle income	0.75 to 1.24x AFI	572,912	480,707	▼16%
Low income	0.5 to 0.74x AFI	123,318	176,219	▲43%
Poor	Under 0.5x AFI	48,920	153,428	▲214%

Note: See Fig. 2.11 for a graphic representation of these data.

of the total population. Not only have the populations of these extreme-income neighborhoods increased, but the number of neighborhoods themselves considered either affluent or poor has grown as well. SEE FIG 2.11 / SEE TABLE 2D

These income inequality trends have direct bearing on the well-being of Greater Hartford residents. A wealth of research shows that regardless of objective economic growth, communities will not become happier without addressing inequality.[76] Income inequality fragments communities by dismantling trust and ties, especially across socioeconomic lines.[77] In regions with higher levels of inequality, people are less likely to belong to social organizations and participate in civic life—all important components of community well-being.[78] The concentration of economically disadvantaged residents in particular neighborhoods has negative impacts on well-being that stem from fewer educational and job opportunities, increased health risks, and limited access to quality community resources.[79] Research indicates that areas that are more residentially segregated by race and income have lower levels of economic mobility, defined as the ability of those in the next generation to move up the economic ladder compared to their parents.[80] In towns experiencing an increasing concentration of low-income population, local governments may struggle to distribute public resources in a manner that meets the basic needs of their residents, resulting in overburdened public schools, underfunded public libraries, and deferred maintenance on parks, roads, and other infrastructure. SEE CHAPTER 4 / SEE FIG 2.12

Rising Low-Income Rate

Since 2000, the low-income rate in Greater Hartford has been on the rise. "Low-income" denotes individuals living in households with annual incomes of less than twice the federal poverty level, also encompassing those living below the poverty line.[81] In 2017, a family of two earning $32,480 or less was considered low-income, as was a family of four earning $49,200 or less.[82] Between 2000 and 2017, the share of Greater Hartford's population living in low-income households increased from 21 percent to 24 percent, similar to the statewide increase from 19 percent to 23 percent.[83] The low-income rate in the region's Inner Ring towns was 21 percent in 2017, well above the 12 percent rate in the Outer Ring, but significantly lower than that of Hartford and New Britain, which had low-income rates of 57 percent and 44 percent, respectively.[84] SEE TABLE 2E

In Greater Hartford and statewide, the low-income rate among children is both higher and growing faster than for the population as a whole. In 2017, about three out of four children ages 0 to 17 in Hartford lived in low-income households, meaning that in that city alone, more than 22,000 youth faced severe economic hardship.[85] Though Hartford had the highest child low-income rate in the region in 2017, the rate among Inner Ring suburbs has seen a sharper uptick, from 19 percent in 2000 to 27 percent in 2017. SEE FIG 2.7

Financial Security

While this report uses the low-income threshold to identify those living under severe economic hardship, many individuals and families above that line struggle mightily to make ends meet. The ALICE Project (Asset Limited, Income Constrained, Employed), a United Way initiative, utilizes a "household survival budget" based on the actual costs of basic necessities such as housing, childcare, food, transportation, and healthcare for different types of households in each county in Connecticut to establish an ALICE income threshold which encompasses households above the poverty line that earn less than the basic cost of living in the county.[86] The most recent ALICE analysis found that in 2016, 29 percent of Hartford County's households qualified as ALICE—along with an additional 11 percent of households below the poverty line. Taken together, 40 percent of households were struggling to satisfy basic needs required to live and work.[87]

DataHaven's 2018 Community Wellbeing Survey results revealed many Greater Hartford residents face financial stress: 33 percent of adults in the region report that they are just getting by or finding it difficult to manage financially.[88] These rates have changed little since the survey's 2015 iteration. SEE TABLE 2F

Low-income population

LOW-INCOME (<200% FPL) POPULATION BY AGE GROUP, GREATER HARTFORD, 2017

LOCATION	ALL AGES, POVERTY STAT. DETERMINED	ALL AGES, LOW-INCOME	ALL AGES, LOW-INCOME RATE	AGES 0–17, POVERTY STAT. DETERMINED	AGES 0–17, LOW-INCOME	AGES 0–17, LOW-INCOME RATE	AGES 0–5, POVERTY STAT. DETERMINED	AGES 0–5, LOW-INCOME	AGES 0–5, LOW-INCOME RATE
United States	313M	102.5M	33%	72.4M	30.6M	42%	23.4M	10.6M	45%
Connecticut	3,486,033	802,453	23%	752,655	225,715	30%	221,412	72,246	33%
Greater Hartford	937,534	222,388	24%	201,741	63,023	31%	59,884	19,846	33%
Hartford	117,628	66,750	57%	30,058	22,170	74%	9,863	7,517	76%
New Britain	70,316	30,743	44%	16,437	10,267	63%	5,167	3,272	63%
GH Inner Ring	414,929	85,420	21%	82,823	22,646	27%	26,214	7,164	27%
East Hartford	50,104	17,229	34%	10,871	5,202	48%	3,678	1,884	51%
Manchester	57,452	14,557	25%	12,439	4,750	38%	4,912	1,732	35%
West Hartford	61,585	10,307	17%	14,293	2,798	20%	3,614	585	16%
GH Outer Ring	334,661	39,475	12%	72,423	7,940	11%	18,640	1,893	10%

TABLE 2F

Financial insecurity

SHARE OF ADULTS, GREATER HARTFORD, 2018

LOCATION	JUST GETTING BY	LESS THAN 2MO SAVINGS	NEGATIVE NET WORTH	FOOD INSECURE	UTILITY SHUTOFF THREAT	TRANSPORTATION INSECURE	NO BANK ACCOUNT
Connecticut	33%	33%	17%	13%	10%	12%	9%
GH	33%	34%	17%	14%	12%	12%	9%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD							
Male	27%	28%	14%	11%	9%	12%	8%
Female	37%	40%	20%	16%	14%	12%	10%
Age 18–34	43%	48%	26%	22%	17%	19%	13%
Age 35–49	37%	41%	18%	17%	20%	12%	9%
Age 50–64	29%	26%	13%	11%	7%	9%	7%
Age 65+	19%	18%	7%	4%	2%	7%	5%
White	28%	31%	14%	11%	7%	9%	6%
Black	53%	45%	32%	23%	23%	24%	12%
Latino	45%	49%	27%	29%	20%	23%	25%
<$15K	66%	62%	47%	37%	22%	37%	35%
$15K–$30K	56%	58%	32%	28%	20%	26%	14%
$30K–$50K	47%	41%	22%	20%	14%	13%	8%
$50K–$75K	38%	32%	13%	15%	16%	11%	8%
$75K–$100K	25%	28%	10%	8%	10%	5%	2%
$100K–$200K	13%	24%	9%	2%	4%	4%	2%
$200K+	3%	13%	2%	3%	5%	3%	3%
BY GEOGRAPHY							
Hartford	49%	46%	29%	23%	24%	26%	23%
New Britain	42%	56%	32%	25%	16%	19%	17%
GH Inner Ring	36%	37%	17%	15%	14%	12%	9%
East Hartford	44%	N/A	N/A	18%	25%	19%	13%
Manchester	36%	27%	22%	23%	16%	12%	12%
West Hartford	17%	16%	18%	5%	7%	6%	5%
GH Outer Ring	20%	28%	8%	8%	3%	7%	5%

"In 2016, the highest-earning 5 percent of households in Greater Hartford earned about $245,000 per year—almost 9 times more than the roughly $28,000 per year earned by the poorest 20 percent of households."
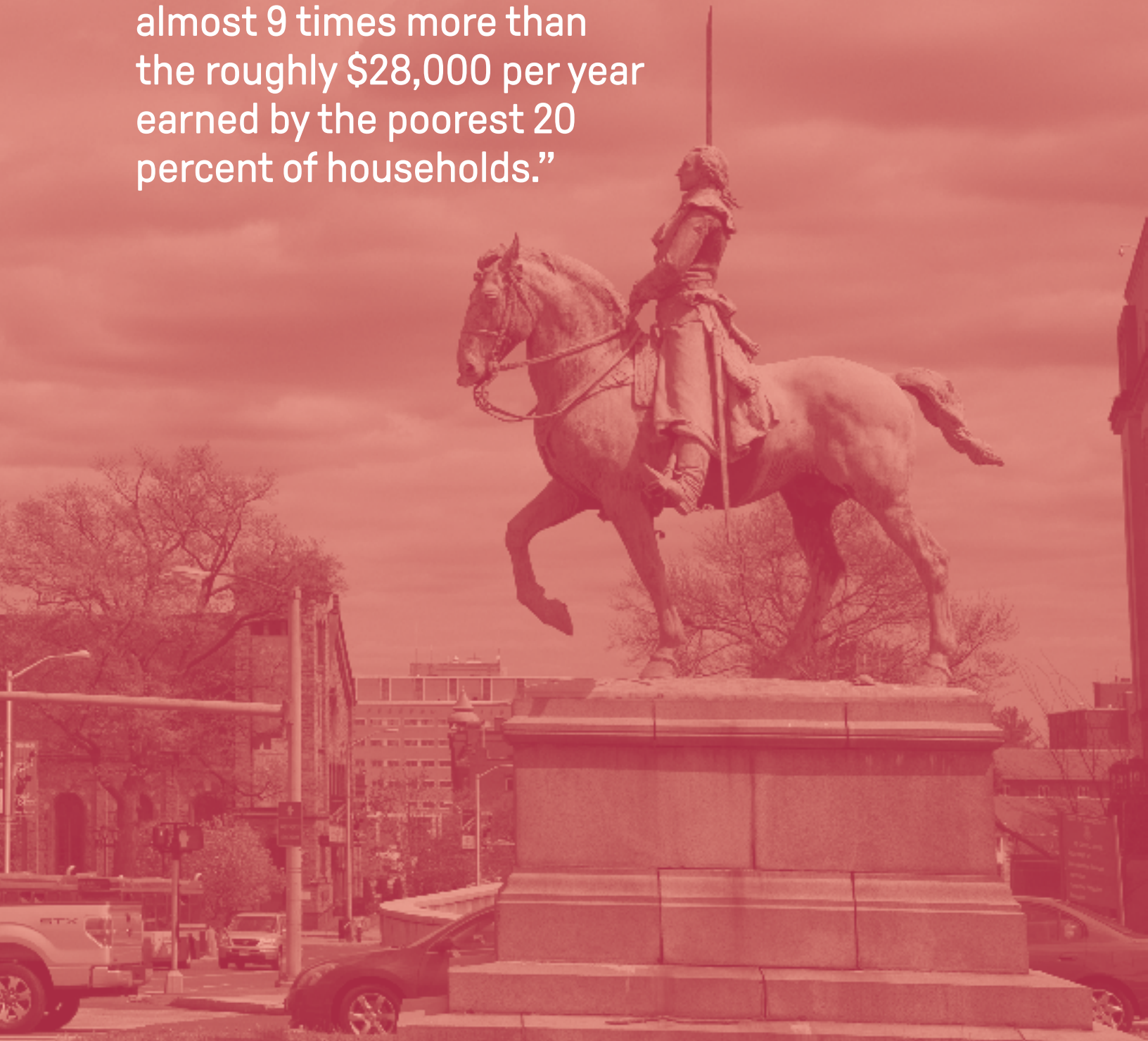
HOUSING

Housing Stock

In 2017, 65 percent of Greater Hartford households owned the home in which they lived, compared to 67 percent statewide.[89] The region's homeownership rate grew slowly but steadily between 1980 and 2010, from 61 to 68 percent.[90] But this gain was diminished between 2010 and 2017, when the rate decreased to 65 percent.[91] The recent decline in homeownership, a trend seen across Connecticut and nationally, reflects the massive impact of the 2008 housing crash and subsequent Great Recession.

Statewide, large cities such as Hartford tend to have lower homeownership rates than surrounding suburbs. Only 24 percent of households in Hartford and 41 percent of households in New Britain are owner-occupied, versus 69 percent of Inner Ring households and 81 percent of Outer Ring households.[92] Homeownership rates also vary widely by race in Greater Hartford. In 2017, 77 percent of white households owned their housing, compared to 41 percent of Black households and 32 percent of Latino households.[93] SEE TABLE 2G

In 2017, the majority of housing units in Greater Hartford were single-family (63 percent), a similar mark as the state overall (65 percent).[94] The region's shifting household structure is affecting the types of housing units being built.[95] Housing units in multi-family residential buildings, historically concentrated in urban areas, are increasingly becoming the housing type of choice for young workers, single adults, and other non-traditional households, due to a preference to be nearer to the amenities typical of denser, urban communities; the inability to afford a single-family home; or a desire to downsize.

Developers continue to respond to this shift in housing demand: 56 percent of housing units built between 2014 and 2017 in Greater Hartford were in multi-family buildings, compared to 33 percent built between 2010 and 2013, and just 20 percent built between 2001 and 2004.[96] In the region's Inner Ring, 75 percent of units built between 2014 and 2017 were in multi-family buildings, compared to 40 percent of units built in the Outer Ring.[97] SEE TABLE 2H

Housing Affordability

The cost of owning a home in Greater Hartford can be high, particularly in the Outer Ring towns. In 2017, Greater Hartford's median housing value was about $249,000, more than $20,000 below the

TABLE 2G

Homeownership

HOMEOWNERSHIP RATE, TOTAL AND BY RACE OF HOUSEHOLDER, GREATER HARTFORD, 2017

LOCATION	TOTAL HOUSE-HOLDS	OWNER OCCUPIED HOUSE-HOLDS	HOME-OWNER-SHIP RATE	WHITE TOTAL HOUSE-HOLDS	WHITE OWNER OCCUPIED HOUSE-HOLDS	WHITE HOME-OWNER-SHIP RATE	BLACK TOTAL HOUSE-HOLDS	BLACK OWNER OCCUPIED HOUSE-HOLDS	BLACK HOME-OWNER-SHIP RATE	LATINO TOTAL HOUSE-HOLDS	LATINO OWNER OCCUPIED HOUSE-HOLDS	LATINO HOME-OWNER-SHIP RATE
United States	118.8M	75.8M	64%	81.3M	58.2M	72%	14.5M	6.1M	42%	15.1M	7M	46%
Connecticut	1.4M	906,798	67%	1M	762,221	76%	130,942	51,237	39%	164,460	55,650	34%
Greater Hartford	374,482	244,711	65%	262,285	200,954	77%	43,204	17,809	41%	48,083	15,364	32%
Hartford	45,822	10,904	24%	7,640	2,990	39%	17,655	4,618	26%	18,694	3,111	17%
New Britain	28,531	11,652	41%	14,164	7,687	54%	3,410	1,209	36%	9,996	2,353	24%
GH Inner Ring	169,750	116,934	69%	122,739	93,269	76%	20,027	10,757	54%	15,668	7,527	48%
East Hartford	19,572	11,105	57%	8,478	6,536	77%	4,748	1,856	39%	5,591	2,314	41%
Manchester	23,728	13,478	57%	15,356	10,538	69%	2,629	964	37%	2,504	961	38%
West Hartford	24,470	17,591	72%	19,440	15,080	78%	1,322	497	38%	1,970	958	49%
GH Outer Ring	130,379	105,221	81%	117,742	97,008	82%	2,112	1,225	58%	3,725	2,373	64%

TABLE 2H

Housing units and new housing permits

HOUSING UNITS PER STRUCTURE (2017) AND NEW HOUSING PERMITS PER YEAR (2001–2017), GREATER HARTFORD

LOCATION	CURRENT HOUSING STOCK							NEW HOUSING PERMITS								
	TOTAL UNITS COUNT	SINGLE FAMILY COUNT	SINGLE FAMILY SHARE	2 TO 9 UNITS COUNT	2 TO 9 UNITS SHARE	10+ UNITS COUNT	10+ UNITS SHARE	ALL UNITS AVG CT. 2001–2004	ALL UNITS AVG CT. 2014–2017	ALL UNITS CHANGE	SINGLE FAMILY AVG CT. 2001–2004	SINGLE FAMILY AVG CT. 2014–2017	SINGLE FAMILY CHANGE	MULTI FAMILY AVG CT. 2001–2004	MULTI FAMILY AVG CT. 2014–2017	MULTI FAMILY CHANGE
Connecticut	1.5M	974K	65%	336.7K	23%	185K	12%	10,323	4,032	↓61%	8,440	1,844	↓78%	1,883	2,188	↑16%
Greater Hartford	403K	255K	63%	92,158	23%	55,141	14%	2,798	1,052	↓62%	2,236	448	↓80%	562	604	↑7%
Hartford	53,671	10,491	20%	26,841	50%	16,339	30%	144	4	↓97%	42	4	↓90%	102	0	↓100%
New Britain	32,038	10,940	34%	15,307	48%	5,791	18%	36	14	↓61%	32	11	↓66%	4	3	↓25%
GH Inner Ring	180K	122K	68%	33,036	18%	24,490	14%	971	480	↓51%	677	108	↓84%	294	372	↑27%
East Hartford	21,062	12,444	59%	4,840	23%	3,778	18%	10	2	↓80%	9	2	↓78%	0	0	N/A
Manchester	25,264	14,150	56%	6,006	24%	5,108	20%	142	39	↓73%	88	8	↓91%	54	30	↓44%
West Hartford	25,742	17,986	70%	3,600	14%	4,156	16%	71	57	↓20%	46	8	↓83%	24	49	↑104%
GH Outer Ring	137K	112K	81%	16,974	12%	8,521	6%	1,648	555	↓66%	1,486	326	↓78%	163	229	↑40%

statewide median of $270,100.[98] In 2017, the median housing value in Greater Hartford's Outer Ring towns was over $291,000, compared to $228,000 in the Inner Ring and well under $200,000 in East Hartford, Hartford, and New Britain.[99] Overall, inflation-adjusted median housing values in the region increased by $33,347, or 16 percent, between 2000 and 2017; the statewide increase during this period was $40,853, or 18 percent.[100] Within Greater Hartford and a few surrounding towns, white homeowners' median home values are similar to the region, approximately $237,100, while Black and Latino homeowners' median values are under $180,000.[101] The substantial differences in housing values between towns in the region and between racial groups mean that many prospective homeowners are limited to more affordable communities, potentially contributing to the region's neighborhood income inequality.

SEE FIG 2.13

In Connecticut in 2017, more than 37,000 mortgages were issued to homebuyers,[102] 5 percent of which qualified as high-cost. High-cost mortgages have annual percentage rates that exceed by a certain threshold the rate that would be granted to a well-qualified borrower.[103] These mortgages are more expensive for borrowers, theoretically increasing the risk of default. In Connecticut, the proportion of mortgages qualifying as high-cost held around 1 percent from

2010 to 2012, peaked at 7 percent in 2014, sharply declined, and now appears to be increasing as of 2016. In Greater Hartford, 4.5 percent of mortgages in 2017 were high-cost, but the share of high-cost mortgages varied widely by town, from 11 percent in East Hartford and 10.5 percent in Hartford to 1 percent or less in Wethersfield and West Hartford.[104]

Historically, Black and Latino homebuyers have received high-cost mortgages more often than white borrowers. In Greater Hartford in 2017, just 3 percent of white borrowers received high-cost mortgages, compared to 10 percent of Latino borrowers and 12 percent of Black borrowers. Statewide in the same year, 4 percent of white borrowers, 12 percent of Black borrowers, and 11 percent of Latino borrowers received high-cost mortgages. These loans are often concentrated in areas with more non-white residents. The average high-cost mortgage in Greater Hartford in 2017 went to a homebuyer in a census tract where 37 percent of the residents were people of color. Non-high cost mortgages were given in census tracts with 24 percent people of color, on average.[105]

Homebuyers with lower incomes are more likely to receive high-cost mortgages. In Greater Hartford, the median income for high-cost borrowers in 2017 was $65,000, compared to $80,000 for borrowers with non-high cost

mortgages. The median loan amount for a high-cost mortgage was $165,000, compared to $200,000 for other mortgages.[106] In both cases, loan amounts are lower than the median home value of $249,000 in Greater Hartford suggesting that more affordable housing is in demand.

Housing affordability is a serious issue in Greater Hartford. The 2018 DataHaven Community Wellbeing Survey found that 8 percent of adults in the region reported not having enough money for housing or shelter at some point in the preceding year.[107] However, data from the U.S. Census Bureau shows that a much larger portion of households in Greater Hartford were housing cost-burdened (34 percent)—meaning that they spent more than the recommended 30 percent of their total income on housing costs—or severely cost-burdened (15 percent), spending more than 50 percent of their income on housing.[108] In the North Hartford Promise Zone and Southside/South End neighborhoods of Hartford, the severe cost-burden rate is 32 percent.[109] Renters are generally at heightened risk: 25 percent of Greater Hartford's renter-occupied households were severely housing cost-burdened, more than double the 10 percent of owner-occupied households.[110]

The overall housing cost-burden rate in Hartford and Tolland Counties peaked in 2010 during the Great Recession at 37 percent, and has steadily decreased during the post-recession years.[111] While the cost-burden rate for homeowners has returned to its 2005 rate of 26 percent, the rate for renters has actually gone up from its pre-Recession value, from 44 percent to 47 percent.[112] SEE FIG 2.14 / SEE TABLES 1B, 2I

In 2017, the median rent for a two-bedroom housing unit in Greater Hartford was $1,132 per month, or $13,584 annually.[113] Based on this, the average renting household in Greater Hartford would need to earn $45,280 per year to be able to avoid being cost-burdened—about $2,600 more than the median household income of the region's renter households.[114] This rent affordability shortfall varies across the region, but is particularly high in Hartford ($12,800) and New Britain ($8,400), where the majority of households rent and where affordable housing is scarce. SEE FIG 2.15

Renters facing this affordability shortfall may also face the possibility of eviction when their wages are not enough to cover rent. The eviction rate (number of evictions per renter-occupied household) in Connecticut between 2001 and 2016 averaged 3.1 percent, peaking at 3.9 percent in 2003. In 2016, the eviction rate in Connecticut was 3.0 percent—or 13,800 households, slightly higher than the national average that year of 2.3 percent. In Greater Hartford, 3.4 percent, or approximately 4,700 renter-occupied households, were evicted in 2016. Forty-three percent of these formal evictions took place in Hartford, where 2,024 or 5.7 percent

TABLE 2I

Housing costs

MEDIAN HOUSING VALUE AND SEVERE HOUSING COST BURDEN, GREATER HARTFORD, 2017

LOCATION	MEDIAN HOUSING VALUE	NUMBER OF HOUSEHOLDS	SEVERELY COST BURDENED	SEVERE COST-BURDEN RATE	NUMBER OF RENTER HOUSEHOLDS	SEVERELY COST BURDENED	RENTER SEVERE COST-BURDEN RATE
United States	$193,500	118,825,921	17,391,545	15%	42,992,786	10,170,930	24%
Connecticut	$270,100	1,361,755	223,106	16%	454,957	115,898	26%
Greater Hartford	$248,916	374,482	56,274	15%	129,771	32,049	25%
Hartford	$162,300	45,822	13,030	28%	34,918	11,208	32%
New Britain	$156,800	28,531	5,864	21%	16,879	4,147	25%
GH Inner Ring	$227,935	169,750	23,078	14%	52,816	11,047	21%
East Hartford	$159,800	19,572	3,586	18%	8,467	2,105	25%
Manchester	$182,100	23,728	3,764	16%	10,250	2,441	24%
West Hartford	$326,000	24,470	3,354	14%	6,879	1,545	23%
GH Outer Ring	$291,410	130,379	14,302	11%	25,158	5,647	22%

of renter-occupied households were evicted in 2016—the highest rate in the region that year, and third highest rate in the state. Suffield had the lowest eviction rate in the region of just 0.3 percent or 3 households. These rates are derived from the best available nationwide evictions dataset, which is based on court-reported filings and whether an eviction took place as a result. Because not all evictions take place through the legal system, and because these data are based solely on available court records, these rates likely do not capture the true magnitude of evictions.[115]

Evictions, whether formal or informal, do not affect all families equally. The 2018 DataHaven Community Wellbeing Survey found that 16 percent of white adults, 26 percent of Black adults, and 38 percent of Latino adults in Greater Hartford had moved within the past three years; of these adults, who were mostly renters, about 7 percent had been evicted.[116] Of those who were not evicted, 13 percent said they had moved in part because of rent increases at their previous home, and 9 percent said they moved because their landlord would not fix things. Low-income adults (earning less than $30,000 per year) and adults living with children were more likely to report having been unable to afford adequate housing at some point in the past year. For children in housing-insecure families, educational and cognitive development outcomes are a concern as they must cope with the stress of increased residential mobility and risk of homelessness.[117]

Housing Discrimination

Redlining is the shorthand used to refer to the practice of rating certain neighborhoods as risky or undesirable for investment for reasons historically rooted in the races, ethnicities, occupations, and income levels of the areas' residents. In the early 1930s, the federal government established the Home Owners' Loan Corporation (HOLC) to help fund mortgages for homebuyers. HOLC created maps of cities that rated neighborhoods from A ("Best") to D ("Hazardous"), including parts of Hartford, West Hartford, East Hartford, and New Britain.[118] Neighborhoods rated as "hazardous" were shaded red and were subsequently considered to be too risky for mortgage loans or other investments.

Today, the impact of redlining on communities across the country remains apparent. Comparing the neighborhoods targeted for investment decades ago to demographics from 2010,[119] we notice comparatively high rates of homeownership in higher-grade areas—80 percent in Greater Hartford's A-grade areas compared to 38 percent across all HOLC-mapped blocks in the region and just 16 percent in D-grade areas. The areas are also racially segregated, and higher-grade areas were predominantly white in 2010. More than 81 percent of residents in A-grade areas were white, compared to just 9 percent in D-grade areas.[120] SEE FIGURES 2.16, 2.17, 2.18

Zoning is perhaps the most common and powerful tool policymakers have at their disposal to encourage the development of more affordable housing where it is needed most, but local zoning codes are often used instead to prevent the development of such units. At their worst, zoning regulations further perpetuate decades of race- and class-based discrimination. A recent Connecticut Mirror/ProPublica article reveals the extent to which zoning regulations in southwest Connecticut prevent willing developers from building affordable housing despite evident need and demand.[121] When they are permitted to break ground, these affordable developments are disproportionately located in low-income neighborhoods and communities of color, further reinforcing social and economic segregation. For example, according to the Connecticut Department of Housing, nearly 39 percent of Hartford's total housing units received some form of government housing assistance in 2018, compared to about 7 percent of units in West Hartford and about 11 percent of the state's housing stock overall.[122]

Wage trends by sector

AVG. WAGE BY INDUSTRY, HARTFORD & TOLLAND
COUNTIES, 2000–2017, IN 2017 DOLLARS

INDUSTRY	WAGE 2017	CHANGE IN WAGE, 2000–2017	PERCENT CHANGE
All NAICS Sectors	$66,107	↑$3,482	↑5.6%
Finance and Insurance	$130,057	↑$31,871	↑32.5%
Health Care and Social Assistance	$52,810	↑$2,293	↑4.5%
Manufacturing	$83,854	↑$4,269	↑5.4%
Professional, Scientific, and Technical Services	$94,999	↑$2,392	↑2.6%
Educational Services	$57,848	↑$1,970	↑3.5%
Public Administration	$76,426	↑$7,831	↑11.4%
Wholesale Trade	$82,603	↓$568	↓0.7%
Retail Trade	$31,764	↓$4,407	↓12.2%
Construction	$71,549	↑$2,870	↑4.2%
Management of Companies and Enterprises	$112,505	↑$25,909	↑29.9%
Administrative and Support and Waste Management and Remediation Services	$41,031	↑$3,411	↑9.1%
Information	$95,494	↑$18,079	↑23.4%
Transportation and Warehousing	$45,701	↑$739	↑1.6%
Accommodation and Food Services	$20,778	↓$972	↓4.5%
Other Services (except Public Administration)	$35,642	↓$1,933	↓5.1%
Real Estate and Rental and Leasing	$69,960	↑$7,289	↑11.6%
Arts, Entertainment, and Recreation	$32,070	↓$455	↓1.4%
Utilities	$102,554	↑$719	↑0.7%
Agriculture, Forestry, Fishing and Hunting	$36,173	↓$867	↓2.3%
Mining, Quarrying, and Oil and Gas Extraction	$61,545	↓$4,394	↓6.7%

Changing industry footprint

SHARE OF TOTAL PAYROLL BY INDUSTRY, HARTFORD & TOLLAND
COUNTIES, 2000–2017

INDUSTRY	PAYROLL	SHARE OF PAYROLL 2000	SHARE OF PAYROLL 2017	CHANGE SHARE OF PAYROLL
All NAICS Sectors	$38,000,000,000	N/A	N/A	N/A
Finance and Insurance	$7,600,000,000	17.2%	20.1%	↑2.9%
Health Care and Social Assistance	$4,800,000,000	9.9%	12.7%	↑2.8%
Manufacturing	$4,700,000,000	17.4%	12.6%	↓4.8%
Professional, Scientific, and Technical Services	$3,300,000,000	7.7%	8.9%	↑1.2%
Educational Services	$2,900,000,000	7.1%	7.8%	↑0.7%
Public Administration	$1,900,000,000	5.3%	5.1%	↓0.2%
Wholesale Trade	$1,800,000,000	6.2%	4.8%	↓1.4%
Retail Trade	$1,700,000,000	6.1%	4.6%	↓1.5%
Construction	$1,400,000,000	4.4%	3.8%	↓0.6%
Management of Companies and Enterprises	$1,400,000,000	2.0%	3.8%	↑1.8%
Administrative and Support and Waste Management and Remediation Services	$1,300,000,000	3.4%	3.6%	↑0.2%
Information	$1,200,000,000	3.9%	3.1%	↓0.8%
Transportation and Warehousing	$890,000,000	2.1%	2.4%	↑0.3%
Accommodation and Food Services	$820,000,000	2.0%	2.2%	↑0.2%
Other Services (except Public Administration)	$690,000,000	2.0%	1.8%	↓0.2%
Real Estate and Rental and Leasing	$480,000,000	1.3%	1.3%	<0.1%
Arts, Entertainment, and Recreation	$330,000,000	0.8%	0.9%	↑0.1%
Utilities	$140,000,000	1.2%	0.4%	↓0.8%
Agriculture, Forestry, Fishing and Hunting	$47,000,000	0.2%	0.1%	↓0.1%
Mining, Quarrying, and Oil and Gas Extraction	$5,900,000	<0.1%	<0.1%	<0.1%

JOBS AND JOBS ACCESS

Regional Job and Wage Trends

Since 2000, the number of jobs in the Hartford area (represented in this subsection by Hartford County and Tolland County) has changed in line with the broader economic climate. The total job count fell following the early 2000s recession, fully bounced back by 2008, and then sharply decreased following the Great Recession. By 2017, the number of jobs in these two counties (568,620) had recovered to its pre-Recession level.[123] This pattern tracked closely with the statewide trend over the same time period.

In the early 2000s, the largest sector in Hartford and Tolland Counties was manufacturing, followed by health care and social assistance. Since then, manufacturing jobs have plummeted by about a quarter, and health care jobs have soared to become far and away the largest sector in the region, with around 91,000 employees.[124] Home health aides, nurses, and health care managers and executives are among the most common occupations within this sector.[125] As the senior population of Hartford and Tolland Counties grows, health care and social assistance workers will likely continue to be in high demand. The Connecticut Department of Labor's most recent 2016 forecast estimates that statewide, the health care and social assistance sector will grow by an additional 11 percent by 2026.[126] Accommodation and food services; professional, scientific and technical services; and educational services also saw growth from 2000 to 2017, adding between 6,000 and 9,000 jobs each.[127] SEE FIG 2.20

In 2017, the average wage in Hartford and Tolland Counties was $66,107, slightly below the state average of $66,990.[128] However, while inflation-adjusted average wages increased statewide by a modest 1.2 percent between 2000 and 2017, Hartford and Tolland Counties experienced a 5.6 percent increase.[129] In the region's faster-growing service sectors, wages are generally lower, and since 2000 have grown little or even declined. Meanwhile, wages in some high-paying sectors have continued to climb. The three sectors whose average wages increased at least 20 percent during this period—finance and insurance, management of companies and enterprises, and information—all paid above the region's average in 2000.[130] Workers in the region's robust finance and insurance sector earned an average $130,057—nearly double the salary of the average Connecticut worker.[131] SEE TABLE 2J

While the finance and insurance sector accounted for only about 10 percent of Hartford and Tolland County's total jobs in 2017, and lost more than 2,600 jobs since the year 2000, the sector made up 20 percent of the region's total payroll (total amount in wages paid to all employees)—an increase of 3 percentage points since 2000.[132] The health care and social assistance sector added about 22,500 jobs between 2000 and 2017, and currently accounts for 16 percent of all jobs in the region, but less than 13 percent of combined payroll.[133] Wage growth in high-paying industries, coupled with an increasing number of lower-wage jobs in the region, likely contributes to increased income inequality. Additionally, the Greater Hartford region's 2019 Comprehensive Economic Development Strategy describes a broad concern that workers who identify as Black or Latino are vastly under-represented in higher-paying occupations within the most profitable industry sectors such as insurance and biosciences.[134] SEE TABLE 2K

Transportation and Job Locations

Transportation is a key factor in access to quality jobs. With Greater Hartford residents holding jobs throughout the region and state, and sometimes even beyond state lines, the importance of reliable and affordable transportation cannot be overstated.[135] Regional commuter rail connections, bus services, and walking or biking provide options for some workers, especially those employed in city centers. However, the vast majority of Greater Hartford's workers rely on a car to reach the greatest number of available jobs within a reasonable commuting distance, as well as necessary services such as shopping and healthcare. Hartford experiences by far the largest net inflow of higher-wage workers in the state (⬆67,000). Like other large cities, this is due to its concentration of higher-paying jobs, though only 6 percent of the high-wage jobs in Hartford are held by Hartford residents. The issue known as spatial mismatch, in which many workers experience "reverse" commutes to get to lower-paying jobs in outer suburbs, is a particular concern. This is seen in the net inflow of lower-wage workers seen in suburbs such as Farmington (⬆12,000), which is home to a

TABLE 2L

Economic opportunity

SHARE OF ADULTS, GREATER HARTFORD, 2018

LOCATION	FEEL AREA HAS GOOD OPPORTUNITIES FOR EMPLOYMENT	FEEL YOUTH HAVE OPPORTUNITIES FOR JOB ADVANCEMENT	UNDEREMPLOYED	HAVE ACCESS TO A CAR
Connecticut	50%	59%	16%	88%
Greater Hartford	54%	60%	15%	88%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD				
Male	54%	64%	14%	89%
Female	53%	58%	15%	88%
Age 18–34	51%	58%	24%	82%
Age 35–49	52%	63%	9%	90%
Age 50–64	54%	59%	12%	92%
Age 65+	58%	67%	11%	89%
White	57%	64%	11%	92%
Black	38%	50%	25%	73%
Latino	42%	56%	34%	79%
<$15K	34%	42%	70%	57%
$15K–$30K	46%	54%	41%	78%
$30K–$50K	48%	53%	19%	88%
$50K–$75K	55%	57%	13%	91%
$75K–$100K	56%	62%	6%	96%
$100K–$200K	65%	72%	4%	98%
$200K+	64%	83%	N/A	96%
BY GEOGRAPHY				
Hartford	34%	42%	33%	69%
New Britain	40%	40%	17%	82%
GH Inner Ring	49%	56%	14%	88%
East Hartford	38%	N/A	N/A	82%
Manchester	45%	60%	N/A	91%
West Hartford	70%	87%	N/A	93%
GH Outer Ring	63%	73%	11%	94%

large indoor shopping center, West Hartford (↑4,900), East Windsor (↑3,200), and Glastonbury (↑3,000), and in the large net outflow of lower-wage workers from New Britain (↓6,100).[136] SEE FIG 2.19

Results from the 2018 DataHaven Community Wellbeing Survey indicate that while 12 percent of Greater Hartford's adults reported not having access to a car when they need it, the rate rose to 43 percent for adults who earn less than $15,000 per year and to 22 percent for those who earn between $15,000 and $30,000.[137] Adults with limited car access report substantially higher levels of underemployment. Additionally, about half of adults who face transportation insecurity report that they have missed a doctor's appointment in the past year due to lack of reliable transportation.[138] These data underscore the importance of alternative local transportation options for low-income adults. SEE TABLE 2L

Lack of car access is far more common for Black (27 percent) and Latino residents (21

percent) than white residents (8 percent).[139] The substantial disparity in median household income and family wealth between white households and Black and Latino households in Greater Hartford is one important factor in explaining these differences.

Additionally, it is important to consider the potential trade-offs between housing and transportation costs. Adults who seek lower-cost housing farther from work or services may shoulder a much greater burden of transportation expenses, and have to cope with the many other potentially-negative impacts of longer daily travel times, including those related to employment and health.[140]

Underemployment

While Greater Hartford's average unemployment rate from 2013 to 2017 was identical to the statewide and nationwide rates (7 percent), there was significant variation by place and race/ethnicity within the region.[141] SEE FIG 1.3, TABLE 1B

A much greater number of residents find economic opportunities to be limited. The unemployment rate measures the share of people without a job but looking for work; it does not consider part-time workers who would prefer full-time work, nor those who are interested in working but not actively searching for a job. The DataHaven Community Wellbeing Survey captures both of these groups in its underemployment measure.

In 2018, 15 percent of Greater Hartford adults reported being underemployed, about the same as the state average.[142] The underemployment rate varies by geography; for example, the underemployment rate in Hartford (33 percent) was more than twice that of the region overall.[143] Across Greater Hartford, both young adults (24 percent) and Black and Latino residents (25 and 34 percent, respectively) face higher rates of underemployment as well. This reality may play a role in the more negative outlook regarding economic opportunities reported by Black and Latino residents. Greater Hartford residents who have higher incomes are more optimistic about economic opportunities in the area.[144] SEE TABLE 2L

EDUCATION

Early Childhood

Children's experiences in their first five years profoundly affect their life outcomes. Their mother's access to prenatal care, the quality of their living environment, and their social interactions affect their brain development, overall well-being and ability to succeed in school and beyond.

According to a 2017 Connecticut Voices for Children report, from 2005 to 2016, the state expanded its childcare funding, with the result that 80 percent of four-year-olds in the state were enrolled in preschool, even though the need for care for infants and toddlers was still well ahead of the available capacity. This Connecticut Voices for Children report notes that community wealth strongly predicts both whether children go to preschool and the level of their later academic performance, suggesting that greater attention should be paid to the economic barriers that prevent many children from accessing high-quality early childhood education.[145]

From 2000 to 2017, the share of three- and four-year-old children enrolled in preschool in Greater Hartford increased from 58 percent to 65 percent. In 2017, 13,531 children were enrolled in preschool, including about 5,900 children in preschool classrooms provided by public school districts.[146] As noted in the DataHaven Community Index, preschool enrollment rates are lower in New Britain and in the Southside/South End group of neighborhoods within Hartford. SEE TABLE 1B

Additionally, 5,060 infants and toddlers were enrolled in childcare, representing only about 20 percent of the region's children under age 3, suggesting a severe shortage in early child care options.[147]

According to the United Way ALICE Project, in 2016 the minimum childcare cost for a young family—a household with two adults, one infant, and one preschooler—is about $1,707 per month in Hartford County.[148] In the Greater Hartford region in 2018, the average childcare facility charged about $230 a week to care for infants and toddlers, and about $215 for preschoolers. According to these figures, the young family described above would spend $23,140 per year on childcare.[149]

These high costs have clear implications for the region's many working families struggling to make ends meet. According to the 2018 DataHaven

Community Wellbeing Survey, of adults in the region living with children below kindergarten age, 60 percent report that it is either somewhat or very difficult to find high-quality, affordable childcare.[150] In Greater Hartford, childcare is both a great financial burden and a great necessity, as it prepares children for the future and enables parents to work.

K-12 and Postsecondary Education

Greater Hartford is home to 144,122 public school students from preschool to 12th grade, including 5,919 in pre-kindergarten programs, 94,335 kindergarten and elementary school students, and 43,870 high schoolers.[151] The region's public school students are about half (49 percent) white, 25 percent Latino, 14 percent Black, and 11 percent other races.[152] Notably, the student body is far less diverse in the Outer Ring districts, where 75 percent of students are white, than in the Inner Ring (49 percent white), Hartford (10 percent white), or New Britain (18 percent white). There are only four districts out of the region's 41—East Hartford, Manchester, Windsor, and the Capitol Region Education Council (CREC) district—where no one racial group constitutes a majority of the student body. The last of these operates throughout the Greater Hartford region and has grown as part of court-mandated school desegregation efforts.[153]

Students who take special education classes, who qualify for free or reduced-price meals (FRPM) at school based on family incomes less than 185 percent of the federal poverty line, or who are English language learners (ELL) are considered to be high-needs students; students may have more than one of these designations.[154] Sixteen percent of Greater Hartford students have a special education designation, 41 percent qualify for FRPM, and 7 percent are ELL. Hartford and its Inner Ring towns serve a larger share of high-needs students compared to districts in the Outer Ring. In particular, the Outer Ring districts serve far smaller shares of ELL students (2 percent of students) than schools in Hartford (21 percent) or the Inner Ring (6 percent). Only 18 percent of Outer Ring students are FRPM-eligible, compared to 78 percent in Hartford and 41 percent in the Inner Ring.[155]

On the state's major standardized test, the Smarter Balanced Assessment Consortium (SBAC), scores rated as meeting or exceeding grade-level goals are considered passing. Since 2015, students

in Greater Hartford public school districts have maintained passing rates nearly identical to statewide averages in both English/language arts (ELA) and math. In the 2017–2018 school year, 54 percent of Greater Hartford students passed the ELA test, and 46 percent passed in math; each of these is just 1 percentage point below statewide passing rates. While Greater Hartford's ELA scores have remained about the same in the few years since the state adopted the SBAC, math pass rates have risen steadily from 41 percent in the 2014–2015 school year.[156]

Stark disparities exist in standardized test performance throughout Greater Hartford. In the 2017–18 school year, white students had more than twice the pass rate (69 percent) of Black (32 percent) and Latino students (29 percent) in ELA, and three times the pass rate (61 percent) of Black and Latino students (both 21 percent) in math. Gaps of similar magnitude exist between students eligible for FRPM and those ineligible, and are even wider between students in special education and those not, and ELL versus non-ELL students.[157] SEE FIG 2.23

Disparities also muddle the region's relatively high four-year high school graduation rates. Greater Hartford's four-year graduation rate increased from 82 percent of the class of 2011 to 88 percent of the class of 2017, about the same as the state average. However, in the class of 2017, only 82 percent of Black students and 75 percent of Latino students graduated high school within four years, compared to 93 percent of white students, a pattern mirrored statewide. The gaps are even wider for high-needs students: the four-year high school graduation rate is only 64 percent each for special education and ELL students, and 77 percent for FRPM students in Greater Hartford.[158]

In discussing achievement gaps, it is worth noting the role of school segregation and distribution of resources. There are 41 public school districts within Greater Hartford, but the majority of Black, Latino, FRPM, and ELL students are concentrated in just a few. The five largest districts—Hartford, New Britain, West Hartford, CREC, and East Hartford—educate a combined 38 percent of the region's students, but are home to 61 percent of the region's Black students, 70 percent of Latino students, 59 percent of FRPM-eligible students, and 72 percent of ELL students. Twenty-nine percent each of the region's Black and Latino students go to school in Hartford alone.[159] These

TABLE 2M

College enrollment, persistence, and completion

COUNT AND RATE OF ENROLLMENT IN COLLEGE, PERSISTENCE INTO 2ND YEAR, AND COMPLETION WITHIN 6 YEARS, CLASS OF 2010 AND 2014, GREATER HARTFORD

LOCATION	CLASS OF 2014					CLASS OF 2010			
	GRADUATED HIGH SCHOOL	ENROLLED IN COLLEGE	ENROLLMENT RATE	PERSISTED	PERSISTENCE RATE	EARNED DEGREE IN 6 YRS	ATTAINMENT RATE	WITH 4 YR DEGREE	WITH 2 YR DEGREE
Connecticut	37,708	27,697	73%	24,540	89%	18,706	49%	16,400	2,306
Greater Hartford	9,835	7,494	76%	6,648	89%	5,132	51%	4,434	698
Hartford	862	509	59%	382	75%	202	23%	156	46
New Britain	440	272	62%	218	80%	133	26%	94	39
GH Inner Ring	3,890	2,906	75%	2,533	87%	2,047	48%	1,696	351
East Hartford	421	261	62%	198	76%	147	28%	105	42
Manchester	386	232	60%	186	80%	170	43%	128	42
West Hartford	709	592	83%	544	92%	475	64%	448	27
GH Outer Ring	4,551	3,726	82%	3,443	92%	2,713	64%	2,457	256

are also towns that have less money available to spend on students and other resources that can support opportunities for young people. SEE CHAPTER 4

One way to level the playing field moving into adulthood might be through post-secondary preparatory programs. Many high schools offer college and career readiness (CCR) programs, including Advanced Placement (AP), International Baccalaureate (IB), career education, and other opportunities. In the 2017–2018 school year, 73 percent of Greater Hartford's 11th- and 12th-graders—or almost 16,000 upperclassmen—were in CCR courses and programs. Enrollment in these programs is higher in the Outer Ring towns (81 percent) than in New Britain (61 percent) or Hartford (57 percent).[160]

While three out of four high school graduates in the region enroll in college within a year, and 89 percent of those students re-enroll for a second consecutive year, just half of the public high school graduates in Greater Hartford have a college degree six years after graduating high school.[161] A 2019 report from Fairfield County's Community Foundation highlights the importance of post-secondary certificates offered in expanding job sectors at community colleges.[162] SEE FIGURE 2.24 / SEE TABLE 2M

Adults with high school diplomas or college degrees have more employment options and considerably higher potential earnings, on average, than those who do not finish high school.[163] In 2017,

10 percent of adults ages 25 and older in the region had less than a high school education, or about 67,000 people. While 38 percent of adults in the region have four-year college degrees, attainment rates are not as high in all areas, including Hartford and New Britain, where 27 and 19 percent of adults 25 years and older lack a high school diploma, respectively.[164] SEE TABLE 1B, 2N

Risk Factors for Youth

There is room for improvement regarding chronic absenteeism in Greater Hartford, which is a detriment to academic success, especially when it occurs in early grades. A national study found that over half of chronically-absent kindergarteners became chronically-absent first graders.[165] Chronic absenteeism is defined as a student missing at least 10 percent of the days for which they were enrolled during a school year. In the 2017–18 school year, 12 percent of students in Greater Hartford were chronically absent from school. This rate included 7 percent of white students, 15 percent of Black students, 22 percent of Latino students, and 9 percent of students of other races/ethnicities. Further, special education students, those eligible for FRPM, and English language learners were more than twice as likely to be chronically-absent as their lower-risk counterparts.[166] Factors that contribute to chronic absenteeism may include individual- and family-level predictors such as asthma and other chronic diseases, poverty, and

TABLE 2N

Educational attainment

EDUCATIONAL ATTAINMENT, ADULTS AGE 25+, GREATER HARTFORD BY TOWN, 2017

LOCATION	POPULATION AGES 25+	NO HIGH SCHOOL DIPLOMA	NO HIGH SCHOOL DIPLOMA SHARE	BACHELORS OR HIGHER	BACHELORS OR HIGHER SHARE	MASTERS OR HIGHER	MASTERS OR HIGHER SHARE
United States	216,271,644	27,437,114	13%	66,887,603	31%	25,510,535	12%
Connecticut	2,480,297	242,500	10%	953,199	38%	421,144	17%
Greater Hartford	666,820	66,973	10%	255,400	38%	111,811	17%
Hartford	74,600	20,370	27%	12,413	17%	5,062	7%
New Britain	48,005	9,290	19%	8,834	18%	3,255	7%
GH Inner Ring	304,299	25,830	9%	116,255	38%	49,744	16%
East Hartford	34,549	5,896	17%	6,475	19%	2,202	6%
Manchester	40,651	2,843	7%	15,834	39%	6,364	16%
West Hartford	43,785	2,483	6%	27,373	63%	14,568	33%
GH Outer Ring	239,916	11,483	5%	117,898	49%	53,750	22%

parent involvement; neighborhood-level issues such as access to transportation and safe routes to school;[167] and school-level factors such as bullying and school maintenance.[168] SEE FIG 2.23

Academic disadvantages that result from chronic absenteeism are also at play for students who miss class due to in-school or out-of-school suspensions. Students who are suspended or expelled from school are more likely to have negative perceptions of school[169] and to have lower GPAs.[170] Perhaps most gravely, they are also more likely to be involved with the juvenile justice system.[171] Black and Latino students—boys especially—are expelled or suspended far more frequently than white students,[172] even as early as preschool.[173] Even when the confounding effects of socioeconomic status are controlled for, Black students are still disciplined more frequently than their white counterparts.[174] In Greater Hartford public schools, Black students are disciplined at a rate almost four times greater than white students, and special education students are disciplined twice as often as students who are not in special education. SEE FIG 2.22

Adults' perceptions of what youth in their towns are likely to experience are generally positive, but vary greatly from town to town. In addition to perceptual differences by place within the region, adults also perceive youth experiences differently depending on race and ethnicity. Black and Latino adults in the region are more likely than white adults to think that children in their

neighborhood will someday be arrested for a felony.[175] SEE FIG 2.25

The relationship between education and subsequent economic opportunity is apparent. The quality of a child's education is highly correlated with upward mobility,[176] but a person's economic future is largely dependent upon the circumstances of their youth. The place a child grows up, their race, and their family's income will generally determine whether that child will move up the socioeconomic ladder. Children in Connecticut are slightly more advantaged than children nationwide[177]—partially due to the state's overall wealth—but other disparities are evident. White children in Hartford and Tolland Counties, regardless of their family's income, are more likely than their Black or Latino peers to experience upward economic mobility. In these counties, the probability of a low-income white child growing up to be within the top 20 percent of households by income (18 percent) is higher than that of a high-income Black child (13 percent) and more than three times that of a low-income Black child (5 percent).[178] As a result of factors beyond their control, these children are subject to the effects of differential access to quality education, post-secondary and employment opportunities, and wealth-building opportunities. Those with better access tend to have correspondingly better overall health and higher quality of life than people with limited access to those opportunities. SEE FIG 2.26 DH

"Immigrants comprised 22 percent of Hartford and East Hartford's populations, and slightly larger shares of Rocky Hill (24 percent) and Bloomfield (23 percent)."

Creating A Healthier Region

Overall, Greater Hartford is a healthy place to call home.

Residents' average self-reported health and life expectancy are similar to those of the state overall and higher than the country.

IN THIS CHAPTER

→ Greater Hartford is relatively healthy, but there are disparities across its towns and diverse demographic groups.

→ Overdose-related deaths are increasing, particularly due to fentanyl.

→ Race-based discrimination is an obstacle to residents moving to certain areas, working, and accessing healthcare.

→ Patterns of inequity can be seen in barriers to healthcare access and in health outcomes.

Executive Summary

Greater Hartford residents' average self-reported health and life expectancy are similar to those of the state overall and higher than the country. However, these measures may mask more concerning health patterns for both lower-income and Black and Latino residents. When compared to residents of affluent suburban neighborhoods, residents of more marginalized neighborhoods of Greater Hartford have lower life expectancies, by up to 19 years; shoulder a higher burden of chronic diseases such as cardiovascular disease and childhood asthma; have considerably higher rates of infant mortality; and are far more likely to be food insecure. The opioid epidemic has been borne to a greater extent by white and Latino residents, but overdose death rates continue to trend upward for all groups.

Disparities also exist in health insurance coverage and preventive care. While only 3 percent of white adults are uninsured, 10 percent of Black adults, 11 percent of Latino adults, and 9 percent of adults with incomes under $30,000 lack health insurance. Almost a quarter of the region's adults reported postponing potentially necessary medical care, citing numerous barriers. These barriers may contribute to residents' reliance on health care delivered in the emergency room: in 2018, more than a quarter of adults in Greater Hartford reported going to the emergency room at least once, a practice that is twice as common among adults with incomes under $30,000 as among those with $100,000-plus incomes.

In addition to the above disparities, hospital encounter data suggest that health inequities across towns in the region are increasing. The data studied, though, do point to some improvements in Greater Hartford residents' health, including slight improvements in hospital encounters related to preventable dental conditions, a possible slowing of overdose death rates, and improvements in some towns' chronic disease burdens. **DH**

"In the 2018 DataHaven Community Wellbeing Survey, about one in every three adults in Greater Hartford reported knowing someone who has struggled with opioid abuse or addiction in the past three years."

Life expectancy in Greater Hartford is high, but often differs by several years between adjacent neighborhoods

ESTIMATED LIFE EXPECTANCY IN YEARS, GREATER HARTFORD, 2010–2015

BY CENSUS TRACT

HARTFORD
77.1 YEARS

NEW BRITAIN
76.6 YEARS

EST. LIFE EXPECTANCY
IN YEARS

- 83.4 TO 85.8
- 80.9 TO 83.4
- 78.2 TO 80.9
- 74.6 TO 78.2
- 68.9 TO 74.6
- NOT AVAILABLE
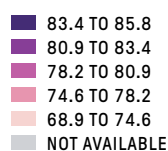
ANDOVER
85.2 YEARS

BY LOCATION, WITH
NEIGHBORING STATES

INNER RING
80.1 YEARS

OUTER RING
81.5 YEARS

GH OUTER RING	81.5
NEW YORK	80.6
MASSACHUSETTS	80.6
CONNECTICUT	80.3
GH INNER RING	80.1
GREATER HARTFORD	79.9
RHODE ISLAND	79.3
UNITED STATES	78.7
HARTFORD	77.1
NEW BRITAIN	76.6
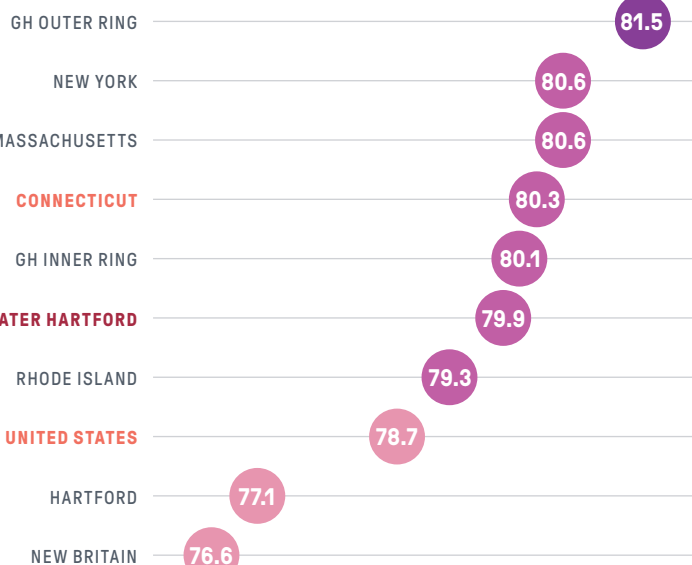
FIG 3.2

Cancers and infant/fetal mortality impact Greater Hartford's lifespans the most

YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75 PER 100,000 RESIDENTS BY CAUSE OF DEATH, GREATER HARTFORD, 2010–2014

GREATER HARTFORD   GH INNER RING
CONNECTICUT   GH OUTER RING
LARGER GH TOWNS

	YEARS OF POTENTIAL LIFE LOST TO AGE 75 PER 100K RESIDENTS	AVG. YEARS LOST PER DEATH	DEATHS BEFORE AGE 75
GENERAL CAUSES			
CANCER		13	4,579
INFANT/FETAL MORTALITY		74.5	528
ACCIDENT		31	1,244
HEART DISEASE		14	2,666
DRUGS		31	619
SUICIDE		30	445
HOMICIDE		40	187
CHRONIC LIVER DISEASE		18	379
STROKE		14	402
DIABETES		14	363
HIV		22	154
CHRONIC LOWER RESPIRATORY DISEASE		10	471
SEPSIS		13	268
KIDNEY DISEASE		12	220
CANCER TYPES			
LUNG		11	1,195
BREAST		16	377
COLORECTAL		15	352
PANCREATIC		12	353
ACCIDENT TYPES			
POISONING		33	568
MOTOR VEHICLE		36	358
FALLS		16	101

Labels on chart: HARTFORD, EAST HARTFORD, NEW BRITAIN, HARTFORD, HARTFORD, NEW BRITAIN

X-axis: 0   500   1,000   1,500   2,000

Rates of hospitalizations and ED visits vary by geography

AGE-ADJUSTED AND RELATIVE AGE-ADJUSTED RATES, PER 10,000 RESIDENTS, 2015–2017
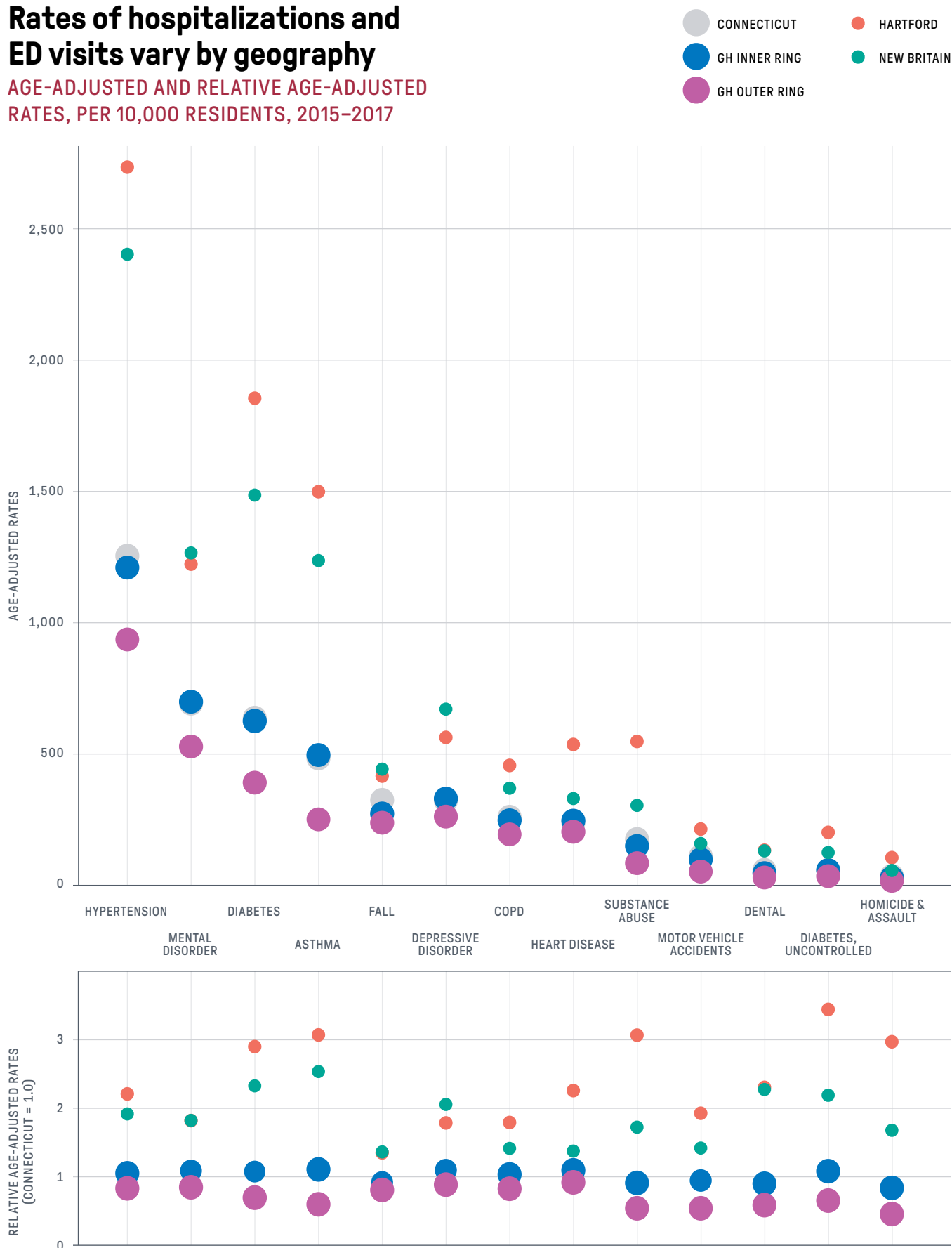
FIG 3.4

Preventable hospital visits show large differences across age and gender

CHRONIC DISEASE, ENCOUNTER RATE (PER 10,000 RESIDENTS), 2015–2017

CONNECTICUT   HARTFORD

GH INNER RING   NEW BRITAIN

GH OUTER RING

FIG 3.5

Preventable hospital visits show large differences across age and gender

OTHER HEALTH ISSUES, ENCOUNTER RATE (PER 10,000 RESIDENTS), 2015–2017

CONNECTICUT   HARTFORD

GH INNER RING   NEW BRITAIN

GH OUTER RING
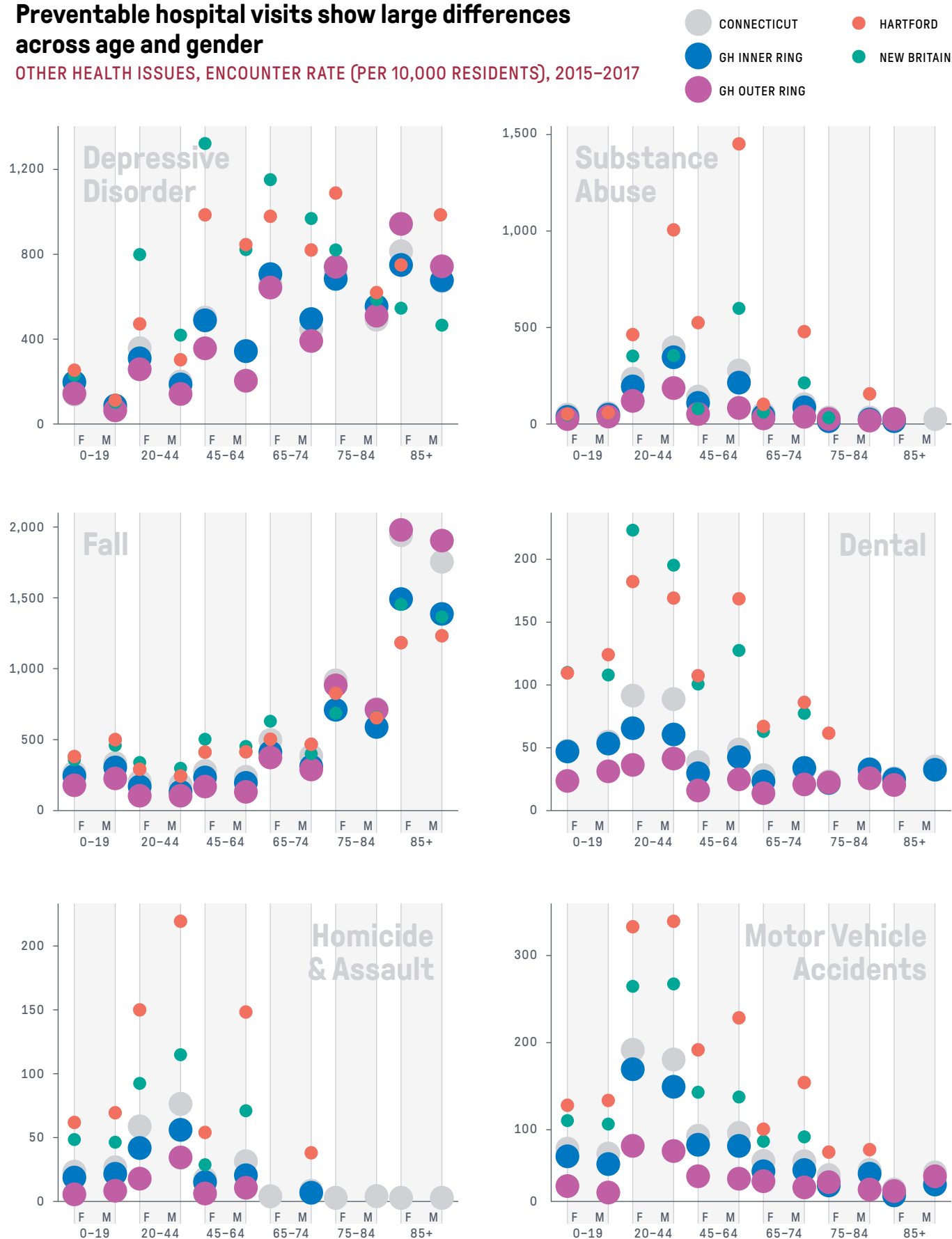
FIG 3.6

Growing inequality in rates of hospital encounters

CHRONIC DISEASE, AGE-ADJUSTED RATE OF HOSPITALIZATIONS AND ED ENCOUNTERS (PER 10,000 RESIDENTS),
2012–2014 TO 2015–2017

RELATIVE RATE, 2012–2014 TO 2015–2017

BETTER ← → WORSE

Heart Disease

HARTFORD	
NEW BRITAIN	
EAST HARTFORD	
MANCHESTER	
BLOOMFIELD	
VERNON	
WINDSOR	
GH INNER RING	
MANSFIELD	
ROCKY HILL	
CONNECTICUT	
SOUTHINGTON	
ENFIELD	
SOUTH WINDSOR	
NEWINGTON	
GLASTONBURY	
FARMINGTON	
BERLIN	
GH OUTER RING	
WEST HARTFORD	
WETHERSFIELD	
SIMSBURY	

100 190 280 370 460 550

Hypertension

HARTFORD	
NEW BRITAIN	
EAST HARTFORD	
VERNON	
MANCHESTER	
SOUTHINGTON	
BLOOMFIELD	
CONNECTICUT	
GH INNER RING	
NEWINGTON	
WINDSOR	
BERLIN	
MANSFIELD	
ENFIELD	
ROCKY HILL	
SOUTH WINDSOR	
FARMINGTON	
WETHERSFIELD	
GH OUTER RING	
WEST HARTFORD	
GLASTONBURY	
SIMSBURY	

500 1,250 2,000 2,750

Diabetes

HARTFORD	
NEW BRITAIN	
EAST HARTFORD	
MANCHESTER	
VERNON	
BLOOMFIELD	
CONNECTICUT	
GH INNER RING	
WINDSOR	
SOUTHINGTON	
NEWINGTON	
ENFIELD	
ROCKY HILL	
BERLIN	
SOUTH WINDSOR	
MANSFIELD	
FARMINGTON	
WETHERSFIELD	
GH OUTER RING	
WEST HARTFORD	
GLASTONBURY	
SIMSBURY	

200 625 1,050 1,475 1,900

Asthma

|	
HARTFORD	
NEW BRITAIN	
VERNON	
EAST HARTFORD	
MANCHESTER	
BLOOMFIELD	
GH INNER RING	
CONNECTICUT	
WINDSOR	
ENFIELD	
NEWINGTON	
SOUTHINGTON	
WEST HARTFORD	
WETHERSFIELD	
SOUTH WINDSOR	
BERLIN	
GH OUTER RING	
ROCKY HILL	
FARMINGTON	
GLASTONBURY	
MANSFIELD	
SIMSBURY	

0 500 1,000 1,500

COPD

|	
HARTFORD	
VERNON	
NEW BRITAIN	
EAST HARTFORD	
MANCHESTER	
ENFIELD	
CONNECTICUT	
MANSFIELD	
SOUTHINGTON	
GH INNER RING	
ROCKY HILL	
NEWINGTON	
SOUTH WINDSOR	
GH OUTER RING	
WINDSOR	
BLOOMFIELD	
BERLIN	
GLASTONBURY	
FARMINGTON	
WETHERSFIELD	
WEST HARTFORD	
SIMSBURY	

100 170 240 310 380 450

FIG 3.7
Growing inequality in rates of hospital encounters
OTHER HEALTH ISSUES, AGE-ADJUSTED RATE OF HOSPITALIZATIONS AND ED ENCOUNTERS (PER 10,000 RESIDENTS), 2012–2014 TO 2015–2017
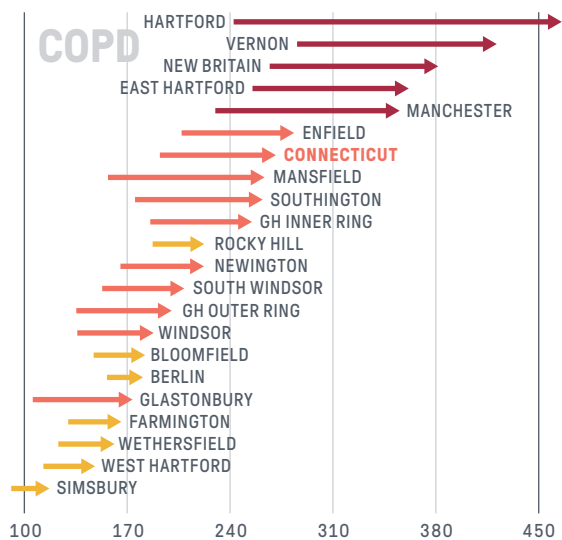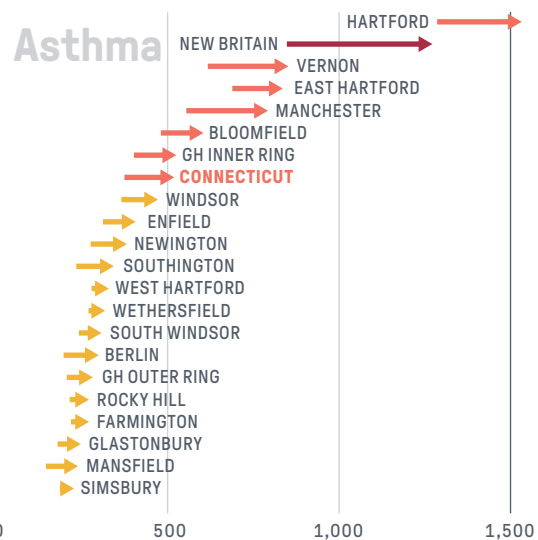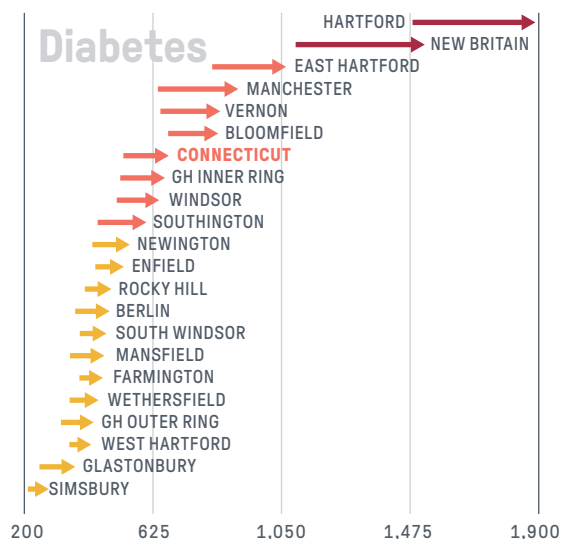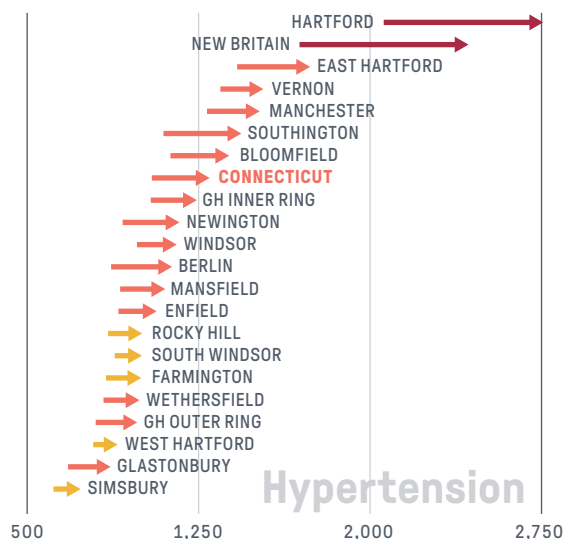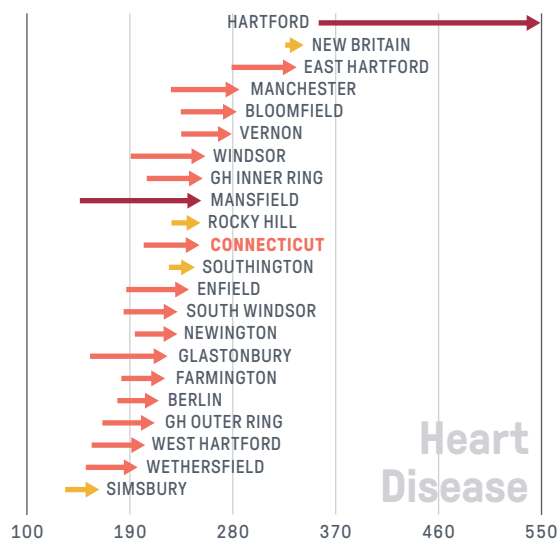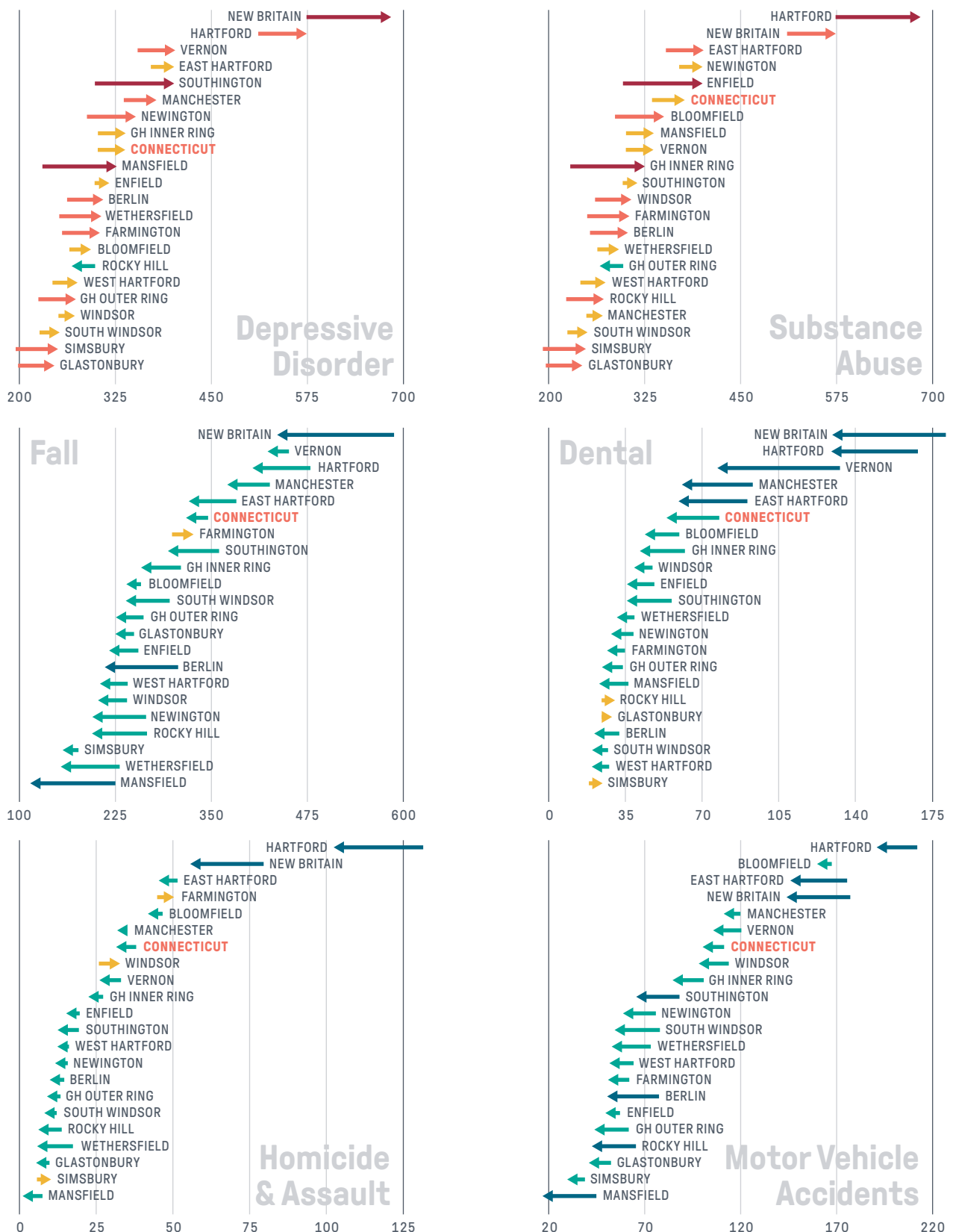
FIG 3.8

Across groups, large shares of adults say youth susceptibility to drug and alcohol abuse is a toss-up

RESIDENTS' RATING OF LIKELIHOOD THAT YOUTH IN THEIR AREA WILL ABUSE DRUGS OR ALCOHOL, PERCENT OF RESPONDENTS BY RACE AND INCOME, GREATER HARTFORD, 2018

Legend:
- NOT AT ALL LIKELY
- NOT VERY LIKELY
- A TOSS UP
- VERY LIKELY
- ALMOST CERTAIN

TOTAL

Group	Almost Certain	Very Likely	A Toss Up	Not Very Likely	Not At All Likely
CONNECTICUT	7%	21%	42%	21%	8%
GREATER HARTFORD	7%	19%	40%	24%	8%
HARTFORD	14%	29%	28%	16%	13%
NEW BRITAIN	18%	32%	31%	14%	7%
GH INNER RING	6%	18%	43%	24%	7%
MANCHESTER	6%	14%	41%	31%	8%
WEST HARTFORD	8%	13%	45%	29%	5%
GH OUTER RING	5%	19%	44%	24%	8%

RACE/ETHNICITY

Group	Almost Certain	Very Likely	A Toss Up	Not Very Likely	Not At All Likely
WHITE	5%	18%	47%	22%	6%
BLACK	11%	30%	30%	19%	12%
LATINO	16%	24%	27%	18%	16%

INCOME

Group	Almost Certain	Very Likely	A Toss Up	Not Very Likely	Not At All Likely
UNDER $30K	8%	25%	28%	29%	11%
$30K–$75K	10%	22%	44%	16%	8%
$75K–$100K	4%	22%	45%	20%	7%
$100K+	6%	14%	46%	25%	7%

FIG 3.9

Overdose death rates have skyrocketed, but show signs of slowing

AGE-ADJUSTED MONTHLY RATE OF DRUG OVERDOSE DEATHS PER 1 MILLION RESIDENTS, 2012–2018
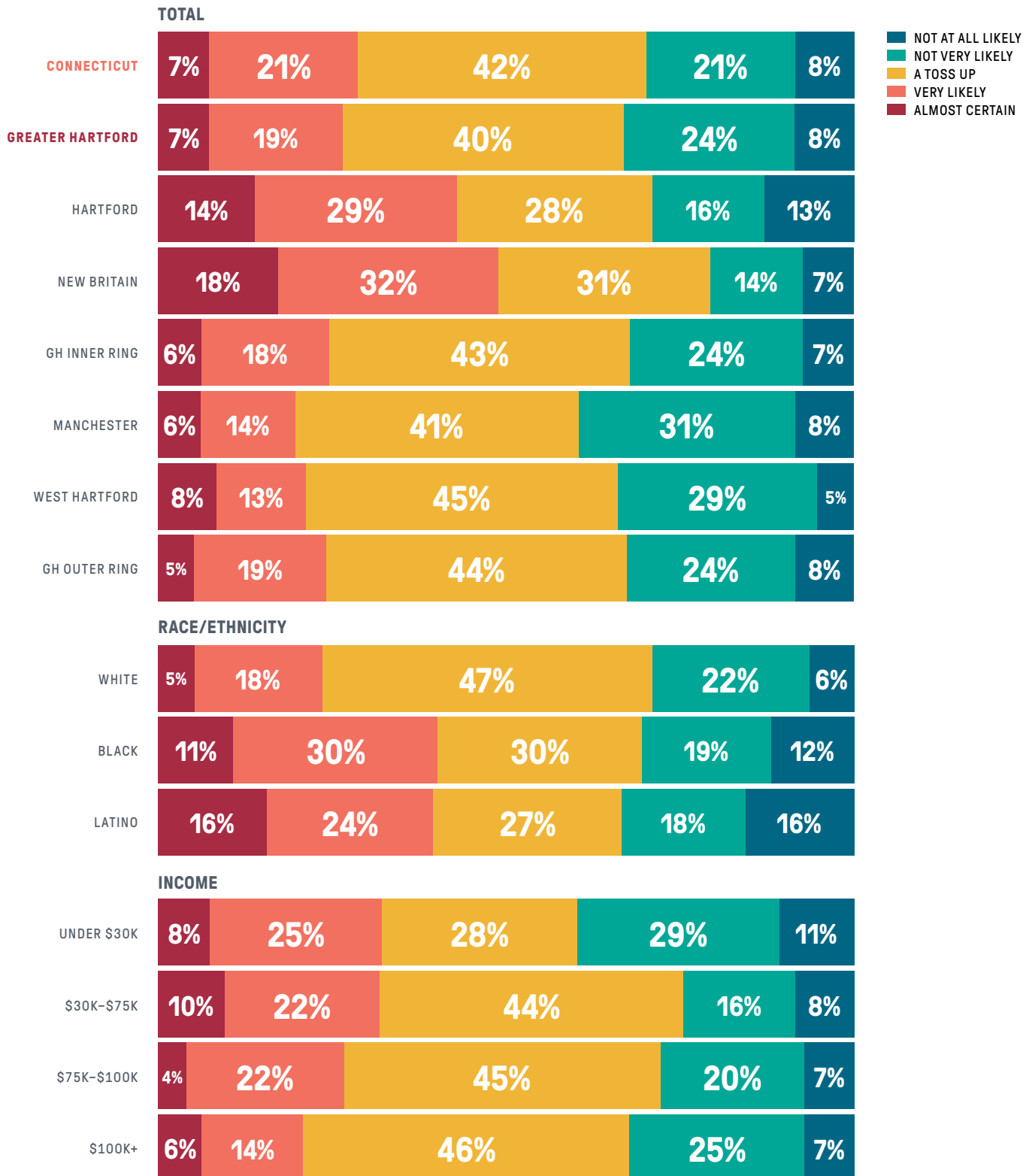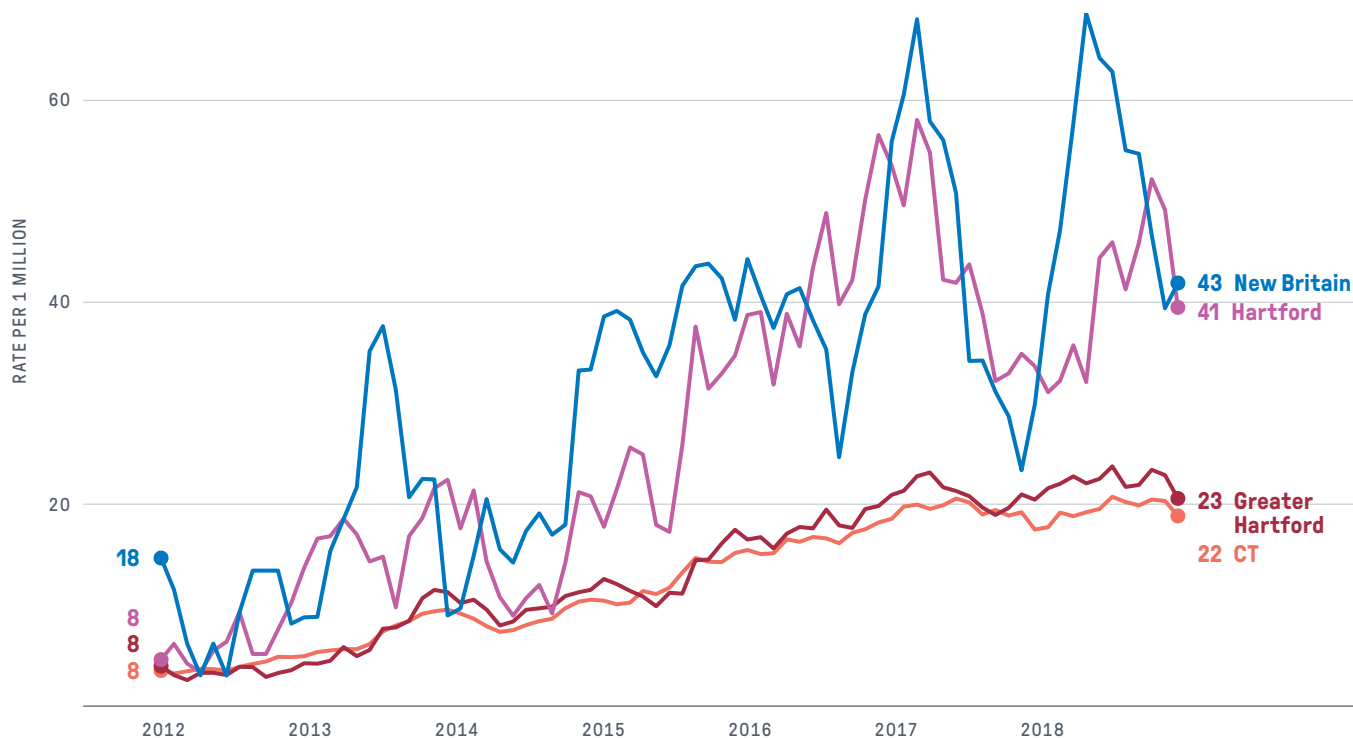

FIG 3.10

Fentanyl's steep rise coincided with overall increasing drug overdoses

COUNT OF DRUG OVERDOSE DEATHS AT 6-MONTH INTERVALS BY PRESENCE OF FENTANYL,
WITH PERCENTAGE OF DEATHS THAT ARE FENTANYL-RELATED, GREATER HARTFORD, 2012–2018
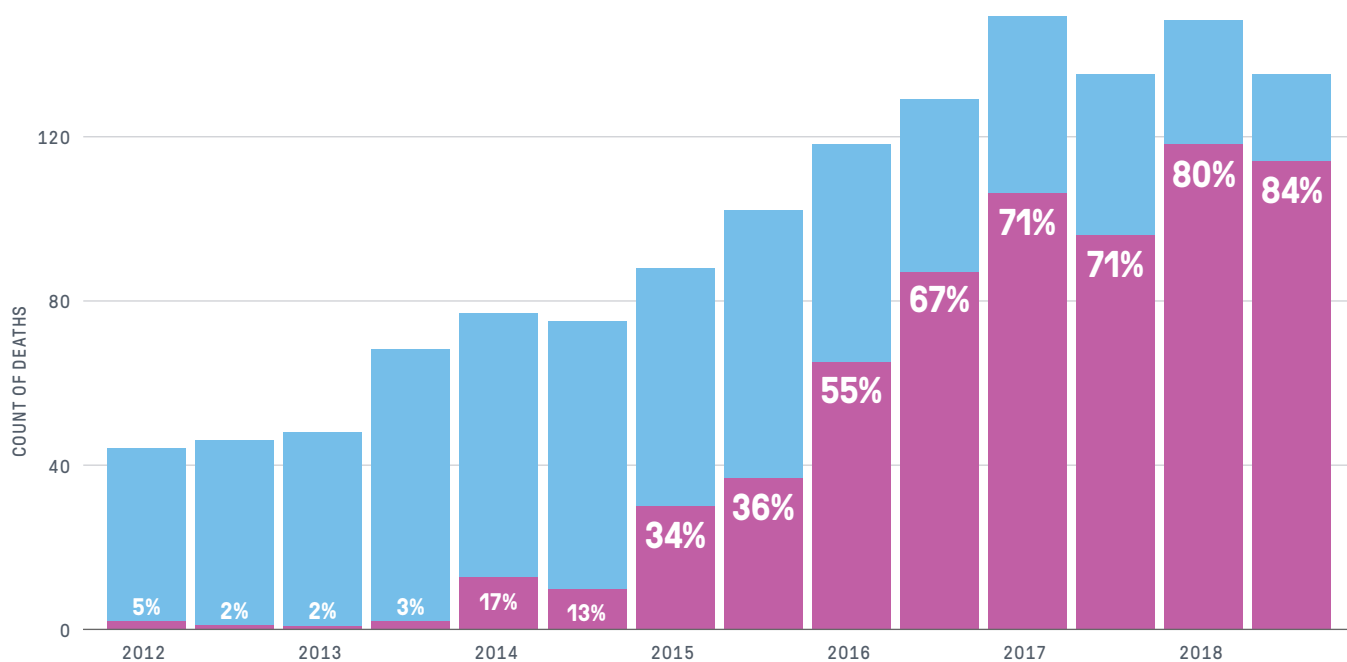
FIG 3.11

Residents often see their race and age as major reasons for discrimination in multiple areas of their lives
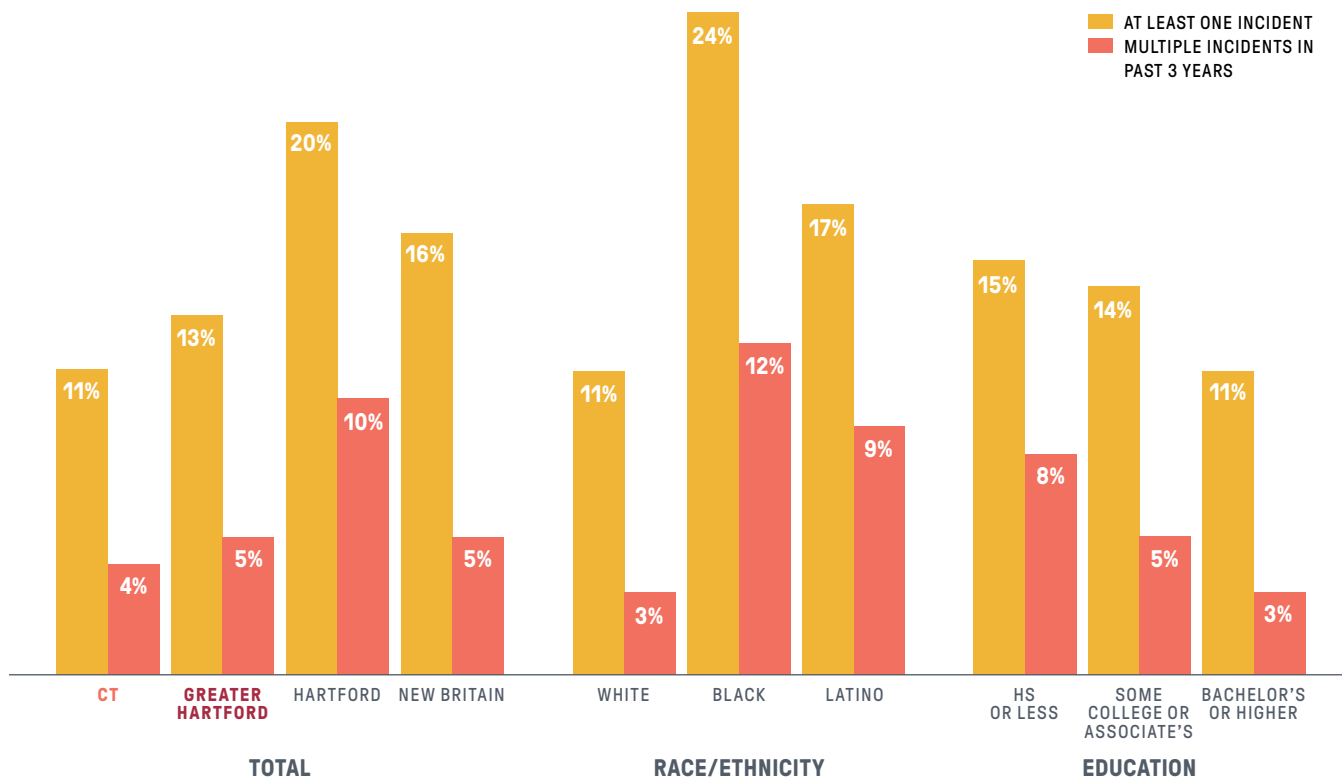
PERCENT OF ADULTS REPORTING PERCEIVED REASONS FOR THEIR DISCRIMINATION, OF ADULTS CITING A REASON FOR EXPERIENCES OF DISCRIMINATION, GREATER HARTFORD, 2018

■ RACE
■ SOME OTHER ASPECT OF PHYSICAL APPEARANCE
■ AGE
■ GENDER
■ HEALTH INSURANCE STATUS
■ EDUCATION OR INCOME LEVEL

NOTE: SURVEY RESPONDENTS WERE ALLOWED TO CITE MORE THAN ONE REASON.

50% 24% 24% 23%	**35%** 29% 26%	**31%** 24% 22% 21%
POLICE STOPS	WORKPLACE	ACCESS TO HEALTHCARE

FIG 3.12

Black and Latino adults and adults with less education disproportionately experience negative encounters with police

PERCENT OF GREATER HARTFORD ADULTS REPORTING UNFAIR POLICE STOPS, SEARCHES, OR OTHER MISTREATMENT AND FREQUENCY OF INCIDENTS, BY RACE AND EDUCATION, 2018

■ AT LEAST ONE INCIDENT
■ MULTIPLE INCIDENTS IN PAST 3 YEARS

11% 4%	13% 5%	20% 10%	16% 5%	11% 3%	24% 12%	17% 9%	15% 8%	14% 5%	11% 3%
CT	GREATER HARTFORD	HARTFORD	NEW BRITAIN	WHITE	BLACK	LATINO	HS OR LESS	SOME COLLEGE OR ASSOCIATE'S	BACHELOR'S OR HIGHER
TOTAL				**RACE/ETHNICITY**			**EDUCATION**		

CONNECTING HEALTH AND WEALTH

As in the nation as a whole, the health of Greater Hartford's residents helps drive their high quality of life and economic vitality. Children and adults who have the resources they need to reach their full health potential face fewer barriers to success in school and in the workforce, and experience fewer health care costs. Over the long term, employers and individual households prefer to establish themselves in areas where they can benefit from this resulting prosperity. Furthermore, any healthy population is going to be stronger, more innovative, and better able to overcome adversity than one facing greater barriers to health.

According to the 2018 DataHaven Community Wellbeing Survey, 59 percent of Greater Hartford's adults reported being in very good health, the same as the statewide average and well above the most recent national rate (51 percent).[180] This measure of self-rated health is widely used, as it is one of the most reliable ways to predict a population's quality of life and lifespan.[181]

Similarly, most Greater Hartford residents can expect to live long and healthy lives. The average life expectancy in the region was 79.9 years from 2010 to 2015, above the national average of 78.7 years, but just below the statewide average of 80.3 years.[182]

There are many opportunities to improve the region even further by reducing or removing the barriers that prevent all residents from reaching their full health potential. The conditions that shape the health a person experiences throughout their lifespan are known as the social determinants of health.

While the U.S. is financially prosperous overall, its income-related health differences are among the highest of all middle- or high-income nations in the world. Nationally, wealthier residents (i.e., those earning $100,000 or more annually) are nearly half as likely as middle-income residents to rate their health as fair or poor, and the percent of low-income residents who reported not being able to access health care due to the cost was 16 percentage points higher than among wealthy residents.[183] Income-related differences in health are also evident in Greater Hartford, where 72 percent of adults earning $100,000 or more per year report being in very good health, compared to just 42 percent of adults who earn less than $30,000 per year.[184]

Income and employment status often drive differences in access to healthcare, the likelihood of getting preventive screenings as recommended, the affordability of life-saving medicines, and the ability to purchase other goods and services, including high-quality housing. These differences can compound over generations, as children who grow up in higher-income households are more likely to succeed in school and obtain jobs with greater potential for advancement.

Factors such as racial or gender-based discrimination, sleep deprivation, health literacy, linguistic isolation, family social history, excessive debt, and variations in the quality of the built environment—all of which can underlie income differences—also play a role in disparate health outcomes. Poor health can worsen as these factors interact with each other.

On the other hand, communities may enact policies and provide resources that can improve the health status of all people. These "protective factors" include stable and affordable housing, accessible childcare, reliable transportation options, green spaces and places to exercise, effective public health services, and policies such as paid family leave. Region-wide efforts to align policies, unify monitoring and data collection systems, and address gaps in services can help begin to create conditions in which everyone can achieve their full health potential.

Information collected during the 2019 Community Health Needs Assessment process—including data on life expectancy, adverse conditions, and self-rated health, as well as interviews and focus groups with hundreds of residents and local experts—reveal that concerns around well-being and the social determinants of health vary significantly from neighborhood to neighborhood within Greater Hartford. Residents and policymakers can use these local data to further elevate the health and prosperity of the region.

Greater Hartford's 19-Year Difference in Life Expectancy

Greater Hartford's average life expectancy of 79.9 years masks a dramatic difference within the region. Life expectancy in one part of Northeast Hartford is just 68.9 years—more than 19 years lower than that of the neighborhood with the highest life expectancy (88.1 years, in Avon).[185] Town-wide averages range from a maximum of 85.2 years in Andover, to a minimum of 76.6 years in New

Britain and 77.1 years in Hartford.SEE FIG 3.1

Differences within cities and towns are significant. Within Hartford, the Downtown neighborhood's life expectancy is above the state average of 80.3 years. Those of the South Green, Parkville, Clay Arsenal, Northeast, and Frog Hollow neighborhoods are at least four years lower. In West Hartford's Kennedy Park, life expectancy is 79.9 years; in Elizabeth Park, life expectancy is 6 years higher, at 86.2 years.[186] Large differences in life expectancy are also found in New Britain, Manchester, and East Hartford neighborhoods, and in several other suburban towns.

These variations in life expectancy can be explained by differences in the rates of premature death within the population—calculated based on the number of years of potential life lost by residents before they reach their 75th birthdays (YPLL-75). Cancers, fetal and infant mortality, cardiovascular diseases, opioid use disorders, suicides, motor vehicle crashes, and homicides are prominent among the causes of premature death as measured by YPLL-75. SEE FIG 3.2

To illustrate the differences in the rates of premature death in Greater Hartford, consider the 4.9 year gap in life expectancy between New Britain and the region's Outer Ring suburban towns. For every 100,000 residents under the age of 75, a total of 8,250 years of potential life were lost due to all premature deaths in New Britain each year from 2010 to 2014, compared to 4,063 in the Outer Ring. Heart disease, one of the leading causes of premature death, cost 1,246 years of life per 100,000 residents in New Britain (based on 55 premature deaths each year, with an average age

at death of 59 years) and 588 years in the Outer Ring (148 premature deaths each year, with an average age at death of 62). In Hartford, homicides are a particular concern: they led to the loss of 667 years of life per 100,000 residents in Hartford (18 premature deaths from homicide each year, with an average age at death of 30), compared to 282 years in New Britain (4 deaths per year) and 38 years in the Outer Ring suburbs (3 deaths per year). SEE TABLE 3A

Leading Causes of Death: Cancer, Heart Disease, and Injuries

Cancers were among the most common causes of premature death in Greater Hartford from 2010 to 2014, with lung cancer by far the most common cause of cancer-related premature mortality. The premature death rate from lung cancer in the region was similar to the state average. However, relatively high rates of premature mortality were seen in New Britain (351 years lost per 100,000 residents) and Greater Hartford's Inner Ring suburbs (339 years lost per 100,000 residents).

From 2015 to 2017, age-adjusted rates of lung cancer-related hospitalizations in the Outer Ring (19 encounters per 10,000 residents per year) were lower than the statewide and Inner Ring averages (23 encounters per 10,000 residents, each). Within the Inner Ring, Plainfield, East Hartford, Vernon, Manchester, and Newington were among the towns with the highest rates from 2015 to 2017.[187]

Premature death rates due to other types of cancer were, for the most part, not statistically different from statewide averages. In the region as a whole, premature death rates were fairly similar

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TABLE 3A

Premature death rates by geography

YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75 (YPLL-75) PER 100,000 RESIDENTS PER YEAR DUE TO LEADING CAUSES, 2010–2014

LOCATION	ALL PREMATURE DEATHS	ALL CANCERS	INFANT AND FETAL DEATH	HEART DISEASE	DRUG-RELATED DEATHS	LUNG CANCER (SUBSET OF CANCER)	SUICIDE	MOTOR VEHICLE CRASHES	HOMICIDE
Connecticut	5,418	1,284	828	802	450	297	287	259	158
Greater Hartford	5,464	1,282	868	807	429	280	290	288	163
Hartford	7,826	1,280	1,874	1,143	497	206	205	360	667
New Britain	8,250	1,489	1,436	1,246	751	351	367	351	282
GH Inner Ring	5,590	1,409	852	833	406	339	297	273	116
GH Outer Ring	4,063	1,085	402	588	358	224	292	267	38

for breast (135 years, compared to 125 years lost per 100,000 residents statewide), colorectal (116 years, compared to 107 years lost per 100,000 residents statewide) and pancreatic cancers (91 years, compared to 81 years lost per 100,000 residents statewide).

Cigarette smoking is one notable risk factor for cancer, causing an estimated 48.5 percent of all deaths from 12 major types of cancer combined.[188] It is a contributing factor in up to 90 percent of lung cancer deaths—as smokers are 15 to 30 times more likely to die of lung cancer than non-smokers[189]— as well as half of bladder cancer deaths. While smoking rates have fallen during the past two decades, they remain relatively high in parts of the region. Obesity, unhealthy diets, alcohol consumption, and physical inactivity are also considered to be significant risk factors for cancer.

Heart disease and other cardiovascular diseases cause one-third of U.S. deaths overall,[190] and are also a leading cause of premature death in Greater Hartford. In 2010 to 2014, Greater Hartford had rates of premature mortality due to heart disease comparable to the statewide average, but in New Britain, Hartford, and several Inner Ring towns, rates were higher than that of the state.

Injury is also a leading cause of death, particularly among younger adults and children. Injuries comprise a broad category that includes deaths from overdoses, motor vehicle crashes, homicides, suicides, and other traumas. From 2010 to 2014, the impact of injuries on premature death rates was similar to that of cancer in most towns. Since 2014, the opioid crisis has made this category even more significant as a cause of reduced life expectancy. Topics related to the leading causes of death are discussed below in more detail.

INFANT AND CHILD HEALTH

Healthy Birth Outcomes

A person's childhood is formative in almost every way, and the health of a child in the first few years of their life strongly determines how healthy they will be as an adult. This path begins while the child is still in the womb—with the health of the child's mother.

Since the dawn of modern public health, statistics on infant outcomes have been considered one of the most effective indicators of the overall health of a community. Despite rising life expectancy overall due to medical advances, rates of infant mortality in the U.S. remain very high relative to what they are in many other advanced economies. In 2017, France, Spain, Italy, the Czech Republic, South Korea, and Hong Kong had infant mortality rates of between 2.6 and 3.3 deaths per 1,000 live births—about half the U.S. rate of 5.8 deaths per 1,000 live births that year.[191] In 2015, the rate of infant mortality in Greater Hartford was 6.3 deaths per 1,000 live births. This was above the state average of 5.6 deaths per 1,000 live births.[192]

Regional averages mask large disparities by race and ethnicity. In Greater Hartford in 2015, the infant mortality rate for babies born to Black mothers was 11.7 deaths per 1,000 live births, and the rate for babies born to Latina mothers was 9.9 per 1,000. Both were well above the rate of 5.4 per 1,000 for babies born to white mothers. The differences in these rates are similar to those observed statewide.[193] Rates differ by geography as well: between 2011 and 2015, Hartford had an average rate of 9.7 deaths per 1,000 live births and New Britain had a rate of 9.2 per 1,000, whereas the rate in the Outer Ring was 3.9 per 1,000.

The two most significant causes of infant mortality are birth defects and conditions related to preterm birth or low birthweight. Birth defects have many causes, some of which are unknown, but some of the most preventable risk factors may include a lack of folic acid, alcohol use, smoking, obesity, and uncontrolled diabetes.[194] Similarly, the causes of premature birth and low birthweight are complex, but some are related to health inequities such as a lack of adequate prenatal care, poor nutrition, and factors that exacerbate the risk of chronic diseases. As shown elsewhere in this report, the rates at which women face these

TABLE 3B

Birth outcomes

DATAHAVEN ANALYSIS OF CTDPH VITAL STATISTICS DATA, 2006–2010 AND 2011–2015

LOCATION	2006–2010 (5 YEARS)			2011–2015 (5 YEARS)			PERCENT CHANGE, 2006–2010 TO 2011–2015		
	TOTAL BIRTHS	PERCENT LOW BIRTH-WEIGHT	PERCENT NON-ADEQUATE PRENATAL CARE	TOTAL BIRTHS	PERCENT LOW BIRTH-WEIGHT	PERCENT NON-ADEQUATE PRENATAL CARE	TOTAL BIRTHS	PERCENT LOW BIRTH-WEIGHT	PERCENT NON-ADEQUATE PRENATAL CARE
Connecticut	200,357	8.0%	20%	181,687	7.8%	23%	-9%	↓3%	↑14%
Greater Hartford	53,462	8.7%	27%	49,118	8.5%	29%	-8%	↓2%	↑10%
Hartford	10,735	11.6%	31%	9,545	11.1%	29%	-11%	↓4%	↓7%
New Britain	5,496	9.2%	38%	5,099	9.3%	42%	-7%	↑1%	↑11%
GH Inner Ring	22,819	8.6%	25%	21,719	8.3%	28%	-5%	↓3%	↑15%
East Hartford	3,627	10.4%	28%	3,319	10.4%	28%	-8%	0%	↓1%
Manchester	3,946	8.3%	22%	3,895	8.6%	23%	-1%	↑4%	↑7%
West Hartford	3,271	7.4%	27%	3,029	7.3%	31%	-7%	↓1%	↑17%
GH Outer Ring	14,412	6.6%	23%	12,755	6.5%	27%	-11%	↓2%	↑17%

conditions diverge along socioeconomic, racial, and geographic lines.

The rate of low-birthweight babies—defined as the percentage of infants born that weigh fewer than roughly five and a half pounds—has been stable in Greater Hartford over the past decade. Between 2006–2010 and 2011–2015, the five-year periods used for our analysis of local area data, the rate of low-birthweight babies in Greater Hartford fell slightly from 8.7 percent to 8.5 percent. Statewide, the low-birthweight rate fell from 8.0 to 7.8 percent during that same time period. The 2011–2015 low-birthweight rate varied from 6.5 percent of infants in the Outer Ring to 8.3 percent in the Inner Ring and 11.1 percent in Hartford. None of these regions experienced a substantial improvement in the past decade. SEE TABLE 3B

The rate of non-adequate prenatal care— meaning that the mother went to fewer than 80 percent of the expected prenatal care visits or did not start the visits until her second trimester— rose from 27 to 29 percent of births in Greater Harford between 2006–2010 and 2011–2015, similar to the trend observed statewide during that time period (an increase from 20 to 23 percent). Hartford was one of the few places in Connecticut that saw an improvement in its rate of non-adequate prenatal care, with the share of births with non-adequate care in that city declining from 31 percent to 29 percent between 2006–2010 and

2011–2015. For comparison, in the similarly-sized cities of Bridgeport and Stamford, non-adequate prenatal care rates were 33 percent in the 2011–2015 period.

Environmental Threats

While lead—a dangerous neurotoxin—is toxic to everyone, lead poisoning is of particular concern to children under the age of six due to rapid development in early childhood. Health problems related to lead are a constant concern in areas with older housing stock that contain lead paint. As such, regulations that aim to limit children's exposure have been tightened. Even at relatively low levels, however, lead poisoning can cause behavioral changes and cognitive impairment in children. As of May 2013, the state's reference level is 5 micrograms of lead per deciliter of blood (μg/dL); a child under six years old with a level higher than that is classified as lead poisoned. In 2016, there were 425 Greater Hartford children under six years old who had blood lead concentrations higher than the reference, or 2.2 percent of those tested. Between 2012 and 2016, at least 3 percent of children tested in Stafford, Hartford, Vernon, New Britain, and Manchester were classified as lead poisoned at the 5 microgram level.[195] Hartford's rate of lead poisoning was 3.9 percent in 2016. By comparison, the statewide rate of lead poisoning was 2.7 percent in 2016.[196]

Children are also at increased risk of asthma exacerbations due to environmental factors, including cockroaches, mold, and traffic pollution.[197] Childhood asthma affects children's quality of life and performance in school and it can be fatal if left untreated. According to the State of Connecticut Department of Public Health's School-Based Asthma Surveillance Report of 2019, on average from 2012 to 2014, 17 percent of Greater Hartford public school students had asthma, above the statewide rate of 14 percent.[198] Rates of childhood asthma in most Greater Hartford public school districts fell below the statewide average, including in Wethersfield, Avon, Glastonbury, and Marlborough where the rates were lower than 9 percent. On the other hand, at least 20 percent of the students in New Britain, Hartford, Tolland, Vernon, Windsor, and Manchester public schools had asthma. Rates of hospital and emergency room encounters for asthma among children four years old and younger also differ from town to town across the region.[199] SEE TABLE 3C

TABLE 3C

Asthma prevalence by public school district
CT DPH SCHOOL-BASED ASTHMA SURVEILLANCE, 2012–2014

SCHOOL DISTRICT [211]	ASTHMA PREVALENCE
Connecticut	14.3%
Greater Hartford	17.1%
Hartford	23.5%
New Britain	27.7%
GH Inner Ring	16.3%
East Hartford	19.5%
Manchester	20.5%
West Hartford	14.1%
GH Outer Ring	12.4%

HEALTH RISK FACTORS

Inadequate Access to Health and Dental Care

Health-related challenges begin with access to health care. In 2018, the percentage of uninsured adults in Greater Hartford was 4 percent, slightly lower than that of Connecticut overall (5 percent), and lower than national averages,[200] yet there are notable disparities. While only 3 percent of Greater Hartford's white population lacks insurance, the numbers jump to 10 percent for its Black population, 11 percent for Latinos, and 9 percent of those who earn less than $30,000 per year.[201] SEE TABLE 3E

Having health insurance, however, does not guarantee timely or high-quality medical care. Reasons for foregoing medical care are complex and overlapping, and lower-income residents may disproportionately be faced with the challenge of pursuing medical care in lieu of other basic necessities. In Greater Hartford, 23 percent of adults reported having postponed necessary medical care within the past year, and 9 percent reported having failed to get care altogether.[202] About half of survey respondents who missed or postponed care cited having been too busy with work or other commitments (52 percent), fearing the cost would be too high (47 percent), or not feeling their issues were serious enough (43 percent). Scheduling problems can disrupt care: 29 percent of adults who missed or postponed care could not get an appointment soon enough, and 26 percent could not get to a provider during their open hours. Insurance not paying for treatment was an issue for 32 percent of adults missing or delaying care, and insurance not being accepted was an issue for 18 percent. Additionally, 23 percent of those with disrupted care cited their caregiving obligations.[203]

Twelve percent of Greater Hartford adults—including 21 percent of young adults—lack a medical home, meaning that they do not have any person or place that they consider to be their personal doctor, who they see on an ongoing basis.[204]

Lacking affordable medical care may play a role in residents relying on the emergency room. In 2018, 28 percent of Greater Hartford adults reported receiving care in a hospital emergency room at least once in the past year.[205] While only 4 percent of adults in the region did so three or more

Frequent emergency room use and health-related social needs

SHARE OF ADULTS, GREATER HARTFORD, 2018

	NO HEALTH INSURANCE	DIDN'T GET MEDICAL CARE THEY NEEDED IN PAST YEAR	FOOD INSECURE	TRANSPORT INSECURE	STAYED HOME FROM DOCTOR IN PAST YEAR DUE TO LACK OF TRANSPORT	THREATENED WITH UTILITY SHUTOFF IN HOME	PHYSICALLY ATTACKED OR THREATENED IN PAST YEAR
All adults in the region, ages 18+	4%	9%	14%	12%	5%	12%	6%
Adults who did not receive care in ER last year	4%	6%	10%	8%	2%	9%	3%
Adults who used ER 1–2x last year	4%	14%	19%	20%	11%	14%	10%
Adults who used ER 3x+ last year	7%	29%	42%	32%	19%	39%	29%
Relative risk: Frequent users vs. non-users of ER	1.7x	4.4x	4.0x	3.8x	10.3x	4.2x	8.3x

times during the past year, this figure was 10 percent among those earning less than $30,000 per year.[206] Lack of transportation, food insecurity, and unstable housing also contribute to frequent use of emergency rooms. In Greater Hartford, residents lacking health insurance were about as likely as those with insurance to be frequent users of an emergency room last year, but residents who experienced food or transportation insecurity were substantially more likely to have visited an emergency room than other residents.[207] SEE TABLE 3D

Healthcare affordability is a challenge for many residents. In 2018, 15 percent of Greater Hartford residents earning less than $30,000 per year did not get prescription medicines they needed because they could not afford the medication, compared to 9 percent of residents overall, and 5 percent of residents earning over $100,000 per year.[208] Additionally, 7 percent of adults in Greater Hartford said that they altered the way they take their prescription medicines last year because they could not afford to get more of them.[209]

Dental care is also important because oral health affects many other areas of life, including overall well-being and performance at school and in work. Good oral health helps prevent infections, heart disease, stroke, adverse birth outcomes, and other serious conditions, and has other impacts on quality of life.[210] According to the CDC, over 40

percent of U.S. adults experience mouth pain each year, causing many people to miss work for emergency dental care. In Connecticut, about 16 percent of elementary school-age children have untreated tooth decay.[211]

In 2018, 24 percent of Greater Hartford adults said they had not been to the dentist in the past year. This rate was higher among younger adults (31 percent), Black and Latino adults (26 percent and 29 percent respectively), and adults earning less than $30,000 per year (44 percent).[212]

Emergency room encounters related to preventable dental conditions are considered an incidence proxy for the lack of timely and adequate oral health care. Seeking acute care at a hospital for a severe tooth infection, for example, may not address the underlying need for preventive dental care. On average, rates for emergency room encounters and hospitalizations for preventable dental conditions were lower in the Greater Hartford Inner and Outer Rings compared to statewide rates. However, the cities of New Britain and Hartford had much higher rates, especially within the 0–19 and 20–44 age groups. Throughout the region, most towns saw decreases in the rates of hospital encounters for preventable dental conditions, with particularly large decreases in the Inner Ring, from 62.5 encounters per 10,000 residents in 2012–2014 to 45.9 per 10,000 in 2015–2017. SEE FIG 3.3, 3.4, 3.5, 3.6, 3.7

TABLE 3E

Barriers to healthcare

SHARE OF ADULTS, GREATER HARTFORD, 2018

LOCATION	DIDN'T GET CARE	POSTPONED CARE	NO MEDICAL HOME
Connecticut	9%	23%	12%
Greater Hartford	9%	23%	12%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD			
Male	9%	19%	13%
Female	9%	27%	9%
Age 18–34	12%	30%	21%
Age 35–49	12%	28%	13%
Age 50–64	8%	23%	7%
Age 65+	4%	11%	N/A
White	8%	24%	10%
Black	10%	23%	13%
Latino	16%	26%	22%
Under $30K	14%	27%	16%
$30K-$100K	10%	26%	13%
$100K+	6%	21%	N/A
BY GEOGRAPHY			
Hartford	16%	26%	18%
New Britain	14%	23%	13%
GH Inner Ring	10%	26%	10%
East Hartford	13%	26%	N/A
Manchester	11%	28%	15%
West Hartford	4%	15%	9%
GH Outer Ring	5%	18%	10%

Experiences of Discrimination

In 2018, the DataHaven Community Wellbeing Survey included for the first time a sequence of questions about experiences of discrimination (EOD), drawn from a body of scientific work pioneered largely by David Williams of the Harvard School of Public Health.[213] Discrimination is a social stressor that impacts mental and physical health both directly and indirectly, especially within the context of structural, institutional, and cultural racism.[214] In 2018, 11 percent of all adults in the region said that, when seeking healthcare, they had been treated with less respect, or received worse care than what others received.[215] For these adults, health insurance status, age, and race were among the three most commonly reported reasons for discrimination. Most of these adults experienced this issue repeatedly: 63 percent said such incidents had happened multiple times in the past three years.

LGBTQ individuals, as a group, have a higher risk for a variety of conditions, including sexually-transmitted diseases, poor mental health, homelessness, harassment, violence, and social isolation.[216] They also face stigmas, lack of cultural competency in healthcare providers, and exclusionary insurance policies.[217] Transgender people in particular often have difficulty simply accessing care: statewide, only 57 percent of self-identifying transgender participants in the DataHaven Community Wellbeing Survey reported that their primary care provider can provide them with trans-inclusive services, and 44 percent said they had forgone medical care in the past year for fear of harassment or mistreatment.[218] These findings match research done nationally by organizations seeking to understand the concrete ways discrimination and lack of access to resources impair the health of LGBTQ people.[219]

In addition to asking about health care discrimination, the 2018 survey probed residents' experiences with negative interactions with and unfair stops by police, differential treatment while searching for housing, and unfair treatment when seeking employment or a promotion. Combining the survey items into an experiences-of-discrimination scale suggests a link between discrimination and poor health in Greater Hartford. In a future report, we will complete a more rigorous statistical analysis of these data.

Adverse Childhood Experiences

According to the Connecticut Department of Public Health, adverse childhood experiences (ACEs) can affect a child's social, emotional, and cognitive development; their adoption of risky behavior later in life; and their chances of disease and even early death. Three of five adults across the state reported having had at least one ACE—ranging from an incarcerated household member or sexual abuse to the more prevalent household drinking problems, divorced parents, and emotional abuse. Two-thirds of those who had had at least one ACE had experienced multiple ACEs.[220]

In the 2018 DataHaven Community Wellbeing Survey, Greater Hartford residents expressed

general concerns for youth living in their neighborhoods. Among all the adults in the region, 8 percent thought it was likely that youth would join a gang, and 13 percent felt the same about the chances of youth getting arrested for felonies.[221] These data varied by town and neighborhood, however. More than 30 percent of adults in Hartford and New Britain believed youth in their area would get arrested for a felony, compared to 5 percent of adults in Outer Ring towns. SEE FIG 2.25, 3.8

Nutrition, Physical Activity, and Substance Use

Attaining and maintaining good health requires not only access to high quality medical services, but also engagement in daily behaviors that promote health. However, broader issues of income, education, employment, and racial and gender discrimination can pose obstacles to living a healthy lifestyle. Being able to afford nutritious food costs money. Taking full advantage of preventive screenings through regular checkups takes time. While tobacco use, poor diet, lack of exercise, and substance use—modifiable behavioral risk factors that are sometimes referred to as the "actual" causes of death— are critical to understand, they should be considered in the context of a growing body of literature that documents their connections to poverty, inequality, and other social issues.

In Connecticut, 29 percent of adults have a body mass index that classifies them as obese. Connecticut's obesity rate has increased dramatically since 1990, when it was estimated to be only 10 percent.[223] Between 2015 and 2018, the

Statistical modeling has revealed the extent to which body weight is influenced by neighborhood factors such as access to healthy foods and walking spaces. Social context can also influence health-related behaviors: for example, if you live in a neighborhood where smoking is prevalent, you are more likely to take up smoking yourself. Or, if recreational sports are important to the fabric of your community, you may be more active. The effects of these ecological drivers on children and adolescents can impact the development of obesity later in life.[222] Consequently, there is a need to intervene on these pervasive drivers of health risks that also contribute to cancer, depression, diabetes, heart disease, stroke, injury, and other conditions that can reduce life expectancy and quality of life.

TABLE 3F

Experiences of discrimination

SHARE OF ADULTS HAVING EVER EXPERIENCED DISCRIMINATION, GREATER HARTFORD, 2018

LOCATION	WORKPLACE	POLICE STOPS	PREVENTED FROM MOVING	RECEIVED POOR SERVICE
Connecticut	27%	11%	4%	10%
Greater Hartford	27%	13%	3%	13%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD				
Male	27%	17%	4%	15%
Female	26%	9%	2%	12%
Age 18–34	24%	14%	4%	N/A
Age 35–49	28%	18%	4%	N/A
Age 50–64	35%	13%	2%	N/A
Age 65+	20%	6%	3%	N/A
White	26%	11%	2%	N/A
Black	30%	24%	7%	N/A
Latino	20%	17%	9%	N/A
Under $30K	31%	16%	8%	N/A
$30K-$75K	24%	15%	2%	N/A
$75K+	28%	11%	2%	N/A
BY GEOGRAPHY				
Hartford	30%	20%	7%	17%
New Britain	28%	16%	13%	N/A
GH Inner Ring	28%	14%	2%	9%
East Hartford	N/A	15%	N/A	N/A
Manchester	30%	25%	6%	N/A
West Hartford	32%	7%	9%	N/A
GH Outer Ring	21%	8%	0%	19%

prevalence of obesity among Greater Hartford adults rose from 27 percent to 28 percent—in line with the trend statewide, where obesity rates rose from 26 percent in 2015 to 29 percent in 2018 according to the DataHaven Community Wellbeing Survey,[224] and from 25 percent in 2015 to 27 percent in 2017 according to the Behavioral Risk Factor Surveillance System.[225] Additionally, while 57 percent of Greater Hartford adults report exercising at least three days per week, the share who report that they did not get exercise even once during a typical week increased slightly between 2015 and 2018, from 17 percent to 20 percent, the same as the statewide rates.[226] Likewise, childhood obesity is a major concern, though Connecticut's

TABLE 3G

Health risk factors

SHARE OF ADULTS WITH WELL-BEING AND CHRONIC DISEASE RISK FACTORS, GREATER HARTFORD, 2018

LOCATION	VERY GOOD SELF-RATED HEALTH	ANXIETY	DIABETES	CURRENT ASTHMA	OBESITY	HAS HEALTH INSURANCE	DENTAL VISIT PAST YR	DEPRE-SSION	SMOKING	FOOD INSECURITY
Connecticut	59%	12%	10%	11%	29%	95%	74%	9%	14%	13%
Greater Hartford	59%	13%	11%	11%	28%	96%	76%	11%	12%	14%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD										
Male	62%	12%	12%	8%	27%	94%	74%	8%	14%	11%
Female	56%	13%	10%	13%	29%	97%	76%	12%	11%	16%
Age 18–34	65%	19%	4%	15%	23%	94%	69%	16%	14%	22%
Age 35–49	59%	9%	7%	14%	32%	95%	73%	11%	16%	17%
Age 50–64	57%	9%	13%	7%	30%	95%	81%	7%	13%	11%
Age 65+	52%	10%	23%	7%	29%	99%	80%	6%	6%	4%
White	60%	11%	10%	10%	27%	97%	76%	9%	12%	11%
Black	53%	14%	15%	11%	32%	90%	74%	13%	16%	23%
Latino	59%	22%	8%	19%	32%	89%	71%	19%	16%	29%
Under $30K	42%	22%	18%	14%	32%	91%	56%	24%	22%	32%
$30K–$100K	60%	12%	11%	11%	29%	96%	75%	8%	12%	14%
$100K+	72%	8%	5%	8%	25%	99%	88%	4%	7%	2%
BY GEOGRAPHY										
Hartford	52%	15%	13%	16%	35%	91%	65%	15%	18%	23%
New Britain	51%	14%	11%	12%	29%	95%	68%	12%	14%	25%
GH Inner Ring	53%	15%	13%	10%	34%	96%	73%	12%	15%	15%
East Hartford	56%	14%	20%	11%	35%	91%	67%	11%	19%	18%
Manchester	60%	21%	8%	12%	28%	94%	72%	19%	21%	23%
West Hartford	76%	8%	6%	7%	15%	96%	83%	3%	5%	5%
GH Outer Ring	67%	9%	8%	9%	22%	97%	82%	7%	7%	8%

estimated 11.9 percent obesity rate among youth ages 10 to 17 is lower than the U.S. rate of 15.8 percent.[227] Local, state, and national rates are calculated based on self-reported or parent and caregiver-reported height and weight, and likely underestimate the actual obesity rate by a few percentage points.

Despite major reductions in cigarette smoking over the past several decades, there is still room for significant progress. The connection between smoking and cancer is discussed above, and smoking and secondhand smoke have been linked to many other health issues including infant health, asthma, and stroke. Fewer adults smoke cigarettes in Greater Hartford (12 percent) than in the state

overall (14 percent). The region's smoking rate fell from 15 percent since 2015; however, it is still relatively high among residents earning less than $30,000 per year (22 percent) and within certain towns such as Hartford (18 percent), East Hartford (19 percent), and Manchester (21 percent).[228] Vaping is becoming more common, particularly among young adults. In 2018, 8 percent of adults in Greater Hartford reported using e-cigarettes or vaping more than once a month, identical to the statewide rate of 8 percent; however, among adults age 18 to 34, 38 percent had tried e-cigarettes as of 2018, and 21 percent were currently using them.[229]

Some in the region struggle with alcohol, marijuana, and opioid use disorders. In 2018, 6

percent of adults reported drinking heavily (more than four drinks at once for women or five drinks for men) at least six times in the past month, and 6 percent of adults—including 12 percent of those ages 18 to 34—reported using marijuana more than 10 times during any given month.[230] Drinking too much can dramatically change mood and behavior, and long-term alcohol use can damage organs including the heart and liver, increasing the risk of cancers and other diseases.[231] Like alcohol, marijuana is associated with depression and anxiety, though it is not yet known whether this is a causal relationship.[232]

The Opioid Crisis

The opioid crisis has made headlines for a few years across the country as abuse of and addiction to opiates and opioids has increased dramatically, with some of the highest overdose death rates occurring in the northeast U.S. In 2016, Connecticut ranked 11th among all states in the country in the rate of overdose deaths, and several nearby states— including New Hampshire, Massachusetts, Rhode Island, and Maine—fell within the top 10.[233] Thousands of Americans die of opioid overdoses each month, including an average of 67 Connecticut residents per month from 2015 to 2018.[234] Between 2015 and 2018, Greater Hartford averaged 25.9 drug overdose deaths per 100,000 residents per year, higher than the state's rate of 24.2 per 100,000; filtered for just opiate- and opioid-related deaths, these rates become 24.6 and 22.8, respectively.[235] SEE TABLES 3H, 3I

The full effect of the opioid crisis in recent years is not captured in the comprehensive 2010–2014 premature mortality data used towards the beginning of this chapter. Over just a few years, the number of deaths from drug overdoses in Greater Hartford more than doubled, from 116 deaths in 2013 to 247 deaths in 2016; this increase was driven mostly by a steep rise in opiate- and opioid-related deaths.[236] The weight of overdose deaths comes not only from sheer numbers, but also from the epidemic's reach: the median age at which a Greater Hartford resident dies of an overdose is 43 years, about 37 years younger than the region's overall life expectancy.[237] When ranking major causes of premature death by years of potential life lost prior to age 75 (YPLL-75) in Greater Hartford, we estimate that deaths from opioid-related overdoses between 2015 and 2018 would rank 3rd highest after cancer

and infant and fetal mortality, and before accidents and heart disease.[238] SEE FIG 3.9, 3.10

The Centers for Disease Control and Prevention characterizes the epidemic as multilayered with three distinct waves.[239] Prescription opioids were the main drivers of the first wave in the 1990s; heroin was largely responsible for the rise in 2010; and synthetic opioids, such as fentanyl, have driven the current wave, which began in 2013.[240]

These patterns hold true in Greater Hartford, where the death rate from drug overdoses has mirrored the upward trend seen throughout the state and country, generally staying about tied with the statewide rate. Similar also is the skyrocketing prominence of fentanyl: the substance was detected in only 6 out of Greater Hartford's 206 overdose deaths (3 percent) in 2012 and 2013, but in 434 of the 567 deaths (77 percent) in 2017 and 2018. One positive note for the region is that, since

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TABLE 3H

Overdose deaths by substance

TOTAL COUNT AND ANNUALIZED AGE-ADJUSTED OVERDOSE DEATH RATE PER 100K RESIDENTS BY PRESENCE OF OPIATES OR OPIOIDS, GREATER HARTFORD, 2015–2018

LOCATION	ANY SUBSTANCE COUNT	ANY SUBSTANCE RATE	OPIATE/OPIOID COUNT	OPIATE/OPIOID RATE
Connecticut	3,423	24.2	3,202	22.8
Greater Hartford	1,004	25.9	950	24.6
GH Inner Ring	419	24.3	396	23.0
GH Outer Ring	213	17.2	204	16.6

TABLE 3I

Overdose deaths by race and ethnicity

TOTAL COUNT AND ANNUALIZED AGE-ADJUSTED OVERDOSE DEATH RATE PER 100K RESIDENTS BY RACE, GREATER HARTFORD, 2015–2018

LOCATION	WHITE COUNT	WHITE RATE	BLACK COUNT	BLACK RATE	LATINO COUNT	LATINO RATE
Connecticut	2,673	29.5	296	18.9	393	19.1
Greater Hartford	718	30.6	88	17.1	175	32.2
GH Inner Ring	339	31.9	30	11.7	41	21.7

mid-2017, overdose death rates in the region may be slowing.[241]

As is the case elsewhere, men make up much larger shares of drug overdose deaths than women: since 2012, women have never accounted for more than a third of the region's overdose deaths in a given year. However, one notable difference between Greater Hartford and other parts of the state is in rates by race: elsewhere, white residents have been dying at greater rates than Black or Latino residents. In Greater Hartford between 2015 and 2018, the age-adjusted overdose death rate for Latinos was slightly higher (32.2 per 100,000 residents per year) than for white residents (30.6). Black residents' rate is much lower at 17.1 per 100,000 per year.[242]

For every person who dies of an opioid overdose, many more seek treatment, often multiple times. Between the 2014 and 2018 fiscal years, Greater Hartford residents were admitted to opioid treatment programs a total of 34,425 times, averaging 6,885 admissions per year, or 706 admissions per 100,000 residents per year. Hartford, New Britain, Plainville, Enfield, and Windsor Locks had rates above the regional average; the rate in Hartford was more than twice as high, at 2,014 admissions per 100,000 residents per year. The majority of these admissions were to programs funded by the state Department of Mental Health and Addiction Services. Though harder to track, people are often admitted to programs multiple times within one year.[243]

Many residents also seek or receive care for substance use disorders at area hospitals and emergency rooms. Compared to Connecticut as a whole, Greater Hartford has lower rates of hospital and emergency room encounters for substance use, a category that includes diagnoses related to use of opioids and other drugs. From 2015 to 2017, Connecticut averaged 178 encounters for substance use per 10,000 residents annually, while the Greater Hartford Inner Ring and Outer Ring averaged 147 and 81, respectively. However, Hartford and New Britain residents experience much higher rates of hospital and emergency room encounters than residents of most other towns: 549 encounters per 10,000 residents for Hartford and 307 for New Britain. Across the state, there is a greater burden of drug-related hospital encounters for males than females, as well as for adults between ages 20 and 64; this was especially pronounced for Hartford.[244]

SEE FIG 3.3, 3.4, 3.5, 3.6, 3.7 / SEE TABLE 3J

The reach of the opioid crisis goes beyond those who have struggled with addiction. In the 2018 DataHaven Community Wellbeing Survey, about one in every three adults in the region reported knowing someone who has struggled with opioid abuse or addiction in the past three years. Out of those respondents, 7 percent said they themselves were struggling with opioids, 34 percent cited a family member, 34 percent cited a close friend, and 54 percent cited an acquaintance. These numbers include respondents who knew multiple people dealing with opioid addiction.[245]

Of all Greater Hartford adults, 24 percent reported knowing at least one person who died of an opioid overdose. Twenty-two percent of these adults lost a family member to an opioid overdose, 36 percent lost a close friend, and 63 percent lost an acquaintance.[246]

A 2019 New England Public Policy Center report found that counties with the lowest rates of opioid prescribing are also those with the lowest rates of fatal overdoses.[247] Additionally, some research has suggested a relationship between opioid misuse and frequent drinking[248] and tobacco use.[249] The frequent use of these substances has been associated with higher pain intensity, which may increase the person's likelihood of developing an opioid dependency. In particular, many studies of alcohol use disorders have established that heavy drinking is a strong predictor of opioid misuse.[250] In addition to improving our understanding of addiction and expanding access to prevention and treatment services, strategies to address the opioid crisis may include the promotion of overdose-reversing drugs such as naloxone, improved prescription monitoring, evidence-based pain management, and public education.

HEALTH OUTCOMES

Early Onset of Chronic Diseases

According to the Centers for Disease Control and Prevention (CDC), six out of every ten adults in the U.S. live with a chronic disease, and four out of every ten have two or more concomitant chronic conditions.[251] These conditions include heart disease, cancer, chronic lung disease, chronic kidney disease, stroke, Alzheimer's, and diabetes. Ninety percent of healthcare expenditures go towards the treatment of chronic and mental health conditions, and in 2010, chronic diseases comprised seven of the top ten causes of mortality in the U.S., accounting for over 65 percent of all deaths.[252, 253] According to the Hospitalization Cost and Utilization Project (HCUP), from 2006 to 2011, emergency department visits for common chronic conditions increased significantly among adults, with the greatest increase observed in adults 85 and over.[254] Disproportionately more clinical visits to physicians' offices and hospitals occur for patients who are in the oldest age groups and those who are more prone to experiencing chronic diseases.[255]

While chronic diseases are a relatively common experience for older adults, they may develop much earlier in life, sometimes even in childhood. The data on Greater Hartford's neighborhood life expectancy and premature mortality reveal large disparities in health and well-being within the region. However, mortality data only tell us about people who die; they do not provide a complete picture of the impact of chronic diseases on people's quality of life throughout youth and middle age. Our analyses of the data collected through the DataHaven Community Wellbeing Survey and of the records of residents' visits to statewide hospitals and emergency rooms over the past six years create a clearer picture of the full burden of these conditions. SEE FIG 3.3, 3.4, 3.5, 3.6, 3.7

In Greater Hartford, chronic diseases such as hypertension, heart disease, diabetes, and chronic lung diseases such as chronic obstructive pulmonary disease (COPD) have consistently ranked among the most common causes for hospitalization and emergency room encounters. From 2015 to 2017, hospital encounter rates due to these conditions were lower than the statewide averages in the Greater Hartford Outer Ring and similar to the statewide averages in the Inner Ring, but were significantly higher in Hartford and New Britain. Comparing this time period to the three year period before that, the region's towns with a greater burden of chronic disease often saw larger increases in their per capita hospital encounter rates than healthier towns.[256] This suggests that health-related inequalities, as measured by the impact that these conditions have on residents of different towns and demographic groups, may have increased in recent years.

Examining data from hospitals and other sources by age, gender, and race/ethnicity reveals disparities in the extent to which chronic diseases develop earlier in life in populations that face greater economic and social adversity. For cardiovascular disease, disparities between Black and white adults are particularly pronounced. A 2010 study found that nationally, 28 percent of cardiovascular disease deaths among Black adults occurred among persons younger than 65 years of age, compared to just 13 percent of white adults.[257] Consistent with statewide and national averages, in Greater Hartford the greatest burden of hospitalization and emergency department visits from 2015 to 2017 due to heart disease fell on older age groups, and among males. While available hospital encounter data has limitations when it comes to fully capturing the race/ethnicity of patients, our analysis suggests that Black adults aged 20 to 64 are several times more likely than whites of the same age to be hospitalized for cardiovascular disease.[258]

Some trends appear to be more positive. When comparing the 2012–2014 and 2015–2017 time periods, relatively small increases were seen in the rates of hospital encounters for heart disease in New Britain, as well as in the rates of many chronic diseases in some of the region's wealthiest towns such as Simsbury. If sustained over time, these trends show how disease prevention efforts or other factors in these towns may be shifting the burden of chronic disease.[259]

Mental Health

As described in the introduction to this report, reducing the frequency at which residents experience depression or other mental health disorders represents one of the greatest opportunities to improve the overall well-being of Greater Hartford. Depression may be rooted within

TABLE 3J

Selected hospital encounters and hospital encounters by age

RATES OF HOSPITALIZATIONS AND ED VISITS PER 10,000 RESIDENTS PER YEAR, 2015–2017

AGE-ADJUSTED RATES OF HOSPITALIZATIONS AND ED VISITS FOR ALL RESIDENTS

LOCATION	DEPRESSIVE DISORDER	DIABETES	FALLS	HEART DISEASE	HYPERTENSION	MENTAL DISORDER	SUBSTANCE ABUSE
Connecticut	326	639	328	240	1,261	694	178
Hartford	563	1,855	414	535	2,735	1,223	549
New Britain	673	1,488	447	330	2,405	1,268	307
GH Inner Ring	327	627	269	243	1,205	688	147
East Hartford	390	1,028	331	324	1,705	846	222
Manchester	367	870	382	275	1,482	808	155
West Hartford	264	382	216	193	855	555	81
GH Outer Ring	262	390	236	202	941	529	81

AGE-SPECIFIC RATES OF HOSPITALIZATIONS AND ED VISITS FOR DIABETES AND HEART DISEASE

LOCATION	DIABETES			HEART DISEASE		
	AGE 20–44	AGE 45–64	AGE 65–74	AGE 20–44	AGE 45–64	AGE 65–74
Connecticut	223	908	1,895	23	193	670
Hartford	563	3,119	5,259	67	678	1,461
New Britain	595	2,585	4,092	29	336	1,108
GH Inner Ring	199	910	1,908	20	200	690
East Hartford	379	1,716	2,795	34	330	961
Manchester	261	1,404	2,571	24	244	811
West Hartford	76	495	1,258	9	132	486
GH Outer Ring	81	406	1,300	12	102	489

Note: See Figures 3.4 and 3.5 for additional age- and gender-specific rates.

many different social, medical, and environmental factors, including substance use, traumatic experiences, and social isolation. Not only is depression underdiagnosed among racial and ethnic minorities, including Black, Latino, and Asian Americans, but these groups are also less likely to have access to and receive adequate care for depression.[260] Depression is a risk factor or cause of many other health problems, including chronic pain, insomnia, and conditions that are exacerbated when patients have difficulty accessing medical care or taking medications according to the instructions of health care providers.[261]

In the 2018 DataHaven Community Wellbeing Survey, 13 percent of Greater Hartford adults reported being anxious most or all of the time, and 11 percent reported feeling down, depressed, or hopeless more than half of the days during the past two weeks, rates that were similar to the statewide average and had changed little since our 2015 survey. These responses were not uniform across income levels, however. Residents with lower incomes experienced higher rates of anxiety and depression. Among adults earning less than $30,000 per year, 24 percent reported feeling depressed more than half of the days during the past two weeks compared to only 4 percent of adults earning over $100,000 per year.[262]

Mental health disorders are significant factors in residents' patterns of receiving care within the state's hospitals and emergency rooms. Statewide and throughout the region, hospital encounter rates for mental disorders other than depression rose considerably between the 2012–2014 period and the 2015–2017 period. During this time frame, rates of encounters for depressive disorders increased slightly across Connecticut as a whole, but rose more quickly in some towns such as New Britain (where they were already particularly high to begin with), Southington, and Mansfield. There is a significant gender disparity in encounters related to depressive disorders, with higher rates for females than males among people under age 85. In particular, among people ages 0 to 19, encounter rates for females are two times higher than for males.

Injuries

Intentional and unintentional injuries, including drug overdoses (covered above), falls, assaults, and suicide, are the leading causes of death in the U.S. for people between the ages of 1 and 44. They also have major consequences on quality of life, as there are 13 hospitalizations and 129 emergency room encounters for every death.[263] Injuries, including the costs of resulting physical and mental disabilities, have a negative impact on productivity and quality of life. Data on hospital and emergency room encounters help illustrate the extent of this burden within Greater Hartford. SEE FIG 3.3, 3.4, 3.5, 3.6, 3.7

Falls are the most common cause of non-fatal injury in the U.S. and within Greater Hartford. Rates of hospital and emergency room encounters are particularly high among older seniors. According to the CDC, one in four adults ages 65 and up will fall each year, and 20 percent of those falls will induce a serious injury such as a hip fracture or traumatic brain injury which can be debilitating and sometimes life-threatening.[264] Extensive and costly treatment may often be required, with greater burden on older adults for whom costs average $30,000 per fall, making them among the 20 most expensive medical conditions.[265] Fall prevention strategies, physical rehabilitation, and close assessments of risk factors offer effective mechanisms for reducing the burden of these types of encounters.[266] As such, fall encounters offer a lens into access to preventive care, safe housing, and ambulatory processes among older populations. Rates of fall-related hospital encounters decreased throughout much of Greater Hartford between the 2012–2014 and 2015–2017 periods, especially in New Britain, Mansfield, and Berlin.

The burden of injuries related to motor vehicle crashes is also substantial. The WHO reported that in 2013, among high-income countries, the U.S. experienced the highest rates of road traffic deaths and second highest in crash deaths related to alcohol.[267] Motor vehicle accidents are preventable using interventions that improve seat belt use, create safer streets for pedestrians and cyclists, and enhance the enforcement of traffic safety laws, especially among youth who are at risk.[268] Rates of crash-related hospital encounters in Greater Hartford decreased throughout the region from 2012–2014 to 2015-2017, especially in the 20–44 age group, and are generally lower than the state average, although residents in Hartford, Bloomfield, East Hartford, and New Britain continue to experience much higher rates. Injuries related to motor vehicle crashes both statewide and in Greater Hartford are highest in the 20–44 age range.[269]

Rates related to intentional injuries, such as those related to youth violence, domestic violence, and suicide attempts, are similarly improving, showing decreases across Greater Hartford between the 2012–2014 and 2015–2017 periods. For example, the greatest burden of hospital encounters related to homicide and assault within the region fall on residents in Hartford and New Britain, although both saw considerable decreases during this time period: 105 encounters per 10,000 residents in 2015–2017, down from 131 in 2012–2014 in Hartford, and a similar decrease to 59 from 80 per 10,000 residents in New Britain. For hospital encounters related to suicide and self-harm, average rates in Greater Hartford were comparable to statewide averages.

Statewide and within the region, the greatest burden of injury due to homicide and assault was seen among adults ages 20 to 44, with higher rates among males compared to females. In Hartford, high rates were also observed among residents ages 0 to 19, and males ages 45 to 64. For suicide and self-harm encounters, residents ages 0 to 44 in the Greater Hartford Inner Ring experienced considerably higher rates than those in the Outer Ring.[270] Both statewide and throughout the region, there is a significantly greater burden of suicide and self-harm among females ages 0 to 19 than among males of the same age. The Connecticut Suicide Prevention Plan (PLAN 2020) contains detailed information on suicide and self-harm data and prevention.[271]

Infectious Diseases

Sexually transmitted infections (STIs) are a concern in Greater Hartford, as throughout the state and nation. Like other infectious organisms, STIs can have long-term implications for health, including reproductive health problems and certain types of cancers. Generally speaking, reported infection rates in Connecticut for chlamydia, which is the most common STI, are nearly double what they were 15 years ago. In both 2011 and 2015, reported chlamydia infection rates in Hartford (1,289 per 100,000 persons in 2015) were more than three times the statewide average (369 per 100,000 people in 2015) and the region's average (416 per 100,000), though all three have declined over this period. Gonorrhea infections in the region have slightly declined over the past two decades, though rates are generally too small to be reportable for smaller towns. Hartford's gonorrhea infection rate

has declined, but was still the highest of any town in the state in both 2011 (414 per 100,000 people) and 2015 (252 per 100,000).[272] STIs can increase the risk of transmission and acquiring diseases such as HIV or hepatitis C, which are also of concern to and a focus area for many local health departments.

Other infectious diseases are also important to the health of the region. The Connecticut Department of Public Health routinely tracks reports of certain infectious diseases such as Lyme disease, West Nile virus, and tuberculosis, as well as of vaccine preventable diseases such as measles and influenza, in order to identify trends and help prevent and control outbreaks.[273] These topics have been covered in previous iterations of the DataHaven Community Index, but were not highlighted by stakeholders and key informants as major community health concerns and thus are not a focus of this year's report. **DH**

Civic Life and Infrastructure

Civic life, defined broadly as the attitudes, activities, and investments that build on the collective resources, skills, expertise, and knowledge of citizens to improve the quality of life in communities, is a powerful dimension of our overall health and well-being.[274]

Civic life represents all the ways that residents can participate in their communities, and help improve the quality of life for everyone.

IN THIS CHAPTER

→ Wealthier towns in Greater Hartford have access to more property tax revenue to fund public resources.

→ Community trust is high but variable—as is participation in public life through voting, volunteering, and advocating for the community.

Executive Summary

This chapter looks at three key components of civic life.

Stewardship of the Public Realm includes how municipalities provide essential services to their residents. In Connecticut, municipal revenue consists primarily of grants and property tax receipts. Reliance on property taxes presents a challenge to Connecticut's larger cities, which tend to house more tax-exempt properties—including colleges and hospitals—and thus impose a higher tax burden on their residents. In addition, as Connecticut's property tax rate is the same regardless of income level, it is regressive and therefore results in lower-income households' taxes consuming a greater share of their income. As a result, wealthier towns generate higher tax receipts, which fund higher-quality public resources, including education, which then attract additional wealthy residents. When considering residents' perceptions of their local governments' stewardship, half of Greater Hartford adults felt positively about the responsiveness of their local government to the needs of residents and three-quarters of adults responded positively about the condition of area parks and public recreational facilities. About one-third of adults felt the area in which they lived was improving. Overall, residents' wealth influences their perceptions, with higher-income residents reporting greater access to and satisfaction with community resources.
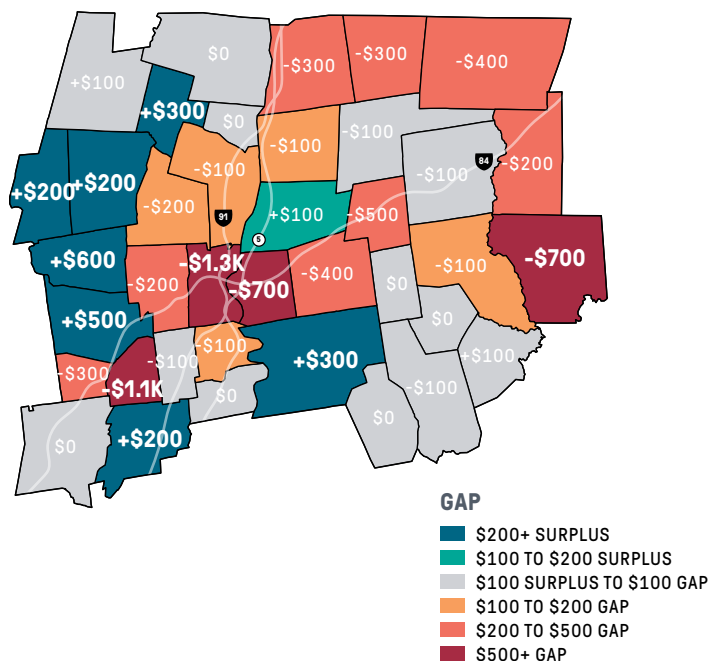
Community Trust and Appreciation: a strong majority of Greater Hartford residents reported trusting neighbors, having reliable social support networks, and feeling satisfied with where they live. While most white residents rated the police positively in terms of keeping residents safe, this measure was not as high among minority residents, who were also more likely to report experiencing unfair or abusive treatment by police multiple times in the past three years.

Participation in Public Life, including volunteering, voting, and using available cultural resources, was more common among higher-income residents and those with more education. In 2018, most Greater Hartford adults felt their neighbors were invested in improving their neighborhood and would organize to prevent the closing of a fire station. Since 2015, adults statewide reported a significant increase in their perceived ability to influence local government decision-making, a positive trend seen within Greater Hartford as well, and which may be due, at least in part, to a national increase in young voters' political engagement. **DH**
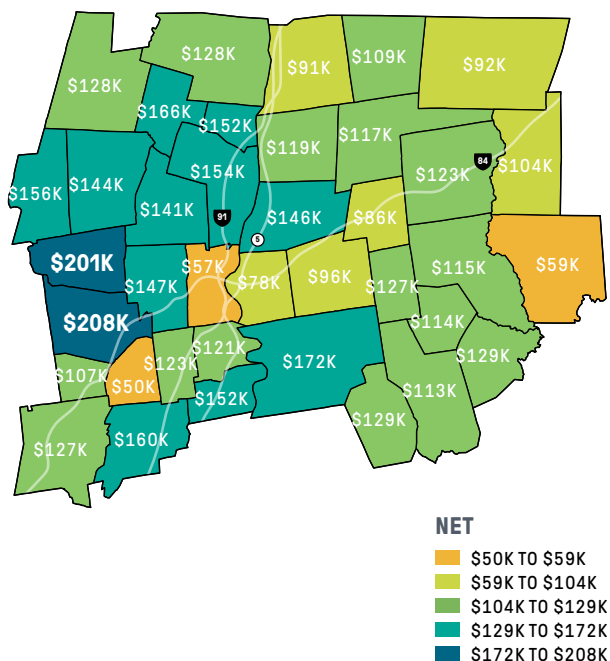
FIG 4.1

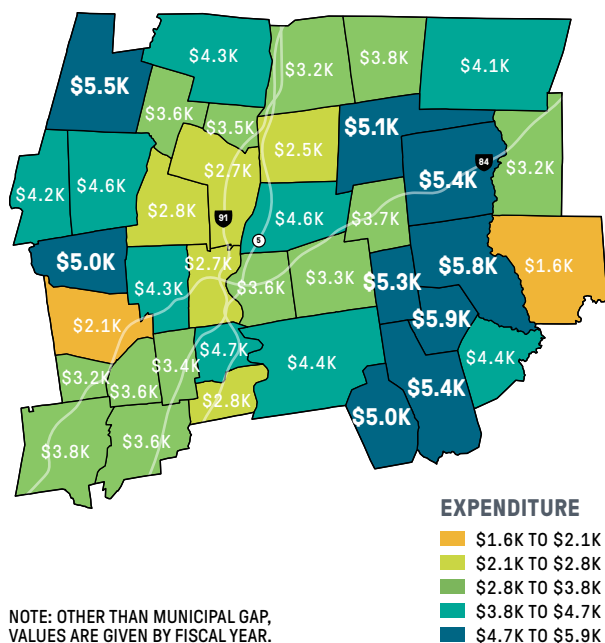# Wealthier towns net more money from property values and spend more money on education
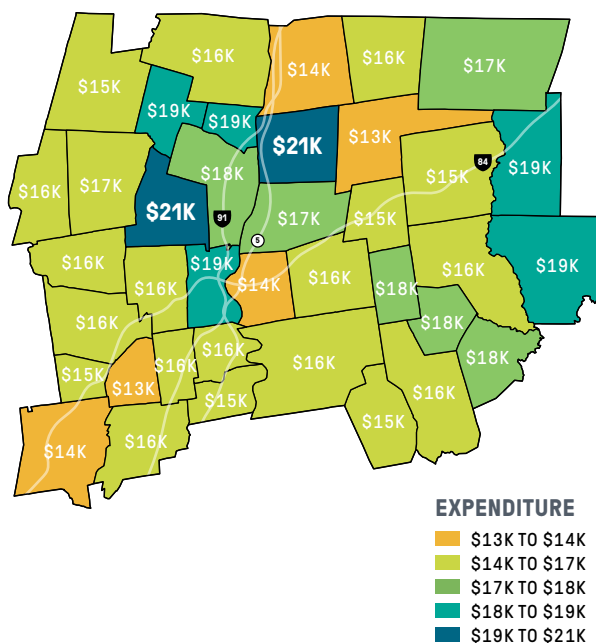
MUNICIPAL GAP/SURPLUS PER CAPITA, 2012

+$100
$0
-$300   -$300   -$400
+$300
$0   -$100   -$100
$0   -$200
+$200   +$200
-$100   -$100   84   -$200
-$200
91
+$600
+$100   -$500
-$1.3K
S
-$700   -$400   -$100   -$700
+$500
-$200
-$300   -$100
-$1.1K   +$100
+$300   -$100 $0   +$100
$0   -$100
+$200
$0

GAP
- $200+ SURPLUS
- $100 TO $200 SURPLUS
- $100 SURPLUS TO $100 GAP
- $100 TO $200 GAP
- $200 TO $500 GAP
- $500+ GAP

EQUALIZED NET GRAND LIST PER CAPITA, 2017

$128K $91K $109K $92K
$128K
$166K $152K
$154K $119K $117K
$156K $144K $123K   84 $104K
$141K   91 $146K $86K
S
$201K
$147K $57K $78K $96K $115K $59K
$208K
$127K
$121K $114K
$107K $123K $172K $129K
$50K
$152K $113K
$127K $160K $129K

NET
- $50K TO $59K
- $59K TO $104K
- $104K TO $129K
- $129K TO $172K
- $172K TO $208K

TOTAL EXPENDITURE PER DAYTIME POPULATION, 2017

$5.5K $4.3K $3.2K $3.8K $4.1K
$3.6K $3.5K
$2.7K $5.1K
$4.2K $4.6K $2.5K   84 $3.2K
$2.8K   91 $4.6K $3.7K $5.4K
S
$5.0K
$2.7K $3.3K $5.3K $5.8K $1.6K
$4.3K $3.6K
$5.9K
$2.1K
$4.7K $5.4K
$3.2K $3.4K $4.4K $4.4K
$3.6K $2.8K
$5.0K
$3.8K $3.6K

EXPENDITURE
- $1.6K TO $2.1K
- $2.1K TO $2.8K
- $2.8K TO $3.8K
- $3.8K TO $4.7K
- $4.7K TO $5.9K

NOTE: OTHER THAN MUNICIPAL GAP, VALUES ARE GIVEN BY FISCAL YEAR.

EDUCATION SPENDING PER PUPIL, 2017

$16K $14K $16K $17K
$15K
$19K $19K
$18K $21K $13K
$16K $17K $15K   84 $19K
$21K   91 $17K $15K
S
$16K $19K $16K $16K
$16K $14K $18K
$16K $16K
$16K $18K
$15K $13K
$16K $15K $18K
$14K $16K $16K
$15K

EXPENDITURE
- $13K TO $14K
- $14K TO $17K
- $17K TO $18K
- $18K TO $19K
- $19K TO $21K

FIG 4.2

In towns with more surplus money, residents rate neighborhood assets and facilities more highly

NEIGHBORHOOD ASSETS INDEX VS MUNICIPAL SURPLUS PER CAPITA

● GH TOWNS   ● OTHER CT TOWNS
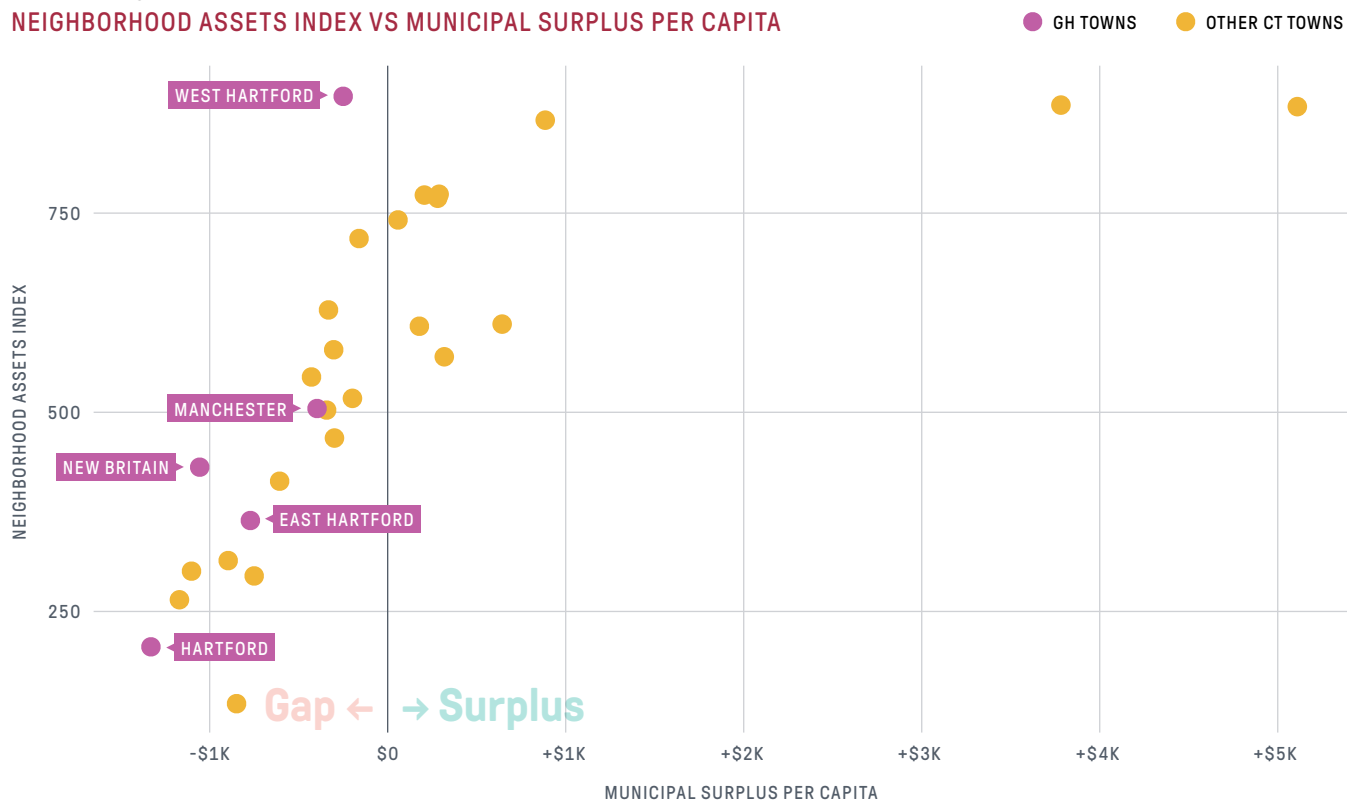
FIG 4.3

Towns that spend more on their libraries see greater library use

AVERAGE TOWN PUBLIC LIBRARY VISITS PER CAPITA AND CIRCULATION PER CAPITA
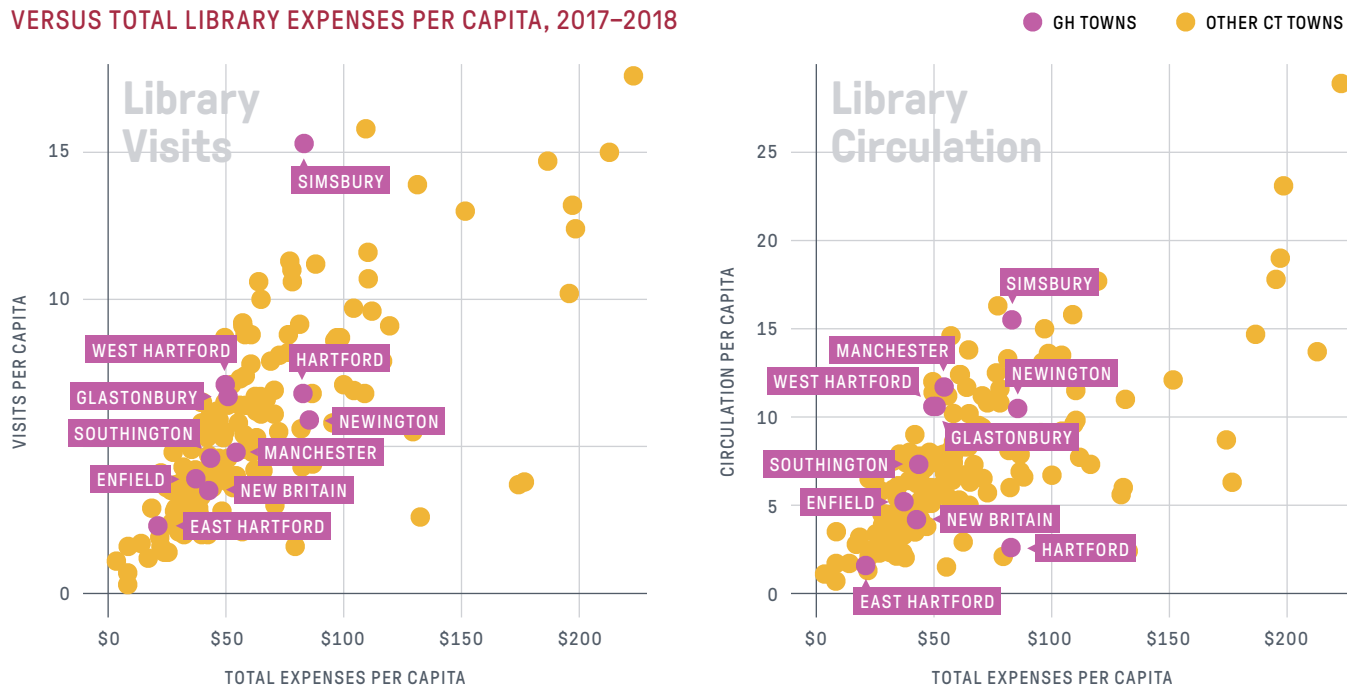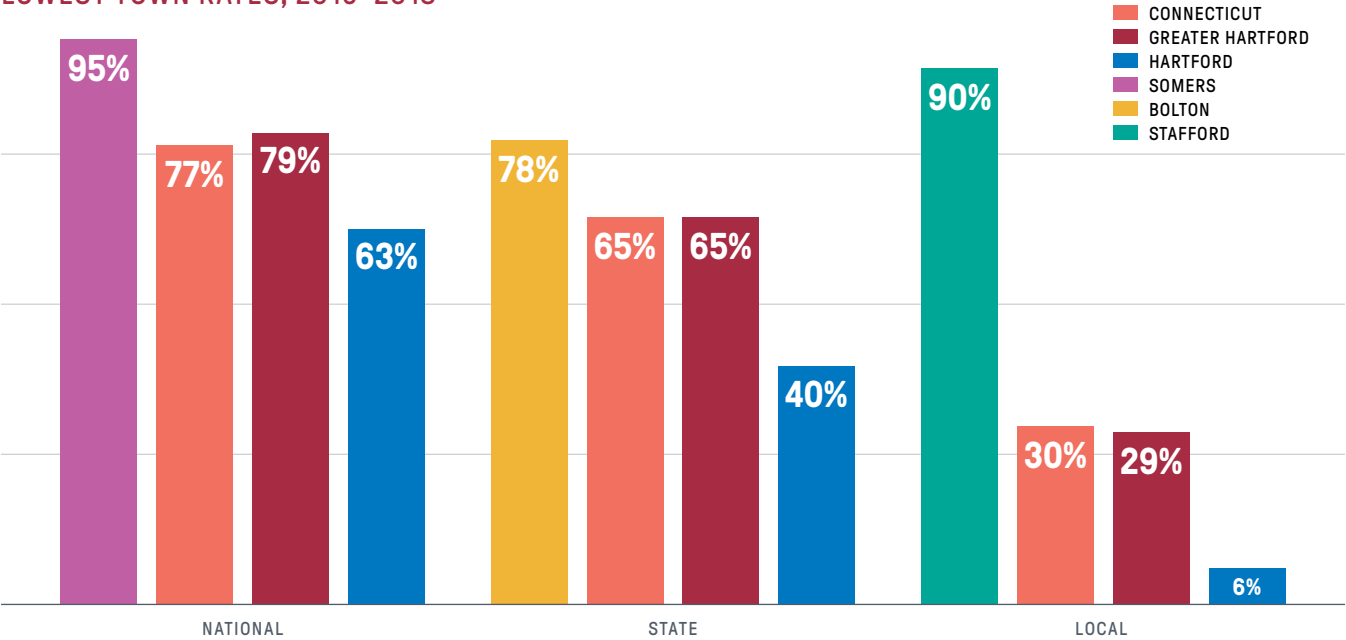VERSUS TOTAL LIBRARY EXPENSES PER CAPITA, 2017–2018

● GH TOWNS   ● OTHER CT TOWNS

Voter turnout is high for national and state elections, but much lower in municipal ones

PERCENT OF ELIGIBLE VOTERS WHO VOTED IN ELECTIONS, WITH GREATER HARTFORD HIGHEST AND LOWEST TOWN RATES, 2016–2018

Legend:
- CONNECTICUT
- GREATER HARTFORD
- HARTFORD
- SOMERS
- BOLTON
- STAFFORD

	NATIONAL	STATE	LOCAL
Somers	95%		
Connecticut	77%	65%	30%
Greater Hartford	79%	65%	29%
Hartford	63%	40%	6%
Bolton		78%	
Stafford			90%

INTRODUCTION

Civic life, defined broadly as the attitudes, activities, and investments that build on the collective resources, skills, expertise, and knowledge of citizens to improve the quality of life in communities, is a powerful dimension of our overall health and well-being.[274] We view civic life broadly, encompassing both engagement and trust, as the sum of all efforts that promote the common good within communities. These range from the more recognizable—like informed local voting and volunteering—to the less obvious, such as access to and quality of public resources, design and upkeep of public parks, and residents' sense of safety in their neighborhoods. Measures of civic life provide insight as to how residents feel about their communities, the ways they choose to get involved, and opportunities for improving life in the cities and towns they share.

As a growing body of research continues to illuminate the strength of the link between civic life and community health and well-being, we are reminded that our connection to and involvement in our communities is inextricably linked to quality of life.[275] Higher levels of civic trust, participation, and engagement are correlated with both more equitable economic outcomes and many positive health outcomes, such as lower mortality rates, improved mental and physical health, and lower crime rates.[276, 277, 278, 279] Based on this body of work, we chose to frame our Civic Life section using three key domains: Stewardship of the Public Realm, Community Trust and Appreciation, and Participation in Public Life.[280]

Greater Hartford towns and cities each have a unique sense of community, with varying traditions, public resources, and physical spaces. Each reader should reflect on the dynamics of civic life within their particular community as they read this section, in order to recognize local assets and identify specific ways in which they can strengthen their communities.

STEWARDSHIP OF THE PUBLIC REALM

Investment in Public Resources: Municipal Financial Capacity

Residents rely on their local governments to provide a wide array of resources. While public education, social and health services, public safety, and infrastructure may come to mind as key municipal responsibilities, local governments offer many additional programs and services— like public libraries and related programming, transportation assistance, and adult education— which underserved or at-risk populations may disproportionately rely on. The fiscal health of local governments directly impacts their ability to invest in such programs and services. These resources are truly a cornerstone of civic life, helping to mitigate socioeconomic inequalities, bridging social divides, and ultimately, fostering trust in the responsiveness of government to community needs.[281]

Local government revenue comes from municipal taxes and fees (almost exclusively property tax in Connecticut), as well as state and federal grants. On a per capita basis, Connecticut's wealthier suburbs—able to draw on stronger tax bases—are the biggest spenders.[282] In 2017, Avon spent the most per resident of Greater Hartford's cities and towns at $5,011—over $1,000 more than the regional average.[283] Between 2002 and 2015, spending in the state's wealthiest communities increased much faster than spending in the poorest communities.[284] In some ways, a more telling figure is expenditures per daytime "resident"—that is, the spending on key services such as road maintenance and public safety needs to support the number of people present in a town during the average workday. In municipalities with large inflows of workers, this measure of per-capita spending drops; bigger cities that act as regional job centers are most impacted. It is a fiscal challenge for these urban areas to provide the resources necessary to support a large inflow of workers, while being unable to draw on these workers as an asset to their taxbase. In Hartford, the city with by far the largest net inflow of workers in the state, municipal spending in 2017 was well above the regional average at $4,697 per resident (also, the highest of any of the state's five largest cities); however, spending per daytime population

TABLE 4A

Municipal expenditures and financial capacity indicators

INDICATORS BY TOWN, GREATER HARTFORD, FY 2017

LOCATION	MUNICIPAL GAP OR SURPLUS PER CAPITA	EXPENDITURE PER DAYTIME POPULATION	EQ. NET GRAND LIST PER CAPITA	SCHOOL SPENDING PER PUPIL
Connecticut	N/A	$3,816	$150,956	$16,592
Greater Hartford	N/A	$3,430	$111,822	$16,259
Andover	-$16	$5,924	$114,419	$17,621
Avon	$631	$4,967	$200,935	$16,239
Berlin	$207	$3,611	$160,094	$16,426
Bloomfield	-$159	$2,779	$141,083	$20,915
Bolton	$36	$5,312	$126,805	$17,604
Canton	$227	$4,168	$156,113	$15,860
Columbia	$62	$4,391	$129,012	$17,638
Coventry	-$121	$5,777	$114,623	$16,310
East Granby	$266	$3,555	$166,297	$19,383
East Hartford	-$740	$3,588	$77,585	$14,278
East Windsor	-$112	$2,479	$118,695	$21,308
Ellington	-$73	$5,052	$117,166	$13,313
Enfield	-$321	$3,246	$91,110	$14,338
Farmington	$517	$2,071	$208,413	$16,470
Glastonbury	$317	$4,439	$172,180	$16,085
Granby	$78	$5,508	$127,547	$15,252
Hartford	-$1,330	$2,698	$57,135	$19,140
Hebron	-$70	$5,431	$112,693	$15,803
Manchester	-$375	$3,251	$95,795	$15,836
Mansfield	-$730	$1,616	$59,307	$18,889
Marlborough	-$35	$5,006	$128,713	$14,539
New Britain	-$1,056	$3,556	$50,329	$13,391
Newington	-$94	$3,361	$122,755	$16,496
Plainville	-$298	$3,213	$107,492	$15,237
Rocky Hill	$32	$2,755	$152,189	$15,038
Simsbury	$211	$4,609	$144,283	$16,618
Somers	-$257	$3,782	$108,854	$15,760
South Windsor	$105	$4,583	$146,258	$17,060
Southington	$3	$3,773	$127,262	$14,230
Stafford	-$367	$4,137	$92,160	$17,303
Suffield	-$37	$4,310	$127,908	$16,049
Tolland	-$86	$5,380	$123,292	$15,223
Vernon	-$503	$3,689	$85,864	$15,484
West Hartford	-$250	$4,306	$146,548	$15,761
Wethersfield	-$140	$4,706	$121,200	$15,528
Willington	-$206	$3,168	$103,861	$18,624
Windsor	-$107	$2,666	$153,646	$17,710
Windsor Locks	$27	$3,532	$151,580	$19,231

Note: Other than municipal gap, values are given by fiscal year.

Perceived access to and quality of community resources

NEIGHBORHOOD ASSETS INDEX: SHARE OF ADULTS BY COMPONENT, AND COMPOSITE SCORE,
GREATER HARTFORD, 2018

LOCATION	GOVT IS RESPONSIVE	GOOD TO RAISE KIDS	GOOD CONDITION OF PARKS	SAFE SIDEWALKS	SAFE BIKING	REC FACILITIES AVAILABLE	NBHOOD ASSETS INDEX
Connecticut	51%	75%	75%	61%	63%	70%	556
Greater Hartford	52%	75%	77%	68%	73%	76%	580
BY DEMOGRAPHIC WITHIN GREATER HARTFORD							
Male	51%	76%	75%	68%	76%	78%	577
Female	53%	74%	77%	67%	70%	75%	595
Age 18–34	48%	68%	71%	72%	72%	77%	536
Age 35–49	46%	72%	72%	70%	72%	77%	537
Age 50–64	53%	77%	79%	64%	75%	74%	633
Age 65+	62%	84%	85%	67%	74%	77%	720
White	56%	80%	82%	63%	74%	75%	652
Black	35%	57%	58%	84%	76%	80%	351
Latino	42%	55%	60%	80%	73%	82%	371
Under $30K	42%	59%	65%	74%	72%	76%	464
$30K-$100K	50%	74%	75%	70%	73%	78%	568
$100K+	59%	87%	85%	61%	76%	74%	718
BY GEOGRAPHY							
Hartford	30%	39%	49%	83%	71%	79%	195
New Britain	44%	47%	69%	76%	77%	77%	419
GH Inner Ring	46%	69%	71%	79%	71%	79%	529
E. Hartford	34%	55%	62%	88%	80%	81%	356
Manchester	51%	65%	69%	81%	78%	86%	511
W. Hartford	68%	97%	92%	91%	89%	92%	884
GH Outer Ring	62%	94%	89%	46%	70%	65%	788

was only $2,698, which was significantly below the regional average of $3,430.[285] SEE FIG 4.1 / SEE TABLE 4A

Research has confirmed that that disparities in towns' "municipal gap"—the difference between a town's costs of providing public services and its ability to pay for such services—are driven primarily by differences in revenue-raising capacity.[286] Wealthier municipalities with greater tax-generating ability can afford to fund more high-quality public resources, while fiscally distressed municipalities may experience challenges in meeting the needs of their residents.[287] Among some Greater Hartford towns, this municipal gap becomes a surplus, with towns taking in more dollars per person in revenue than they need to spend; meanwhile, the cities of East Hartford, New Britain, and Hartford operate on gaps of $740, $1,056, and $1,330 per resident, respectively.[288] There is a correlation between the size of a municipality's equalized net grand list per capita (an estimate of the market value of all taxable property per resident) and overall spending; even when they do not have high tax rates, towns with more taxable wealth are able to spend more money on resources for residents. Three of Greater Hartford's wealthiest towns had equalized net grand lists per capita of over $170,000 in 2017, compared to $111,822 in the

region overall.[289] The per capita value of taxable property was lower in the region's urban areas, especially East Hartford ($77,585), Hartford ($57,135) and New Britain ($50,329).[290]

Connecticut municipalities' reliance on property taxes to generate revenue is particularly troublesome for larger cities, many of which are home to a disproportionate number of tax-exempt state-owned and private properties, like hospitals and colleges.[291] For example, as the state's capital, nearly 50 percent of Hartford's 2016 total grand list was tax-exempt—one of the highest shares of any major city in the state; to compare, this figure was substantially smaller in Greater Hartford's towns with the highest equalized net grand lists per capita: Farmington (21 percent), Avon (9 percent), and Glastonbury (6 percent).[292] While state PILOT (payment in lieu of taxes) grants were designed to partially reimburse municipalities for funds lost due to tax exempt properties, these reimbursements have declined.[293, 294] A 2017 report estimated that Hartford should have received $60.7 million in PILOT reimbursements for tax-exempt hospitals and colleges based on state statutory obligations for the 2015–16 fiscal year, but actually received only $25.3 million—an estimated shortfall in excess of $35 million.[295]

Local property taxes play an important role in funding public schools; in Connecticut, 58 percent of all education funding comes from this source.[296] Though spending per student varies widely, even among municipalities with similar populations, the state's wealthiest suburbs generally spend more per student than its largest cities.[297, 298] There is a wide range of per-student spending per year in Greater Hartford. In 2017, average per-pupil spending in the region was $16,259, similar to the state overall at $16,592.[299] However, there are towns that spend less than $13,500 per student (Ellington and New Britain), while others spend over $20,000 per student (Bloomfield and East Windsor).[300] SEE FIG 4.1 / SEE TABLE 4A

Cities and towns with lower property values may be forced to levy higher property taxes to fund public education and other critical municipal programs and services. For example, based on the most updated mill rates for the 2019 fiscal year, the owner of a $200,000 home would pay $3,805 in property taxes in Farmington, but $7,070 in New Britain.[301] Research shows that the property tax has the largest impact on Connecticut households of any state or municipal tax and is indeed

regressive, meaning low-income households pay a higher share of their incomes than wealthy households because assessed property value, rather than income level, determines the tax.[302]

Perceived Access to and Quality of Community Resources

On the whole, Greater Hartford respondents to the 2018 DataHaven Community Wellbeing Survey indicated general satisfaction with the quality of and access to public resources while acknowledging room for improvement. When asked about the responsiveness of their local government, 52 percent of adults in Greater Hartford described it as "excellent" or "good," about the same as the statewide average.[303] When asked whether the area in which they lived was getting better or worse, 29 percent indicated that it was getting much or somewhat better, while 51 percent reported that it was about the same.[304] Over three-quarters rated the condition of public parks and other public recreational facilities as "excellent" or "good," similar to the state average.[305] Disaggregating survey results by town and income levels reveals that wealthier individuals and residents of wealthier towns report greater access to and satisfaction with goods and services, cultural events, and recreational facilities in their communities.[306] SEE FIG 4.2 / SEE TABLE 4B

Food deserts, defined as areas where it is difficult to purchase fresh fruits, vegetables, and other healthful whole foods, typically occur in economically distressed urban areas.[307] The people with limited incomes who live in those areas are less likely to have the car access needed to get to grocery stores across the region.[308] One recent study found that some of Hartford's most socioeconomically disadvantaged neighborhoods have fewer nearby grocery stores than wealthier suburban areas, meaning those residents may be more vulnerable to inadequate fresh food access were those stores to close.[309] The DataHaven Community Wellbeing Survey reveals similar patterns of differential access: in 2018, only 54 percent of Hartford and 60 percent of New Britain adults reported good or excellent access to affordable, high-quality fruits and vegetables, contrasted with 73 percent of Inner Ring and 84 percent of Outer Ring adults.[310]

"Between 2002 and 2015, spending in the state's wealthiest communities increased much faster than spending in the poorest communities."

Highlight: Public Libraries

Public libraries are invaluable anchor institutions that transcend their traditional role of lending books. While their utilization and functions vary greatly from community to community, they often act as centers for educational programming, incubators for entrepreneurs and ideas, hubs for technology and digital learning, and platforms for civic engagement and arts education and appreciation. Overall, library spending in Greater Hartford in fiscal years 2017 and 2018 averaged $57 per resident—slightly below the state average of $60.[311] However, some towns spent much less, while others exceeded the region's average spending; East Hartford spent only $21 per capita, while Avon spent $97.[312]

Towns that spend more on their libraries generally see higher use in the form of more visits and higher circulation per capita than lower-spending towns. For example, in 2017 and 2018, East Hartford's public library—the lowest spending in the region—averaged 2.3 visits per capita and a circulation per capita of 1.6, while Avon's public library averaged 8.7 visits per capita and a circulation per capita of 15.[313] Greater Hartford's Outer Ring suburbs spent $60 per capita, compared to $50 among Inner Ring towns; the higher-spending Outer Ring suburbs also saw slightly more library use than the Inner Ring towns. Hartford actually outspends many of its suburbs—$83 per capita—and is visited more often.[314] Statewide, library circulation per capita has trended downward since the early 2000s, decreasing from 8.5 in 2001 and 2002 to 6.7 in 2017 and 2018.[315]

As libraries have evolved over the years, the way residents interact with and utilize them is changing. For lower-income residents—less likely to own an internet connected device or have wifi access at home—library computers are a critical resource. In 2017 and 2018, Greater Hartford's higher-spending Outer Ring towns had more public library computers available per 10,000 residents (12.3) than the region's Inner Ring towns (9.3); smaller cities like New Britain (5.2) and Manchester (2.9) had even fewer.[316] However, the city of Hartford has made a strong investment in computers, with 21.3 available per 10,000 residents.[317]

Highlight: Climate Stewardship

Carbon dioxide and other greenhouse gas emissions, driven by human activity, are increasing global temperatures and contributing to issues that have major implications for Greater Hartford: damage to ecosystems, severe storms, extreme flooding, and more heat waves.[318] One study projects that the average summer temperature high in Hartford in 2050 will be 87.3 degrees, an increase of 5 degrees since 2000.[319]

According to the City of Hartford's 2017 Climate Action Plan, the city's close proximity to the Connecticut River means a major flood could impact up to 25 percent of Hartford's land area, or one-fifth of the grand list. The creation of Hartford's first-ever climate action plan, developed through a community-wide initiative, represents an inclusive model of using collective action to combat climate change at the local level.[320] As Hartford's Sustainability Office works to implement this plan, other towns across the region, such as Coventry, Glastonbury, Hebron, South Windsor, and West Hartford, have taken steps to become more sustainable—all having become voluntarily certified through Sustainable CT, an independently funded, grassroots, municipal effort working across the state.[321]

Looking at the bigger picture, efforts to address climate change and its symptoms should lead to infrastructure and policy changes that reduce carbon dioxide emissions, such as more efficient housing, transportation, and land use. Currently, the estimated annual carbon footprint of each Greater Hartford household ranges from roughly 30 metric tons of emissions in the central areas of Hartford, to 65 or more metric tons in a number of the region's Outer Ring suburbs.[322]

COMMUNITY TRUST AND APPRECIATION

At a fundamental level, civic trust helps to bridge divides and foster cooperation—conditions necessary for both political engagement and economic development; in fact, research has shown strong, positive correlations between regions' levels of civic trust and economic performance.[323, 324] Higher levels of civic trust also lead to healthier and more cohesive communities, encouraging the growth of social organizations, some of which promote equitable access to much-needed local programs and services in education, transportation, community health, and recreation.

TABLE 4C

Community trust and appreciation

SHARE OF ADULTS, GREATER HARTFORD, 2018

LOCATION	SATISFIED W/ AREA	POLICE APPROVAL	SAFE WALKING AT NIGHT	TRUST NEIGHBORS	POSITIVE ROLE MODELS	RECEIVE SOCIAL SUPPORT
Connecticut	82%	78%	70%	85%	78%	71%
GH	82%	80%	71%	86%	78%	71%
BY DEMOGRAPHIC WITHIN GREATER HARTFORD						
Male	80%	80%	78%	86%	79%	70%
Female	83%	80%	66%	85%	78%	71%
Age 18–34	81%	73%	70%	79%	72%	64%
Age 35–49	79%	77%	71%	85%	75%	68%
Age 50–64	82%	83%	76%	90%	84%	72%
Age 65+	86%	89%	69%	92%	88%	81%
White	84%	87%	75%	90%	83%	74%
Black	78%	64%	61%	71%	67%	58%
Latino	82%	62%	59%	67%	64%	61%
<$15K	76%	61%	58%	67%	57%	55%
$15K–$30K	81%	75%	60%	76%	72%	59%
$30K–$50K	79%	76%	62%	83%	74%	65%
$50K–$75K	81%	82%	69%	87%	76%	67%
$75K–$100K	82%	83%	76%	88%	82%	76%
$100K–$200K	84%	84%	81%	93%	85%	78%
$200K+	88%	95%	87%	98%	95%	88%
BY GEOGRAPHY						
Hartford	71%	51%	46%	61%	50%	61%
New Britain	72%	67%	58%	72%	53%	62%
GH Inner Ring	77%	79%	69%	85%	75%	66%
East Hartford	77%	67%	59%	77%	66%	55%
Manchester	77%	71%	61%	78%	68%	64%
West Hartford	88%	96%	88%	96%	90%	84%
GH Outer Ring	90%	93%	81%	94%	92%	81%

Overall, Greater Hartford adults report positive feelings of trust in one another, good relationships with friends and family, and appreciation for the communities in which they live. The 2018 DataHaven Community Wellbeing Survey showed that 86 percent of adults agreed that people in their neighborhood could be trusted, 71 percent usually or always receive the social support they need, and 82 percent were satisfied with where they live.[325] Greater Hartford adults also indicated they felt safe in their communities, as 80 percent rated the job done by police to keep residents safe as excellent or good, and 71 percent felt safe walking in their neighborhoods at night—about the same as statewide rates for both measures.[326] However, only 64 percent of Black adults and 62 percent of Latino adults in the region said local police are doing a good or excellent job, compared to 87 percent of white adults.[327] This may stem from these communities' interactions with the police force: 24 percent of Black adults and 17 percent of Latino adults reported experiencing an

unfair stop, search, or other incident of mistreatment by the police at least once, compared to only 11 percent of white adults.[328] SEE FIG 3.12 / TABLE 4C

Confidence in organizations serving the area is another important aspect of community trust. Community philanthropy that supports locally driven development, strengthens community capacity and voices, builds on local resources, and holds itself accountable not only produces lasting results but also increases residents' trust in their community institutions.[329]

Highlight: Local News Coverage

Local news coverage is a vital tool for encouraging political participation and accountability. A growing body of literature has documented the effect of news coverage on measures of local civic trust and engagement. Areas with fewer local news outlets and declining coverage tend to have lower levels of civic participation and voter turnout.[330] Individuals who are more likely to volunteer, vote, and be active in their communities, are also more likely than less engaged residents to use and value local news.[331] Cities served by newspapers experiencing sharp declines in staffing see reduced political competition in mayoral elections.[332] Additionally, declining local news

coverage has been linked to a reduction in community political knowledge and participation, and ongoing research suggests that the closure of a local newspaper may actually increase cost of government due to reduced journalistic scrutiny of deals and spending.[333, 334]

In recent years, local political news coverage has continued to diminish as the industry's revenue declines, with well over a thousand local newspapers being shuttered across the U.S. over the last 15 years.[335] According to the 2018 Pew Research Center's Local News Survey, 85 percent of adults living in the Hartford MSA did not pay for local news during the past year—though nearly 80 percent reported following local news very or somewhat closely.[336]

It is important to note that several new nonprofit digital journalism platforms are available in Connecticut. We can get an idea of the demand for local journalism in Greater Hartford by looking at data for usage of The Connecticut Mirror, a nonprofit media organization headquartered in Hartford that focuses on public policy and political issues in the state. Between July 2018 and July 2019, CT Mirror recorded nearly 430,000 readers in Greater Hartford, a 15 percent increase from the previous year.[337]

TABLE 4D

Participation in public life

SHARE OF ADULTS, GREATER HARTFORD, 2018

LOCATION	VOLUNTEER	UTILIZE ARTS & CULTURAL RESOURCES	NEIGHBORS INVOLVED IN IMPROVING AREA	NEIGHBORS WOULD ORGANIZE FOR FIRE STATION	CAN INFLUENCE LOCAL GOVERNMENT
Connecticut	41%	64%	77%	84%	72%
Greater Hartford	42%	64%	79%	83%	72%
Ages 18–34	44%	59%	72%	N/A	73%
Ages 35–49	44%	63%	76%	N/A	69%
Ages 50–64	38%	71%	81%	N/A	71%
Ages 65+	38%	62%	87%	N/A	78%
Hartford	45%	69%	62%	67%	70%
New Britain	N/A	N/A	61%	N/A	65%
GH Inner Ring	35%	56%	76%	85%	66%
East Hartford	N/A	N/A	68%	N/A	59%
Manchester	N/A	N/A	75%	N/A	71%
West Hartford	N/A	N/A	89%	N/A	73%
GH Outer Ring	43%	65%	86%	98%	79%

TABLE 4E
Recent voter turnout
SHARE OF ELIGIBLE VOTERS VOTING IN 2016, 2017, AND 2018 ELECTIONS

LOCATION	2018 MIDTERM	2017 MUNICIPAL*	2016 PRESIDENTIAL
Connecticut	65%	30%	77%
Greater Hartford	65%	29%	79%
Hartford	40%	6%	63%
New Britain	54%	30%	73%
GH Inner Ring	68%	30%	79%
East Hartford	52%	12%	67%
Manchester	69%	30%	81%
West Hartford	75%	32%	78%
GH Outer Ring	71%	33%	83%

* Unofficial Results: note, only towns holding November municipal elections were included in these rates.

PARTICIPATION IN PUBLIC LIFE

Community and civic engagement can take many forms, from more commonly cited activities—like volunteering and voting—to the vast array of opportunities provided by arts and cultural events, community and school meetings, and religious organizations. As different as they may be, these forms of participation in public life arise from a shared sense of responsibility and belonging, as well as investment and ownership in the local, regional, national, and international communities to which residents belong.[338] The quality of our communities, and our democracy, depend on participation and citizen engagement across the various dimensions of public life.[339]

Opportunities for and rates of civic participation are impacted by socioeconomic status in both Connecticut and Greater Hartford; rates of volunteering, voting, and using cultural resources were lower for individuals with lower incomes and levels of educational attainment, indicating that structural inequalities may create obstacles to actively participating in public life.[340]

Volunteering
In 2018, 42 percent of Greater Hartford adults reported having volunteered in the past year, about equal to the state level.[341] However, statewide data reveals that some residents volunteer more than others. As educational attainment and personal income increase, so do rates of volunteering. For example, only 29 percent of adults with a high school degree or less reported volunteering, compared to 48 percent of those with a bachelor's degree or higher; 27 percent of adults earning less than $30,000 per year volunteered, compared to 54 percent of adults earning over $100,000.[342]

The DataHaven Community Wellbeing Survey attempts to capture neighborhood engagement beyond formal volunteering; the survey asks about collective efficacy, such as whether people nearby are involved in trying to improve their neighborhood, and how likely it is that they would organize to prevent the closing of a local fire station.[343] In 2018, 79 percent of Greater Hartford adults felt their neighbors were invested in improving the neighborhood, while 83 percent believed neighbors would organize to prevent the closing of a fire station.[344] Though difficult to measure at the local level, "informal volunteering"—such as supporting family and friends or doing favors for neighbors—is also an important aspect of community life. According to the Corporation for National and Community Service, in 2018, national rates for these activities were 43 percent and 51 percent, respectively.[345]

Arts and Culture
Community-based arts and cultural resources serve as venues for creativity, innovation, dissent, and dialogue; nurture cultural movements; cultivate public imagination; and drive and inspire authentic civic engagement. From film festivals to theatre groups and museums, these assets provide opportunities for bringing together diverse groups of people and building social capital, both between people and across organizations, like block associations, civic groups, congregations, and political and business groups.[346] By providing the physical and experiential space for people to connect, build trust, and cultivate understanding, local arts and cultural resources act as platforms for public dialogue and engagement—critical elements of a healthy democracy.[347]

Research has shown access to arts and culture fosters stewardship, participation, and

civic trust. People who partake in the arts and cultural activities were 12 percent more likely to donate money to a local organization, 14 percent more likely to attend local events, and 21 percent more likely to rate local leaders as effective.[348] In 2018, 64 percent of Greater Hartford adults utilized arts and cultural resources in the area, such as concerts, museums, and cultural events, at least a few times over the past year, the same as the statewide rate.[349]

Voting

As is the trend nationally, voter turnout in Greater Hartford varies by type of election, with greater turnout for higher-office elections. The region's turnout rate was 79 percent in the 2016 presidential election, 65 percent in the 2018 midterm election, and only 29 percent in the 2017 municipal election.[350] These rates were nearly identical to the statewide marks, and significantly higher than national levels. Nationally, turnout in the 2018 midterms was the highest in four decades, reversing a trend of declining interest in midterm elections and likely reflecting the tumultuous political landscape following the 2016 presidential election.[351]

Town-level voter turnout rates reinforce the finding that socioeconomic status affects participation in public life. Across the three most recent major elections, turnout rates were lower in the city of Hartford than in the city of New Britain or the region's other large towns. Hartford's recent voter turnout rates were 40 percent in the 2018 midterm, 6 percent in the 2017 municipal elections, and 63 percent in the 2016 presidential election; meanwhile, recent turnout rates in Greater Hartford's Outer Ring suburbs were 71 percent, 33 percent, and 83 percent, respectively.[352] Low voter turnout is driven by a range of factors, including a lack of basic information on elections, access to polling stations and hours of operation, inflexible work schedules, limited transportation, and other barriers that disproportionately affect economically distressed communities and communities of color. SEE FIG 4.4 / SEE TABLE 4E
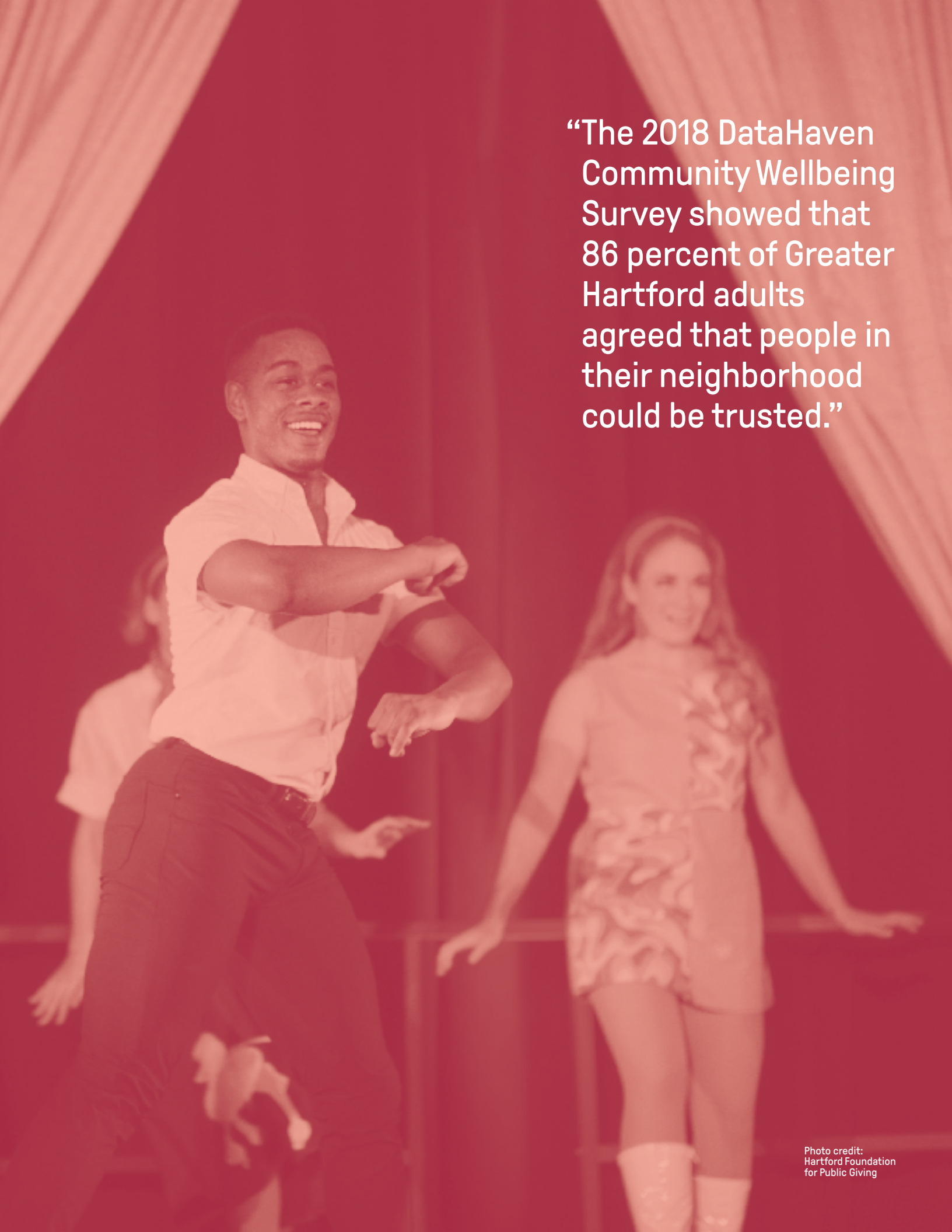
Between 2015 and 2018, Greater Hartford adults' perceived ability to influence local government decision-making increased substantially, a trend also seen statewide. The share of residents believing they had at least a little influence on local government increased by 8 percentage points— from 64 percent to 72 percent for Greater Hartford

(and from 62 percent to 70 percent statewide).[353] This jump may reflect the recent surge in political energy and interest across the nation, and particularly among younger voters. Voter turnout for adults ages 18 to 29 increased a whopping 79 percent between the 2014 and 2018 midterm elections nationwide.[354] The share of Greater Hartford residents ages 18 to 34 who felt they had at least a little influence on local government increased 7 percentage points between 2015 and 2018 to 73 percent—similar to the region's overall rate.[355]

Highlight: Community Design

The design of neighborhoods and public spaces impacts residents' civic health. Cycling, walking, and access to nature and green spaces are all connected to civic trust and participation; urban parks are particularly important, as they promote inclusion and strengthen social networks across diverse groups of people.[356, 357] Individuals residing in walkable neighborhoods report higher levels of civic trust and participation, while those with access to parks and green space are more likely to trust their neighbors and believe community members are willing to help one another.[358, 359]

Research has shown that even the presence of a community garden in easy walking distance is associated with increased participation in public life and more informed local voting.[360] Access to well-maintained green spaces, safe sidewalks, and quality cycling infrastructure are positively associated with many indicators that promote well-being, like increased physical activity, lower levels of stress, stronger social connections, and even reduced mortality.[361, 362, 363, 364] Investment in well-designed and equitable communities is not simply about making neighborhoods more visibly desirable, but rather about using the built environment as a tool to deliver increased well-being to residents. DH

"The 2018 DataHaven Community Wellbeing Survey showed that 86 percent of Greater Hartford adults agreed that people in their neighborhood could be trusted."

Conclusion and Endnotes

Behind every number in this document are people, families, and communities that are far more complex than a few summary statistics. Human beings never match all the averages used to describe them.

Data can help us tell stories, but they cannot tell complete stories on their own.

THE 2020 CENSUS

→ "With $10.7 billion dollars in annual federal funding to the state on the line, an accurate count of the people living in Connecticut is crucial."
Susan Bysiewicz, Lieutenant Governor of Connecticut

→ "The Constitution requires that every ten years, the nation undertakes what is arguably its most essential task: ensuring a fair and valid count of every single one of its now 330 million residents…. The products of these efforts are data sets that characterize our population, create political districts, and enable virtually all other ongoing data collection efforts."
Aparna Nathan and Mark Abraham, DataHaven. (2017, October 2). At Risk: Fair and Valid Census Data for Connecticut. The Connecticut Mirror.

Conclusion

Connecticut is changing: our population is growing older and more diverse, our neighborhoods are becoming more stratified, our coastline faces rising sea levels. Data help us understand these changes, and increased data literacy brings more people and new approaches into that work. But the undercurrents of inequality and segregation that define much of life in Connecticut are not absolute. Our neighborhoods are always more than just two-dimensional places of either never-ending hardship or trouble-free affluence. Our attempts at presenting a more nuanced view are nowhere near perfect. Any researchers, ourselves included, have blindspots that influence what we prioritize and what we leave out of our analysis.

Data are never truly objective, either. They might help identify patterns and connect bits of information, but every decision that goes into how data are defined, measured, interpreted, and acted upon is subject to the same bias we know exists in our society. In a time of climate change denial, re-politicization of the Census, and fake news—both the accusation used to deflect criticism and the actual, webclick-optimized phenomenon—dry facts are not enough in pushing for a more just, equitable, and sustainable society.

Data are even used in ways that deepen inequality. Mortgage approvals and bail amounts are made by black-box algorithms that their subjects do not even know about. Data tools, such as the Constitutionally-mandated Census count or the geographical demarcation of where you vote and how much your vote matters, can be used to include and support people, or to render them uncounted, unheard, and invisible. The fact that data can be used in these ways shows just how powerful they can be, and why it is important to understand that social prejudice is often reflected in something presented as impartial.

Our hope is that you will help make this document more whole. Critique it. Find its blind spots, take its conclusions in different directions, and use it to think more critically about the world around you. Share an interesting fact you read here with your neighbor, and see how you might both relate to it differently. Fill in the gaps between data points with your stories. Work with neighbors to help ensure a more equitable and complete population count during the 2020 Census.

Above all, not everything important can be measured. Take what is on the pages here and bring it to life and to action.

2019 COMMUNITY CONVERSATIONS IN GREATER HARTFORD

As part of the creation of this report, between February and June, 2019, DataHaven, the City of Hartford Department of Health and Human Services, Saint Francis Hospital, the North Hartford Triple Aim Collaborative at the United Way of Central and Northeastern Connecticut, Connecticut Children's Medical Center, and the Hartford Foundation for Public Giving collected additional qualitative input on the health and health-related concerns that are most important to the Greater Hartford community, and to residents of the City of Hartford in particular. This summary synthesizes major themes related to their concerns.

This input was gathered from:

1   A regional key informant meeting held on February 28 at the Hartford Foundation for Public Giving, with over 70 participants. These key informants represented various sectors including health care, education, public health, housing, and human services. At this event, DataHaven organized a "data walk," with small groups circulating among about a dozen posters on different topics and providing comments to a facilitator. Additionally, a brief paper survey was collected from meeting attendees (34 respondents).

2   Focus groups for Hartford North End (April 2, 13 participants) and South End (June 11, 11 participants) community members.

3   A survey of school health care providers (March 8, 29 respondents).

Participants described various social determinants as major barriers to overall health.

1   Of key informants, 88 percent reported that "poverty/food insecurity/transportation" was the greatest concern in the community (including 100 percent of Hartford residents and 80 percent of non-residents). They also often cited generational poverty, income inequality, and related systemic issues in housing, employment, and education.

2   North End community members discussed eviction and housing insecurity related to specific health outcomes, and poor perceptions of their neighborhood due to housing issues.

3   The South End focus group proposed language and cultural barriers to obtaining employment were associated with overall health. They expressed the need for resources to improve adult educational outcomes to gain access to employment.

4   More than 80 percent of key informants ranked job access and housing affordability as highly or extremely concerning. Key informants were curious about housing and transportation affordability and their relationship with unemployment.

5   School health care providers' responses centered around the affordability of healthcare and access to healthy resources.

Each group offered specific environmental factors contributing to poor health in their community.

1   Substandard housing was specifically mentioned by North End community members as it related to specific health outcomes (e.g., asthma, influenza, lead poisoning, bed bugs).

2   The lack of access to affordable recreation programs/facilities was often cited as a barrier to good health as well as a solution to improve community health. Obesity, diabetes, high blood pressure and cholesterol, and the association between diet and cancer were all specifically mentioned.
→ School health care providers ranked limited opportunities for physical activity and lack of access to healthy food as priority health issues for children.
→ North End residents described the poor perception of public parks as a barrier to using those spaces for recreation.
→ North and South End residents expressed concern over unsafe environmental conditions (traffic, snow/ice, incinerators) contributing to injury and illness, especially among children.

3   Limited access to healthy foods and the relationship between diet and health were cited by school health care providers and community members.
→ South End community members further presented this as an opportunity for parents to learn how to prepare cultural foods in healthier ways.

4   North End residents lamented having too few necessary resources in their community (urgent care facilities, grocery stores, banks), but an abundance of unwanted resources, such as liquor stores.

5   Converging with community members' opinions, more than 80 percent of key informants regarded food insecurity (coupled with poverty and transportation) as a major problem, but only 41 percent rated recreational opportunities as highly or extremely important.

Community members often described affordability of and access to health care, coverage, and treatment as a significant disadvantage.

1   School health care providers expressed concern over families' health insurance coverage.

2   Key informants were alarmed to discover how frequently families delayed or went without health care. School health care providers described lack of timely care as a primary concern.

3   South End community members praised their neighborhood healthcare assets, yet stated they were often unable to meet their needs because of affordability or underinsurance.

4   School health providers described a lack of understanding when to visit a primary care physician versus the emergency department, but North End community members specifically called out a lack of resources in their neighborhood other than the emergency department.

5   Seventy-seven percent of key informants thought a lack of health care was a high or extreme concern. Sixty-one percent were similarly concerned about the affordability of prescriptions.

6   Key informants and school health care providers also worried over the reliance upon nonprofit and philanthropic dollars to meet community health needs.

Participants raised specific health issues related to particular populations.

1   Nearly all community members participating in focus groups described mental health as the specific health issue of greatest concern in their communities, including:
    → Depression (raised by South End community members and school health care providers)
    → Trauma (76 percent of key informants felt ACEs were of high or extreme concern)
    → Stress and anxiety (especially cultural attitudes and the impact of stress on caregivers)

2   The community often referred to the prevalence of violence. North End community members and school health care providers raised the issue of interpersonal violence. Key informants were also concerned about family and domestic violence.

3   Substance use generally and opioid use specifically were mentioned by North End community members and key informants. Eighty-eight percent of key informants were highly or extremely concerned about substance/opioid use.

4   Other population-specific health needs included:
    → Aging and the growing number of older adults
    → Maternal health

Input revealed emergent concerns over social supports with downstream effects on health.

1   North End community members lamented the absence of foot police when noting the perception of crime in their neighborhood. Over half of community members felt police-community relationships were highly or extremely concerning.

2   Key informants also raised the issue of social isolation regarding older and single adults.

3   School health care providers indicated the need to educate parents on the impact of social media and technology overuse on children.

4   Key informants mentioned the barriers imposed by re-entry and justice involvement, citing few resources available to help justice-involved neighbors realign with housing and employment opportunities. **DH**

SECTION 1. NOTES ON FIGURES AND TABLES

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/datahaven-community-wellbeing-survey**

GENERAL NOTE ON GEOGRAPHY

Greater Hartford is defined by the towns included within the Capitol Region Council of Governments (CRCOG). These 38 towns cover nearly all of both Hartford and Tolland Counties: Avon, Berlin, Bloomfield, Canton, East Granby, East Hartford, East Windsor, Enfield, Farmington, Glastonbury, Granby, Hartford, Manchester, Marlborough, New Britain, Newington, Plainville, Rocky Hill, Simsbury, South Windsor, Southington, Suffield, West Hartford, Wethersfield, Windsor, and Windsor Locks within Hartford County; and Andover, Bolton, Columbia, Coventry, Ellington, Hebron, Mansfield, Somers, Stafford, Tolland, Vernon, and Willington in Tolland County.

Within this region, we often compare the two major cities, Hartford and New Britain, with Hartford's Inner Ring suburbs (Berlin, Bloomfield, East Hartford, Enfield, Manchester, Newington, Plainville, Rocky Hill, Vernon, West Hartford, Wethersfield, Windsor, Windsor Locks) and Outer Ring suburbs (Andover, Avon, Bolton, Canton, Columbia, Coventry, East Granby, East Windsor, Ellington, Farmington, Glastonbury, Granby, Hebron, Mansfield, Marlborough, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, Willington). When possible, we also highlight larger individual towns, often East Hartford, West Hartford, and Manchester.

Analysis of PUMS data is done for combinations of public use microdata areas (PUMAs), the smallest geographic unit for which public use microdata sample (PUMS) data is available. The closest combination of PUMAs to the Greater Hartford region is simply the PUMAs that cover all of Hartford and Tolland Counties (Connecticut PUMAs 00300, 00301, 00302, 00303, 00304, 00305, 00306, and 01300).

Chapter 1

FIG 1.1. COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX, 2017

DataHaven analysis (2019). The 12 indicators used in the Community Index include: (1) Opportunity youth, or the share of people ages 16 to 19 who are neither in school nor working, (2) the unemployment rate, (3) the overall poverty rate, (4) the share of children ages 0 to 5 living in poverty, (5) the share of adults with a high school education or more, (6) the share of people with health insurance, (7) severe housing cost burden, or the share of households paying 50 percent or more of their income towards housing costs, (8) the share of three- and four-year-olds enrolled in preschool, (9) average life expectancy, (10) the share of workers whose commutes are 30 minutes or less, (11) youthful workforce, or the share of the population ages 25 to 44, and (12) median household income.

The Community Index assigns each of the 12 component indicators a relative value from 0 to 1,000, where 1,000 is assigned to the best/preferred outcome. In other words, the value is generated relative to the areas with the highest and lowest indicator values. This helps to control for the different distributions of each indicator, but may exaggerate the effect of outliers. Colors indicate how each area ranks relative to other locations in the analysis as better or worse than average. Data tables contain "N/A" where information is not available. In addition to major geographic regions, the larger towns or regions with the best and worst values are displayed to the right of the chart.

Because the data used for these indicators are available at different geographic levels nationwide, local neighborhoods, towns, and regions in Connecticut were compared not just to each other, but to U.S. averages and metropolitan areas. SEE FIG 1.2 FOR DETAILS ON METROPOLITAN AREAS

Data are from two main sources: The National Center for Health Statistics, U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015, and U.S. Census Bureau American Community Survey (ACS) 2012 and 2017 5-year estimates, Tables B01001, Sex by Age; B08303, Travel Time to Work; B14003, Sex by School Enrollment by Type of School by Age for the Population 3 Years and Over; B14005, Sex by School Enrollment by Educational Attainment by Employment Status for the Population 16 to 19 Years; 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; B19001, Household Income in the Past 12 Months (in 2017 Inflation-Adjusted Dollars); B19013, Median Household Income in the Past 12 Months (in 2017 Inflation-Adjusted Dollars); B19127, Aggregate Family Income in the Past 12 Months (in 2017 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. ACS tables available at **https://factfinder.census.gov**. 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. The latest available data for life expectancy covers the period from 2010 to 2015 and is summarized here as the population-weighted average life expectancy for each geographic area based on the census tracts within that area. SEE FIG 3.1 FOR MORE GRANULAR ANALYSIS OF LIFE EXPECTANCY DATA

The Community Index uses Census ACS estimates for health insurance coverage to allow for nationwide comparisons at many geographic levels. Elsewhere in this report, health insurance coverage is reported from DataHaven's Community Wellbeing Survey.

The average (mean) of the 12 scaled indicators represents the area's Community Index score. Five-year averages for 2008–2012 and 2013–2017 were used because they represent non-overlapping estimate ranges; only the 2013–2017 values are shown in figures. SEE TABLE 1A FOR 2008–2012 VALUES

FIG 1.2. COMPOSITE SCORE OF THE DATAHAVEN COMMUNITY INDEX BY AREA, 2017

SEE FIG 1.1 FOR METHODOLOGY BEHIND THE COMMUNITY INDEX Metropolitan areas are defined by the federal Office of Management and Budget. While metropolitan areas from around the country were used in ranking values, only those in New England states with at least 300,000 people, and New York, NY, are displayed here.

Within Hartford, Census tracts were clustered into neighborhood groups, with Hartford Central/West as tracts 502100, 503100, 503300, 503800, 503900, 504000, 504200, 524501, 524502, and 524600; Hartford Southside/South End as tracts 500100, 500200, 500300, 500400, 500500, 502300, 502400, 502500, 502600, 502700, 502800, 502900, 503000, 504100, 504300, 504500, 504800, 504900, and 524700; and the North Hartford Promise Zone as tracts 500900, 501200, 501300, 501400, 501500, 501700, 501800, 503500, 503700, and 524400. Index components were then calculated for these clusters with the same methods as for towns and other regions. All tracts are within Hartford County (FIPS code 09003).

FIG 1.3. COMPONENTS OF THE DATAHAVEN COMMUNITY INDEX BY RACE/ETHNICITY, 2017

SEE FIG 1.1 Many American Community Survey subtables are available for individual racial/ethnic groups; these were used to calculate Community Index indicators by race/ethnicity. For indicators not available through American Community Survey tables (severe housing cost burden, and the share of workers with short commutes), additional DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year public use microdata sample (PUMS) data was conducted. Analysis of PUMS data involves weighting survey responses to reflect overall population demographics. For life expectancy, results are reported as the population-weighted life expectancy for tracts by racial/ethnic group comprising the largest share of population in that tract. Due to low sample sizes, age ranges for preschool enrollment differ between population-level tables and subtables. Since the two are not comparable, that indicator is removed from this Index. SEE NOTE ON GEOGRAPHY AT THE BEGINNING OF THIS SECTION

PUMS data accessed via IPUMS. Steven Ruggles, Sarah Flood, Ronald Goeken, Josiah Grover, Erin Meyer, Jose Pacas and Matthew Sobek. IPUMS USA: Version 9.0 2013–2017 ACS 5-year Census microdata. Minneapolis, MN: IPUMS, 2019. **https://doi.org/10.18128/D010. V9.0**

FIG 1.4. DATAHAVEN PERSONAL WELLBEING INDEX VS COMMUNITY INDEX; DATAHAVEN PERSONAL WELLBEING INDEX VS NEIGHBORHOOD ASSETS INDEX

SEE FIG 1.1 FOR COMMUNITY INDEX DETAILS / SEE TABLE 1C FOR PERSONAL WELLBEING INDEX DETAILS The Neighborhood Assets Index is an aggregate of 2018 DataHaven Community Wellbeing Survey participants' positive ratings on 6 indicators about the area where they live: (1) condition of local parks, (2) quality of the area as a place to raise children, (3) responsiveness of local government, (4) availability of recreation facilities, and the presence of (5) safe places to bike and (6) safe sidewalks and crosswalks. Likert-style responses (e.g. "excellent," "good," "fair," "poor") were converted to scaled numeric values, averaged, and used for factor analysis to get a single composite score for each location and demographic group. These scores were then scaled to range from 0 (lower ratings of assets) to 1,000 (higher ratings of assets). SEE TABLE 4B

TABLE 1A. DATAHAVEN COMMUNITY INDEX SCORES FOR LARGE U.S. METROPOLITAN AREAS AND LOCAL CITIES, TOWNS, AND NEIGHBORHOODS, 2012 AND 2017

SEE FIG 1.1 FOR METHODOLOGY AND DETAILS The top-ranking 35 metropolitan areas are reported, along with the seven bottom-ranking areas and select areas in New England. Metropolitan areas' boundaries change periodically, most recently in 2015. This analysis considers all U.S. metropolitan areas using 2015 geographic boundaries with populations of at least 500,000 in 2017.

TABLE 1B. DATAHAVEN COMMUNITY INDEX DATA COMPONENTS BY AREA AND NEIGHBORHOOD, 2017

SEE FIG 1.1

TABLE 1C. DATAHAVEN INDEX SCORES BY DEMOGRAPHIC GROUP AND TOWN, 2017

DataHaven analysis (2019) of questions from 2018 DataHaven Community Wellbeing Survey. The Personal Wellbeing Index is an aggregate of survey participants' positive ratings on four indicators about their health: (1) current anxiety, (2) current happiness, (3) satisfaction with their life, and (4) overall self-rated health. Likert-style responses (e.g. "excellent," "very good," "good," "fair," "poor") were converted to scaled numeric values, averaged, and used for factor analysis to get a single composite score for each location and demographic group. These scores were then scaled to range from 0 (lower ratings of health) to 1,000 (higher ratings of health).

Chapter 2

FIG 2.1. POPULATION AND CHANGE BY AGE GROUP, 1990–2035

DataHaven analysis (2019). 1990 and 2000 figures are from the U.S. Census Bureau Decennial Census; for 1990, SF1 Table P11; and for 2000, SF1 Table P12, Sex by Age. 2015 figures are from U.S. Census Bureau American Community Survey 2015 5-year estimates Table B01001. 1990 figures accessible via Census Data API; all other above tables available at **https://factfinder. census.gov**. 2035 projected figures are from the Connecticut State Data Center (2017) 2015–2040 Population Projections—Town Level. Available at **https://data.ct.gov/ resource/hxnh-2e3k**

FIG 2.2. POPULATION BY AGE AND RACE, 2010

DataHaven analysis (2019) of U.S. Census Bureau Decennial Census SF1 Table P12; and subtables P12B, Sex by Age (Black or African-American Alone); P12H, Sex by Age (Hispanic or Latino); and P12I, Sex by Age (White Alone, not Hispanic or Latino). Available at **https:// factfinder.census.gov**

FIG 2.3. NON-WHITE SHARE OF POPULATION, 1990–2017

DataHaven analysis (2019). 1990 figures are from U.S. Census Bureau Decennial Census SF1 Tables P1 and P8, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B03002, Hispanic or Latino Origin by Race. Available at **https://factfinder.census.gov**

FIG 2.4. FOREIGN-BORN SHARE OF POPULATION, 1990 AND 2017

DataHaven analysis (2019). 1990 figures are from U.S. Census Bureau Decennial Census SF3 Table P42, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B05001, Nativity and Citizenship Status in the United States. Available at **https://factfinder.census.gov**

FIG 2.5. FOREIGN-BORN SHARE OF POPULATION, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B05001. Available at **https://factfinder.census.gov**

FIG 2.6. HOUSEHOLDS BY TYPE, 1990–2017

DataHaven analysis (2019). 1990 and 2000 figures are from the U.S. Census Bureau Decennial Census; for 1990, SF1 Table P16; and for 2000, SF1 Table P18, Household Size, Household Type, and Presence of Own Children. 2010 and 2017 figures are from U.S. Census Bureau American Community Survey 2010 and 2017 5-year estimates Tables B11001, Household Type (Including Living Alone); and B11003, Family Type by Presence and Age of Own Children Under 18 Years. 1990 figures accessible via Census Data API; all other above tables available at **https://factfinder.census.gov**

FIG 2.7. LOW-INCOME RATE BY AGE, 2000–2017

DataHaven analysis (2019). 2000 figures are from U.S. Census Bureau Decennial Census SF3 Tables P88, Ratio of Income in 1999 to Poverty Level; and PCT50, Age by Ratio of Income in 1999 to Poverty Level. U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B17024, Age by Ratio of Income to Poverty Level in the Past 12 Months; and C17002, Ratio of Income to Poverty Level in the Past 12 Months. Available at **https://factfinder.census.gov**. As described in the report text, "low-income" is defined here as individuals living in households where the household income is less than twice (200 percent of) the federal poverty level.

FIG 2.8. MEDIAN HOUSEHOLD INCOME BY TOWN, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B19013. Available at **https://factfinder.census.gov**

FIG 2.9. MEDIAN HOUSEHOLD INCOME BY QUANTILE, 2016

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2016 5-year public use microdata sample (PUMS) data. Analysis of PUMS data involves weighting survey responses to reflect overall population demographics. Values shown here represent the 20th, 50th (median), 80th, and 95th percentiles of total household incomes. SEE NOTE ON GEOGRAPHY AT THE BEGINNING OF THIS SECTION

PUMS data accessed via IPUMS. Ruggles et al. 2012–2016 ACS 5-year Census microdata.

FIG 2.10. MEDIAN INCOME OF FULL-TIME ADULT WORKERS, 2016

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2016 5-year public use microdata sample (PUMS) data. Analysis of PUMS data involves weighting survey responses to reflect overall population demographics. To enable comparison between groups, as well as comparison with other related analyses, adults here are filtered to only include those ages 25 and over working full-time. In this and other analyses, we define full-time workers as workers with positive earnings who, over the previous 12 months, were employed at least 50 weeks

and worked an average of at least 35 hours per week. Median income is defined as each group's median earnings from work, excluding other non-work sources of income. SEE NOTE ON GEOGRAPHY AT THE BEGINNING OF THIS SECTION   PUMS data accessed via IPUMS. Ruggles et al. 2012–2016 ACS 5-year Census microdata.

FIG 2.11. DISTRIBUTION OF POPULATION BY NEIGHBORHOOD INCOME LEVEL, 1980–2017

DataHaven analysis (2019) of household income and population data by census tract. Due to changes in census tract boundaries over time, in order to allow comparability to current census tract data, the 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 with support from the Rockefeller Foundation (2012), a dataset that is designed to hold neighborhood-level geographic boundaries constant over time. 2017 values are calculated from U.S. Census Bureau American Community Survey 2017 5-year estimates Tables B01003, Total Population; B19101, Family Income in the Past 12 Months (in 2017 Inflation-Adjusted Dollars); and B19127. Available at **https://factfinder.census.gov**. Neighborhood income categories are determined by comparing average family income by census tract to the state average family income, using ratios described in the table. The percent of total population living in each neighborhood income category is compared across decades to illustrate change in neighborhood inequality. SEE TABLE 2D FOR DEFINITIONS OF INCOME BRACKETS

FIG 2.12. MEDIAN HOUSEHOLD INCOME, 1990–2017

DataHaven analysis (2019).1990 figures come from U.S. Census Bureau Decennial Census SF3 Table P80A, accessible via Census Data API. 2017 figures are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B19013. Available at **https://factfinder.census. gov**. Inflation adjustment for 1990 incomes was done using the Bureau of Labor Statistics' Consumer Price Index, Urban Consumers, Research Series (CPI-U-RS), available at **https:// www.bls.gov/cpi/research-series/home.htm**

FIG 2.13. MEDIAN HOUSING VALUE BY TOWN, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B25077, Median Value (Dollars). Available at **https://factfinder.census.gov**

FIG 2.14. COST-BURDEN AND SEVERE COST-BURDEN RATES BY TENURE, 2005–2017

DataHaven analysis (2019). All figures are from U.S. Census Bureau American Community Survey. 2005 values are from Tables B25070 and B25091. 2010 and 2015 figures are from 5-year estimates, Tables B25074, Household Income by Gross Rent as a Percentage of Household Income in the Past 12 Months; and B25091.

Available at **https://factfinder.census.gov**. 2005 ACS data is only available for the largest towns in Connecticut; as such, values here are totalled for Hartford and Tolland Counties for each year shown.

FIG 2.15. MEDIAN RENTER HOUSEHOLD INCOME AND MINIMUM HOUSEHOLD INCOME TO AFFORD 2BR HOUSING, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25031, Median Gross Rent by Bedrooms; B25042, Tenure by Bedrooms; and B25119, Median Household Income the Past 12 Months (in 2017 Inflation-Adjusted Dollars) by Tenure. Available at **https://factfinder.census. gov**. For comparison, we only studied two-bedroom apartments, both for median rent and median household income. Because some towns have few renters, leading to larger margins of error, values were filtered to only include towns with relatively small margins of error compared to median rent and where at least 20 percent of households were renter-occupied. Rent is considered affordable based on Federal Department of Housing and Urban Development (HUD) guidelines that housing costs total no more than 30 percent of a household's total income. We calculated the minimum household income needed for the median rent of a two-bedroom apartment to be affordable under this guideline, and consider the shortfall to be the difference between this minimum household income and the median income of a renter household in a two-bedroom apartment.

See also HUD, "Defining Housing Affordability," **https://www.huduser.gov/portal/pdredge/pdr-edge-featd-article-081417.html**

FIG 2.16. HOMEOWNERSHIP RATE BY HISTORIC REDLINING GRADE, 2010

DataHaven analysis (2019). To calculate current demographic data of areas by HOLC grade, we used digitized versions of historical HOLC maps from Mapping Inequality (see reference below) and overlaid these shapefiles with shapefiles of current census blocks from U.S. Census Bureau TIGER/Line shapefiles, available at **https://www. census.gov/programs-surveys/geography/ geographies/mapping-files.html**. We then aggregated 2010 Decennial Census data, the most recent data available at the block level, for each of these graded areas. Homeownership data comes from U.S. Census Bureau 2010 Decennial Census SF1 Table H4, Tenure, available at **https://factfinder.census.gov**

SEE FIG 2.18 FOR LOCAL RECREATION OF HOLC MAPS   See also Robert K. Nelson, LaDale Winling, Richard Marciano, Nathan Connolly, et al., "Mapping Inequality," American Panorama, ed. Robert K. Nelson and Edward L. Ayers, available at **https://dsl.richmond.edu/panorama/redlining**

FIG 2.17. WHITE PERCENTAGE OF POPULATION BY HISTORIC REDLINING GRADE, 2010

DataHaven analysis (2019) of U.S. Census Bureau 2010 Decennial Census SF1 Table P5, Hispanic or Latino Origin by Race, available at **https://factfinder.census.gov**; and Nelson, et al. Mapping Inequality. White population is defined as non-Hispanic white residents of each area. SEE FIG 2.16 FOR SPATIAL ANALYSIS METHODOLOGY / SEE FIG 2.18 FOR LOCAL RECREATION OF HOLC MAPS

FIG 2.18. HOLC REDLINED AREAS, 1937

DataHaven recreation of Robert K. Nelson, LaDale Winling, Richard Marciano, Nathan Connolly, et al., "Mapping Inequality," American Panorama, ed. Robert K. Nelson and Edward L. Ayers, available at **https://dsl.richmond.edu/panorama/redlining**. HOLC created one set of maps of the Hartford area, and one of New Britain.

FIG 2.19. NET INFLOW OF WORKERS BY TOWN AND WAGE, 2015

DataHaven analysis (2019) of U.S. Census Bureau Longitudinal Employer-Household Dynamics Origin-Destination Employment Statistics (LODES) to construct a directional network of workers moving between pairs of towns in the region. LODES data reports the census block in which workers live and the census block in which they are employed, though employer locations are based on the location of payroll and other financial offices, rather than physical place of employment. Presumably, workers work in the same town as the financial office that represents the employer. The analysis includes people who 1) both live and work in Connecticut; 2) live in New York, New Jersey, Rhode Island, Massachusetts, or Pennsylvania but work in Connecticut; or 3) live in Connecticut but work in New York, New Jersey, Rhode Island, Massachusetts, or Pennsylvania. This should capture most workers with interstate commutes, but may miss small numbers of people working remotely and either living or working in Connecticut. In this analysis, high-wage jobs are those paying more than $3,333 per month, or $39,996 annually, while low-wage jobs are those paying $39,996 or less annually. Block-level LODES files are available at **http://lehd.ces.census.gov/data**

FIG 2.20. NUMBER OF JOBS BY SECTOR, 2000–2017

DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators (QWI), available at **http://qwiexplorer.ces.census.gov** at the county level. Industries are categorized based on the North American Industry Classification System (NAICS); those shown are sectors in which there were an average of at least 20,000 workers in the region in 2017. Job trends displayed are actually quarterly counts adjusted with the LOESS method to show changes within years while smoothing out sharp fluctuations. In a few cases, quarterly counts were unavailable and thus annual averages were not reported; in these cases, annual values are the mean of that year's available quarters.

Numbers shown at each endpoint are their respective years' annual averages, not quarterly counts. QWI data is only available at county levels; therefore, numbers here are totalled for all of Hartford and Tolland Counties.

FIG 2.21. COUNT OF K–12 STUDENTS BY RACE, PER 100 STUDENTS, 2018–2019

DataHaven analysis (2019) of 2018–2019 school year enrollment data from the Connecticut State Department of Education, accessed via EdSight at **http://edsight.ct.gov**. For this and other indicators based on public school districts, regional districts were included as parts of regions to which their sending towns belong; in some cases, these towns also run their own districts for elementary school, but send middle and/or high school students to the regional district. Greater Hartford values include Regional School District 8, serving middle and high school students from Andover, Hebron, and Marlborough; Regional School District 19, serving high school students from Ashford, Mansfield, and Willington; and the Capitol Region Education Council (CREC) district, which runs interdistrict magnet schools from preschool through high school as part of court-mandated school desegregation efforts. Note that of these, Ashford would not otherwise be included within Greater Hartford.

FIG 2.22. PERCENTAGE OF STUDENTS SUSPENDED OR EXPELLED AT LEAST ONCE, K–12 DISTRICTS, 2017–2018

DataHaven analysis (2019) of 2017–2018 school year discipline data from the Connecticut State Department of Education, accessed via EdSight at **http://edsight.ct.gov**. Numbers here represent the share of students who have been suspended (in-school or out-of-school) or expelled in the past school year, not deduplicated suspension rates. SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

FIG 2.23. PERCENT OF PUBLIC K–12 STUDENTS MEETING ACHIEVEMENT MEASURES, 2017–2018

DataHaven analysis (2019) of data from the Connecticut State Department of Education, accessed via EdSight at **http://edsight.ct.gov**. Graduation rates presented are four-year cohort graduation rates, giving the percentage of students in the graduating class of 2017 who earned a high school diploma alongside the cohort with which they started 9th grade. A student is considered chronically absent if they miss at least 10 percent of the school days for which they were enrolled in a year for any reason; the chronic absenteeism rate is then the percentage of enrolled students who are chronically absent in a year. The Smarter Balanced Assessment Consortium (SBAC) standardized test is the Common Core-aligned test used in Connecticut since 2015 for both English/language arts (ELA) and math. Students are considered to pass a test if they score as meeting or exceeding grade-level goals; proficiency rates here are the share of students taking each test who passed. Chronic

absenteeism and SBAC proficiency rates are from the 2017–2018 school year. SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

FIG 2.24. NUMBER AND PERCENTAGE OF STUDENTS ENROLLING IN, PERSISTING IN, AND GRADUATING FROM COLLEGE

DataHaven analysis (2019) of data from the Connecticut State Department of Education, accessed via EdSight at **http://edsight.ct.gov**. Enrollment rates are defined as the percentage of students from a given graduating class who enroll in college within one year of graduation. Persistence rates are defined as the percentage of students who, after enrolling in college within one year of high school, continue into a second, consecutive year of college. Attainment rates are the percentage of students who earn a two- or four-year degree within six years of graduating high school, out of the entire high school graduating class. The most recent available data is shown here, which is the high school graduating class of 2014 for graduation, enrollment, and persistence rates, and the class of 2010 for degree attainment rates. SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

FIG 2.25. PERCENTAGE OF ADULTS RATING AS ALMOST CERTAIN OR VERY LIKELY THAT YOUNG PEOPLE IN THEIR AREA HAVE THE FOLLOWING EXPERIENCES, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Indicators show percentage of survey participants who believe the chances of each experience are almost certain or very likely, disaggregated by location, self-reported race/ethnicity, and income. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE START OF THIS SECTION

FIG 2.26. PROBABILITY (%) OF REACHING TOP 20% OF HOUSEHOLD INCOMES AS ADULTS BY RACE AND CHILDHOOD HOUSEHOLD INCOME

DataHaven analysis (2019) of data from Chetty, R., Friedman, J. N., Hendren, N., Jones, M. R., & Porter, S. R. (2018). The Opportunity Atlas: Mapping the Childhood Roots of Social Mobility. Table 5: All Outcomes by County, Race, Gender and Parental Income Percentile. See paper and data at **https://opportunityinsights.org/paper/the-opportunity-atlas**. Chetty et al. used deidentified Census data to model the upward mobility of people of different demographic groups, based on the percentile of household income of the household in which they grew up. Percentages here represent the share of children of each racial group born between 1978 and 1983 whose childhood household was low-income (at the national 25th percentile), middle-income (50th percentile), or high-income (75th percentile) who then lived in households with incomes in the top 20 percent nationally in 2014 and 2015.

TABLE 2A. POPULATION AND GROWTH, 1990 AND 2017

DataHaven analysis (2019). 1990 population figures are from the U.S. Census Bureau Decennial Census, SF1 Table P1, accessible via Census Data API. 2017 population figures are from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B01003. 2000 median age is from U.S. Census Bureau Decennial Census, SF1 Table P13, Median Age by Sex. 2017 median age is from U.S. Census Bureau American Community Survey 2017 5-year estimate, Table B01002, Median Age by Sex. All above tables available at https://factfinder. census.gov. Population density is based on 2017 population (above) and land area calculated from U.S. Census Bureau TIGER/Line shapefiles, available at https://www.census.gov/programs-surveys/geography/geographies/mapping-files. html

TABLE 2B. CHARACTERISTICS BY RACE AND ORIGIN, 2017

DataHaven analysis (2019). Populations by race and ethnicity are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B03002. Foreign-born population comes from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B05001. Tables available at https://factfinder.census.gov

TABLE 2C. HOUSEHOLD STRUCTURE, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B11001 and B11003. Tables available at https://factfinder.census.gov

TABLE 2D. GROWING NEIGHBORHOOD INCOME INEQUALITY, 2017

SEE NOTE FOR FIG 2.11

TABLE 2E. LOW-INCOME POPULATION, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B17024; and C17002. Tables available at https://factfinder.census.gov. As described in the report text, "low-income" is defined here as individuals living in households where the household income is less than twice (200 percent of) the federal poverty level.

TABLE 2F. FINANCIAL INSECURITY, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. For share "just getting by," survey participants, when asked how well they were managing financially, responded that they were just getting by, finding it difficult, or finding it very difficult. Less than two months savings is based on participants' estimate. Negative net worth is based on participants' estimates of whether they would have money left over were their household to liquidate its assets and major possessions and pay off all debts. Transportation insecurity is defined

as the share of participants reporting that at some point in the past 12 months, they could not go somewhere due to lack of reliable transportation. Likewise, 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. Utility shutoffs are based on participants who reported having received a utility shutoff warning or completion during the past 12 months. Values are disaggregated by location and self-reported demographic groups. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

TABLE 2G. HOMEOWNERSHIP, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25003, Tenure; B25003B, Tenure (Black or African American Alone Householder); B25003H, Tenure (White Alone, Not Hispanic or Latino Householder); and B25003I, Tenure (Hispanic or Latino Householder). Tables available at https:// factfinder.census.gov

TABLE 2H. HOUSING UNITS, 2017, AND NEW HOUSING PERMITS, 2001–2017

DataHaven analysis (2019). Counts of housing unit types, and shares of all housing units, are from U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B25024, Units in Structure. Available at https://factfinder.census.gov. Data on housing permits from Connecticut Department of Economic and Community Development Export, Housing, and Income Data, available at https:// portal.ct.gov/DECD/Content/About_DECD/ Research-and-Publications/01_Access-Research/Exports-and-Housing-and-Income-Data. Numbers of permits are averaged over four-year periods to smooth out fluctuations in construction from year to year, for example when a single large building is built.

TABLE 2I. HOUSING COSTS, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Tables B25077, B25074, and B25091. Tables available at https://factfinder.census. gov SEE ALSO FIG 2.13 AND 2.14

TABLE 2J. WAGE TRENDS BY SECTOR, 2000–2017

DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov at county level. Average wages are given, and are calculated here as means of total annual payroll over annual average employment by sector. 2000 wages are adjusted for inflation in order to accurately calculate changes in average wages over time. Industries are categorized based on the North American Industry Classification System (NAICS); those shown are sectors in which there were at least 20,000 workers in the region in 2017. SEE FIG 2.20 FOR DETAILS ON GEOGRAPHY

TABLE 2K. CHANGING INDUSTRY FOOTPRINT, 2000–2017

DataHaven analysis (2019) of U.S. Census Bureau Quarterly Workforce Indicators, available at http://qwiexplorer.ces.census.gov at county level. Each share is given as that sector's payroll divided by the region's total payroll across all sectors. This includes the sectors with fewer than 20,000 workers that were excluded from Figure 2.20. SEE FIG 2.20 FOR DETAILS ON GEOGRAPHY

TABLE 2L. ECONOMIC OPPORTUNITY, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Access to good opportunities for employment is the share of survey participants rating the ability of residents to obtain suitable employment as excellent or good. Youth opportunities for job advancement is the share of participants estimating that it is almost certain or very likely that young people in their area will get a job with opportunity for advancement. Car access is the share of participants saying they very often or fairly often have access to a car when they need it. 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 2M. COLLEGE ENROLLMENT, PERSISTENCE, AND COMPLETION

SEE FIG 2.24 / SEE FIG 2.21 FOR DETAILS ON REGIONAL DISTRICTS

TABLE 2N. EDUCATIONAL ATTAINMENT, 2017

DataHaven analysis (2019) of U.S. Census Bureau American Community Survey 2017 5-year estimates, Table B15003, Educational Attainment for the Population 25 Years and Over. Available at https://factfinder.census.gov

Chapter 3

FIG 3.1. ESTIMATED LIFE EXPECTANCY IN YEARS, 2010–2015

DataHaven analysis (2019) of data from the National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates Files, 2010–2015. National Center for Health Statistics. 2018. Available from **https://www.cdc.gov/nchs/nvss/usaleep/usaleep.html**. Town and regional averages were calculated as population-weighted means of available Census tract values. See also Arias, E., Escobedo, L. A., Kennedy, J., Fu, C., & Cisewki, J. (2018). U.S. Small-area Life Expectancy Estimates Project: Methodology and Results Summary. Vital and Health Statistics. Series 2, Data Evaluation and Methods Research, (181), 1–40.

FIG 3.2. YEARS OF POTENTIAL LIFE LOST BEFORE AGE 75 PER 100,000 RESIDENTS BY CAUSE OF DEATH, 2010–2014

DataHaven analysis (2019) of data from the Connecticut Department of Public Health. For Years of Potential Life Lost (YPLL), we created annualized YPLL rates (or "Premature Death Rates") by cause using the 2010–2014 dataset at the town level; geographies presented here include the state, county, and selected individual towns. Data represent annualized averages over that five year period of time. We calculated the YPLL rate as the sum of the YPLL divided by (the total population under 75 years old*5)*100,000. The average YPLL under 75 years of age, or "Years Lost Per Death," was calculated by taking the sum of the YPLL divided by the number of deaths under 75 years of age. For YPLL due to fetal/infant deaths (summed fetal deaths plus infant deaths), we used annualized CTDPH data and used an average age at death of 0.5 years, hence the average YPLL of 74.5 years per death computed for these deaths as the basis of the comparison to standard causes of death.

FIG 3.3. ANNUAL ABSOLUTE AND RELATIVE AGE-ADJUSTED ENCOUNTER RATES PER 10,000 RESIDENTS, 2015–2017

DataHaven analysis (2019) of CHIME data. 2018. Data about residents' visits to hospitals and emergency rooms may be used as a tool to examine variations in health and quality of life by geography and within specific populations. Unless otherwise noted, all information from this source is based on a DataHaven analysis of 2012–2014 and 2015–2017 CHIME data provided by the Connecticut Hospital Association upon request from and special study agreement with partner hospitals and DataHaven.

The CHIME hospital encounter data extraction included de-identified information for each of over 10,000,000 Connecticut hospital and emergency department encounters incurred by any residents of any town in Connecticut during the six year period studied. Any encounter incurred by any resident of these towns at any Connecticut hospital is included in this dataset, regardless of where they received treatment. Each encounter observation had a unique encounter ID and was populated with one or more "indicator flags" representing a variety of conditions. Each encounter could include multiple indicator flags. Because CHIME is Connecticut-based, only hospital encounters occurring in CT were captured; therefore, encounters for individuals residing in CT towns bordering other states are more likely under-reported.

Annualized encounter rates were calculated for the indicator flags assigned within the dataset including Asthma, COPD, Substance Abuse, and many other conditions. Analyses in this document describe data on "all hospital encounters" including inpatient, emergency department (ED), and observation encounters. Annualized encounter rates per 10,000 persons were calculated for the three-year period 2012–2014 and the three-year period 2015–2017 by merging CHIME data with population data. For each geographic area and indicator, our analysis generally included an annualized encounter rate for populations in each of six age strata (0–19, 20–44, 45–64, 65–74, 75–84, and 85+ years), and by gender, as well as a single age-adjusted annualized encounter rate. It is important to note that there is no way to discern the unique number of individuals in any zip code, town, area, or region who experienced hospital encounters during the period under examination or the number of encounters that represented repeat encounters by the same individual for the same or different conditions. To better examine encounter rates for asthma, a more appropriate set of age groupings was used (0–4, 5–19, 20–44, 45–64, 65–74, and 75+ years), so age-adjusted rates were not calculated for asthma. Please contact DataHaven for further information.

FIG 3.4. CHRONIC DISEASE, ENCOUNTER RATES PER 10,000 RESIDENTS 2015–2017

SEE FIG 3.3

FIG 3.5. OTHER HEALTH ISSUES, ENCOUNTER RATES PER 10,000 RESIDENTS, 2015–2017

SEE FIG 3.3

FIG 3.6. CHRONIC DISEASE, AGE-ADJUSTED RATE OF HOSPITALIZATIONS AND ENCOUNTERS PER 10,000 RESIDENTS, 2012–2014 TO 2015–2017

SEE FIG 3.3

FIG 3.7. OTHER HEALTH ISSUES, AGE-ADJUSTED RATE OF HOSPITALIZATIONS AND ENCOUNTERS PER 10,000 RESIDENTS, 2012–2014 TO 2015–2017

SEE FIG 3.3

FIG 3.8. RESIDENTS' RATING OF LIKELIHOOD THAT YOUTH IN THEIR AREA WILL ABUSE DRUGS OR ALCOHOL, BY RACE AND INCOME, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Indicators show percentage of survey participants guessing that chances of each experience are of each likelihood shown, disaggregated by location and self-reported race/ethnicity and income. Unlike similar questions where the focus was the percentage of adults estimating each event as almost certain or very likely, on this indicator, we chose to focus instead on participants' uncertainty, illustrating that the risk of drug and alcohol abuse is a problem seen across demographic groups. SEE FIG 2.25 FOR OTHER QUESTIONS IN THIS BANK, AND COMMUNITY WELLBEING SURVEY NOTE

FIG 3.9. AGE-ADJUSTED MONTHLY RATE OF DRUG OVERDOSE DEATHS PER 1 MILLION RESIDENTS, 2012–2018

DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at **https://data.ct.gov/resource/rybz-nyjw**. Data is given for each individual to have died in Connecticut of a drug overdose from 2012 to 2018. For this analysis, data was filtered to only include people with a Connecticut town listed as their place of residence at the time of death and with their age on record. Monthly counts by age were used to calculate crude rates of overdose deaths per 1 million residents of each age group. To get age-adjusted rates, crude rates by age group were then weighted with the U.S. Centers for Disease Control and Prevention (CDC) 2000 U.S. Standard Population 18 age group weights available at **https://seer.cancer.gov/stdpopulations**. The rates shown here are 6-month rolling averages; that is, the rate for any given point shown in the chart represents the age-adjusted overdose death rate for that month averaged with the rates of the five months preceding it.

FIG 3.10. COUNT OF DRUG OVERDOSE DEATHS AT 6-MONTH INTERVALS BY PRESENCE OF FENTANYL, WITH PERCENTAGE OF DEATHS THAT ARE FENTANYL-RELATED, 2012–2018

DataHaven analysis (2019) of data from the Connecticut Office of the Chief Medical Examiner, available at **https://data.ct.gov/resource/rybz-nyjw**. In data on drug overdose deaths, individuals are marked for several common substances that may be found by the medical examiner, and may also have a more detailed cause of death written out. The categories in the data include heroin, fentanyl, and generic names of several opioids, such as oxycodone and hydromorphone. We used text mining techniques to find additional names of opiates and opioids from the cause of death text in order to fill in cases where those substances were not checked off otherwise, relevant substances didn't fit into a given category, or where substances were misspelled or abbreviated. In total, more than a dozen substances were included as search terms

to mark a death as opiate- or opioid-related; these deaths may have involved non-opiates as well. Similarly, cases were marked as fentanyl-related if either checked categories or text fields reported fentanyl or any fentanyl-analogues being found. SEE ALSO FIG 3.9

FIG 3.11. PERCENT OF ADULTS REPORTING PERCEIVED REASONS FOR THEIR DISCRIMINATION, OF ADULTS CITING A REASON FOR EXPERIENCES OF DISCRIMINATION, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked a bank of questions on experiences of discrimination, namely whether at any point in their lives they had been discriminated against or treated unfairly in each of several settings, including workplace hiring and promotion; police encounters; ability to move into a neighborhood, based on access to renting or buying housing; and quality of health care services. If respondents answered that they had been discriminated against in one of these areas, they were then asked to identify the reasons why they thought this happened; those reasons are included here if at least 20 percent of respondents cited them. Note that respondents were allowed to identify more than one issue. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

FIG 3.12. PERCENT OF ADULTS REPORTING UNFAIR POLICE STOPS, SEARCHES, OR OTHER MISTREATMENT AND FREQUENCY OF INCIDENTS, BY DEMOGRAPHIC, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Survey participants were asked about whether they had ever been unfairly stopped, searched, or otherwise mistreated by police; if so, they were then asked about the frequency of these incidents within the past three years. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

TABLE 3A. PREMATURE DEATH RATES BY GEOGRAPHY, 2010–2014

SEE FIG 3.2

TABLE 3B. BIRTH OUTCOMES, 2006–2010 AND 2011–2015

DataHaven analysis (2019) of data from the Connecticut Department of Public Health Vital Statistics for the 2006–2010 and 2011–2015 periods, available at **https://portal.ct.gov/DPH/ Health-Information-Systems--Reporting/ Hisrhome/Vital-Statistics-Registration-Reports**. Low birthweight is defined as less than 2,500 grams (roughly 5.5 pounds). Non-adequate prenatal care indicates that the mother attended fewer than 80 percent of expected prenatal care visits, or did not start attended visits until the second trimester. Both the low birthweight and non-adequate prenatal care rates are given as a percent of total births for each of the 5-year periods. Percent change in

both indicators are given as a percent change in the rate of each.

TABLE 3C. ASTHMA PREVALENCE BY PUBLIC SCHOOL DISTRICT, 2012–2014

DataHaven analysis (2019) of data from the Connecticut Department of Public Health School-Based Asthma Surveillance Report of 2019, available at **https://portal.ct.gov/-/media/ Departments-and-Agencies/DPH/dph/hems/ asthma/pdf/SBASS_2012_2014.pdf?la=en**. Asthma prevalence rates for regions are given as the weighted average of districts within the region based on the percent of students enrolled in that district in the 2018–2019 academic year. Very small school districts had suppressed values and were omitted from averages.

TABLE 3D. FREQUENT EMERGENCY ROOM USE AND HEALTH-RELATED SOCIAL NEEDS, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. Respondents were asked to self-report the number of times in the past 12 months they visited the emergency room or urgent care clinic. We then looked at other responses provided by those adults to further reveal characteristics about their health and well-being, including whether, in the past 12 months, they chose to forego medical care for any reason; there had been times they were unable to afford food; they had access to a car less than "fairly often" when needed; were threatened with a utility shut-off notice; or whether they self-reported that they had been physically attacked or threatened.

TABLE 3E. BARRIERS TO HEALTHCARE, 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, and whether they have any person or place they think of as their personal doctor or medical care provider. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

TABLE 3F. EXPERIENCES OF DISCRIMINATION, 2018

SEE FIG 3.11

TABLE 3G. HEALTH RISK FACTORS, 2018

DataHaven analysis (2019) of questions from 2018 DataHaven Community Wellbeing Survey. Adult respondents were asked to rate their overall health; report recent levels of depression and anxiety; and report whether they had even been told by a doctor or medical professional that they had diabetes or asthma. 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. For food insecurity, participants were asked whether there had been times in the past

12 months that they did not have enough money to provide food for their families. 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. Participants were asked to self-report whether they currently have health insurance, and whether they had seen a dentist in the past 12 months. SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION

TABLE 3H. OVERDOSE DEATHS BY SUBSTANCE, 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**. Shown here are aggregated counts of accidental overdose deaths between 2015 and 2018, with annualized age-adjusted rates over that period. SEE FIG 3.9 FOR DETAILS ON AGE-ADJUSTMENT / SEE FIG 3.10 FOR DETAILS ON CATEGORIZING OF SUBSTANCES

TABLE 3I. OVERDOSE DEATHS BY RACE AND ETHNICITY, 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**. Shown here are aggregated counts of accidental overdose deaths between 2015 and 2018 by race/ethnicity as given in their medical examiner record, with annualized age-adjusted rates over that period. SEE FIG 3.9 FOR DETAILS ON AGE-ADJUSTMENT

TABLE 3J. SELECTED HOSPITAL ENCOUNTERS AND HOSPITAL ENCOUNTERS BY AGE, 2015–2017

SEE FIG 3.3

Chapter 4

FIG 4.1. MEASURES OF PER-PERSON MUNICIPAL ASSETS AND SPENDING

DataHaven analysis (2019). Equalized net grand list (ENGL), total expenditures, and education spending data are from the fiscal years 2013–2017 municipal fiscal indicators database from the Connecticut Office of Policy and Management (OPM), available at **https://portal.ct.gov/OPM/IGP-MUNFINSR/Municipal-Financial-Services/Municipal-Fiscal-Indicators**. Each of these values included are for fiscal year 2017. ENGL is divided by 2017 town populations to get per-capita values. Education spending is divided by the number of enrolled public school students in each town; in cases of regional school districts that span more than one town, their pupils were allocated to towns by weighting by each town's population under age 18. OPM's website gives details on which types of expenditures are included or excluded in calculating education spending. Total expenditures are divided by towns' daytime population, calculated as a town's population plus the number of people who work in that town minus the number of residents who leave the town for work; this better captures the financial strains put on towns with large numbers of incoming commuters. Municipal gap/surplus comes from the New England Public Policy Center. Municipal surplus per capita is the difference between a town's municipal capacity per resident, or the amount of money from tax revenue available to that municipality, and municipal cost per resident, or the amount of money needed to cover the town's estimated public expenses. Negative values signify a gap in funding available to cover those costs. See Zhao, B., & Weiner, J. (2015). Measuring municipal fiscal disparities in Connecticut. Federal Reserve Bank of Boston, New England Public Policy Center Research Report, 15–1.

FIG 4.2. NEIGHBORHOOD ASSET INDEX VS MUNICIPAL SURPLUS PER CAPITA

DataHaven analysis (2019). **SEE FIG 1.4 FOR DEFINITION OF NEIGHBORHOOD ASSET INDEX / SEE FIG 4.1 FOR DEFINITION OF MUNICIPAL GAP/SURPLUS** Towns may have a negative surplus (i.e. a gap), in which case they are shown to the left of $0 along the bottom axis. Towns to the right of $0 operate on a surplus, or higher capacity than cost per person.

FIG 4.3. AVERAGE TOWN PUBLIC LIBRARY VISITS PER CAPITA AND CIRCULATION PER CAPITA VS TOTAL LIBRARY EXPENSES PER CAPITA, 2017–2018

DataHaven analysis (2019) of Connecticut State Library Statistical Profiles, available at **http://libguides.ctstatelibrary.org/dld/stats**. Data for fiscal years 2017 and 2018 were averaged to control for single-year major spending (such as on facility renovations). Expenses per capita is the average of the total expenditure divided by the total population, as given by the State Library profiles. Similarly, averages of total units circulated and visits are divided by the population given by the State Library profiles.

FIG 4.4. PERCENT OF ELIGIBLE VOTERS WHO VOTED IN ELECTIONS, BY REGION AND WITH HIGHEST AND LOWEST TOWN RATES, 2016–2018

DataHaven analysis (2019) of voter turnout data from the Connecticut Secretary of the State, available at **https://ctemspublic.pcctg.net**. Voter turnout is defined as the percentage of officially registered voters who are documented as having voted. This includes overseas ballots but does not include absentee voters. Note that the years differ in which presidential, midterm, and local elections are held; as such, the most recent data for each type of election was used. As of 2019, this includes the 2018 state elections, including Congressional midterms; 2017 municipal elections, held in most but not all towns; and 2016 national elections, including votes for president. Participants in the 2018 DataHaven Community Wellbeing Survey also answered a question regarding their registration to vote.

TABLE 4A. MUNICIPAL EXPENDITURES AND FINANCIAL CAPACITY INDICATORS, FY2017

SEE FIG 4.1

TABLE 4B. PERCEIVED ACCESS TO AND QUALITY OF COMMUNITY RESOURCES, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. The indicators shown are the unscaled components of the Neighborhood Assets Index. **SEE FIG 1.4 FOR DETAIL ON THE NEIGHBORHOOD ASSETS INDEX / SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION**

TABLE 4C. COMMUNITY TRUST AND APPRECIATION, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown. Data are disaggregated by geographic area, self-reported age group, and household income. **SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION**

TABLE 4D. PARTICIPATION IN PUBLIC LIFE, 2018

DataHaven analysis (2019) of questions from the 2018 DataHaven Community Wellbeing Survey. The indicators shown here indicate the percentage of adults in each area who answered affirmatively to the questions shown. Data are disaggregated by geographic area, self-reported age group, and household income. Due to low sample sizes, only select disaggregations are provided. **SEE COMMUNITY WELLBEING SURVEY NOTE AT THE BEGINNING OF THIS SECTION**

TABLE 4E. RECENT VOTER TURNOUT, 2016–2018

SEE FIG 4.4

SECTION 2. TEXT ENDNOTES

1   Barrington-Leigh, C. & Wollenberg, J. (2018). Informing policy priorities using inference from life satisfaction responses in a large community survey. *Applied Research in Quality of Life.* **https://doi.org/10.1007/s11482-018-9629-9**

2   Partington, R. (2019, May 24). Wellbeing should replace growth as 'main aim of UK spending.' The Guardian. Retrieved from **https://www.theguardian.com**

3   The New Zealand Treasury. (2018, December 4). Living Standards. Retrieved from **https://treasury.govt.nz/information-and-services/nz-economy/living-standards**

4   SEE NOTES FOR FIG 1.1

5   SEE NOTES FOR FIG 1.2

6   SEE NOTES FOR FIG 1.1

7   The Community Index uses Census ACS estimates for health insurance coverage to allow for nationwide comparisons at many geographic levels. Elsewhere in this report, health insurance coverage is reported from the 2018 DataHaven Community Wellbeing Survey.

8   Greater Hartford's Inner Ring suburbs include: Berlin, Bloomfield, East Hartford, Enfield, Manchester, Newington, Plainville, Rocky Hill, Vernon, West Hartford, Wethersfield, Windsor, and Windsor Locks. The Outer Ring suburbs include Andover, Avon, Bolton, Canton, Columbia, Coventry, East Granby, East Windsor, Ellington, Farmington, Glastonbury, Granby, Hebron, Mansfield, Marlborough, Simsbury, Somers, South Windsor, Southington, Stafford, Suffield, Tolland, and Willington.

9   U.S. Census Bureau. American Community Survey 2012 and 2017 5-year estimates, Table B17001, Poverty Status in the Past 12 Months by Sex by Age.

10 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B23025, Employment Status for the Population 16 Years and Over.

11 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B19013, Median Household Income in the Past 12 Months (In 2017 Inflation-Adjusted Dollars).

12 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B17001.

13 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Tables B25070, Gross Rent as a Percentage of Household Income in the Past 12 Months; and B25091, Mortgage Status by Selected Monthly Owner Costs as a Percentage of Household Income in the Past 12 Months.

14 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B14003, Sex by School Enrollment by Type of School by Age for the Population 3 Years and Over.

15 U.S. Census Bureau. American Community Survey 5-year estimates, Table B15001, Sex by Age by Educational Attainment for the Population 18 Years and Over.

16 The tract with the lowest life expectancy (68.9 years) is 09003501200; the tract with the highest (88.1 years) is 09003462202.

17 SEE NOTES FOR FIG 1.3

18 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Tables B19013B, B19013D, B19013H, and B19013I, Median Household Income in the Past 12 Months (in 2017 Inflation-Adjusted Dollars).

19 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Tables B17020B, B17020D, B17020H, and B17020I, Poverty Status in the Past 12 Months by Age.

20 DataHaven analysis (2019) of Ruggles, S., et al. (2019). IPUMS USA: Version 9.0 American Community Survey 2017 5-year Census microdata. **https://doi.org/10.18128/D010. V9.0** SEE ALSO NOTE ON GEOGRAPHY IN THE TABLE AND FIGURE NOTES

21 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Tables C23002B, C23002D, C23002H, and C23002I, Sex by Age by Employment Status for the Population 16 Years and Over.

22 DataHaven analysis (2019) of Ruggles et al. American Community Survey 2017 5-year Census microdata.

23 Belfield, C. R., Levin, H. M., & Rosen, R. (2012). *The Economic Value of Opportunity Youth.* Retrieved from **https://files. eric.ed.gov/fulltext/ED528650.pdf**. For Connecticut-specific data on Opportunity Youth produced by The Parthenon Group, please see **www.ctopportunityproject.org**

24 SEE NOTE ON GEOGRAPHY IN THE TABLE AND FIGURE NOTES

25 SEE NOTES FOR TABLE 2A Median age of the region is determined by taking the mean of all towns' median ages weighted by town populations.

26 Ibid.

27 Ibid.

28 SEE NOTES FOR FIG 2.1

29 Ibid.

30 Ibid.

31 Ibid.

32 Ibid.

33 Ibid.

34 Ibid.

35 SEE NOTES FOR FIG 2.3

36 Ibid.

37 Ibid.

38 SEE NOTES FOR FIG 2.2

39 Ibid.

40 SEE NOTES FOR FIG 2.4

41 SEE NOTES FOR FIG 2.5

42 Ibid.

43 Ibid.

44 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B05006, Place of Birth for the Foreign-Born Population in the United States.

45 Ibid.

46 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B05001, Nativity and Citizenship Status in the United States.

47 Ibid..

48 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B05007, Place of Birth by Year of Entry by Citizenship Status for the Foreign-Born Population.

49 Ibid.

50 DataHaven analysis (2019) of Ruggles et al. American Community Survey 2016 5-year Census microdata. Because of changes the Census Bureau made to classification of languages, including Haitian Creole, values here may not be directly comparable to ACS tables. SEE ALSO NOTE ON GEOGRAPHY IN THE TABLE AND FIGURE NOTES

51 Ibid.

52 U.S. Census Bureau. American Community Survey 2017 5-year estimates, Table B06007, Place of Birth by Language Spoken at Home and Ability to Speak English in the United States.

53 Ibid.

54 Reynolds, D. (2017, January 12). Gallup Poll: A Record Number of Americans Identify as LGBT. *Advocate.* Retrieved from **https:// www.advocate.com**. While our preference, and what we use elsewhere, is the grouping "lesbian, gay, bisexual, transgender, or queer" (LGBTQ), we follow the language used in sources such as this one.

55 In data from the U.S. Census Bureau and represented here, a household is defined as one or more people who occupy a house, apartment, or other group of rooms with separate living quarters.

56 SEE NOTES FOR FIG 2.6

57 Ibid.

58 SEE NOTES FOR TABLE 2C

59 Ibid.

60 SEE NOTES FOR FIG 2.8

61 SEE NOTES FOR FIG 2.12

62 Berube, A. (2018, February 5). City and metropolitan income inequality data reveal ups and downs through 2016. Retrieved from **https://www.brookings.edu/research/city- and-metropolitan-income-inequality-data- reveal-ups-and-downs-through-2016**

63 SEE NOTES FOR FIG 2.8

64 SEE NOTES FOR FIG 2.9

65 SEE NOTES FOR FIG 2.10

66 DataHaven analysis (2019) of Ruggles et al. American Community Survey 2016 5-year Census microdata. SEE ALSO NOTE ON GEOGRAPHY IN THE TABLE AND FIGURE NOTES

67 Ibid.

68 Ibid.

69 Urban Institute. (2017, October 5). Nine Charts about Wealth Inequality in America. Retrieved from **https://apps.urban.org/ features/wealth-inequality-charts**

70 Perry, A. M., Rothwell, J., & Harshbarger, D. (2018, November 27). The devaluation of assets in black neighborhoods: The case of residential property. Retrieved from **https:// www.brookings.edu/research/devaluation- of-assets-in-black-neighborhoods**

71 SEE NOTES FOR TABLE 2F

72 Institute on Metropolitan Opportunity at the University of Minnesota Law School. (2019, April). Executive summary: American neighborhood change in the 21st century. Retrieved from **https://www.law.umn. edu/institute-metropolitan-opportunity/ gentrification**

73 Ibid.

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