Community Health Equity

A Chicago Reader

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Contents

Introduction

You must always remember that the sociology, the history, the economics, the graphs, the charts, the regressions all land, with great violence, upon the body. — Ta-Nehisi Coates

This *Reader* tells the story of a divided city, a metropolis whose unequal distribution of power and resources limits the capacity of its residents to live long and healthy lives. We present a rich collection of documents and research studies, taking a historical and interdisciplinary perspective. At their best, these documents challenge the status quo—identifying inequalities (which were previously hidden), highlighting historical patterns (often neglected), and exerting all of us to think critically about the fundamental causes of health inequities in Chicago. As we will see, these documents also show us important weaknesses in our collective efforts; in particular, they remind us that it is not enough simply to collect data and write reports—simply to *describe* the problem (when we already know it exists) would be unethical.[1] Rather, the documents in this *Reader* are a testament to a powerful idea: deliberate action based on data can change seemingly intractable problems.

In Chicago, the latest evidence indicates that life expectancy varies by as much as sixteen years between the worst-off and the best-off communities.[2,3] Similarly, we know that infant mortality varies from a low of 2.2 deaths per 1,000 live births to more than 17—meaning that, while affluent communities like Lincoln Park have infant mortality rates that are on par with those in Japan and Sweden, African American communities such as West Garfield Park, Auburn Gresham, and Roseland are more similar to so-called Third World countries. One's zip code should not predict one's life expectancy, but it does.

The numbers are clear: Chicago suffers from profound health inequities. But why? Is this the result of poor lifestyle choices? After all, we know what it takes to be healthy: eat the right foods, get sufficient exercise, don't smoke, and follow medical advice as needed. In the United States, many of us think nothing else matters because we consider health a personal issue, a personal responsibility. Yet that is not the whole story. While each of us has some degree of control over our health, our capacity to make healthy choices is constrained not just by our own resources but by the characteristics of the places where we live. Our health is shaped by society, not just by our own individual choices and behaviors. In Chicago—a large and highly segregated city—we can see powerful evidence of what are called *the social determinants of health*.[4,5]

In today's Chicago, sixteen-year-old black males have a 50% chance of surviving to age sixty-five—a statistic many people attribute to violence and homicide. While those things do account for a significant proportion of those deaths, more than half of the burden is due to premature heart disease and cancer, which in turn are linked to stress caused by social and economic inequities.[6] Social, economic, and racial inequities can be considered a form of violence called *structural violence*, and they are every bit as deadly as gun violence when it comes to health. We are dealing, in other words, with a burden of largely preventable and treatable conditions made worse by social conditions.[7] This reality shatters the idea that health is solely a personal responsibility when, instead, it is more appropriately seen as a public issue, one shaped by economics, politics, the legal system, and the education system as well as by the health system.[8] Together, those forces are often known as *social structure*.

Chicago is the focus of our book, and, while it is one of the largest and most unequal cities in the United States, it is of course not the only city grappling with health inequities. In the past decade, the concept of health equity has received increasing attention both nationwide and around the world. It features in academic research in a wide range of disciplines and is invoked in the mission statements and strategic plans of numerous hospitals and medical centers. Its importance is clear.

Over time, the research community has explored different ways of defining *health equity*. Perhaps the most powerful definition comes from the Centers for Disease Control, which argues that "health equity is achieved when every person has the opportunity to attain his or

her full health potential." Similarly, *Healthy People 2020*—an agenda-setting report published by the US Department of Health and Human Services—defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[9] Recently, the Commission on the Social Determinants of Health of the World Health Organization (WHO) concluded: "Reducing health inequalities is . . . an ethical imperative. Social injustice is killing people on a grand scale."[10] The WHO commission took an openly progressive political stance, emphasizing: "It does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. Putting right these inequities—the huge and remediable differences in health between and within countries—is a matter of social justice."[10] Health equity has become a concern for us all.

We believe that, with its rich history of inquiry and activism, Chicago is a particularly fitting case study in the long campaign for health equity. Today, health equity has become the central plank in the city's public health plan, Healthy Chicago 2.0,[3] but studies of the city and its characteristics have a long pedigree. One early example is C. T. Bushnell's 1901 map linking child mortality and factors that would now be called *social determinants of health*: overcrowding, lack of sanitation, and economic distress (see figure 1).[11]

One hundred sixteen years later, we have better data and better maps, but the fundamental problem is the same. If anything, the association between place and health that Bushnell's map illuminated geographically is even more pronounced.

The same is true of residential segregation, which remains a key driver of social inequity in Chicago.[12] The structural roots of residential segregation in Chicago were laid in the 1930s, with the infamous "redlining" of nonwhite neighborhoods by the Federal Home Owners' Loan Corporation. Residents of red areas—nearly all of whom were nonwhite—were effectively denied access to Federal Housing Administration–backed mortgages.[12–14] Coates's assessment of redlining is poignant: "Redlining destroyed the possibility of investment wherever black people lived."[13] This and other discriminatory practices (from restrictive covenants to

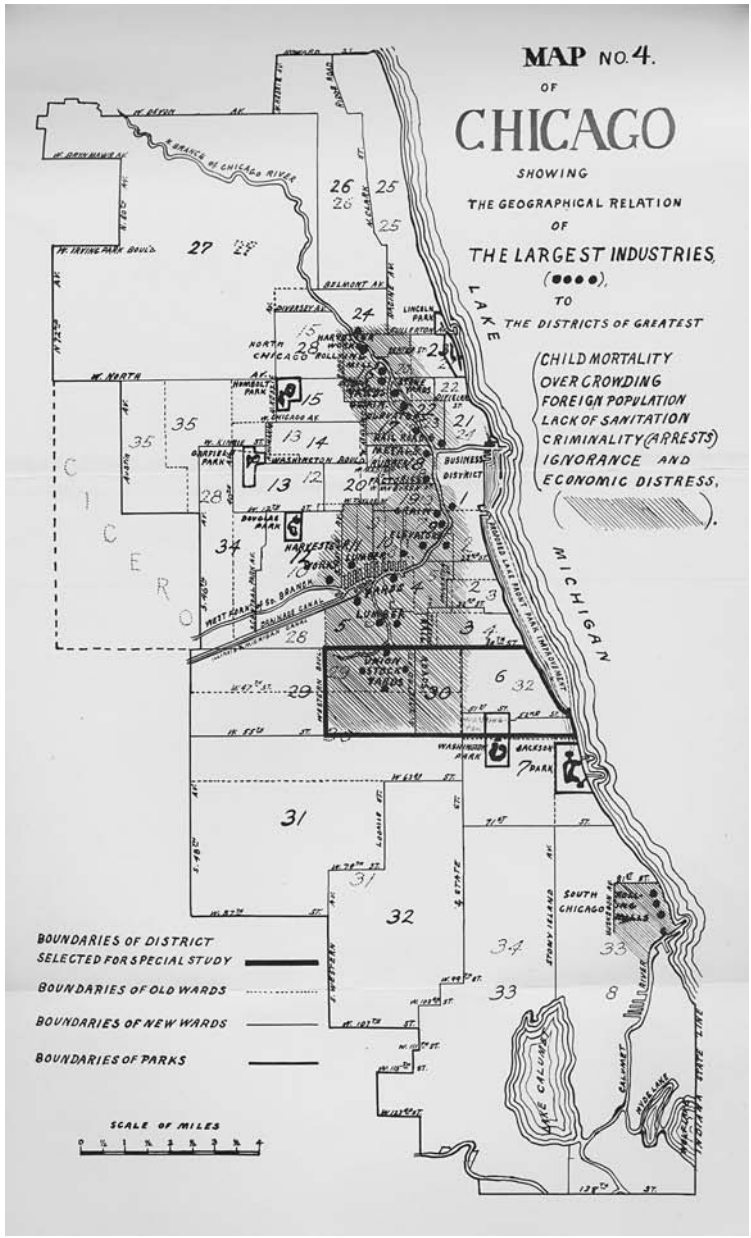

FIGURE 1. Place and health in Chicago, 1901

Source: Bushnell CT. Some social aspects of the Chicago Stock Yards: Chapter II. The Stock Yard community at Chicago. *American Journal of Sociology*. 1901;7(3):289–330.

physical violence) excluded black people from the real estate market—a policy that has affected families across generations.[15] This historical injustice is one of many that continue to affect people today, constraining our collective capacity to achieve health equity across the city.

Redlining is only one example of *structural violence*, which Paul Farmer defined as "social arrangements that put individuals and populations in harm's way. The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people."[16] Above all, this book is a record of the impact structural violence exacts on health.

Structural violence manifests in many ways, including through socioeconomic divisions, gender inequality, ageism, sex discrimination, and—as the record of Chicago illustrates—racism. We argue that *structural* racism—and not biology—explains many of the patterns that will be depicted in this book. By *structural racism*, we mean "the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."[17] Used similarly by Camara Jones, *structural racism* is "normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need."[18]

By reflecting on the contours of health equity research in Chicago, we can take stock of what we know, what we have tried, and what has been debated. Taking a wide and historical view of health equity in Chicago will remind us of, among other things, the importance of social structure, the frustrating permanence of structural violence, and the ongoing burden of racism in our society. Taken together, these documents teach us about the importance (and limits) of research. On the one hand, research can identify inequalities—this is often by disaggregating averages, which can hide differences between groups, or by describing historical trends and geographic differences. Examples in this *Reader* teach us about the importance of local (community-level) data and show historical echoes (e.g., as we will see later in the book, findings from analyses of white-black differences in mortality from tuberculosis in the 1920s

are not dissimilar from the same analyses of mortality from breast cancer in the first decade of the twenty-first century). On the other hand, research has often been rooted in *description*—identifying the scope of problems, testing hypotheses about correlation, association, and sometimes causality, but then falling short of naming the fundamental causes of our health problems. Thus, structural violence is an *unnamed* source of health inequities in the documents in this *Reader*, despite evidence pointing to the health-damaging consequences of structural racism seen in many of these documents.

About This *Reader*

A careful review of decades' worth of articles, reports, and other documents about health equity in Chicago preceded the assembly of this book. We chose documents primarily for what they taught us—sometimes in their presentation of new data or the use of a new research method. Sometimes this involved the creation of a new quantitative measure (e.g., measures of community vitality or collective efficacy); other times the document involved the application of qualitative techniques to gather data on peoples' lived experiences (personal narratives that are often missing in quantitative research). But we were also drawn to documents that seemed to have a lasting importance—those that we wanted our students and colleagues to read and discuss with us. Our collection is certainly not a meta-analysis or a systematic review, so by design it cannot wholly represent the literature—there are thousands of published papers and reports on health equity in Chicago, far too many to include or even cite. Nevertheless, we believe that it tells an important story about Chicago, its history, and our attempts to make it healthier and fairer.

The book is divided into five parts to mirror the most important elements of the Healthy People 2020 definition of *health equity*. Part 1, "A Divided City," illustrates historical and contemporary injustices. Part 2, "The Health Gap," focuses on Chicago's problems in achieving the highest level of health for all people and documents contemporary patterns of avoidable inequalities. Part 3, "Separate and Unequal Health Care," and part 4, "Communities Matter," reflect on two fundamental drivers of community health: access to the health care system and the social condi-

tions of communities themselves. Part 5, "Taking Action," engages with ongoing societal efforts to address avoidable inequalities at the level of health care access or community.

A Divided City

Cities are divided. Why? Are they intentionally designed that way according to some master urban plan about how cities should be structured? Is their evolution based on choices favored by the many? Is the evolution of a city characterized by some of both? Chicago as a city is a dynamic and multilayered construct. It had a unique opportunity to redefine itself as it reemerged from the ashes of the Great Chicago Fire of 1871 and as waves of immigrants poured in from elsewhere in the United States and abroad. As stated in Daniel Burnham's 1909 Plan of Chicago: "The people of Chicago have ceased to be impressed by rapid growth or the great size of the city. What they insist [on] asking now is, How are we living?"[19] How *are* we living? That question remains current a century later. Excerpts from Sampson's *Great American City* provide a glimpse at the effects of the interplay between time and space have left on Chicago's lived environment and deep-rooted patterns of segregation. The other documents in this part—published between 1927 and 2012—reflect critical aspects of the city's social divisions. In different ways, they express the importance of the social determinants of health, and they document with startling detail the value of community-level data in a city as divided as Chicago.

The Health Gap

Part 2 examines a rich collection of studies describing health inequities in Chicago, often with a focus on race/racism. While we highlight a wide range of conditions—cancer, birth weight, AIDS, breast cancer, and hypertension—our emphasis is not on the conditions but on how these health outcomes reflect social inequalities. Most of these studies are quantitative in design, reflecting the strengths of epidemiology and population health research. Not only are these studies important for their descriptive insight (they tell us about the scope of the problem); they also begin to illuminate how these health gaps came to be. They are not natural but, rather, a reflection of the social, structural, and political deter-

minants of health. Nor are they static—health gaps change over time and vary from community to community.

Separate and Unequal Health Care

Health equity requires the elimination of unjust health care disparities, an issue of profound importance in Chicago. Our selection of articles here starts with a 1954 pamphlet from the Committee to End Discrimination in Chicago Medical Institutions analyzing the distribution of Negro births and deaths in Chicago hospitals. Its scathing critique of racism in health care directly asked: "What color are your germs?" This part also quotes the Black Panthers, who ran a community clinic in the city. Other selections document the work of the Uptown People's Health Center, quantify the harm of patient dumping at Cook County Hospital in the 1980s, and investigate trauma deserts in the poorest parts of the city in 2015. Altogether, these documents reveal how structural violence is manifest within the health care system and also give a glimpse of the change that is possible through concerted social action.

Communities Matter

This part explores the literature on how community characteristics affect the health of residents—either increasing the risk of disease or protecting health. Here, readers will begin to see how structural violence is linked to community characteristics, through concepts such as collective efficacy, structural disadvantage, social capital, and community vitality. The studies selected raise methodological challenges about how to measure community characteristics and how to link them to individual health. Again, we did not restrict our choice of studies by disease categories. Readers will find a wide range of topics—from smoking cessation to life expectancy, from pregnancy outcomes to heart disease, and from childhood asthma to gun violence.

Taking Action

The final part features Chicago's historical and contemporary efforts to address avoidable inequalities and nurture health equity through two key structural targets: health care systems and communities them-

selves. In this part, readers will discover successful initiatives to reduce the gap in mortality between blacks and whites with breast cancer. They will also explore the youth-led movement that pushed for the opening of an adult trauma center on the South Side. We conclude with the public health metrics of Healthy Chicago 2.0—quantitative targets for improving health in the city's most disadvantaged communities. We also explore a tension in the literature between problem-focused and solution-focused research, raising the question of how to change to help make Chicago a healthier and more equitable city.

What Must Be Done?

In total, this collection documents more than a century of work on health equity. While the history of Chicago's profound inequality can overwhelm, this work testifies to the relentless efforts of many people from many communities determined to achieve something better, more humane and just. Public health research shows that history matters. Our health is not just the product of our individual behaviors, and disease is in many ways the embodiment of structural violence, generations in the making.[20]

All our solutions are interrelated. We cannot address inequities in diabetes and diabetes-related hospitalizations without first addressing food security. We cannot address the obesity epidemic without recognizing the place of neighborhood safety. Nor can we reduce preventable and avoidable morbidities without considering the social determinants of health—ranging from poverty and economic inequality to racism and gender inequality—as well as political processes that disenfranchise and marginalize whole communities.

While, by design, this *Reader* looks back into the literature—our concern is with the present and the future. Thus, we urge readers to approach this book with a critical perspective, questioning what must be done to make a difference. Whether college students, medical students, or established professionals, they will, we hope, be inspired to join this struggle. What can we do together so that someday the story will be different and we can say that everyone in Chicago really has the opportunity to attain his or her full health potential? The readings that follow offer lessons for taking up that critical task.

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