

BOOK REVIEW

The Death Gap: How Inequality Kills

by David A. Ansell

Chicago: University of Chicago Press, 2019

David Ansell is the author of *The Death Gap: How Inequality Kills*, which will be re-released in 2021 by the University of Chicago Press with an introduction by the Mayor of Chicago, Lori Lightfoot, and an Afterward by the author with updates which address the current health care crisis. Dr. Ansell is the Associate Provost of Community Affairs and epidemiologist at the Rush Medical Center in Chicago. He is also the Michael E. Kelly, MD. Presidential Professor of Internal Medicine, and the Senior Vice President for Community Health Equity for Rush University. Ansell worked at the Cook County Hospital and Mount Sinai Hospital before joining the Rush Medical faculty and staff. He previously authored *County: Life, Death and Politics in Chicago's Public Hospital* (2012), and wrote the Introduction to *Momma Might Be Better Off Dead: The Failure of Health Care in Urban America*, by Laurie Kaye Abraham (2019).

Ansell has appeared on the TED Talks circuit, the Chicago Humanities Festival, and in numerous conferences and gatherings of medical professionals to share and expand on his experience and views as a doctor, epidemiologist, and health care equity advocate. In a recent YouTube video lecture (2021), Ansell began his comments by noting that his parents came to the United States after the horrors of the Holocaust. He noted that the racism, exclusion, and intentional health care policies in the US today are based on some of the same ideas of white supremacy that led to the Holocaust's impacts on Jewish people in the Second World War. In the United States, the life expectancy of African Americans is almost about 15 years less than that of Euro Americans. This is a strong claim, but one based on Ansell's experience, examination of factual data, interviews with patients. His work also provides an analysis of cultural attitudes and public policies that govern for profit health care institutions in America.

In the Preface, "One Street, Two Worlds," Ansell argues that Ogden Avenue in Chicago (also Highway 66) demonstrates the reality of health care inequality in Chicago, and by inference other cities and places in the US and globally as well. Ogden Avenue runs from downtown Chicago through the Health Care complex on Chicago's West Side, Mount Sinai Hospital in the low-income community of Lawndale, to affluent communities in the western suburbs. If you live in the Loop, Ansell argues, your life expectancy would be 85 years of age. But if you live in Lawndale, or Garfield Park, your life expectancy would be closer to 69 years of age. A sixteen-year-old African American teenager in Garfield Park has a 50% chance of reaching the age of 65, as in other dense, low-income African American communities elsewhere. The results are what Ansell calls the "death gap." The death gap is more than just

“health care inequities.” Rather, it describes more accurately the “actual outcomes of health inequity” (15). For Ansell, the measure of “life expectancy” is a way to incorporate the many factors and root causes that lead to the differences in mortality rates from one neighborhood to another, and from one social group to another. For example, “A woman’s neighborhood (place of residence) can determine whether or not she will survive breast cancer or die from it” (114). To understand these realities, Ansell states that he had to re-learn everything he learned in medical school and assumed to be true. The typical answer to why the “death gap” exists is due to physical violence, behavior, or genetics. But this is not the case. While violence and genetics do play a role, the primary reasons for the death gap are what Ansell calls “structural violence.” Issues of nutrition, health care access, and the quality of life in urban communities are the root causes. Alluding to the influential work by Robert J. Sampson, *Great American City: Chicago and the Enduring Neighborhood Effect* (2013), Ansell argues that such “neighborhood effects” are the result of intentional policy directives. The correct word for this situation is not “poverty,” but “economic deprivation,” a phrase also used by Dr. Martin Luther King, Jr. The social conditions facing low-income African Americans and others are due to funding and policy priorities that reflect the values and practices of the current capitalist system.

Ansell relates stories and case studies of his former patients who do not have adequate health care access or insurance policies that ensure quality health care. While low-income persons of color were faced with a longer line to get an organ transplant, thus resulting in greater mortality, Euro Americans could expect treatment and intervention much sooner. Ironically, white Americans often received organs donated by recently deceased African Americans or Latino patients, even though the latter persons were not able to get the same medical intervention. What is the issue? The problem is that the best hospitals in Chicago are near downtown or on the Northside in more affluent white communities. On the South and West Sides, there is a lack of hospitals and clinics, and the ones present do not have the same technology or resources to give equivalent quality of care. Ansell and others only recently fought to have the University of Chicago Hospitals open a Trauma Clinic on the South Side. Also, the current economic system is based on profits and market rate schedules for health care costs. If one is white and affluent in any of the 117 cities in the US, the chance of getting quality care is greater than any black community in the United States, regardless of income status. As Ansell summarizes:

The nation’s hospitals have been organized for the most part to make money by attracting the best clientele with the best insurance policies. For most hospitals this means avoiding poor and minority neighborhoods. Those frayed and capital poor hospitals that have made it their mission to care for poor and uninsured often struggle in poverty like their clients. (131)

The issue is location, the disinvested geographies that exacerbate racial and economic disparities. Ansell argues that the entire system must be called into question. In the early 19th century, medical personnel thought disease was caused by odors, or “humors” (smells). It was not until the late 19th century that medical research pointed to water and air-borne particles (such as the influenza of 1918-19) as the cause of disease. In the 21st century, most health care practice assumes that the problems are genetic, behavioral, or cultural. They are assumed to reside in the individual person and are in a distinct culture group. Hospital practice is championed by private hospitals which are supported by private insurance companies and public sector programs like Medicare and Medicaid. This is outdated. Ansell argues that there are two problems that current practice is not considering. First, it must consider the environment and the social structure of urban communities. Second, the capitalist economic system rewards persons who are white who have private insurance or private economic resources. The economic system does not provide or support equity; it intentionally demands the opposite. But health care should not be determined by the market; it should be a human right. In a recent YouTube presentation, Ansell cited Franklin Delano Roosevelt’s *Economic Bill of Rights* of January 1944 as a better economic model, one that treats health care as a human right. Further, Ansell argues that health care must be viewed in a holistic, integrated way. One cannot take the individual out of the neighborhood, therefore hospitals and health care policy must address the equity needs of their communities.

Low-income communities in urban areas face several deficits. After World War II, jobs and middle-class people left the city for the suburbs. Economic wealth and power also left those communities, leaving neighborhoods facing divestment, bank red-lining, real estate racial steering practices, and health care institutions that relocated to profitable communities. In other words, health care institutions made and followed policies that abandoned low-income urban communities. The same may be said of poor white and American indigenous communities as well. The economic system is thus part of the problem. It can only be fixed by a public policy that advances universal health care provisions, including quality health care for all persons.

Ansell argues that these problems are fixable. Hospitals must see themselves as part of urban communities, not in isolation. Government policies must intervene to address the inequities of the health care market. Inner city communities need investment in the form of education, nutrition, economic development, and quality health care provision. Writes Ansell, “If we really want to achieve equity in health care outcomes, then we have to invest more into the institutions serving those who need care the most.... This means redistributing capital dollars based on need... (which is) the opposite of how the health care system works ... (in) America” (128).

Ansell believes that several things need to occur to advance equity in the fields of health care. First, research and data must be collected. Under Ansell’s supervision, Rush has done

sociological field research to determine what the issues and needs are in urban communities near the West Side Health Care complex in Chicago. Second, policy changes must be developed in concert with community-based organizations. Leaders from affected communities must not only be at the table but should be respected as leaders in the development of viable health care policy alternatives. Third, strategic steps to remedy the lack of access to quality health care must be taken to ensure that meaningful goals are achieved. Seven hospitals in Chicago have pledged to reduce the “death gap” on the West Side of Chicago by 50% by 2025. In recent presentations, Ansell has argued that the COVID-19 pandemic has wreaked havoc in the African American community in Chicago. Of the first 100 persons who contracted COVID-19 in Chicago in March of 2020, 72% were African Americans (Zaru 2020). Fourth, resources must be allocated to low-income communities to address the root causes of health care inequity. This means supporting community leadership, and funding educational and economic opportunities which lead to greater human flourishing, especially for the most vulnerable and needy among us.

The implications for the global world are obvious. The same health care inequities that plague US cities also plague the cities of the developing world. By some measures, the inner cities of Chicago look a lot like Haiti or Bangladesh. In a society that champions individual liberty, issues of the common good are often cynically rejected. However, if anything, the current health care pandemic has taught us that the public good must transcend private interests, even as those interests are also threatened. If health care is a human right, it cannot be guaranteed by the private market. It must be assessed and funded by public institutions who are invested in the public good. As Ansell summarizes, “Business as usual will not reverse the epidemic of ill health and high mortality in our neighborhoods. A few systems have recognized that they will have to tackle the structural and social determinants of health. For many, this is a new concept, but one with great consequences” (188).

But there are signs of hope. Local communities can make a difference too. They can develop their social capital, their internal and external networks, and their social ties. The communities that have more social capital and “community efficacy” have the ability to mitigate local neighborhood problems by demonstrating more social cohesion, “collective efficacy,” common purpose, and collective concern for the common good (147). Communities with high rates of community efficacy also have a high degree of “social altruism,” the concern for the neighbor, especially the ones who need it most. Furthermore, hospital institutions have a role as well, but they must rethink their mission and purpose in the communities that they serve.

What if the mission of our nation’s health care systems were shifted to generate economic and health returns aimed to revitalize neighborhoods? Hospitals and health systems can use their heft as employers and as purchasers to bring jobs and other resources to the high-mortality, high-poverty neighborhoods in their environs. (189)

This would mean that hospital systems, supported by the larger political and economic systems of our society, must move beyond “community service programs” to address the root causes of our problems. “This could extend from job creation, safe housing, access to healthcare, and affordable food to business partnerships and loans” (189).

Other institutions in civil society have a role to play as well. In religious communities, faith-based institutions are often governed by a belief system that seeks the good of the neighbor and recognizes that the love of God values the whole creation, especially the neediest among us, not just the privileged ones who directly benefit from unjust and inequitable health care systems. However, to address the seriousness and pervasive character of the health care needs that face global communities, a new social contract of collaboration and cooperation, now a necessity, must be formed. As David Korten (2007) put it, we have two choices: the social structure of empire and the economic system of market-oriented capitalism based on profit, or an earth community that recognizes our growing interdependence with each other on a shrinking planet.

References

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