Variations in mortality data show health inequity isn’t inevitable

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Collecting data is an important part of achieving health equity. Acting on that data is even more important.

This point was made at an Institute of Medicine of Chicago program by Fernando De Maio, PhD, director of research and data use at the AMA Center for Health Equity, and Maureen Benjamins, PhD, senior research fellow at the Sinai Urban Health Institute (SUHI) while speaking about the book they co-edited, Unequal Cities: Structural Racism and the Death Gap in America’s Largest Cities.

The book is dedicated to the memory of SUHI founder Steve Whitman, PhD, and Benjamins told the story of when researchers from the institute discovered that Chicago’s Black mortality rate for breast cancer was two times higher than the city’s white mortality rate. This led to the formation of the Metropolitan Chicago Breast Cancer Task Force, now known as Equal Hope, which then took specific action to reduce this inequity.

“It got a lot of attention … from the popular press and in academic journals,” Benjamins said of the study. “But what was really important to us was that it led to real changes.”

Remember the people behind the data

“This book serves as a powerful call to action for health equity advocates and city leaders alike,” said Institute of Medicine Chicago President Cheryl Rucker-Whitaker, MD, MPH, as she introduced Benjamins and De Maio.

“The authors have stated: ‘We are here to change the landscape, not to do more studies.’ Amen! It’s about people.”
Benjamins said this was a point frequently made by Whitman, who would look out his office window at Mount Sinai Hospital in Chicago’s North Lawndale neighborhood and remind people not to “get lost in the data,” because it literally could be a matter of someone’s life or death.

“He’d say, ‘That’s who we’re talking about when we talk about excess Black deaths,’” Benjamins recalled. “It’s our friends, it’s our neighbors, it’s our family. It’s the people we’re looking at right now.”

The book analyzes National Vital Statistics System death-certificate data from 13.5 million deaths that occurred in the 29 most-populated U.S. cities from 2013–2017. From there, life expectancy rates and mortality rates for the 10 leading causes of death were calculated for each city, which were then further broken down between those cities’ Black and white residents.

“We chose to focus on the Black and white rates because the Black mortality rates are noticeably worse than the white rates, as well as the rates for the other largest racial and ethnic groups in our country,” Benjamins said.

If lessening the life-expectancy gap between a city’s Black and white residents may be the ultimate goal, looking at specific mortality causes helps to focus action.

“When you look at cause-specific mortality, it’s a little easier to think of policy changes or programming that might influence that particular outcome,” she explained.

For the nation, there is a 4.1-year life expectancy gap between white people (78.4 years of life expectancy) and Black people (74.4 years), but much larger gaps exist in cities such as Washington (12.1 years) and San Francisco (10.5).

El Paso, Texas, was the only city studied where Black people had a longer life expectancy: 78.4 years, compared with 77.8 years for whites during the period. Nevertheless, El Paso also had its share of health problems, including the highest overall mortality rate for diabetes.

### Inequity unfair, but also avoidable

Health inequities “are deeply entrenched, rooted in our history, in our politics and our economics,” De Maio said. “But they vary from place to place, and they vary across time. And that for me is a source of hope, because—if we can identify those patterns—we can change them.”

The book highlights a Chicago initiative, West Side United, in which the AMA and other organizations are using a combination of research and data, community mobilization and political will to work toward the common goal of cutting in half the life-expectancy gap between the city’s economically or socially marginalized neighborhoods to the west and the more affluent areas downtown.
The AMA is contributing a $2 million investment over two years and is also working with neighborhood clinics to lower their patients’ systolic BP by at least 10 mm Hg or to achieve BP control in patients with hypertension.