



Mortgage Markets and the Roots of Racial Health Disparities

June 2017 podcast episode transcript

Featuring [Abigail Sewell](#),
Assistant Professor of Sociology, Emory University

Hosted by Dave Chancellor

Chancellor Hello and thanks for joining us for the Poverty Research and Policy Podcast from the Institute for Research on Poverty at the University of Wisconsin-Madison. I'm Dave Chancellor.

This is our June 2017 episode and for this episode, I interviewed Abigail Sewell, who is a sociologist at Emory University. Dr. Sewell visited IRP in December of this past year. During her visit we talked about her research on racial disparities in health and how those disparities may be linked to larger political and economic processes. She says that we can think of these kinds of processes as a sort of origin story behind health disparities, so I asked her to explain what she means by this.

Sewell What I mean by the development of the origin story is that we have been looking at what I would call mechanisms or mediators of disparities in health without understanding where those mediators come from. What I try to do in my research in general is examine the causes of the causes. If you scale back maybe 10-15 years ago, what that meant was studying things like segregation, so people said, well, it's not health behaviors, it's not resources in the home. It's the fact that these places are segregated. So, in fact, segregation is often been considered a root cause. What I say is, it is a root cause, but there's also a root cause to segregation.

Chancellor Sewell says that to think about these root causes of segregation, we should look at the underlying processes of how racially unequal or racist structures develop.

Sewell We come to live in segregated spaces or isolated spaces, places that are isolated from racially privileged people or racially dominant populations through the practices and policies of institutions, the norms, the rituals and the rights of passage that are set up through institutional gatekeepers like underwriters, right? Loan officers. So by studying by what they do and don't do, their actions and inactions, we may be able to think about tractable places of intervention whereby segregation is bad for health or not bad for health. So in some sense, one of my points of departure from the prior literature is that living with people who are racially marginalized is bad for health, not because they're racially marginalized but because they're living in degenerated areas so if we were able to find the roots of that, we would get a better understanding of how to break apart the systems that recreate both segregation and health risk.

Chancellor It makes sense that living in a degenerated area can have health consequences, but Professor Sewell says housing especially matters because it's so linked to wealth and the resources that a family has the ability to accumulate.

Sewell We have been trained to think about flows of cash into a household — income. We've been trained to think about the level of statuses that we can attain, education. And we've been trained to think about the prestige of the work that we do — occupation. But in fact, and while there are disparities there by race, in fact the

Sewell, continued largest disparities are by wealth which is the amount of assets, resources, sometimes capital-producing resources that we have to rely on in times of duress. And what that captures is that while there may be 70, 80 cents to the dollar with regards to black-white inequalities in income, it's more like it would take 230 years for blacks to catch up in regards to wealth to that of whites. In many cases, in particular parts of the income distribution, blacks have one cent to the dollar in net assets that whites have. So wealth is a driving mechanism of socioeconomic status differences as well as a contributor to the sedimentation of inequality across generation. A primary form or domain by which wealth accumulates is the home. The ability to have a home as well as the value that's placed on one's home. And that's where the mortgage market as the dispenser of access to housing equity comes to be seen as very important.

Chancellor Professor Sewell says when we think about mortgages and questions of access as connected to health, it's important to understand the distinction between public loans and private loans.

Sewell The extent to which the loans are overseen by the government as well as the extent to which the government takes on the risk of default, that's really the difference between private and public, but the other question that's embedded in that is why would one be bad and the other be good? Because, in fact, you're more likely to have a private loan if you have a lot of assets in the bank. If you put 20 percent down, the loan is automatically a private loan, you have no mortgage insurance. Why would that be bad? Well, it's not bad, and my research shows that just having access, an influx of private loans in an area isn't bad for health, it's when those loans are more likely to be given to minorities that it's bad for health. So we see this from the perspective of the research on predatory and fringe institutions — fringe institutions are more likely to broker loans for minorities and for people who apply for loans in minority areas than for whites who are getting prime loans.

Chancellor To better understand these processes, Sewell began looking at a sample of kids who were in Chicago between 1997 and 2000 and then looked at that group's health as they aged between 1994 and 2003, which is also the period when the subprime mortgage market began to gain steam, especially in the minority communities.

Sewell And then I looked at racial differences in private loans. And the first key finding we find is that children, who in 1997 lived in neighborhoods where there were large racial disparities in access to private credit or the distribution of private credit, particularly in 1994, had a 33 percent increase in the likelihood of an asthma diagnosis. The second thing we learn is that while there is a palpable effect, substantive effect of the political economy as I describe it — these discriminatory political economies, on asthma, they don't account for racial disparities in health. What accounts for racial disparities in health are household factors. And these household factors are also linked to or differentiated by the specific type of discriminatory environments that are codified in racial differences in private credit. And specifically we have household income, family structures and street block ambient hazards.

Chancellor Professor Sewell says that these things suggest three main types of mechanisms that connect racial disparities in health to the political economy.

Sewell One is a sorting process where different types of households are sorted into degenerating neighborhoods. And the second part is a process of unsustainability where once they are in these neighborhoods, they are exposed to unsustainable forms of credit or assets that lead to higher levels of foreclosure, debt accumulation in those neighborhoods which trigger and set off health problems for the adults in the household as well as for the children in the household. And then the last part that I examined was showing that among individuals who aged in households that were characterized by racial disparities in private credit. They were more likely to receive an asthma diagnosis if those neighborhoods had as little as a 10 percent increase in the likelihood of minorities receiving loans. So there's two things here. One, there's a gap of seven years between the likelihood of getting an asthma diagnosis for a child that lives in a neighborhood with a 10 percent in the likelihood of getting a private loan for minorities versus a neighborhood where there's a 10 percent decrease in the likelihood of getting a private loans for minorities. And, by the age of 18, people with children who lived in the least discriminatory neighborhoods, neighborhoods where

- Sewell, continued whites actually were targeted or preferred for private loans never faced an increase in the likelihood of being diagnosed with asthma — at least no increase above the average. Whereas, something like 25, 27 percent of 18 year olds who lived in the most discriminatory neighborhoods had had an increase in the likelihood of being diagnosed with asthma. So we get very different asthma realities for these children who are having higher exposures to discriminatory political economies.
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- Chancellor I asked Professor Sewell to tell us more about this link between asthma and exposure to neighborhoods where minorities were more likely to get private loans.
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- Sewell There's two ways to think about asthma. One, it's one of six indicators that I actually looked at in the original study. We looked at caregiver rating health, obesity, acute physical symptoms, ear infections, asthma, and lead poisoning. Asthma and lead poisoning both had some of the most consistent effects with regards to political/economic dimensions of the mortgage market. Number two, the theory I walked into the analysis with was that these political economies degenerated environments. They sorted people into areas where there were more toxins, there were mold spores, there was more old paint chips that were peeling off houses. There were more roaches and rat feces in the homes which to certain extents have been attributed to lead poisoning rates as well asthma rates among children.
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- Chancellor Professor Sewell says that the literature on asthma shows that there's a clear environmental risk associated with asthma, but the question she's trying to answer is how political and economic processes map onto those environmental risks.
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- Sewell Now, we don't have the data for it as specific as the things we mentioned, but the street block ambient hazards measure is a mediator between racial differences and asthma and political economy is a measure of the quality of the streets, the house, the playgrounds, the noise levels, air pollution, land pollution on the street block, so there's some suggestion that yes, there is an environmental link between race, political economy, and health, but overall the main effect of the political economy, at least for asthma, didn't attenuate. I mean we went from 33 percent likelihood of increased risk in the unadjusted models to, once everything was in there, all the potential alternative hypotheses, a 29 percent increase. That's really no change at all. And so we actually go back to a different argument, we end with a different argument than we start off with. We start off with "it's environmental and that's why we want to look at asthma and lead poisoning and stuff like that." We end with an argument saying that we may actually be looking at more of fundamental cause that the real problem is possibly wealth. Not necessarily wealth accumulation, but an inability to accumulate wealth, as well as unsecured debt accumulation when people have to rely on credit cards in order to make home improvements as well as to ward off any other problems. And we deal with this issue of foreclosures that may be happening in these communities.
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- Chancellor Dr. Sewell says that one of her goals with this kind of work is to better understand and convince people to look at upstream factors or root causes that are behind health disparities.
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- Sewell So, there are a lot of processes that influence segregation or where people live. And some of them are choice and agency and other things like that but I think we don't capture in our measures, these Census-based, people-based measures of segregation -- the limited agency that people have in where they end up. And we have to get to that in order to really understand why segregation is bad for health, if it's bad for health. And I think that looking at the things, using a place-based stratification approach that contributes to why people live certain places is the answer, right? Not coming up with different types of measures of segregation but literally looking at what are the institutional practices that lead to segregation. So that's one thing, that's what I want people to take away, what are the upstream causes that have policy implications. But a second part is what is the issue that I want to know based off of these results? It's actually really simple. Early exposures, even early exposures, you don't have to live in a neighborhood forever, but early exposures to these discriminatory political environments set people on a trajectory of poor health. And that's what you get with findings in regards to the early life course of asthma.
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Chancellor Sewell says that this research also has worrying implications when we look ahead to some of the health-related outcomes of the Great Recession.

Sewell For me, when I finished completing the analysis, I actually cried, because I realized that if we in 2003 are marking these correlations, these associations between political economies that basically caused the recession in health, and then the Recession occurs, we can only expect that this will get worse, that these effects are going to be multiplicative, right? Or additive. And there's nobody to my knowledge at least that has taken a political economic approach to understanding the Great Recession. Most studies that look at Great Recession effects do before and after and just do population changes in the level of illness or utilization behaviors. They don't ask the question of why. Why are certain populations overexposed or more sensitive to the Great Recession than others? And I think a place-based neighborhood effects paradigm can lead us to much more concrete, tractable, and policy-driven or inspiring answers than simply pre/post effects.

Chancellor Thanks to Abigail Sewell for sharing this work with us.

This podcast is supported as part of a grant from the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation but its contents don't necessarily reflect any positions of ASPE or IRP.

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