The Lines That Define Us:

Racial Residential Segregation and Health Disparities for African Americans

Tyra Barrett ‘18

Washington and Lee University

Poverty and Human Capability Studies Capstone

Professor Eastwood

April 9, 2018

Acknowledgments

First and foremost, I would like to thank the Shepherd Program at Washington and Lee University for providing my fellow peers and me with countless interdisciplinary opportunities to critically engage with poverty. Without their steadfast dedication, projects like my own would not be possible. I would like to thank Dean Timothy Diette for agreeing to take time out of his schedule to be my second reader. I would like to extend a special thanks to my housemates Dana Droz ‘18, Ashley Faulkner ‘18, and Lauren Hoffman ’18 for constantly encouraging me throughout this semester. I am forever grateful to Professor Jonathan Eastwood for providing critical support and guidance for this capstone. Finally, I would like to thank my mother, Dr. Maxine Brown, for being a sounding board throughout the formation of this capstone and supporting me unconditionally in all of my endeavors.

Abstract

This capstone explored the mechanisms underlying the relationship between racial residential segregation and health disparities for African Americans. This relationship was examined through the analysis of how racial residential segregation began in America, how it is still perpetuated today, and how it is linked to health outcomes for African Americans. The implications of racial residential segregation in regards to health were examined within two ethical frameworks: the Capabilities Approach and the Rawlsian Theory on justice as fairness. This capstone ultimately came to the conclusion that not only is racial residential segregation a serious public health issue, but it is also a serious justice issue. This capstone conceptualized a theoretical framework to cultivate critical thinking on how to create future policy interventions to curtail racial residential segregation in the United States.

Table of Contents

Introduction

Racial residential segregation is defined as the practice of "the physical separation of the races in [neighborhood] contexts" (Williams & Collins, 2001, p. 405). Often times, when we think about racial residential segregation in American society, it is often thought about in the past tense. We believe that racial residential segregation only existed in the early and mid 20th century through discriminatory legislation, such as Jim Crow laws and redlining, and that we dismantled racial residential segregation during the Civil Rights Movement of the 1960's, particularly through the passage of the Fair Housing Act of 1968. This major piece of legislation sought to end structural residential segregation by banning housing discrimination against racial minorities and we believed that we successfully transitioned away from the consequences of these explicit actions (Rothstein, 2014; Trifun, 2009, pp. 14-16).

Nevertheless, while racial residential segregation has decreased somewhat since its peak during the mid 20th century, this phenomenon is still extremely prevalent today with astoundingly negative consequences (Picker, 2015). Current research has found that people who live in highly segregated neighborhoods often experience compounded inequalities in income, education, social associations, and overall poverty (Iceland, 2014, pp. 2-3; Rothstein, 2014). On the other hand, racial residential segregation is not just limited to these mentioned inequalities; this phenomenon is often associated with disparities of health and is considered a social determinant of health (Healthy People 2020, 2018). Developing research has demonstrated that one's neighborhood can be a greater factor in one's health outcomes than one's own genetic code (Graham, Ostrowski, & Sabina, 2015). For example, people that live in highly segregated neighborhoods often

experience poorer health outcomes, such as higher mortality rates and greater burden of diseases (Iceland, 2014, p. 3). Unfortunately, African Americans are the racial minority that are most likely to live in highly segregated neighborhoods, and, consequently, bear the burden of these inequalities, even when factors, such as income, are considered (Firebaugh, Iceland, Matthews, & Lee, 2015, p. 361; Eligon & Gebeloff, 2016).

It has been stated that residential segregation is "a fundamental cause of racial [health] disparities", yet there has been a paucity of thorough policies to address residential segregation as a public health issue (Williams & Collins, 2001; Healthy People 2020, 2018). Because of this, there is reason to believe that a majority of racial health disparities, especially among African Americans, will continue to persist unless the role of residential segregation is examined and addressed. In this capstone, I will analyze the relationship between residential segregation and health outcomes as it pertains to African Americans. Through the review of the historical context of racial residential segregation, the examination of present implications and empirical data of racial residential segregation on health, and the analysis of selected normative works, I hope to argue for the importance of policies to directly address residential segregation as a pathway to improve health outcomes and disparities for African Americans.

Literature Review

This literature review seeks to construct the contextual framework surrounding the overarching question: "How does residential segregation affect health disparities for African Americans?" In order to understand this question, it is important to analyze three underlying questions: 1) What is the historical context of racial residential segregation in

America? , 2) How has the structural influence of racial residential segregation manifested in present society? and 3) What are the consequences of racial residential segregation on health outcomes for African Americans? By constructing and examining these questions, we can then begin to understand our responsibilities concerning racial residential segregation.

I. What is the historical context of racial residential segregation in America?

Racial residential segregation in America can be traced back before the 20th century. This concept gains prominence in the American public sphere after the end of Civil War through the passage of the 13th Amendment. The first section of this amendment (which is the most notably recognized section) explicitly abolished slavery. On the other hand, this amendment included a second section. This crucial successive section endorsed Congress with the power to enforce section one. This allowed Congress to pass a Civil Rights Act in 1866, which "[prohibited] actions… [that] perpetuated the characteristics of slavery." (Rothstein, 2017, p. viii) This included a ban on racial housing discrimination. Yet, by 1883, the Supreme Court ruled that housing discrimination did not perpetuate the characteristics of slavery (Rothstein, 2017, pp. viii-ix). This allowed racial residential segregation to plant roots in American society. Yet, by the 1940s, levels of segregation had doubled all over America and we begin to see the trends prevalent today (Picker, 2015). What caused this spike?

The codification of racial residential segregation that led to this spike can be traced all the way back to the late 19th century, however, I would like to focus on the federal laws and guidelines in the 20th century that heavily accelerated contemporary

segregation. During the Great Depression, there was a housing shortage for American families (Rothstein, 2014). In order to address this, the government established the Federal Housing Authority in 1934 with the hope to improve the housing market. However, the policies implemented by the Federal Housing Authority were rooted in discrimination (Gross, 2017).

For instance, early data collected by the Federal Housing Authority demonstrated that African Americans actually increased property values because they were willing to pay more for housing due to the fact that they had fewer housing options. Yet, the Federal Housing Authority ignored this and facilitated the misconception that African Americans decreased property values (Gross, 2017). This faulty logic created the basis for "redlining", the practice used by the Federal Housing Authority and other organizations, such as the Home Owners Loan Corporation, to categorize neighborhoods on a grading scale of A ("first grade" or "best") to D ("fourth grade" or "hazardous") (Madrigal, 2014; Nelson, Winling, Marciano, & Connolly, 2017). African Americans were often denied loans for A and B grade neighborhoods; hence, they were regulated to C and D grade neighborhoods. This explicit racial segregation even permeated within the allocation of public housing (Rothstein, Modern Segregation, 2014; Gross, 2017). Ultimately, redlining sought to "[withhold] mortgage credit from… [African American neighborhoods]", which decimated "the possibility of investment wherever [African Americans] lived." (Kantor & Nystuen, 1982, p. 309; Madrigal, 2014)

After World War II, the housing shortage ended, yet the Federal Housing Authority still supported explicit racial segregation. As the suburbs boomed during this time period, the Federal Housing Authority initiated the relocation of whites to suburbs,

but not for African Americans. This was done through the distribution of loans to suburban builders on the "explicit condition" that sales and re-sales to African Americans were prohibited (Rothstein, 2014). In short, while there are plenty of players involved in residential racial segregation, it was ultimately government sponsored. This explicit racial segregation did not stop until the passage of the Fair Housing Act of 1968 (Trifun, 2009, p. 14).

II. How has the structural influence of racial residential segregation manifested in present society?

In general, African American-white American segregation has declined in the 21st century. Yet, the rates of segregation are still extreme (Stoll, 2008, pp. 214-215). In order to explain these persistent patterns, scholars and policy makers alike have adopted the explanation of *de facto* segregation, which states that segregation is a matter of "private practices" or choices (Rothstein, 2017, p. vii). This is in stark contrast to the *de jure* segregation, which is explicit segregation due to governmental policy (Rothstein, 2017, p. viii). *De jure* segregation is often thought to be a negative relic whose consequences only exist in the past. Yet, there has been increasing evidence to suggest that *de facto* segregation cannot be the sole explanation of residential segregation (Erickson, 2011, p. 43). While there are instances of *de facto* segregation, these effects are not comprehensive enough to account for the disparate levels of residential segregation. Therefore, it is also important to analyze if *de jure* segregation affects contemporary racial residential segregation.

a. *De Facto* Segregation in Current American Society

The first factor that most commonly comes to mind when discussing *de facto* segregation is self-segregation or isolation, particularly white flight. White flight is the colloquialism used to describe the phenomenon of white Americans leaving a neighborhood when the percentage of other races becomes too high for comfort. Research has shown that as the proportion of African American residents increase, the likelihood of white families to move increase as well (Boustan, 2011, p. 325). For white Americans, research has shown that when African Americans constitute 10% of the neighborhood, white Americans begin to leave (Rothstein, 2017, p. 223). This then begins an influx of African Americans, resulting in an African American-majority neighborhood. On the other hand, before the last resort of white flight, some white American-majority neighborhoods have implemented policies to keep African Americans out in the first place, such as exclusionary zoning laws (Semeuls, 2015).

There has been some research into the role of self-segregation as perpetrated by African Americans. This was investigated through the Multi-City Study on Urban Inequality, "a survey conducted in Atlanta, Detroit, and Los Angeles in the mid-1970s and early 1990s." (Boustan, 2011, p. 322) The research found that the majority of African American respondents ranked integrated neighborhoods as their first choice, yet the data demonstrated that African Americans were living in African American-majority neighborhoods. The African American respondents suggested that they were reluctant to initially move to white American-majority neighborhoods because of perceived discrimination. When the mechanisms of white flight are considered, it was not surprising that scholars have found that African Americans were "unable, not unwilling" to live in

the neighborhoods that they preferred. It has been ultimately concluded that African American self-segregation did not provide a major impact to residential segregation (Boustan, 2011, pp. 322-323).

Furthermore, when talking about *de facto* segregation, it is important to speak about larger institutions that perpetuate segregation, but are not directly linked to the government. The largest example of this is redlining as practiced by banks and loaning institutions. This can be seen in loan approvals. African Americans are denied home loans at rates that nearly triple those of white Americans. Furthermore, if they are approved, African Americans are more likely to receive higher mortgage rates than their white counterparts (DeSilver & Bialik, 2017). On the other hand, in today's society, redlining is most prevalent in the form of "reverse redlining." This is defined as "excessive marketing of exploitative loans." (Rothstein, 2017, p. 109) This practice is heavily applied in African American communities, where potential borrowers were offered subprime mortgages that have higher interest payments and higher default risks (Rothstein, 2017, p. 109). Furthermore, a 2016 study conducted by the National Bureau of Economic Research found that "high-cost lenders" aggressively targeted minorities for home loans. Once minorities committed to the loan, these high-cost lenders gave minorities inferior agreement terms compared to white Americans. Even when various factors were controlled, there was a stark disparity in the quality of loan terms between white Americans and minorities (White, 2016).

b. The Current Implications of *De Jure* Segregation

In the previous section, I discussed the examples of segregation that are most commonly referenced when Americans discuss the sources of modern day segregation.

On the other hand, scholars are now learning that this overemphasis on *de facto* segregation only analyzes the superficial visible features of this complex issue (Erickson, 2011, pp. 42-43; Rothstein, 2017, p. viii). Rothstein contextualizes that we must critically analyze *de jure* segregation because not only did it cultivate an environment for *de facto* segregation to thrive, but its effects also permeate into modern day society.

In terms of the examples of *de facto* segregation discussed, it is important to analyze how 20th century *de jure* segregation bolstered them. When one considers white flight, it was proliferated in the 20th century, first by the Federal Housing Authority's staunch, yet unsupported, stance that African Americans decreased property values (Gross, 2017; Rothstein, 2017, pp. 93-95). Then, politicians and home speculators alike used this perceived fear to generate white panic. Politicians pushed for platforms and policies that sought to keep African Americans out (Rothstein, 2017, pp. 27-30, 35-37). Moreover, home speculators used white panic to get white homeowners to sell their homes at deep discounts, and then resold these homes to African Americans at steep prices (Rothstein, 2017, p. 100). Furthermore, in regards to redlining, the government implicitly and explicitly encouraged banks and loaning institutions to exclude minorities from a thriving housing market and regulate them in stagnant neighborhoods (Rothstein, 2017, pp. 65-67, 70-75).

Even though Civil Rights reforms in the 20th century dismantled these explicit forms of *de jure* segregation, these reforms never addressed the damages caused by *de jure* segregation. Because of this, its effects are still powerful today, even under race neutral policies (Rothstein, 2017, p. 180). Because African Americans were regulated to lower quality neighborhoods during the 20th century, they were in environments that

cultivated scarce economic opportunity, which reduced income growth opportunities (Rothstein, 2017, pp. 179-180). Furthermore, because white Americans were allowed to purchase suburban housing while African Americans were not, they were able to appreciate housing equity that contributed to their overall wealth. By the time that African Americans were allowed equal access to the housing market, most working and lower middle class African American families could no longer afford to integrate into middle class neighborhoods (Rothstein, 2017, pp. 180, 184). This created great ramifications for current society. Currently, median white household wealth is about $134,000 compared to $11,000 for African American households (Rothstein, 2017, p. 184). Fewer than 25% of African American children whose parents resided in the bottom wealth quintile rise to the middle quintile, compared to 42% of white children (Rothstein, 2017, p. 185). Research has showed that "[parental] economic status is commonly replicated in the next generation" and through racial segregation policies of the past, negative ramifications only continue to persist for African Americans (Rothstein, 2017, p. 179). Unfortunately, these consequences do not just stop with socioeconomic inequalities.

III. What are the consequences of racial residential segregation on health outcomes for African Americans?

Not only do African Americans experience the most segregation, but they also are the most likely to be segregated into poor neighborhoods (Rothstein, 2017, pp. 186-187; Eligon & Gebeloff, 2016). When one's environment is framed in a state of poverty, it can have drastic effects on its inhabitants, even more so than one's individual status of poverty (Rothstein, 2017, p. 187; Graham, Ostrowski, & Sabina, 2015). This is

particularly true when health disparities are considered. In this section, I will analyze four categories of health determinants as conceptualized by the County Health Rankings & Roadmaps (Health Behaviors, Clinical Care, Social and Economic Factors, and Physical Environment) and how they affect health disparities (County Health Rankings & Roadmaps, 2017).

a. Clinical Care

Clinical care is probably the most recognizable facet of health. It can be measured within two categories: access to care and quality of care (County Health Rankings & Roadmaps, 2017). One of the first steps of access to care is having insurance. In general, African Americans who live in segregated neighborhoods are less likely to have health insurance (Anderson & Fullerton, 2012, p. 133). One of the next steps of having access to healthcare is to actually having physicians and healthcare facilities to utilize. African American majority neighborhoods have fewer primary care physicians and healthcare facilities (Rothstein, 2017, p. 187; Landrine & Corral, 2009, p. 180). Furthermore, neighborhoods with a high African American population, "combined with a high percentage of poor residents," led to a higher likelihood of hospitals closing (Ko, Needleman, Derose, Laugesen, & Ponce, 2014, p. 243).

In terms of quality of care, African American neighborhoods typically have lower quality primary care physicians and healthcare facilities compared to white neighborhoods. For example, healthcare facilities are less likely to have up-to-date technological resources and medical specialists. Furthermore, primary care physicians in African American neighborhoods are less likely to be board certified. This has been associated with a lower likelihood of physicians treating underlying diseases. (Rothstein,

2017, p. 187; Landrine & Corral, 2009, p. 180). This is also associated with "less extensive treatment options from physicians." (Newkirk II, 2016). For example, a 2016 study found that African American patients with "early-stage non-small cell lung cancer" who lived in highly segregated neighborhoods were less likely to receive surgery. Furthermore, African American patients with this illness who lived in highly segregated neighborhoods were more likely to die, even when surgery was controlled for (Johnson, Johnson, Hines, & Bayakly, 2016, p. 750).

b. Physical Environment

When researchers speak about the physical environment of a neighborhood, it is mostly in the context of environmental quality. For example, various studies have found that African American neighborhoods have a substantial amount of toxic waste facilities and pollution industries within their boundaries (Rothstein, 2017, pp. 54-57). This exposes African Americans who live in these neighborhoods to a greater amount of air pollutants and persistent organic pollutants, such as pesticides. Studies have shown that exposure to these elements play a strong role in the development of chronic diseases, such as asthma, which is overrepresented in the African American population (Landrine & Corral, 2009, pp. 180-181; Morello-Frosch & Lopez, 2006, p. 191). For instance, African Americans are twice as likely to develop asthma compared to white Americans due to their greater likelihood of being exposed to hazardous pollutants (Rothstein, 2017, pp. 196-197). On the other hand, physical environment of a neighborhood is also associated with community safety. A 2009 study found that residents who lived in highly segregated neighborhoods, regardless of race, were more likely to encounter violent crime (Kuhl, Krivo, & Peterson, 2009, pp. 1765, 1793).

c. Health Behaviors

Health behaviors are actions taken by individuals that are related to overall health and wellbeing maintenance. This can include sexual activity and drug use (County Health Rankings & Roadmaps, 2017). However, for the sake of this paper, I would like to analyze one of the most mundane health behaviors in relation to health outcomes: diet and exercise. African American majority neighborhoods are more likely to contain fast food establishments and less likely to have access to supermarkets and recreational facilities (Kwate, 2008, p. 32; Landrine & Corral, 2009, pp. 181-182). This spatial trend is associated with lower consumption of fruits and vegetables and lower rates of exercise in highly segregated neighborhoods (Corral, Landrine, Hao, Zhao, Mellerson, & Cooper, 2011, pp. 1, 5-6; Landrine & Corral, 2009, pp. 181-182). The spatial constraints seen here negatively impact health behaviors for African Americans and give rise to diet-related noncommunicable diseases, such as heart disease, diabetes, and obesity. In fact, African Americans are significantly more likely to have these listed diseases than white Americans, regardless of age or gender (National Center for Chronic Disease Prevention and Health Promotion, 2017; The State of Obesity, 2014; Landrine & Corral, 2009, pp. 181-182).

d. Social and Economic Factors

Social and Economic Factors consist of the attributes that contribute to socioeconomic status, primarily education, income, and wealth. I wanted to save this category for last because it has been established that residential segregation affects socioeconomic status; however, it is important to note that socioeconomic status, in turn, is a strong indicator of health outcomes and affects the previous three health categories

described (Adler & Newman, 2002, pp. 60-61). For example, low socioeconomic status has been shown to be associated with higher levels of stress hormones (like cortisol), which lead to higher rates of chronic stress (Cohen, Doyle, & Baum, 2006). However, I would like to analyze specific examples of socioeconomic factors related to residential segregation, particularly income and education.

As established in previous sections, residential segregation for African Americans negatively impacts income. Those who have a lower income have increased difficulty finding adequate housing, attending a quality physician, and buying adequate quality and quantity of food (Johns Hopkins Center for Health Equity, 2010). This trend can also be seen in education, particularly in schools. Schools are more segregated in today's society than in the 20th century. This is due to the rate of residential segregation within the neighborhoods in which these schools are located (Rothstein, 2017, p. 179). Minority majority neighborhoods are often associated with concentrated poverty. This means that schools within these neighborhoods often have access to fewer resources to improve their education (Keierleber, 2018). A 2008 longitudinal study found that, overall, people with fewer educational advantages had greater health disparities as they aged. Moreover, through more in-depth examination, African Americans made up the majority of those with fewer educational advantages. Furthermore, within this group, African Americans bore greater health burdens as they aged compared to all other racial groups (Walsemann, Geronimus, & Gee, 2008, p. 169).

An Overview of the Ethical Analysis

In this analysis, I will examine normative works of selected philosophers in order to argue why we should seriously consider racial residential segregation as a moral threat to the health and wellbeing of African Americans. This analysis will be divided into two sections: "What Makes Health Morally Significant?" and "What Makes Racial Residential Segregation Morally Problematic In Terms of Health?" Within the first section, I will analyze what health is and why health has such moral importance in our society. The second section will analyze how racial residential segregation threatens the moral sanctity of health. The selected works that I will be examining will be rooted in one of two theoretical frameworks: the Capabilities Approach, as developed by Amartya Sen and Martha Nussbaum, and John Rawls's theory of justice as fairness.

I wanted to use both of these ethical frameworks because even though they are constructed from different foundations, they come to similar conclusions in terms of health. Often, these frameworks are pitted against each other in normative public health discussions. Those who favor the Capabilities Approach state that the Rawlsian theory either does not fully develop the complexities of health or ignores health completely (Alexander, 2011, p. 603). Those who favor Rawlsian theory state that the Capabilities Approach may either be too ambiguous or may advocate too narrow of a view on health (Venkatapuram, 2012, pp. 71-72). While early iterations of the Capabilities Approach and Rawlsian theory may have been distinct, the selected works have further developed both the Capabilities Approach and Rawls's theory of justice. While there may be limitations to the compatibility of these ethical frameworks together, these frameworks still formulate similar conceptualizations of health and unjust threats. As Norman Daniels

summarized in *Just Health*, for the most part, the differences in these two frameworks lie more in terminology than in concepts (Daniels, 2008, p. 66). Because these frameworks provide similar yet unique insights, I will be examining arguments from both of these frameworks to craft my argument.

I. A Brief Overview of the Basics of the Capabilities Approach and Rawlsian Theory on Justice as Fairness

In order to understand the conceptualization of health within these frameworks, it is important to understand the basics of these frameworks. Therefore, I will briefly summarize these frameworks. The Capabilities Approach, as developed by Sen, is structured on the principles of functionings and capabilities. Functionings are a set of beings (such as being well-nourished) and doings (such as being able to eat) and capabilities are the freedoms to achieve these functionings (Robeyns, 2016; Nussbaum, 2011, pp. 17-18). Nussbaum goes one step further and places the Capabilities Approach within a justice framework and defines the Ten Central Capabilities, which she believes are fundamental freedoms that citizens should be able to gain equal access to. The Ten Central Capabilities are:

1. Life,
2. Bodily Health,
3. Bodily Integrity,
4. Senses, Imagination and Thought,
5. Emotions,
6. Practical Reason,
7. Affiliation,

8. Other Species,
9. Play,
10. and Control Over One's Environment (Nussbaum, 2011, pp. 33-34).

Under Nussbaum's conceptualization, if citizens are not allowed equal access to these capabilities, then their dignity is threatened.

On the other hand, the Rawlsian theory on justice as fairness is structured on the idea that when individual doctrine is set aside (behind "the veil of ignorance"), citizens will create a society where equality is the standard and if inequalities are present, they are still to the benefit of those who may be worse off (D'Amato, 2014). This basic foundation is supported by two principles. The first principle involves the guarantee of equal basic liberties for all citizens and the second principle states that social and economic inequalities are justified if there is fair equality of opportunity and the greatest benefit is given to those who are the worst off (Rid, 2008; Wenar, 2017). These principles enable the just distribution of primary goods, which Rawls described as entities that help us, as citizens, reach a normal range of opportunities that we should be free to explore (Wenar, 2017; Daniels, 2008, pp. 30, 35).

Ethical Analysis

I. What Makes Health Morally Significant?

A major component of what makes this capstone particularly poignant is how we conceptualize the significance of health. However, there is an overarching question that must be answered – "What is health?" Typically, when explaining what health is, the definition of health as created by the World Health Organization (WHO) is often cited in

major papers. The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2018). On the other hand, even though the WHO is a well-respected organization, this definition has often been the subject of criticism. This is true especially in philosophical works, which have stated that the WHO's definition is ambiguous, misguided, and "incoherent" (Daniels, 2008, pp. 37-38; Venkatapuram, 2012, p. 77).

Other works have tried to alter this definition to fix these issues. Daniels's *Just Health*, which analyzed health from a Rawlsian perspective, argued that health is a complex entity that is a factor of the foundation that helps us achieve a "range of exercisable opportunities" within our individual "normal functioning". Furthermore, there are a series of pathologies that can negatively affect health and seriously reduce our range of opportunities (Daniels, 2008, pp. 30, 35-38). Sridhar Venkatapuram used a "Sen-Nussbaum 'hybrid'" Capabilities Approach to conceptualize health as a value of freedom and the basis of human dignity (Venkatapuram, 2012, pp. 78-79). He defined health as "a cluster of basic capabilities… [that enable us] to be capable of doing and being some basic things that constitute a life with equal human dignity." (Venkatapuram, 2012, p. 77) While the terminology is different, both of these definitions come to similar conclusions – health is a critical fundamental factor that gives us unadulterated access to societal freedoms and choices.

These definitions, unlike the WHO definition, help us to think about why health is morally significant. Recent public health discourse tells us that heath is a highly complex unit that does not just occur in a vacuum; in fact, it manifests almost everyone. Traditional perspectives only conceptualized health in the "healthcare sector" (i.e.

medical facilities, medical personnel, etc.) (Daniels, 2008, pp. 12-13). However, current research tells us that health can be made up from "non-health public goods" (such as social networks) and can occur in "non-health sectors" (such as the employment sector) (Daniels, 2008, pp. 12-13; Venkatapuram, 2012, pp. 75-76). Even though health is an intensely complex subject, we can still discern that health does not just casually occur by chance; we know that there are "socially controlled factors" within our influence as a society that determine health outcomes (Daniels, 2008, p. 13).

Because health is not solely a product of "luck", it is difficult for us as a society to be apathetic or combative about health (Daniels, 2008, p. 13). This is evident in our societal attitudes about health disparities compared to other societal variations, such as socioeconomic inequalities. While there are deep and divisive debates about the acceptability of socioeconomic inequalities, there seems to be more agreeable discussions about the reduction of health disparities across societies. Even in the United States, which is the only developed country to not have a universal healthcare system, this trend is true. America has programs (like Medicare and Medicaid) to make healthcare accessible to those who have the least access (Daniels, 2008, p. 18). Furthermore, often times, when we disagree about health inequalities, it is frequently about the circumstances that perpetuate inequalities, and not necessarily the acceptability of these inequalities (Asada, 2012, pp. 157-159; Cole, 2012, pp. 213-214). Moreover, even if a citizen's health status is a consequence of "bad luck", such as the acquirement of a disability, we as a society still create guidelines to protect them, like the Americans with Disabilities Act and the Individuals with Disabilities Education Act in the United States. As Daniels summarized, "misfortune should not beget injustice" and most societies try to abide by this sentiment

(Daniels, 2008, p. 13). In short, the reason why we acknowledge health as morally significant is because we recognize that it is instrumental to ensuring that we have a sufficient foundation to access various freedoms and opportunities.

II. What Makes Racial Residential Segregation Morally Problematic for Health?

As mentioned in the introduction, both the Capabilities Approach and the Rawlsian theory of justice as fairness come to similar conclusions involving health and health disparities. On the other hand, as I examined how racial residential segregation proves to be a moral obstacle to health, I found that these two ethical frameworks conceptualized the threat of racial residential segregation differently. Therefore, the first section, "Unjust Distribution of Socially Controlled Determinants of Health", will discuss the moral health dilemma of racial residential segregation from the perspective of Rawlsian theory. The second section, "Limitation of Capabilities", will discuss the same dilemma from the perspective of the Capabilities Approach.

a. Unjust Distribution of Socially Controlled Determinants of Health

As established in the first section, health is not just regulated to healthcare; there are societal implications as well. For example, income and education both have an impact on health outcomes, even though they are not healthcare factors. In short, it is almost impossible to discuss health outcomes without discussing societal factors (Daniels, 2008, p. 88). These societal factors, as we have learned, can have a profound effect on health outcomes (Daniels, 2008, pp. 79-80, 91). Yet, how do we understand the mechanisms between health outcomes and societal factors?

Daniels does give insight on where to begin to focus our efforts. He believes that social policies offer a better explanation of social and health variations. This is important when racial disparities are considered, especially in America, where there is a history of social policies that have excluded and discriminated against minorities from society (Daniels, 2008, pp. 80-81, 89-91). This trend is extremely poignant when we examine racial residential segregation in America. As established in the literature review, 20th century housing policies excluded African Americans from the housing market and utilized discrimination to keep African Americans out. Even though Civil Rights Era legislation sought to eliminate the previous discriminatory directives, these laws never sought to fix the ingrained issues caused by the previous regulations. Therefore, these issues were allowed to manifest and compound and further impair the quality of life for African Americans.

Because these racial biases became so ingrained and were never resolved, even African Americans who were able to gain considerable advances in societal factors, such as education and income, could not escape segregation and its consequences. For example, in Mary Pattillo-McCoy's *Black Picket Fences*, Pattillo-McCoy analyzed a middle class African American neighborhood in Chicago. While technically this African American neighborhood qualified as "middle class", this neighborhood often faced problems that their white middle class counterparts did not encounter, such as concentrated disadvantage in terms of poverty, crime, and educational attainment. If these communities are the same economic level, what is causing these differences? A major cause of this is racial residential segregation, where African Americans were either unable to move to a different neighborhood or were discouraged from moving due to

fears of discrimination (Pattillo-McCoy, 1999, pp. 1-3, 44). This sentiment was echoed in a more recent piece in The New York Times that sought to explore why affluent African American families in Milwaukee, Wisconsin still end up in "poor and segregated communities". Many of the families interviewed cited past events of exclusion and discrimination that pushed them into segregated neighborhoods (Eligon & Gebeloff, 2016).

Yet, how is this unjust within the Rawlsian theory of justice as fairness? Racial residential segregation was a phenomenon that was created without "the veil of ignorance" (D'Amato, 2014; Wenar, 2017). This structural policy used racial biases and discrimination to unfairly distribute negative social determinants of health to predominately African American neighborhoods. While inequalities to a certain extent are justifiable under this Rawlsian theory, these particular inequalities are not justified because they are not fairly distributed among the general population and they do not exist for the betterment of African Americans. In fact, they exist for detriment of African Americans, burdening this population with extremely negative health outcomes.

b. Limitation of Capabilities

Shifting our focus towards the Capabilities Approach, how does racial residential segregation threaten the moral right of health under this framework? If one examines Sen's conceptualization of the Capabilities Approach, even though it is extremely basic, it states that everyone should have equal opportunity to functionings through equal access of capabilities (Venkatapuram, 2012, pp. 78-79; Asada, 2012, p. 161). Racial residential segregation fundamentally undermines this because there is not equal opportunity for these functionings through equal access of the capability of health, as defined by

Venkatapuram (Venkatapuram, 2012, p. 77). For example, as stated in the literature review, African American majority neighborhoods are more likely to contain fast food restaurants and less likely to have grocery stores and access to recreational facilities (Kwate, 2008, p. 32; Landrine & Corral, 2009, pp. 181-182). If a family within this neighborhood is trying to achieve the functioning of being nutritious and physically active, it is going to be extremely difficult because they have restricted access to the capability of achieving this functioning. Even from an extremely broad analysis of the Capabilities Approach, racial residential segregation can be viewed as morally problematic.

When one examines Nussbaum's more in-depth conceptualization of the Capabilities Approach, she explicitly outlined the bare minimum capabilities that every human is entitled to receive, also known as the Ten Central Capabilities (Nussbaum, 2011, pp. 33-34; Asada, 2012, p. 161). It is fairly evident that all of these capabilities have societal implications; however, especially when one analyzes the concept of the social determinants of health, every one of these Ten Central Capabilities, even the less obvious ones, falls within the range of health. For example, let us examine the capability of play. Having open access to recreation has been linked to a reduction in obesity, heart disease, diabetes, cancer, stress and depression. Furthermore, it has been found to improve an individual's immune system and overall quality and longevity of life (State of California Resources Agency, 2005, p. 5).

As stated in the last paragraph, all ten of the Central Capabilities have societal implications. Racial residential segregation is, at its core, a social policy with social consequences that can implicate every one of these Ten Central Capabilities. Let us

reexamine the capability of play. A 2013 study found that predominately African American neighborhoods in Boston "were less likely to have recreational open spaces." (Duncan, Kawachi, White, & Williams, 2013, p. 618) As discussed in the previous section, health outcomes and social factors are entangled together. Even though the pathways are not perfectly linear, it is still relatively clear that racial residential segregation negatively controls social factors that negatively impact access to the Ten Central Capabilities, which can negatively compound health outcomes.

What distinguishes this conceptualization from Sen's is that it is grounded in the establishment that every human is entitled to dignity and, hence, is entitled to live a dignified life (Venkatapuram, 2012, pp. 77-79). If these Ten Central Capabilities are restricted for certain citizens, how can these citizens be expected to have equal access to functionings? This, from a Nussbaum perspective, threatens the dignity of our citizens (Venkatapuram, 2012, pp. 77-79; Nussbaum, 2011, p. 33). In short, from the perspective of the Capabilities Approach, racial residential segregation is unjust because it unfairly limits capabilities to certain citizens, so they do not have equal access to functionings.

Discussion and Concluding Remarks

Racial residential segregation has complex, deep roots within our society. Even though we have passed legislation to create equal access to integrated neighborhoods, we have not mitigated the inequalities that stemmed from the previous explicit exclusion. Because of this, racial residential segregation has formed the foundation for an entanglement of maladies that have ensured that African Americans affected by this cannot reach their full health capacities. Not only should this be a concern from a public

health perspective, but this should also be a concern from a justice perspective. These health disparities do not stem from inherent biological differences, but from unjust social policies that sought to separate and remove any benefits for African Americans. I do not proclaim that if we fix racial residential segregation, then all health disparities will dissipate. Nevertheless, if we critically examined this issue, then we could truly mitigate health disparities.

But where do we go from here? It is established that this is an issue, yet there has been a paucity of policies to address this. I will not make policy recommendations because I am not in the position to do so. However, I will try to conceptualize a framework that should be considered when creating and implementing policy interventions for racial residential segregation. First and foremost, we need to recognize the extent of past policies of segregation and the mechanisms that still allow them to be potent today (Rothstein, 2017, pp. vii, 215-218). If we cannot reach this first crucial step, then we will never truly fix racial residential segregation. Once we have reached this step, then we can begin to tackle this issue. To borrow from Iceland (2014), the policies that address racial residential segregation must be twofold; it must seek to reduce segregation and facilitate meaningful integration (Iceland, 2014, pp. 7-9).

There is a multitude of ways that we can reduce segregation, however, I will only outline a few examples. To begin with, we should curtail the use of exclusionary zoning ordinances, which seek to "prevent… lower-income and middle-class families from settling in affluent suburbs." (Rothstein, 2017, p. 204) Because there are economic racial disparities in the United States, these policies, while based on economics, further perpetuate racial residential segregation (Matthew, Rodrigue, & Reeves, 2016). The

replacement for this policy would be inclusionary zoning, which would provide "a positive effort to integrate low- and moderate-income families into middle-class and affluent neighborhoods." (Rothstein, 2017, p. 205). Another major step includes increasing mobility, whether that be "expanding mobility counseling" or expanding small area fair market rents, which would allow families with housing vouchers to more effectively move into neighborhoods with lower rates of concentrated disadvantage (Matthew, Rodrigue, & Reeves, 2016). On the other hand, in general, we need governmental entities to more aggressively require cities to be unequivocally dedicated to reducing segregation. Several sources that I analyzed referenced the desegregation policies under the former Secretary of Housing and Urban Development (HUD) George Romney (1969-1973) (U.S. Department of Housing and Urban Development, 2017). He conceptualized a program called Open Communities "that would deny federal funds (for water and sewer upgrades, green space, sidewalk improvements and other projects for which HUD financial support is needed)" to neighborhoods that were actively engaging in desegregation (Rothstein, 2017, pp. 201-202). Yet, the backlash was so swift and so strong that the Nixon administration soon curtailed this program (Rothstein, 2017, p. 201). Even though the same tools that Romney used are still at HUD's disposal today, few administrations have yet to be as steadfast in their commitment to desegregation as Romney (Matthew, Rodrigue, & Reeves, 2016; Rothstein, 2017, p. 202). If there was more pressure to seriously reduce segregation, then there may be more resolve to actually take action.

Looking at the second fold, what does it mean to have "meaningful" integration? Based on the research that I have examined, meaningful integration means that we are

addressing ALL of the barriers of access to opportunities and not just the visible or superficial barriers. For example, let us consider education. There has been growing research that examined racial composition within schools. In terms of the overall racial composition, there are schools that seem fairly integrated. However, under more in-depth analysis, researchers found that these schools are highly segregated within themselves, regulating minority students to low track academic pathways (Pootinath & Walsh, 2011). This is not meaningful integration because the barriers to equal access are still there. This engagement of meaningful integration is of particular importance for middle-class African American families, who may have the resources to integrate into once-exclusive neighborhoods, but either by structural forces or by fear of hostile discrimination, do not integrate (Rothstein, 2017, pp. 203-204). Perceived discrimination has been a recurring issue in the research for this capstone and can play a major role in whether a family feels comfortable in a neighborhood. Rothstein suggested that communities seeking to integrate African American families should insist on implementing comprehensive interventions that aim to assuage these fears, such as “appropriate police training.” (Rothstein, 2017, p. 204) While these are not policy recommendations, I hope that these examples provide a pathway for critical thinking about future policy interventions.

Bibliography

Adler, N. E., & Newman, K. (2002). Socioeconomic Disparities In Health: Pathways And Policies . *Health Affairs , 21* (2), 60-76.

Alexander, M. J. (2011). Health Justice: An Argument from the Capabilites Approach. *Journal of Human Capabilities and Development* , 603-605.

Anderson, K., & Fullerton, A. (2012). Racial residential segregation and access to health-care coverage: A multilevel analysis. In J. Jacobs Kronenfeld, *Issues in Health and Health Care Related to Race/Ethnicity, Immigration, SES and Gender* (Vol. 30, pp. 133-158). Bingley, United Kingdom: Emerald Group Publishing Limited.

Asada, Y. (2012). Exploring A Sufficiency View of Health Equity. In P. T. Lenard, & C. Straehle, *Health Inequalities and Global Justice* (pp. 157-175). Edinburgh, Scotland, United Kingdom: Edinburgh University Press.

Boustan, L. (2011). Racial Residential Segregation in American Cities. In N. Brooks, K. Donaghy, & G.-J. Knaap, *The Oxford Handbook of Urban Economics and Planning* (pp. 318-339). Oxford University Press.

Cohen, S., Doyle, W., & Baum, A. (2006). Socioeconomic status is associated with stress hormones. *Psychosomatic Medicine , 68* (3), 414-420.

Cole, P. (2012). 'Illegal' Migrants and Access To Public Health: A Human Rights Approach. In P. T. Lenard, & C. Straehle, *Health Inequalities and Global Justice* (pp. 213-229). Edinburgh, Scotland, United Kingdom: Ediinburgh University Press.

Corral, I., Landrine, H., Hao, Y., Zhao, L., Mellerson, J. L., & Cooper, D. L. (2011). Residential segregation, health behavior and overweight/obesity among a national sample of African American adults. *Journal of Health Psychology* , 1-8.

County Health Rankings & Roadmaps. (2017). *Rankings Reports*. Retrieved January 2, 2018, from County Health Rankings & Roadmaps: http://www.countyhealthrankings.org/explore-health-rankings/reports

D'Amato, C. (2014). Rawls and capabilities: the current debate. Blacksburg, Virginia, United States of America.

Daniels, N. (2008). *Just Health: Meeting Health Needs Fairly.* New York City, New York, United States of America: Cambridge University Press.

DeSilver, D., & Bialik, K. (2017, January 10). *Blacks and Hispanics face extra challenges in getting home loans*. Retrieved December 7, 2017, from Pew Research Center: http://www.pewresearch.org/fact-tank/2017/01/10/blacks-and-hispanics-face-extra-challenges-in-getting-home-loans/

Duncan, D. T., Kawachi, I., White, K., & Williams, D. R. (2013). The Geography of Recreational Open Space: Influence of Neighborhood Racial Composition and Neighborhood Poverty. *Journal of Urban Health , 90* (4), 618-631.

Eligon, J., & Gebeloff, R. (2016, August 20). *Affluent and Black, and Still Trapped by Segregation*. Retrieved January 18, 2018, from The New York Times: https://www.nytimes.com/2016/08/21/us/milwaukee-segregation-wealthy-black-families.html

Erickson, A. T. (2011). The Rhetoric of Choice: Segregation, Desegregation, and Charter Schools. *Dissent , 58* (4), 41-46.

Firebaugh, G., Iceland, J., Matthews, S. A., & Lee, B. A. (2015, June 9). Residential Inequality: Significant Findings and Policy Implications. *The ANNALS of the American Academy of Political and Social Science* , 360-366.

Graham, G., Ostrowski, M., & Sabina, A. (2015, August 6). *Defeating The ZIP Code Health Paradigm: Data, Technology, And Collaboration Are Key*. Retrieved January 19, 2018, from Health Affairs: https://www.healthaffairs.org/do/10.1377/hblog20150806.049730/full/

Gross, T. (2017, May 3). *A 'Forgotten History' Of How The U.S. Government Segregated America*. Retrieved January 19, 2018, from National Public Radio, Inc.: https://www.npr.org/2017/05/03/526655831/a-forgotten-history-of-how-the-u-s-government-segregated-america

Healthy People 2020. (2018, January 19). *Social Determinants of Health*. Retrieved January 20, 2018, from Healthy People 2020: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Iceland, J. (2014). *Residential Segregation: A Transatlantic Analysis.* Washington, D.C.: Migration Policy Institute.

Johns Hopkins Center for Health Equity. (2010). *Income*. Retrieved March 24, 2018, from Johns Hopkins Center for Health Equity: https://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-health-equity/about/influences_on_health/income.html

Johnson, A. M., Johnson, A., Hines, R. B., & Bayakly, R. (2016). The Effects of Residential Segregation and Neighborhood Characteristics on Surgery and Survival in Patients with Early-Stage Non–Small Cell Lung Cancer. *Cancer Epidemiology, Biomarkers & Prevention , 25* (5), 750-758.

Kantor, A. C., & Nystuen, J. D. (1982). De Facto Redlining a Geographic View. *Economic Geography , 58* (4), 309-328.

Keierleber, M. (2018, January 11). *As Low-Income, Minority Schools See Fewer Resources, Civil Rights Commission Calls on Congress to Act*. Retrieved March 24, 2018, from The 74 Million: https://www.the74million.org/as-low-income-minority-schools-see-fewer-resources-civil-rights-commission-calls-on-congress-to-act/

Ko, M., Needleman, J., Derose, K. P., Laugesen, M. J., & Ponce, N. A. (2014). Residential Segregation and the Survival of U.S. Urban Public Hospitals. *Medical Care Research and Review , 71* (3), 243-260.

Kuhl, D. C., Krivo, L. J., & Peterson, R. D. (2009, April). Segregation, Racial Structure, and Neighborhood Violent Crime. *Sociology Faculty Publications* , 1765-1802.

Kwate, N. O. (2008). Fried chicken and fresh apples: Racial segregation as a fundamental cause of fast food density in black neighborhoods. *Health & Place , 14*, 32-44.

Landrine, H., & Corral, I. (2009). Separate and Unequal: Residential Segregation and Black Health Disparities. *Ethnicity & Disease , 19*, 179-184.

Madrigal, A. C. (2014, May 22). *The Racist Housing Policy That Made Your Neighborhood*. Retrieved January 19, 2018, from The Atlantic: https://www.theatlantic.com/business/archive/2014/05/the-racist-housing-policy-that-made-your-neighborhood/371439/

Matthew, D. B., Rodrigue, E., & Reeves, R. V. (2016). *Time for justice: Tackling race inequalities in health and housing.* New York City: Brookings Institute.

Morello-Frosch, R., & Lopez, R. (2006). The riskscape and the color line: Examining the role of segregation in environmental health disparities. *Environmental Research , 102* (2), 181-196.

National Center for Chronic Disease Prevention and Health Promotion. (2017, July 3). *African American Health: Creating equal opportunities for health*. Retrieved February 11, 2018, from Centers for Disease Control and Prevention: https://www.cdc.gov/vitalsigns/aahealth/index.html

Nelson, R. K., Winling, L., Marciano, R., & Connolly, N. (2017). *Mapping Inequality*. Retrieved January 19, 2018, from American Panorama: https://dsl.richmond.edu/panorama/redlining/#loc=6/33.852/-87.572&opacity=0.8&text=about

Newkirk II, V. R. (2016, May 18). *America's Health Segregation Problem*. Retrieved March 24, 2018, from The Atlantic: https://www.theatlantic.com/politics/archive/2016/05/americas-health-segregation-problem/483219/

Nussbaum, M. C. (2011). The Central Capabilities. In M. C. Nussbaum, *Creating Capabilities:* (pp. 17-45). Cambridge, Massachusetts, United States of America: Harvard University Press.

Pattillo-McCoy, M. (1999). *Black Picket Fences: Privilege and Peril Among The Black Middle Class.* Chicago: The University of Chicago Press.

Picker, L. (2015, May 8). *A history of residential segregation in the US*. Retrieved January 19, 2018, from World Economic Forum: https://www.weforum.org/agenda/2015/05/a-history-of-residential-segregation-in-the-us/

Pootinath, P., & Walsh, N. (2011, December 6). *Desegregated Schools with Segregated Classrooms: The Reality of Racialized Tracking at Magnet Schools* . Retrieved April 9, 2018, from Cities, Suburbs & Schools Project at Trinity College: http://commons.trincoll.edu/cssp/2011/12/06/pornpat-and-nathan-temporary-title/

Rid, A. (2008). Just health: meeting health needs fairly. *Bulletin of the World Health Organization , 86*, 577-656.

Robeyns, I. (2016, October 3). *The Capability Approach*. Retrieved March 11, 2018, from Stanford Encyclopedia of Philosophy: https://plato.stanford.edu/entries/capability-approach/

Rothstein, R. (2014, March 6). *Modern Segregation.* Retrieved January 18, 2018, from Economic Policy Institute: http://www.epi.org/publication/modern-segregation/

Rothstein, R. (2017). *The Color of Law: A Forgotten History of How Our Government Segregated America.* New York, New York, United States of America: Liveright Publishing Corporation.

Semeuls, A. (2015, July 30). *White Flight Never Ended*. Retrieved February 10, 2018, from The Atlantic: https://www.theatlantic.com/business/archive/2015/07/white-flight-alive-and-well/399980/

State of California Resources Agency. (2005). *The Health and Social Benefits of Recreation: An Element of the California Outdoor Recreation Planning Program.* Sacramento: State of California Resources Agency.

Stoll, M. A. (2008). Race, Place, and Poverty Revisted. In A. C. Lin, & D. R. Harris, *The Colors of Poverty: Why Racial and Ethnic Disparities Persist* (pp. 201-231). New York, New York, United States of America: Russell Sage Foundation.

The State of Obesity. (2014). *Racial and Ethnic Disparities in Obesity*. Retrieved February 11, 2018, from The State of Obesity: https://stateofobesity.org/disparities/

Trifun, N. M. (2009). Residential Segregation after the Fair Housing Act. *Human Rights , 36* (1), 14-18.

U.S. Department of Housing and Urban Development. (2017). *HUD History*. Retrieved April 8, 2018, from U.S. Department of Housing and Urban Development: https://www.hud.gov/about/hud_history

Venkatapuram, S. (2012). Health Inequalities, Capabilities, and Global Justice. In P. T. Lenard, *Health Inequalities and Global Justice* (pp. 65-82). Edinburgh, Scotland, United Kingdom: Edinburgh University Press.

Walsemann, K. M., Geronimus, A. T., & Gee, G. C. (2008). Accumulating Disadvantage Over the Life Course: Evidence From a Longitudinal Study Investigating the

Relationship Between Educational Advantage in Youth and Health in Middle Age. *Research on Aging , 30* (2), 169-199.

Wenar, L. (2017, January 9). *John Rawls.* Retrieved March 11, 2018, from Stanford Encyclopedia of Philosophy: https://plato.stanford.edu/entries/rawls/

White, G. B. (2016, February 25). *Why Blacks and Hispanics Have Such Expensive Mortgages*. Retrieved December 7, 2017, from The Atlantic: https://www.theatlantic.com/business/archive/2016/02/blacks-hispanics-mortgages/471024/

Williams, D. R., & Collins, C. (2001). Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health. *Public Health Reports , 116* (5), 404-416.

World Health Organization. (2018). *Frequently Asked Questions*. Retrieved March 11, 2018, from World Health Organization: http://www.who.int/suggestions/faq/en/