



The high price of debt: Household financial debt and its impact on mental and physical health



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ABSTRACT

Household financial debt in America has risen dramatically in recent years. While there is evidence that debt is associated with adverse psychological health, its relationship with other health outcomes is relatively unknown. We investigate the associations of multiple indices of financial debt with psychological and general health outcomes among 8400 young adult respondents from the National Longitudinal Study of Adolescent Health (Add Health). Our findings show that reporting high financial debt relative to available assets is associated with higher perceived stress and depression, worse self-reported general health, and higher diastolic blood pressure. These associations remain significant when controlling for prior socioeconomic status, psychological and physical health, and other demographic factors. The results suggest that debt is an important socioeconomic determinant of health that should be explored further in social epidemiology research.

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Introduction

It is difficult to miss the growing impact of financial debt in the everyday lives of Americans. Since the 1980s overall debt in American households has tripled (Harvey, 2010). Between 1989 and 2006, total consumer credit card debt rose from \$211 billion to \$876 billion (2006 dollars), and the proportion of indebted households carrying over \$10,000 in credit card debt rose from 3% to 27% (Garcia, 2007). Home foreclosures have also skyrocketed; recent foreclosure rates are nearly 5 times higher than at any other time since 1979 (Gruenstein Brocman, Wei & Ernst, 2010). And, widely publicized in March of 2012, Americans' student loan debt recently surpassed \$1 trillion (Mitchell & Jackson-Randall, 2012). Concomitant with these rises in debt, credit industry deregulation, including key legislative decisions in 1978 and 1996, have led to widespread increases in loan fees and interest rates and a relaxation of loan granting conditions (Garcia, 2007). The resulting "democratization" of credit availability has meant that segments of the American population

previously excluded from many forms of credit now have more equal opportunities to accumulate debt. In short, financial debt has become a fixture of the American household economy.

Despite the growing significance of indebtedness in the economic lives of Americans, financial debt is largely neglected in research on social and economic determinants of health. This is surprising since debt is clearly an increasingly important category of socioeconomic experience. The link between socioeconomic status (SES) and health has long been recognized (Adler et al., 1994; Adler & Stewart, 2010), but so too have the inadequacies of standard SES indices – income, education, and occupation – to fully capture the meaning of socioeconomic experience (Adler, 2009; Braveman et al., 2005; Shavers, 2007; Sweet, 2011). Other factors are important constituents of socioeconomic position, such as wealth, assets, symbolic capital and, notably, debt, but these are rarely considered in health research (Adler, 2009; Sweet, 2011). Drete and Reynolds (2012) recently made a call for greater attention to household debt in work on the social determinants of health. Here we echo that sentiment and offer evidence that debt is indeed an important predictor of health outcomes.

To date, existing research on the health consequences of debt has focused largely on psychological health. Historical and ethnographic research has characterized the severe social stigma and

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psychological burden associated with being indebted (Dossey, 2007; Dudley, 2000; Graeber, 2011; Williams, 2005, 2008). And indeed several empirical studies have found that financial strains such as personal debt and home foreclosures are strong predictors of depression, general psychological distress, mental disorders, and suicidal ideation and behavior (Bridges & Disney, 2010; Brown, Taylor & Price, 2005; Drentea & Reynolds, 2012; Jenkins et al., 2008; McLaughlin et al., 2011; Meltzer et al., 2011; Pollack & Lynch, 2009; Reading & Reynolds, 2001; Selenko & Batinic, 2011). These findings highlight the psychological potency of being indebted and, as others have noted, have implications for other health consequences of debt (Dossey, 2007; Drentea & Lavrakas, 2000).

Psychosocial factors, including stress and its mental health correlates like depression and anxiety, are thought to be key mechanisms through which SES “gets under the skin” to impact health and health disparities, and a substantial body of work has now investigated this pathway (reviewed in: Matthews & Gallo (2011)). The experience of stress is known to lead to short- and long-term physiological changes that play key roles in several disease processes, particularly those involving metabolic and cardiovascular systems (McEwen, 2004). Stress can also impact health indirectly by influencing health behaviors, including diet, physical activity, and substance use (McEwen & Seeman, 1999). Therefore, considering the ample evidence that debt has psychological consequences, it is possible that it could also impact other health outcomes through psychosocial pathways.

Remarkably few studies, however, have explicitly examined financial debt in relation to health. Drentea and Lavrakas (2000), in an Ohio-based study of credit card debt, stress, and health, found debt-to-income ratio and debt-related stress to be associated with worse self-reported health and physical functioning. Subsequent studies have explored debt only indirectly, finding that debt-related financial stress is associated with worse self-reported health (Kim et al., 2003; O'Neill et al., 2006), and that clients of credit counseling services have higher odds of being overweight or obese than the general population (Munster, Ruger, Ochsmann, Letzel & Toschke, 2009). Clearly, more work is needed to confirm and better understand the relation of financial debt to health, including clarifying the measures of debt that matter for health and well-being and investigating their impact on a broader array of health outcomes.

Moreover there is a need to more fully account for prior conditions and experiences that may complicate the association of debt with health. Drentea and Lavrakas (2000) have suggested that debt “may be a more sensitive barometer of financial well-being than income” because it represents accumulated hardships over time. While this observation reinforces the likely importance of debt as a socioeconomic indicator, it also points to the potential confounding that arises from longitudinal accumulation of debt. Personal financial debt may result from acute life events, such as job loss, divorce, or medical emergencies, which may themselves be psychosocial stressors or health determinants. Accounting for prior psychosocial, socioeconomic and health conditions is therefore critical for understanding the relationship between financial debt and health.

In this paper we aim to bring greater attention to debt as a social determinant of health by exploring its association with both psychological and general health outcomes. Specifically, we explore the relationship of personal financial debt with health outcomes in young adults (aged 24–32 years) in the National Longitudinal Study of Adolescent Health (Add Health). This nationally representative cohort study has followed participants for over 15 years and is thus an excellent data source for examining the association of debt with health while accounting for prior conditions and events. Further, the Add Health study contains data on multiple indices of debt, including subject-reported absolute levels of household debt as well as perceptions of debts relative to assets. We therefore explore

the association of multiple measures of debt with health outcomes in order to isolate dimensions of debt that matter most for health. Furthermore, we explore the association of debt with multiple measures of health: to establish consistency with prior findings, we examine two outcomes related to psychological health – perceived stress and depressive symptoms; we also expand our investigation to test the impact of debt on three additional health outcomes – self-reported general health, systolic and diastolic blood pressure. By exploring basic health impacts of financial debt, we aim to establish a baseline from which future research can further investigate this relatively neglected socioeconomic health determinant.

Methods

Study design and sample

Add Health is a nationally representative cohort study with four waves of in-home interviews conducted since its initiation in school year 1994/1995. At Wave I, approximately 20,000 adolescents in grades 7–12 participated in in-home interviews. A clustered sampling design was utilized, in which an 80-school sample was selected that was nationally representative in terms of ethnicity, urbanicity, school size, type, and US region. Within these schools, students were randomly chosen within grade and sex strata. Some sub-groups of students were over-sampled, including African American adolescents from higher-educated families. Wave II was conducted one year after Wave I. While 15,000 of the original respondents were re-interviewed at Wave II, those who had graduated were not included. Wave III data collection took place in 2002/2003 and included 15,170 of the original respondents plus 1507 partners of those respondents. The most recent wave of data collection (Wave IV) took place in 2007/2008 when the cohort was 24–32 years old, and included 15,701 of the original respondents.

In all waves in-home interview data was collected via computer-assisted personal interview/computer-assisted self-interview (CAPI/CASI). Interview questions covered participant demographic and socioeconomic conditions, as well as psychological and general health, health services use, behavior, and extensive social relationship information. In Wave IV measures of blood pressure and other cardiovascular and metabolic biomarkers were introduced, as were questions about household and personal financial debt.

In this paper we restrict our analyses to data from Waves I, III, and IV. All key independent (debt) and dependent variables (health outcomes) are from Wave IV. Data on sociodemographic, psychosocial, and general health from Waves I and III which could influence both debt and health status at Wave IV are also included in analyses as control variables. Since Wave II was conducted only one year after Wave I and excluded all graduating seniors, we do not use data from that wave. All original Wave I respondents were eligible to participate at Wave IV, and therefore the most recent wave of data collection includes some respondents who did not participate in Wave III. Our analytic sample is thus smaller than the full Wave IV sample since it includes only those respondents who participated in each of the three waves of data that we are using (Waves I, III, and IV) and who are not missing sampling weight information ($n = 9421$). Further, we exclude respondents with missing data on key independent and dependent variables (described below). Our final analytic sample includes 8400 respondents. Approval was obtained from the Northwestern University Institutional Review Board to conduct secondary analyses of the Add Health data.

Debt

Personal financial debt was measured at Wave IV in two ways. First, a subjective assessment of net status asked respondents to

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