

Analyzing the Racial Wealth Gap and Implications for Health Equity

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This paper contains key insights from a series of meetings cohosted in November 2021 and February 2022 by the Federal Reserve Bank of New York's Community Development Unit and the NYC Department of Health and Mental Hygiene on the intersection of racial wealth and health gaps. It is designed to encourage further discussion around transformative solutions.

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About the NYC Department of Health and Mental Hygiene

The NYC Department of Health and Mental Hygiene is one of the largest public health agencies in the world. The NYC Health Department is also one of the nation's oldest public health agencies, with more than 200 years of leadership in the field. The NYC Health Department works to protect and improve the health of more than 8 million New Yorkers. They work to prevent both chronic and infectious diseases, all while working to address enduring inequities in health outcomes. The NYC Health Department has a history of tackling public health issues with innovative policies and programs, many of which have gone on to influence other local and national jurisdictions.

Executive Summary

Wealth, or the difference between the value of assets owned and the amount owed in debts, is considered one of the most important indicators of well-being by helping families invest in health-promoting behaviors, weather financial shocks and achieve long-term financial security.

Research consistently demonstrates that an individual's economic position at birth has an important role in shaping health throughout their life. Studies demonstrate that when individuals and households have more wealth, they experience fewer chronic diseases, greater life expectancy, and even reduced COVID-19 transmission. However, there are pervasive and substantial wealth disparities across racial and ethnic groups in the U.S., often referred to as the racial wealth gap. The most recent data estimates that the average White family holds nearly eight times the wealth of the average Black family and more than five times the wealth of the average Hispanic family. The Black-White wealth disparity, in particular, has been created and reinforced by a complex web of historical policies and practices including racial segregation laws, redlining, the discriminatory implementation of the New Deal and the G.I. Bill, and more.

Together, with the Federal Reserve Bank of New York's Community Development Unit, the New York City Department of Health and Mental Hygiene (NYC Health Department) hosted a series of roundtable discussions to facilitate discourse among experts about racial wealth and health gaps. The goal of this paper is to explore the existing literature of the wealth-health connection and relay roundtable participant recommendations to address the racial wealth and health gap.

Key themes of this paper include the following:

- There are long-standing, stark wealth gaps between racial and ethnic groups. Racism, both historical and structural, and the intergenerational impacts of the enslavement of Black people, have broad impacts on the wealth and health inequities observed today.
- Wealth is an integral driver of health outcomes. However, this relationship is nuanced: assets are found to consistently improve health while certain debts are associated with worse health outcomes, even after adjusting for total net worth. Different types of assets and debts also are associated with differential effects on health outcomes.
- Our ability to understand complex relationships between race, wealth, and health is limited due to methodological, geographic, and demographic limitations of current data collection methods.

Key Recommendations

Effective solutions to racial inequities in wealth and health must address challenges at the individual, household, community, and systems level. Roundtable participants had three main recommendations: implement bold public policy, improve measurement and data collection, and increase community ownership of health care delivery.

Recommendation #1:

Implement Bold Public Policy

Experts from the nonprofit, research, policy, and government sectors were invited to a roundtable discussion to share their thoughts on the solutions, policies, and tools that should be considered to meaningfully address racial wealth and health gaps in the U.S. With their diverse range of experience and expertise, participants cited a variety of bold public policies — including universal health care and Medicaid expansion, medical debt cancellation, student loan forgiveness, reparations, and baby bonds — as potential mechanisms to help eliminate existing inequities.

Recommendation #2:

Improve Measurement and Data Collection on Wealth and Health Outcomes

In another roundtable discussion, academics, and researchers from a range of backgrounds discussed the current state of measuring wealth and health data, highlighting the methodological, geographic, and demographic limitations that currently constrain our understanding of racial wealth and health gaps. The consensus from experts was that improvements in wealth and health measurement and data collection practices are needed to estimate more accurately the extent of inequitable disparities and to inform solutions. Further, the roundtable discussion underscored a need for the integration of comprehensive and systematic collection of wealth data into regular public health surveillance across the U.S. to unpack the complex and nuanced relationship between race/ethnicity, wealth, and health.

Recommendation #3:

Increase Community Ownership and Leadership of Health Care Delivery

Due to decades of policies and practices, communities across the U.S. have experienced widespread disinvestment that leave them with fewer capital resources to support the infrastructure and elements of a healthy community. Beyond individual wealth, the wealth of institutions within these communities, including health systems, hospitals, and other health care facilities, also has important effects on individual and community health. Increasing community engagement and ownership within health care delivery systems and other local institutions, through approaches like community-oriented primary care or participatory budgeting, places communities at the center of public health care delivery and local decision-making and creates opportunities for community-informed outcomes.

Introduction

It is well established that the economic position into which an individual is born will shape opportunities, outcomes, and health throughout their life.¹ **Income** and **wealth** are two distinct, yet related indicators of economic position. Income is primarily measured by earnings during a specified time period, while wealth is typically measured as the difference between the value of **assets** owned and the amount owed in **debts**, the net value of an individual or a household's property.^{1,2} Because wealth incorporates the value of assets accumulated over time, including across generations, it provides a more comprehensive representation of one's economic resources.¹ Though more difficult to measure, wealth is perhaps one of the most important indicators of individual and household well-being in the U.S. Wealth makes it possible for households to save money, weather financial shocks, pay for housing and education, and provide long-term financial security in retirement and for generations beyond.

Wealth has important implications for our ability to advance **health equity**. A growing body of evidence suggests that greater wealth can lead to better health outcomes, including lower rates of chronic disease and depression, lower mortality, reduced functional impairment (for example, physical, emotional, and cognitive functioning), reduced COVID-19 transmission, and higher life expectancy.^{3,4,5,6,7,8} However, inequitable policies and practices in the U.S. have limited opportunities for wealth accumulation for some racial and ethnic groups, while, simultaneously favoring others. Over time, this has resulted in dramatic differences in wealth and health outcomes for households that identify as Black, Latino or Indigenous, particularly when compared with those that identify as White. The latter have benefited disproportionately from long-term wealth accumulation and intergenerational wealth transfers.¹

The NYC Health Department aims to better understand how the **racial wealth gap** shapes the racial health gap and to identify transformative solutions that can increase racial equity in individual, household, and community well-being in NYC. Ultimately, understanding and addressing deeply rooted inequities in wealth and health is critical to building an inclusive and strong economy.

This paper will explore existing literature and provide recommendations to address racial wealth and health gaps. While wealth and health gaps exist among multiple racial and ethnic groups, and based on other sociodemographic characteristics, the scope of this paper will concentrate on Black-White and Hispanic-White differences* due to limitations in the availability of data to identify gaps between other racial and ethnic groups.⁹

*Race and ethnicity are social constructs, representing distinct but interrelated concepts.^{10,11,12} In this paper, we use the terms as they were collected in the 2019 Survey of Consumer Finances (SCF), or however the authors of the cited study collected race and ethnicity data. The race and ethnicity of a family in the SCF are classified according to the self-identification of that family's original respondent to the SCF interview, as White non-Hispanic, Black or African American non-Hispanic, Hispanic or Latino, and other or multiple race (we will henceforth refer to these groups as White, Black, Hispanic, and other, respectively).⁹

At the NYC Health Department, equity is a core value shaping all of the work we do to create a city where all New Yorkers can realize their full health potential, regardless of who they are, where they are from or where they live.¹⁵ The NYC Health Department is also committed to racial justice, which focuses specifically on addressing racialized patterns of inequity. Examples of the NYC Health Department's commitments to equity and racial justice include:

- *The Board of Health's Resolution Declaring Racism a Public Health Crisis*¹⁶ — In 2021, the NYC Board of Health passed a resolution declaring racism as a public health crisis. This declaration was accompanied by a series of specific actions the NYC Health Department is required to take to expand its anti-racism work. The declaration recommits the NYC Health Department to creating a more equitable city and a just recovery from COVID-19, which disproportionately impacted communities of color.
- *Birth Equity Initiatives*¹⁷ — Pregnant people of color, particularly Black and Hispanic women and birthing people in NYC, have an increased risk of death and complication related to their pregnancies and births.^{18,19} Considering these inequities, the NYC Health Department has adopted a comprehensive approach that involves government agencies, health care systems, and community organizations and members. Multiple initiatives are included in this effort such as the Maternity Hospital Quality Improvement Network, the Respectful Maternity Care initiative, the Community-Based Doula program, and Neighborhood Birth Justice Hubs. Together, these initiatives help address the root causes of preventable racial and ethnic inequities in maternal outcomes.
- *Public Health Corps*²⁰ — Launched in September of 2021, the NYC Public Health Corps (PHC) is a joint equity initiative with Health + Hospitals, the public hospital system in NYC. PHC was established to strengthen the city's community health infrastructure and to promote health equity in the communities hardest hit by the pandemic. PHC tackles issues related to COVID-19 and COVID-19 vaccines, expanding access to health care, and assisting patients in meeting their health goals. Using a community-centered approach and community partnerships, PHC helped dramatically increase COVID-19 vaccine uptake in some of the hardest hit neighborhoods across the city and provided over 304,000 referrals to medical and social services in the past year.

What Is Health Equity?

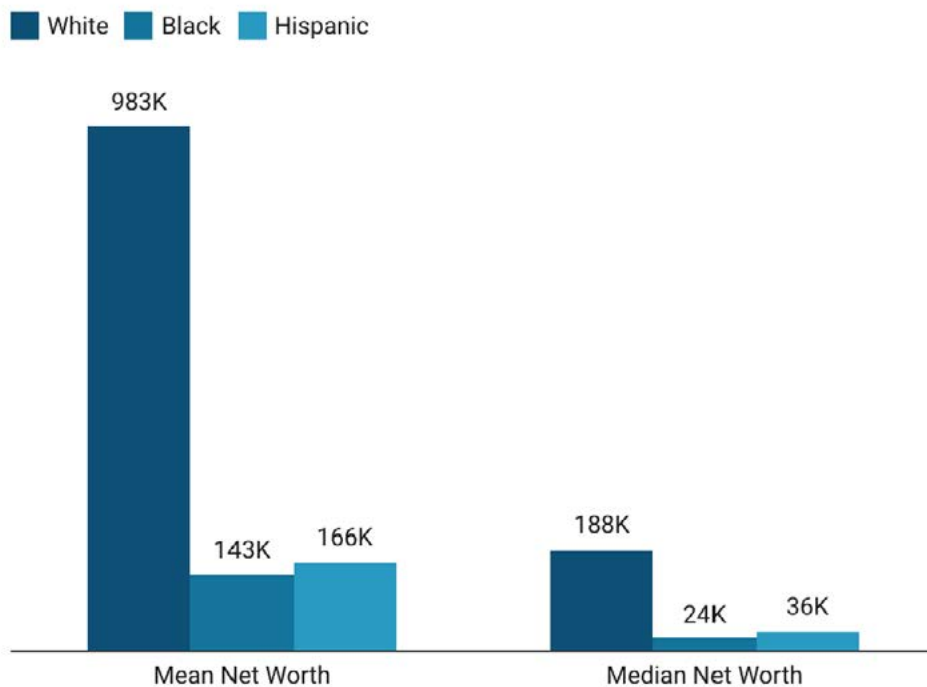
Health equity is when every person has the opportunity to “attain full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”¹³ In practice, health equity is achieved when disparities in health, and the key social determinants that shape these disparities, are eliminated.¹⁴ We can realize the vision of health equity by removing the obstacles — the social and medical determinants of health — that interfere with people's opportunities to be healthy.

What Is the Racial Wealth Gap?

Throughout history, the distribution of wealth in the U.S. has, and continues to be largely unequal.²¹ In particular, long-standing and substantial wealth inequities among racial and ethnic groups in the U.S., often referred to as the racial wealth gap, have existed for most of our nation's history and have only increased over time.^{22,23} The Federal Reserve Board's 2019 Survey of Consumer Finances (SCF) shows that, nationally, the average White family holds nearly eight times the wealth of the average Black family and over five times the wealth of the average Hispanic family (Figure 1).⁹ "The Color of Wealth" series written by scholars at Duke University used the National Asset Scorecard for Communities of Color to collect more granular data on race, ethnicity, and country of origin, and found even larger wealth gaps in different metropolitan areas.^{24,25,26} For example, they found that Dominican households and U.S. Black households held less than 0.1 cent of median wealth for every dollar of median wealth a White household held in Boston.²⁴

Figure 1: Mean & Median Net Worth by Race & Ethnicity in the United States

White families have more wealth than Black and Hispanic families.

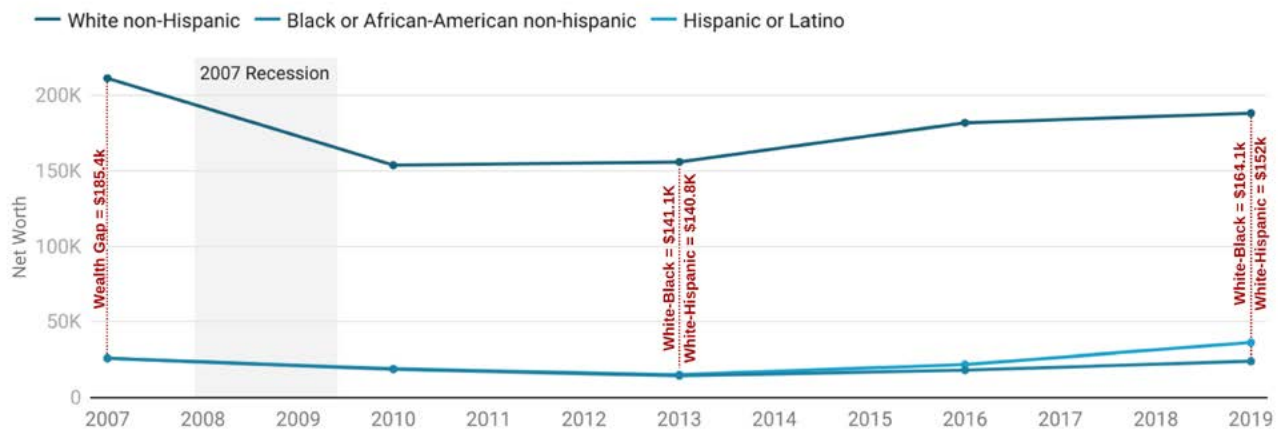


Source: Survey of Consumer Finances (SCF) 2019

The Great Recession of 2007-2009 triggered unprecedented wealth declines for families in the U.S. and was among the most significant declines for Black and Hispanic households in recent history. Black and Hispanic households lost a greater percentage of their wealth (48 and 44 percent, respectively) compared to White households (26 percent).²⁷ Although all households have since made gains in wealth accumulation, the racial wealth gap remains significant (Figure 2).⁹

Figure 2: Family Net Worth by Race & Ethnicity in the United States

Black-White and Hispanic-White wealth gaps have remained significant over time.



Source: Survey of Consumer Finances (SCF) 2019

Historical Context for the Racial Wealth Gap

For much of American history, there has been a record of systematic policies implemented by the federal government that helped build wealth for White households while suppressing wealth accumulation for other groups, including Black and Hispanic households.²⁸ While the most explicit racially discriminatory policies have been repealed or otherwise formally abandoned, unequal enforcement and lack of investment in certain individuals, populations, and institutions have resulted in stark inequities between racial and ethnic groups in America.^{29,30} Today's racial wealth inequities are the result of barriers created by a complex web of historical policies and practices, that often reinforce one another, including, but not limited to, the following:

- *Government Failure to Provide 40-acre Land Grants (1862-1976)*. Following the Civil War, several federal policies were established to distribute land to the formerly enslaved. In 1865, General William T. Sherman issued Special Field Orders No. 15 designating 40-acre land grants to freed slaves in the South. However, President Andrew Johnson ended the project after 40,000 formerly enslaved had settled 400,000 acres, restoring the land back to former slaveholders, stripping the formerly enslaved of an economic foundation to prosper.^{28,31} At the same time, the Homestead Act of 1862 distributed over 270 million acres of western land in 160-acre plots to 1.5 million White Americans — including recent European immigrants — and was only repealed in 1976. Of the Americans who received land patents during this period, as many as

45 million of their living descendants continue to reap the wealth benefits.³² Of note, these, and other race-based policies, also displaced Native people from their tribal lands, and similarly devastated wealth-building opportunities for Native peoples.³³ The federal government's land allotment policies, and failure to deliver the promised land grants to the formerly enslaved is a central origin point for the contemporary Black-White racial wealth gaps observed today.

- *Racial Segregation Laws (1865-1968)*. State and local laws often mandated or supported **segregation** of employment, housing, legal systems, public facilities, transportation, and health care by race. The most notorious, the Black Codes or Jim Crow, was a collection of state and local laws in Southern states that began as early as 1865 to severely limit the political and economic autonomy of, and gains made by, Black Americans after slavery was abolished.³⁴ In Northern cities like New York, Chicago, and Philadelphia, local segregation ordinances, restrictive covenants, and labor laws confined Black residents to overcrowded neighborhoods and limited employment opportunities.^{35,36,37} Segregation laws had large economic ramifications for Black Americans, barring them from opportunities and access to certain jobs, neighborhoods, schools, property ownership, and hospitals, among other restrictions. Notably, these laws also enabled widespread racial discrimination against Mexican Americans in the Southwestern U.S. and Asian Americans on the West Coast.^{38,39,40} Today's racial wealth gap is a byproduct of **systemic racism**, including the legacy of enslavement, segregation, and other policies that prevented wealth accumulation and social mobility for racial and ethnic subgroups.⁴¹
- *The New Deal (1933)*. The New Deal of 1933 introduced a series of programs and projects during the Great Depression that aimed to restore prosperity to millions of Americans. However, the exclusion of agricultural and domestic employees — a large percentage of whom were Black Americans — from key programs like the Social Security Act and the National Labor Relations Act is well-understood by some experts to have created greater barriers to statutory benefits and protections for Black Americans compared to White Americans.^{42,43} Although exclusion of these groups was removed from the Social Security Act by 1950,⁴⁴ it is estimated that the total value of benefits lost under Social Security amounted to over \$150 billion between 1937 and 1952.⁴⁵
- *The Home Owners' Loan Corporation (HOLC) (1933)*. HOLC, established in 1933 by the U.S. Congress to assist homeowners who were in default on their mortgages and in foreclosure, created guidelines that used neighborhood racial and ethnic composition to assess the riskiness of mortgage lending, a practice referred to as **redlining**. Later adopted by private banks across the nation, redlining resulted in financial exclusion in areas identified as “hazardous” for lending — primarily Black, immigrant and low-income neighborhoods.⁴⁶ Redlining is an often-referenced example of systemic racism and has significant financial implications for Black, Latino, and other marginalized communities.^{46,47}

- *The Federal Housing Administration (FHA) (1934)*. The FHA, established in 1934, furthered segregation efforts by refusing to insure mortgages near Black neighborhoods while, at the same time, subsidizing builders to develop housing in White neighborhoods that were inaccessible to Black families to prevent the creation of mixed-race neighborhoods and the subsequent insurance or financial “risk” such neighborhoods would impose.^{48,49} This redlining also negatively affected other populations including Hispanic residents, low-income residents, noncitizens, and other populations deemed “risky.” Today, formerly redlined areas are more likely to have a high concentration of Black residents, as well as households with lower incomes, lower rates of homeownership and lower home values, all contributing to ongoing wealth inequities.⁵⁰
- *The G.I. Bill (1944)*. In 1944, the G.I. Bill promised many benefits for World War II veterans — including low-cost mortgages, low-interest loans, and financial support for college or vocational school — and was a key source of intergenerational wealth for White middle-class families. Redlining practices prevented many Black veterans from accessing home loans and, subsequently, excluded a majority of the population from the post-war housing boom. For example, by 1947, only two of the 3,299 VA-guaranteed home loans in 13 Mississippi cities went to Black borrowers despite Black individuals accounting for half the population of the state.⁵¹ In New York and the northern New Jersey suburbs, fewer than 100 of the 67,000 mortgages insured by the G.I. Bill supported home purchases by non-Whites.⁵¹ Evidence suggests that G.I. benefits had a substantial and positive impact on educational attainment of White and Black men born outside of the South.⁵² However, Black veterans in the South were limited by Jim Crow laws that allowed universities to refuse Black people and quota systems that prevented many of them from attending well-funded universities.
- *The “War on Crime” (1965) and the “War on Drugs” (1971)*. The “War on Crime” issued under President Lyndon B. Johnson’s 1965 Commission created a new, federally directed set of guidelines for local policing, courts and state prisons, laying the foundation for new social programs that centered carceral control, surveillance, and incarceration.^{53,54} The following “War on Drugs” popularized by President Richard Nixon in 1971 established further initiatives that aimed to reduce the illegal drug trade in the U.S.⁵⁵ These sanctions targeted urban areas, low-income communities, and communities with a larger representation of racial and ethnic subgroups, resulting in disproportionate incarceration of Black and Hispanic populations that has persisted. Today, Black individuals are incarcerated in state prisons at nearly 5 times the rate of White individuals, and Hispanic individuals at 1.3 times the rate of White individuals.⁵⁶ A 2016 analysis of the Survey of Income and Program Participation finds that having an incarcerated family member reduced household assets by 64.3%.⁵⁷ Other studies find that incarceration is associated with decreased rates of homeownership and net worth for former offenders, with compounding effects on entire households over time.^{58,59,60}

These historical policies and practices, in conjunction with ongoing discrimination and systemic racism, continue to shape the racial wealth gap today primarily through their effect on long-term wealth accumulation and the transfer of resources across generations. Wealth accumulation is a life course process. As people age, their wealth grows over time which they can then transfer to future generations either directly through gifts or inheritances, or indirectly through investments like paying college tuition.⁹ Differences in familial wealth create racial wealth gaps early in life that only widen as White households accumulate wealth at faster rates.^{9,61} These gaps are then inherited across generations as families unequally transfer wealth to their descendants. It is this intergenerational process that accounts for more of the racial wealth gap than any other demographic or socioeconomic indicators, such as income, or education.⁶²

Wealth Relates to Health in Different, Complex, and Meaningful Ways

A large and growing body of research reveals that wealth is consistently correlated with health outcomes.⁶¹ Boen, Keister, and Aronson examine this complex relationship by looking closely at the components of net worth — assets and debts. While net worth is found to be a protective factor against poor health, assets such as savings, stock ownership, or homeownership, are found to consistently improve health, and debts such as student loans, credit card debt, or medical debt are associated with worse health, even after adjusting for total net worth.⁶¹

There are stark differences in the prevalence of assets and debts by race and ethnicity. White households are more likely than Black and Hispanic households to hold all asset types, including **appreciating assets** that are integral for wealth building (for example, home equity, retirement accounts) and **liquid assets** that help families safeguard against financial hardship (for example, checking accounts) (Figure 3).⁶³ In addition, even when Black and Hispanic households hold certain assets, such as vehicles or homes, they are worth less than the those held by White households. For example, Black and Hispanic household's vehicles and primary residences are worth about two-thirds and 85% of White household's assets respectively.⁶⁴ Ultimately, the median White household has assets more than four times the value of those held by the median Black household, underscoring that the racial wealth gap is primarily driven by differences in asset holdings.⁶⁵

There are also clear differences in the types of debt held by households based on race and ethnicity (Figure 4).⁶³ White households are more likely to hold **secured debts** (for example, home debt, vehicle debt) compared to Black and Hispanic households, while Black and Hispanic households are more likely to hold **unsecured debts** (for example, credit card debt, medical debt, student loan debt). While secured debt can be a useful tool for promoting **consumption** of goods and services and financial investments that generate assets (for example, business loans), there is evidence that unsecured debts, particularly those with high interest rates, can be an impediment to economic stability and are linked to poorer health and well-being.^{66,67,68} In the case of student loans, Black borrowers tend to incur more student debt, and pay off debts more slowly compared to non-Black borrowers. The burden of this student debt negatively impacts credit, the consequences of which can include lower rates of homeownership, which is often the main contributor to a household's wealth.^{9,69} Although medical bills and the accrual of medical debt is often an unexpected occurrence, it affects low-wealth and Black households disproportionately, leading many to delay or avoid necessary medical care.⁷⁰ These examples highlight the adverse economic and health consequences of debt as it relates to racialized differences in the types of debts households incur.

Figure 3: Asset Prevalence by Race and Ethnicity in the United States

White households are more likely to hold all assets compared to Black and Hispanic households.

■ White, Non-Hispanic ■ Black, Non-Hispanic ■ Hispanic

Total assets at financial institutions



Checking accounts at financial institutions



Equity in motor vehicles



Equity in own home



Retirement assets



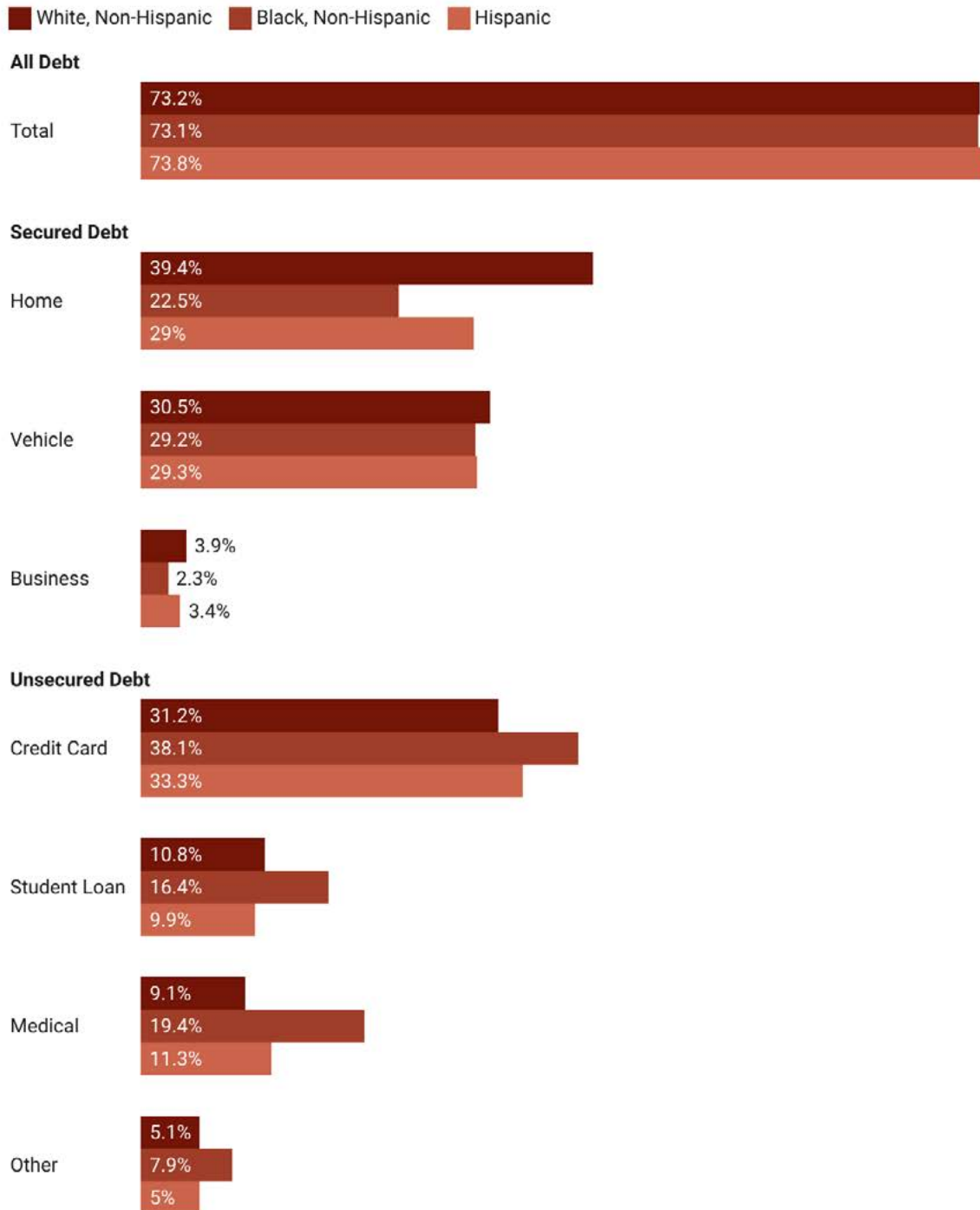
Equity in business



Source: Survey of Income and Program Participation (SIPP), 2020

Figure 4: Debt Prevalence by Race in the United States

White households are more likely to hold secured debts compared to Black and Hispanic households. At the same time, Black and Hispanic households are more likely to hold unsecured debts.



Source: Survey of Income and Program Participation (SIPP), 2020

Wealth and Health

Wealth is strongly correlated with individual and population health in more ways than one. Wealth positively affects household income and consumption, allowing families to afford better medical care, higher quality insurance, and goods and services that promote physical and mental well-being.⁶¹ Liquid assets, like savings and stocks, allow households to more readily pay for basic needs, preventative and routine medical care, and weather financial shocks.⁷¹ Greater wealth allows people to live in neighborhoods with fewer environmental hazards, such as lead exposure and air pollution, fewer fast food outlets, and more parks and green spaces for people to exercise.^{72,73} Wealth can protect families from the negative consequences of financial hardship, including job loss, homelessness or housing insecurity, food insecurity, and the negative psychological effects associated with financial hardship. Lastly, intergenerational wealth passed down through inheritance can provide educational and social opportunities that can benefit health in the long run.¹

Conversely, research shows that when household budgets are constrained, families tend to reduce spending on medical care, groceries, and other health-related goods. Households with limited liquid assets may be less able to afford health-promoting opportunities (for example, quality medical care, physical activity) and more likely to forgo preventative or emergency medical treatments.⁶¹ Financial hardship is consistently correlated with poorer self-rated health, more chronic diseases, and depressive symptoms in children and adults.⁷⁴ Low levels of wealth can contribute to worsening health due to stress and negative feelings surrounding a lack of control over important life decisions.⁷⁴

Debt and Health

Household debt is an important factor in well-being yet is largely neglected in research investigations of racial inequities in social and economic determinants of health. Debt type plays an important role in health and well-being in both positive and negative ways. For instance, higher levels of home and student loan debt are associated with greater socioemotional well-being for children, whereas higher levels of and increases in unsecured debt (for example, credit card debt) are associated with lower levels of and declines in child socioemotional well-being, respectively.⁷⁵ Further, while debt is hypothesized to positively impact child well-being through greater investment in children's social or human capital, it can also negatively impact levels of anxiety and stress when burdensome.⁷⁶

Studies show that debt and economic hardship are associated with poorer mental health outcomes, elevated levels of stress and depressive symptoms, and higher rates of pain that interferes with daily activity.^{76,77,78} At the household level, high debts or low assets can increase anxiety, frustration, and hopelessness, and can also lead to health deterioration due to stress.⁷⁹ When looking at young adults with student debt, those with high levels of debt stress reported feeling more tense and anxious, troubled by physical problems, and had greater difficulty getting to sleep than students with low levels of debt stress.⁸⁰

Wealth, Health and Racial/Ethnic Trends

Racial and ethnic inequities associated with wealth are consistently found in self-reported health and chronic conditions.⁶¹ One study finds that Black and Hispanic individuals reported higher rates of poor or fair health compared to White individuals — and White respondents in this particular study had a net worth six and a half times greater than Black respondents, and over eight and a half times greater than Hispanic respondents.⁸¹ The same study shows that within younger and older Black and White populations and among older Hispanic populations, being in the lowest quartile of wealth was associated with three to five times higher odds of reporting fair or poor health status compared to those in the highest quartiles of wealth.

Data shows that Black-White health inequities have not narrowed over time. For example, Black-White ratios of mortality from coronary heart disease, cancer, diabetes, cirrhosis of the liver, and infant mortality were larger in the late 1990s than in 1950.⁸² Between 2019 and 2021, the U.S. experienced a widening of its life expectancy gap during the COVID-19 pandemic with Hispanic and non-Hispanic Black populations experiencing larger declines in life expectancy over the two-year period than non-Hispanic White populations.⁸³ Systemic racism, especially residential segregation may be a key explanatory factor in racial health outcomes like those described above. Several recent studies have explored associations between redlining and health outcomes, finding that residents of neighborhoods with “hazardous” ratings from historical redlining policies have increased risk of pre-term birth and worse cardiovascular health compared to residents of the then deemed “best” or “still desirable” neighborhoods.^{84,85} Another recent study found that of 202 U.S. cities, neighborhoods that were redlined beginning in the 1930s had present-day worse air quality than neighborhoods that were not redlined.⁸⁶ Separately, predominantly Black neighborhoods are more likely to face shortages of primary care providers, offer fewer ambulatory facilities, have limited access to physicians, and a lower supply of surgeons.^{87,88}

What We Do Not Know About Wealth and Health Gaps

The NYC Health Department and Federal Reserve Bank of New York's Community Development Unit cohosted a series of roundtables bringing together public health professionals, nonprofit leaders, and academic researchers to understand racial wealth and health inequities. The first of the two roundtable discussions explored the current state of measuring wealth and health at the population level. Despite extensive literature linking wealth and health gaps, roundtable participants highlighted several methodological, geographic, and demographic limitations that confine our understanding, and are ripe for further exploration:

- *Measuring net worth is more challenging than measuring income.* The existing tools that measure wealth at the national level, such as the SCF and the Panel Study of Income Dynamics, take substantial time and preparation for participants to answer accurately.^{89,90} In general, income is much faster to report, and individuals are better prepared to answer questions about income than net worth. For these reasons, income disparities are extremely well studied in the U.S. and net worth disparities are comparatively rarely studied.⁹¹
- *Data linking health and wealth outcomes are needed.* Due to the prominence of income-related survey questions within national health datasets, considerable evidence of the relationship between income and health exists. In contrast, few studies explore the relationship between wealth and health, despite the clear connection between them. The limited availability of wealth and health data hinders public health advancements related to analyses of wealth and health inequities, including solutions to correct such inequities. Therefore, measurement of both wealth and health should be a core function within public health. Such data can be utilized to track local racial wealth and health gaps and measure the impact of solutions-based approaches to decrease inequities in debt and assets.
- *Wealth exists at extreme scales in the U.S.* It is challenging to accurately measure and report on all household wealth within a single study due to the wildly different scale of net worth in the U.S. For example, in 2019, the median net worth for all households below the 25th percentile was \$310 compared to \$2,598,400 for all those in the 90-100th percentiles.⁹² A few studies have used exponential categories to be able to make comparisons. Additionally, there exists an entire body of work in economics dedicated to accurately measuring net worth for high-net-worth individuals. The extreme scale of wealth in the U.S. also highlights a key methodological debate about measuring wealth at the median or the mean. Relying on median measures of wealth, as most studies do, obscures the severity of the racial wealth gap and economic inequities more broadly.⁹³

- *Wealth can have differing effects.* The components of net worth can act differently in individuals' lives, and quantitative data collected in surveys often belies a lot of complexity. For example, the health benefits of owning a home are nuanced and complex and can change over time.⁶¹ Homeownership also has different values along racialized lines. Various policies and practices, from redlining to predatory lending to racist credit scoring systems, for decades have systematically taken economic value out of Black-owned homes. Additionally, because net worth is measured at the household level, it is challenging to identify how other systems of oppression that operate at the individual level, such as gender, intersect with systemic racism and impact net worth, evidenced by the relative dearth of literature on the gendered nature of wealth and wealth inequities.⁹⁴
- *Demographic data is insufficient.* Most of the data collected within large national studies is based on racial categories found in the Office of Management and Budget (OMB) 1997 standards, at best. Yet, these categories are broad (for example, "Asian," "Latino," "Indigenous") and insufficiently group together a wide diversity of racial and ethnic experiences. "The Color of Wealth" is a series written by scholars at Duke University with an in-depth sampling framework that was adopted to the unique population in each city it studied, with intentional oversampling of subpopulations, according to race, ethnicity, and country of origin — granular detail typically unavailable in public datasets — to be able to speak with statistical significance to differences in how wealth was experienced.²⁴ For example, in lieu of OMB's standard race/ethnicity categories, the sampling frame used in the Los Angeles Color of Wealth study included: Mexicans, other Latinos (inclusive of Puerto Ricans, Cubans, Salvadorans, other South Americans, other Central Americans, and Europeans), Asian Indians, Chinese (inclusive of Taiwanese), Japanese, Korean, Filipino, and Vietnamese. For African Americans, categories were based on nativity including U.S. Black descendants and recent immigrants from the African continent.²⁵ Without more granular racial and ethnic categories, larger sample sizes, and intentional oversampling of subpopulations according to race, ethnicity, and country of origin, researchers cannot collect or analyze data that can speak to the variety of lived experiences of wealth and health. Invisibility through poor demographic data collection in this way continues to perpetuate racism for many groups.

Integrating Wealth and Health Into Public Health Practice and Community Development

Effective solutions to racial inequities in wealth and health must simultaneously address challenges at the individual, household, and community level, and the inequitable systems that produce wealth and health gaps. To advance these solutions, bold public policy, better data collection, and increased community ownership are needed.

Public Policy and the Racial Wealth Gap

The second roundtable discussion asked panelists to describe the solutions, policies, and tools that should be employed to help address racial wealth and health gaps. Roundtable participants felt bold public policies are needed to meaningfully address racial wealth and health gaps and advance equity, wellbeing, and racial justice. Several policies were highlighted by experts, with reparations considered to be best poised to directly impact the racial wealth gap:

1. *Universal Health Care*. In 2020, 28 million people in the U.S. had no health insurance coverage.⁹⁵ Universal health care is a system that provides quality medical services to all citizens with limited cost-sharing. Medicare for All is a single, national health insurance program provided by the federal government, rather than through an insurance company, that would cover all households in the U.S. In its most comprehensive form, it would pay for every medically necessary service, including dental and vision care, mental health, and prescription drugs. If passed, Medicare for All would be a concrete path to achieve health care coverage for millions of Americans currently living without this access. By providing low-cost health care to all Americans, universal health care would help prevent individuals from acquiring medical debt and its subsequent deleterious effects on health and financial security.⁷⁰

An intermediate step on the longer path towards universal health care in the U.S. is Medicaid expansion. Expanding Medicaid would allow more people in low income households to qualify for the income-based health care program. As of this paper's publication, while 40 states (including DC) have expanded Medicaid, 11 states have not despite the passage of the American Rescue Plan Act of 2021, which included financial incentives to encourage expansion (South Dakota expanded Medicaid through ballot initiative in November 2022 with an effective date of July 2023).^{96,97} Medicaid expansion appears to be a protective factor against medical indebtedness, with residents of non-expansion states having a 40% greater chance of acquiring medical debt than residents in expansion states between 2017 and 2019.⁹⁸ Further, studies show that states who expanded Medicaid experienced reductions in uninsured rates, increases in health care access, improved health outcomes and financial well-being.⁹⁹ In

2014, one study found that the implementation of Medicaid expansion in New York State was associated with a significant reduction in the incidence of severe maternal morbidity in women with low household income compared with women with high household income.¹⁰⁰

Maternal health policies were also introduced by roundtable participants as a specific health care priority given the vast racial and ethnic inequities in maternal health and birth outcomes. While the American Rescue Plan Act of 2021, provided states with another opportunity to extend postpartum Medicaid coverage to twelve months, other policies, such as the Black Maternal Health Momnibus Act of 2021, build on efforts to comprehensively address every dimension of the maternal health crisis in America.^{101,102}

2. *Medical Debt Cancellation.* Medical debt, or medical costs people are unable to pay upfront or when they received care, unequally impacts racial and ethnic communities.^{103,104} Estimates by the U.S. Census Bureau show that 28 percent of Black households carry medical debt, compared with 17 percent of White households.¹⁰⁴ While the nation's largest credit reporting agencies recently announced plans to reform and minimize the impact of medical debt collection accounts on consumer credit reports, a more impactful strategy to address inequities in medical debt may be through medical debt cancellation.¹⁰⁵ Additional policies roundtable participants introduced as a mechanism for alleviating inequities in medical debt included: federal and/or state programs to improve requirements for charity care and/or financial assistance and relief programs offered by hospitals to their patients; stronger policies preventing aggressive debt collection practices; and restrictions on hospitals selling medical debts to third party collectors.
3. *Student Debt Cancellation.* Disparities exist in student debt burdens by race. According to the 2019 SCF, Black Americans hold the most student loan debt — \$44,880 on average — compared to other races and ethnicities.¹⁰⁶ Although full student debt cancellation would significantly reduce financial pressures on student loan borrowers — disproportionately benefitting Black Americans holding this type of debt — and reduce racial disparities in student loan liabilities, it would not make much headway toward elimination of the racial wealth gap.¹⁰⁷ In 2022, President Biden announced an income-based student loan relief plan, demonstrating feasibility to address student loan debts at the federal level. Supporters of student debt relief have critiqued President Biden's plan, stating that a loan forgiveness program that relies on wealth, rather than income, would more equitably provide debt relief to those who need it most. Further, a more systemic solution could include a universal public option for four-year postsecondary education, which would address the ongoing realities of the high-cost education system in the U.S.
4. *Baby Bonds.* Baby bonds are an innovative policy that provide children with publicly funded investment accounts that can be accessed beginning at the age of 18 for specific uses including education, homeownership, small business, and retirement. Several states and localities across the country have introduced or passed legislation to establish baby bonds.* To have

*For more information on state and local baby bonds policies: Brown M, Bui O, Harvey C, Shanks TR. The state of baby bonds. Urban Institute: Washington DC; 2023. Accessed February 20, 2023. [urban.org/research/publication/state-baby-bonds](https://www.urban.org/research/publication/state-baby-bonds)

a meaningful impact on the racial wealth gap, any baby bonds proposal should allocate the most resources (in other words, higher initial deposits or greater yearly contributions) to those with the greatest need, disproportionately benefitting Black, Latinx and indigenous children.¹⁰⁸ A baby bonds program designed this way represents an anti-racist policy that can help create and maintain equity between racial groups.¹⁰⁹

A 2019 study used an anti-racist baby bonds policy to model the effect of such a policy on the median racial wealth gap at young adulthood, when wealth gaps among race/ethnicities are at their smallest.^{110,111} The study found that if a national baby bonds program were implemented during the mid-1990s, the wealth gap between young White households and young Black households would have decreased substantially.¹¹⁰ However, when the Black-White wealth differential is measured at the mean, baby bonds will have only a marginal impact on the racial wealth gap.¹¹² Ultimately, this study lends credence to the importance of race-specific policies to address the racial wealth gap.¹¹² Nevertheless, baby bonds — and Child Development Accounts, another vehicle that uses publicly or privately funded matched savings or investment accounts to supplement savings for a child — are mechanisms to enhance individual savings and asset building for long-term prosperity.

5. *Reparations.* A reparations program, such as federally paid cash to Black descendants of enslaved people, would eliminate the Black-White wealth gap, thereby promoting racial equity, if the payment amounts established by the program were predicated on the average difference in Black and White wealth.²⁸ This model of reparations was discussed during the roundtable due to the focus specifically on Black-White wealth gaps, however other models of reparations or restitutive programs may be employed to address other racial wealth gaps (in other words, Indigenous or other groups). The goal of a reparations program would be to seek acknowledgment, redress, and closure for America's complicity in federal, state, and local policies — including slavery, Jim Crow, and ongoing systemic racism — that have deprived Black Americans of equitable access to wealth and wealth-building opportunities.¹¹³ While some localities have begun to explore reparations or restitutive solutions to repair historical wealth and opportunity gaps for Black Americans, advocates of reparations underscore the importance of a federal program in order to meaningfully address the racial wealth gap and its adverse consequences for health.²⁸

Several recent modeling studies have demonstrated the potential health implications of closing the racial wealth gap through simulating the effects of a federal reparations program on selected health outcomes. In one study, reparations were projected to reduce the gap in longevity (in other words, differences in mortality rates) between Black and White Americans by 65.0-102.5%.¹¹⁴ A 2020 study found that if a federal reparations program had been in place prior to COVID-19, it would have reduced exposure risks in Black communities with high-poverty rates, thereby lowering the number of Black Americans with COVID-19. The study also found that the reparations program would have lowered transmission of the virus at a population level by 31-68%, highlighting the broader public health benefits of addressing existing inequity.⁸

Improve Measurement and Data Collection on Wealth and Health Outcomes

To effectively describe and address racial wealth and health gaps, better data collection is needed to measure the extent of inequities, inform short and long-term solutions, and track progress over time. Any data collection effort should be sure to address the shortcomings of existing wealth data collection that were expressed by roundtable participants and described thoroughly in the above section. Ultimately, measuring wealth should be as core of a public health function as measuring income. An integral step to understanding and resolving racial gaps in wealth and health is to improve measurement and data collection of wealth and health outcomes.

A dataset linking wealth and health indicators at the individual level is essential for analysis of racial wealth and health gaps. Comprehensive data collection on net worth needs to be integrated into regular public health epidemiological surveillance at the local, state, and federal level in the U.S. Consistent and systematic collection of wealth data is necessary for surveilling health, addressing racial inequities, and evaluating successful outcomes in achieving health equity. Our ability to understand the multi-faceted components of the overall wealth-health relationship is ultimately incomplete due to data limitations. Two measurement examples — one for wealth and health respectively — exist that may serve as useful models that overcome some of the limitations of other wealth and health data collection efforts:

- The National Asset Score Card for Communities of Color (NASCC) survey addresses two shortcomings of existing public datasets with asset and debt measurements as follows: (1) lack of information for specific geographic areas and (2) limited disaggregated information by race, ethnicity, and/or ancestral origin. Because key asset drivers and racial/ethnic demographics vary by geography, the NASCC survey was designed to collect data at the level of the metropolitan statistical area, thus allowing for geographically specific granularity in analyses of wealth gaps. In addition, the NASCC survey gathered more detailed data on subpopulations, according to race, ethnicity, and country of origin.^{24,25} This level of disaggregation allows researchers to understand patterns of how wealth is accumulated or hindered among different racial and ethnic groups.
- The National Institutes of Health launched the National COVID Cohort Collaborative (N3C) during the COVID-19 pandemic to allow rapid data collection from hospitals and health care plans.¹¹⁵ This initiative helped advance research on the virus by providing a platform for centralized health care data sharing, while measuring and surveilling health outcomes in addition to usage of health care services. The N3C, which promptly gathers and facilitates translation of real-world data into meaningful knowledge to address the COVID-19 pandemic, offers a model for the type of large, centralized, data collection approaches needed to efficiently identify and disseminate wealth and health data to better understand racial inequities, improve population health and to understand the impacts of the nation's medical debt.¹⁰⁴

Increase Community Ownership and Leadership of Health Care Delivery

Over time, historical policies and practices have resulted in patterns of community disinvestment and predatory inclusion that leave neighborhoods with less infrastructure to support elements of a healthy and vibrant community such as affordable housing, school buildings, and grocery stores.^{47,116,117,118,119} Disinvestment limits access to health-promoting resources for individuals, including access to quality health care, and can perpetuate racial gaps in institutional wealth by impacting the resources and capacities of key public institutions (for example, hospitals, libraries, etc.) serving these communities.^{87,88,120}

A recent study found that the capital assets (for example, value of land, buildings, and equipment) of hospitals serving primarily Black or Hispanic communities differed significantly compared to capital assets in hospitals serving other communities. For example, the total value of capital assets per patient-day for Black- and Hispanic-serving hospitals across the U.S. was \$5,179 and \$5,763, respectively, compared to an average total value of \$8,325 at other hospitals.¹²¹ This same study noted that Black- and Hispanic-serving hospitals had similar inequities in rates of new capital investments, underscoring the potential for these stark differences to grow. As a consequence of large gaps in capital assets, Black- and Hispanic-serving hospitals were also less likely to offer certain capital-intensive services.¹²¹ Black-serving hospitals also receive lower payments for patient care and accrue lower profits/surpluses than other hospitals, which may similarly affect the technology and services a hospital can offer.¹²² Given the positive relationship between hospital investment and the quality of patient care, disparities in assets offer one explanatory pathway for persistent racial health inequities, especially among communities experiencing disinvestment.^{121,123,124}

In light of these recent findings, health systems are well-positioned to assist in closing racial wealth and health gaps and can do so partly by adopting an asset-based approach and increasing community-engaged partnerships and processes.¹²⁵ Increasing the presence of community-led or community-oriented primary care (COPC) offers an opportunity to shrink racial health gaps by re-orienting the health care delivery system in a way that centers community ownership and involvement to better address communities' needs for and barriers to health care.

First introduced in South Africa in the 1940s, COPC is a continuous process that integrates public health practice with primary care for a defined community and prioritizes outcomes and interventions on the basis of community-informed health assessments.¹²⁶ Core elements of South Africa's COPC model have influenced various programs, including the community health center movement in the U.S. Health systems across the country and internationally have also adopted this model to integrate clinical and public health approaches and improve both individual and community health.^{127,128,129,130,131} COPC requires health care providers to invest time and resources into the communities it serves. However, this investment can facilitate shared ownership of individual and community health outcomes and create a new form of social capital by connecting communities with other resources and institutions.¹³²

The expansion of community-informed partnership and engagement, as seen in the COPC model, should not be limited to health care delivery, but should be extended to other public institutions (for example, schools, libraries, transportation systems, budgeting processes, etc.). For example, participatory budgeting offers an approach through which community residents collectively decide how to spend part of a public budget. Community members are involved in each stage of the process from project or idea development to implementation. Such intensive engagement can be empowering to individuals, fostering civic engagement in local decision making, and more equitably redistributing important resources to communities in order to address their self-identified needs.¹³³

Another example, the NYC Health Department's Neighborhood Health Action Centers bring together health care partners, city agencies, and community-based organizations to facilitate access to different services.¹³⁴ Currently in Harlem, Brooklyn, and the Bronx, the Health Action Center model leverages community and government assets to collaboratively address health disparities and institutionalized racism in the city.^{135,136,137} Place-based investment, such as NYC's Neighborhood Health Action Center model helps galvanize a variety of community partners to engage in developing and implementing solutions that can facilitate community ownership of outcomes and promote equity. Implementation of the systemic changes needed to close racial wealth and health gaps requires a reimagining of public institutions and processes to center community voices and achieve meaningful, community-informed outcomes.¹³⁸

Next Steps

Following the release of this paper, the NYC Health Department will continue to engage in assessing and addressing the racial wealth gap and its connection to health. An example of this engagement may include deepening our understanding of the connection between wealth and health on the local level by exploring opportunities for novel data collection. Beyond data collection, the NYC Health Department will also continue the dialogue around the policy solutions at local, state, and federal levels that may have a meaningful impact on closing the racial wealth gap and promoting health equity.

Glossary

Asset — A resource owned with market or economic value. An asset can be a potential source of future income to meet debts, facilitate additional accumulation of resources, or meet other commitments.

Appreciating Assets — Any asset which value is increasing.

Consumption — The use of goods and services by households.

Debt — Money owed or due to another party.

Health Equity — Fair and just opportunity for each person to be as healthy as possible, and no one is disadvantaged from achieving this potential due to social position or socially determined circumstances. Health equity is reflected in differences in length of life, quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.¹⁴

Income — A flow of resources received on a regular basis, generally from earnings, investments, sale of an item, or transfers.

Liquid Assets — Assets that can be quickly and easily converted to cash.

Racial Wealth Gap — The difference in net worth between socially identified racial groups.

Redlining — A discriminatory practice by which firms such as banks and insurance companies refused or limited loans, mortgages, and/or insurance coverage within specific geographic areas with primarily Black, immigrant and low-income residents.⁴⁶

Segregation — The practice of restricting people to certain circumscribed areas of residence or to separate institutions (for example, schools, churches) and facilities (for example, parks, playgrounds, restaurants, restrooms) on the basis of race or alleged race.¹³⁹

Secured Debts — Debts for which the borrower puts up some asset as surety or collateral for the loan.

Systemic Racism, or Structural Racism — The totality of ways in which societies foster racial discrimination, via mutually reinforcing inequitable systems (for example, in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values, and distribution of resources, reflected in history, culture, and interconnected institutions.^{47,140}

Unsecured Debts — Debt created without any collateral promised to the creditor.

Wealth, or Net Worth — The difference between the market value of what one has (assets) and what one owes (debts). Wealth, or net worth, is the net value of an individual, household, or organization's property. Wealth can be transferred across generations.

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