Statement on Wealth Inequality

Student National Medical Association
Health Policy and Legislative Affairs Committee
Statement on Wealth Inequality

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INTRODUCTION

Founded in 1964 by medical students from Howard University School of Medicine and Meharry Medical College, the Student National Medical Association (SNMA) is the nation’s oldest and largest, independent, student-governed organization focused on the needs and concerns of medical students of color. The SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians.

Wealth inequality refers to the disparity between the richest and poorest citizens of the world. This growing inequality is demonstrated by data that shows the wealthiest 10% of adults in the world account for 85% of the total global household wealth, while the bottom half accounts for only 1%. Although wealth inequality is a global issue, the United States (US) has the largest wealth gap among the developed countries. US income data from 2016 shows that the top 10% of earners in the US accounted for 77% of the total household wealth, while the bottom 50% of Americans, which account for over 65 million families, made up only 1% of the total US household wealth. This stark difference in wealth between the rich and poor is only growing as the top 10% continues to become richer at exponentially faster rates than the bottom half of the population, fluctuating with global and national economic recessions.

Wealth inequality is well-researched and has been shown to correlate with socioeconomic status, which is widely regarded as a major social determinant of health. Socioeconomic status contributes greatly to health disparities, with the majority of the national burden of disease falling on the poor. This correlation is especially prominent because patients with low socioeconomic status account for a disproportionate share of poor health outcomes during the novel coronavirus (SARS-CoV2) disease 2019 (COVID-19) pandemic. Research has also demonstrated greater economic inequality is associated with increased mortality in individuals with COVID-19. This disparity is especially prominent in marginalized and minority populations, with COVID-19 death rates up to nine times higher in substantially non-white communities compared to predominantly white communities even when controlling for median income. This suggests income is not the only determinant to consider, but also race, community resources, and overall wealth.

The SNMA is dedicated to addressing the needs of underserved and minority communities, which tend to fall in the bottom half of the wealth gap. The purpose of this statement is to highlight...
the etiology of the wealth gap in these communities and the detrimental effects this inequality has had on past generations and will continue to have on future generations if left unaddressed. It is our hope that we can move towards a more equitable global and national economy that ensures all of its citizens have access to better wealth, education and health outcomes.

**BACKGROUND**

Wealth can be associated with “net worth,” which equates to the total accumulation of one’s assets, not including any liabilities one possesses.² Individuals with a greater value in assets (e.g., stocks, properties, investments) have a more valuable and profitable net worth than others without such assets. These members are generally classified as the upper class, usually among the top 10%, where individuals with even greater assets represent the top 1%.¹⁰ As a result, this upper class benefits greatly from wealth and are able to easily accumulate more wealth, while lower and middle classes struggle to accumulate wealth and often experience a lack of social and economic resources (e.g., quality schools, transportation, safe housing, stable job market) in their communities.¹¹ Without such resources, upward mobility is incredibly challenging for individuals in the lower class.¹²

Wealth inequality has remained one of the most alarming concerns in our nation. This is mainly focused within the wealthiest 1%, who accounted for 35.5% of all American household wealth in 2013.¹³ For example, investor Warren Buffet, Microsoft founder Bill Gates, and Amazon founder Jeff Bezos were classified by *Forbes* as a few of the richest individuals in the world in 2018. In fact, their combined fortunes are worth more than the total wealth of half of the poorest Americans.² While individuals with higher social status continue to increase their net worth, this inequality of wealth causes more vulnerable and marginalized populations to continue to lag behind.

One of the most important examples of wealth inequality is the large gap seen within racial and ethnic groups amongst the different social classes. Among lower income families, white households have a net worth of $22,900, whereas Hispanic/Latinx households have a net worth of $7,900, and Black/African Americans households stand at $5,000.¹⁴ A similar trend can be seen among middle income families, with net worth of $154,400, $46,000, and $38,300 for white, Hispanic/Latinx, and Black/African American households, respectively. The largest disparity is seen when comparing the middle class to the upper class, where the median white household has
a net worth of $971,500, nearly six times greater than their middle-class counterparts. This disparity gives white upper-class households a clear advantage, while racial groups in the lower stratifications of society are negatively impacted by a lack of wealth. The disparity may be further observed by stratifying national overall median wealth by race: white households stand at $171,000, which is eight times greater than that of Hispanic/Latinx households ($20,6000), and 10 times greater than that of Black/African American households ($17,100). Inequality of wealth amongst marginalized racial groups evidently leads to greater disadvantages in other socioeconomic factors, such as lower educational attainment, increased rate of incarceration, and worse health outcomes. Bridging the gap between these racial and social class divides will help create a more just economic system, allowing all households and families to benefit from equitable distribution of wealth in our nation.

Over the years, several policies and legislation have directly or indirectly widened the wealth inequality gap, especially in minority communities. The Servicemen’s Readjustment Act, better known as the G.I. Bill of Rights, was passed by Congress in 1944 in an effort to help veterans assimilate back into civilian life. While the bill worked as intended for white veterans, Black/African American veterans did not experience the same benefit. Black/African American veterans were more likely to be dishonorably discharged than their white counterparts, which disqualified them from accessing G.I. Bill benefits. They were also coerced into moving to particular neighborhoods and did not receive the same compensation for their service. Black/African American veterans also had reduced access to community services and facilities. In combination with the disparate implementation of the G.I. Bill, these systemic barriers played a major role in increasing the gaps in wealth and education between white and Black/African American individuals.

Redlining, a policy introduced in the 1930s by the Home Owners’ Loan Corporation (HOLC), also contributed to the increasing wealth inequality gap we have today. The HOLC provided a guideline for lenders when issuing mortgages by creating residential security maps that outlined the best neighborhoods for secure investments as well as the neighborhoods that were considered “hazardous” investments. These maps were color-coded: Green (grade A) neighborhoods were considered “Best,” blue (grade B) considered “Still Desirable,” yellow (grade C) considered “Definitely Declining,” and red (grade D) considered “Hazardous.” The financially undesirable neighborhoods were typically occupied by poor and minority communities whose
inhabitants struggled to get loans due to their neighborhoods not being qualified for backing by the Federal Housing Administration. While the Fair Housing Act of 1968 condemned racial discrimination and repealed policies like redlining, the effects of these practices can still be seen today. Many of the neighborhoods that were considered “Hazardous” are currently still underserved and underdeveloped compared to the historically “Still Desirable” and “Best” neighborhoods, which are mostly occupied by white populations and individuals with significant wealth.

Since the quality of one’s neighborhood is also a social determinant of health, policies such as redlining and the discriminatory administration of the G.I. Bill continues to have a detrimental effect on health outcomes for generations today. A study assessing the effect of historical redlining and foreclosures on self-rated health of Detroit residents demonstrated slower foreclosure recovery after the 2007-2008 recession is associated with poorer self-rated health among adults. When studying the association of historical redlining with preterm birth, low birth weight (LBW), and small-for-gestational age (SGA), researchers in California determined neighborhoods with worse HOLC grades have higher prevalence of perinatal mortality, preterm birth, and SGA. Yet another study conducted in New York City demonstrated that infants born in areas with a HOLC grade D are more likely to be preterm than those born in areas with HOLC grade A. These findings show the detrimental effect wealth inequality, perpetuated by discriminatory policies, has on health outcomes. Bridging the wealth inequality gap and redistributing wealth across different socioeconomic groups is a critical step in addressing health disparities.

**SCOPE OF THE PROBLEM**

On March 23, 2010, President Barack Obama took an integral step in acknowledging the link between wealth, health, and economic prosperity. As a result of the Affordable Care Act (ACA), health insurance coverage was expanded via subsidies to those who could not otherwise afford it, leading to an additional 20 million Americans enrolling in health insurance. This bill highlighted the interdependent tie of wealth and financial means to the health of the American citizen. In the third chapter of *Care Without Coverage: Too Little, Too Late*, the authors detail the effects of health insurance coverage on health by looking across a large scope of health problems. They concluded individuals with health insurance generally experience better health outcomes, including higher life expectancy, less complications from chronic disease, and more appropriate
health care treatment with preventative and acute care services. Other studies have observed that areas with greater income inequality have larger health disparities, suggesting a potential correlation between wealth and income with poor health outcomes (e.g., mortality rates). Therefore, it is reasonable to assign the importance of wealth to both access to insurance and positive health outcomes.

Deeper ingrained in wealth inequality and health outcomes are the “non-health” aspects of society. It is natural to focus on mainstream factors with direct links to health (e.g., smoking, insurance, diet) and propose policy interventions targeting those factors, but it would be remiss to ignore abstract, underlying factors at play in our health. In How Economic Inequality Inflicts Real Biological Harm, Sapolsky explains how psychosocial stress, crime rates, teenage pregnancy, and bullying are societal elements that are also negatively correlated to wealth inequality. Each of the aforementioned factors greatly impact health and are exacerbated by lack of wealth.

Wealth inequality is deeply intertwined with the success and prosperity of this nation and, more importantly, its people. The health outcomes detailed in this statement are a few of many that have been studied in connection with wealth inequality. We must always remember the contributors to health, continue to ask ourselves who has the resources to achieve wealth, and acknowledge how people are affected in every aspect of life when lacking said resources.

**STATEMENT OF POSITION AND RECOMMENDATIONS**

As an organization committed to addressing the health of minority and underserved communities, the SNMA is deeply concerned about the growing wealth inequality in the US and its inescapable impact on health outcomes. The wealth gap, which disproportionately affects minority populations, is not the result of any individual’s choices. Rather, the wealth gap is a direct result of policies enacted at the state and federal levels that were designed for the accumulation of wealth by white individuals and communities. Because of the long-standing, policy-driven history of wealth inequality in the US, addressing individual choices will not suffice to reverse this inequality. Wealth inequality from previous generations persists into later generations and, on average, Black/African American individuals have less wealthy parents compared to white individuals. Importantly, structural factors in the work environment exacerbate existing wealth inequalities, with minorities experiencing higher levels of unemployment and lower wages across every education level and across every occupation, making individual wealth accumulation
exceedingly difficult. In order to realize the level of wealth equity necessary to reduce the negative health impacts stemming from wealth inequality, the SNMA recommends ongoing and intentional research, legislative and organizational discourse, and implementation of the most effective policies to reduce wealth inequality.

A successful approach to reducing wealth inequality will require a combination of policy solutions. Some of the solutions that have been proposed include progressive taxes, a more equitable distribution of tax subsidies, and baby bonds. A progressive tax is defined as a flexible tax rate that increases as wealth increases. On its own, a progressive tax is not enough to adequately redistribute wealth but, when combined with equitable distribution of tax subsidies, it may have tangible results. Research by the Urban Institute in 2013 found the federal government spent almost $385 billion on tax subsidies to aid in wealth building. Seventy percent (70%) of these subsidies were returned to the top 20% of income earners, effectively widening the wealth gap. Policies that allow this inappropriate distribution of subsidies preserve and expand the current inequities in wealth and cannot continue.

One proposed alternative to the traditional model of subsidy distribution is a baby bond, providing between $500 and $60,000 to newborns, with those born to wealth-poor families receiving a larger sum. This would benefit individuals with lower levels of wealth accumulation, independent of income level or individual savings. Such a policy would act in direct opposition to the historical policies enacted to prevent minority communities from accumulating wealth.

Members of the SNMA must advocate for the implementation of policies the aforementioned – policies that work toward equitable distribution of wealth. In order to improve the health of minority and underserved communities, policies that redistribute wealth must be discussed at medical schools and institutions, as well as on the local, state, and federal levels.


