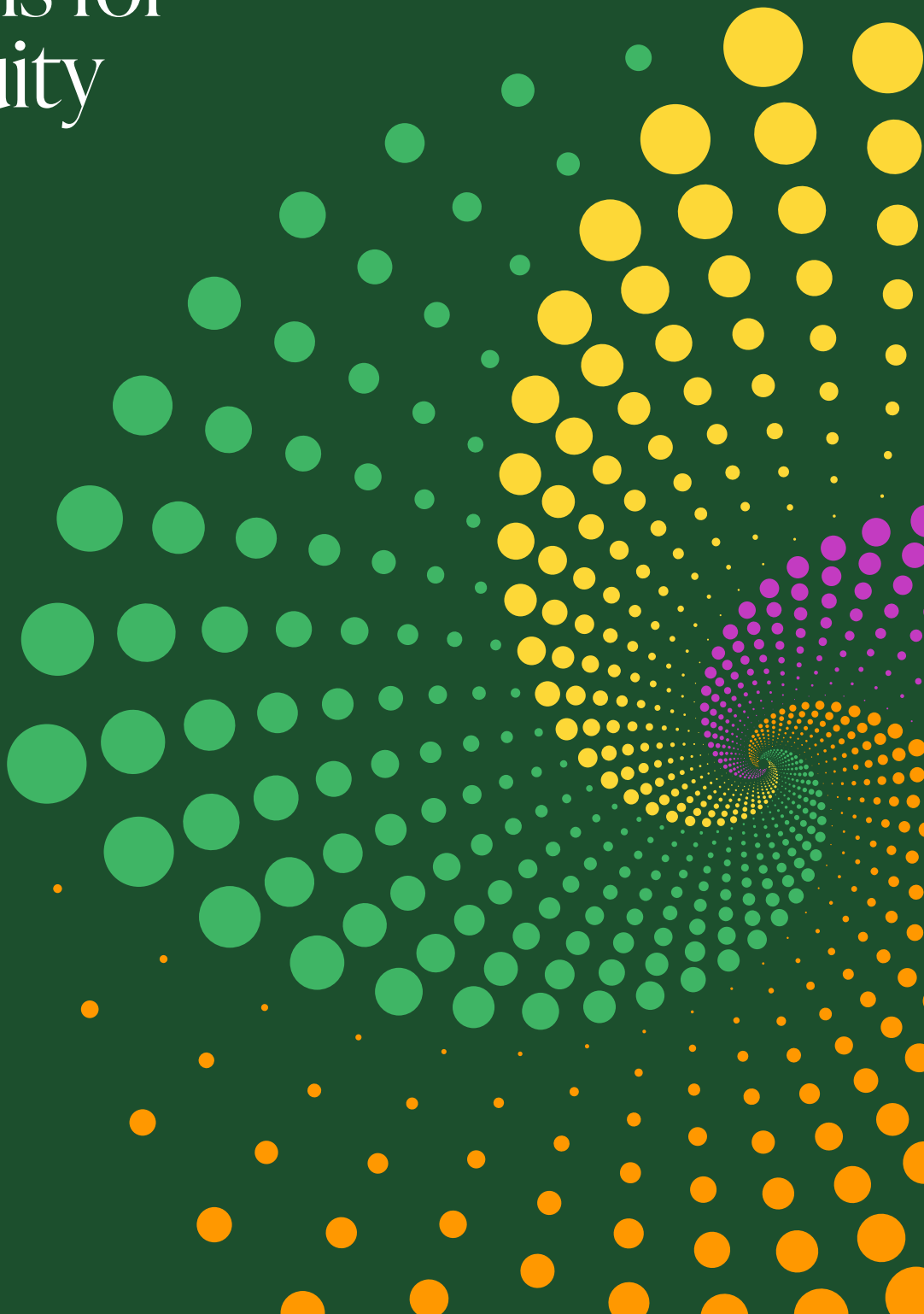
Policy Brief

NCHE

The Economic Well-being of Black Americans and the Implications for Health Equity



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About the Author

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Dr. Gaskin is an international leader in health policy. He is a member of the National Academy of Medicine. He is a research associate of the National Bureau of Economic Research. He serves on the Congressional Budget Office Panel of Health Advisors and the Board of Directors of the American Society of Health Economists. He has served in leadership roles in AcademyHealth, the American Public Health Association, the National Academy for State Health Policy, and the National Economics Association. He is a 2019 recipient of the Presidential Early Career Award for Scientists and Engineers.

Dr. Gaskin has a Ph.D. in public health economics from the Johns Hopkins University. He holds a MS degree in economics from the Massachusetts Institute of Technology, and a BA degree in economics from Brandeis University. Dr. Gaskin is an ordained minister in the African Methodist Episcopal Zion Church. He served as Pastor of the Beth Shalom AME Zion Church from 1991 to 2023.

Since its inception, the National Collaborative for Health Equity (NCHE) has dedicated its programs and activities to creating health equity in the United States by ending racial and ethnic health inequities. NCHE's leadership, staff, and consultants always recognized that ending racism requires achieving and sustaining meaningful progress toward this goal. Beginning in 2020, NCHE joined over 150 other nonprofit and philanthropic organizations in leveraging the pillars of the Truth, Racial Healing, and Transformation (TRHT) Framework to inform programs, policy research, and action. These five pillars (Narrative Change, Racial Healing and Relationship Building, Separation, Law, and the Economy) offer a comprehensive and holistic conceptual framework for action to end racism and jettison the deeply embedded belief in a false hierarchy of human values.

NCHE's vision is embodied in our name. We work in collaboration with others to help our nation achieve health equity. NCHE's mission is to promote health equity by harnessing data, developing leaders, and catalyzing partnerships across the many sectors that share responsibility for creating a more equitable and just society. As NCHE continues to collaborate with others, we implement three key strategies: (1) Supporting Leaders, (2) Applying Data Research and Information, and (3) Expanding the TRHT Movement. NCHE equips institutions and leaders to work effectively with and within historically marginalized and excluded communities, providing tools to help improve the social, economic, and environmental conditions that shape health. We help organizations and communities to envision and actualize an America that has faced and redressed historic and contemporary effects of racism in all its forms.

I am pleased to present this new collection of briefs offering insights into each TRHT pillar. Leaders, practitioners, and researchers can utilize these resources committed to overcoming the unique racial history and legacy of the United States.

The original organizations that participated in the design phase of TRHT in 2016 were included in a platform created by the W. K. Kellogg Foundation, *Connected Communities*. Based on preliminary Connected Communities research, these participating organizations and representatives from over 150 nonprofit entities could reach over 189,000,000 people in the United States. A lot has happened since 2016. The momentum continues to increase for the expansion of local and national efforts to address and heal from the historic and contemporary effects of racism.

While the potential of reaching almost 200 million people has yet to be realized, recent surveys suggest that tens of millions are aware of the effort, and the work continues to expand. As the momentum has increased, resistance and backlash to this progress grows. The resources or tools provided in these briefs can help leaders, practitioners, and researchers maintain momentum in the face of resistance.

There are many consequences of chronic exposure to structural racism and racial discrimination. The most insidious consequences are disease and health inequities. Our failure to effectively address and redress America's legacy of racial hierarchy has economic costs that reach well into trillions of dollars for our society. But it is communities of color that bear the lion's share of the burden of the costs of failing to eliminate racism and its consequences. The courageous and dedicated work of leaders in communities across America provides hope that we will succeed in overcoming racism. We offer these resources as support for these ongoing efforts.

Sincerely,

Gail C. Christopher
Executive Director
National Collaborative for Health Equity

Abstract

Black Americans are not achieving their best health and wellness outcomes. The health inequities experienced by Black Americans have persisted over many years, though they were first documented by the Heckler Report in 1985. Since then, the Office of Minority Health has issued reports annually on the health inequities suffered by Black Americans and other racial and ethnic minorities. These inequities are rooted in inequities in the labor and capital markets. Because Black Americans face discrimination in the labor market, they have lower incomes, less health insurance coverage, and lower-quality jobs. As a result, they have less money to buy goods and services to maintain their health, have less access to quality health care, and are more likely to suffer illnesses related to job-related stress.

Black Americans face discrimination in the capital markets, and they are less likely to receive loans to buy a home or to invest in a business. This lack of private and public investment results in Black Americans living in lower-quality housing and communities. Specifically, the places where Black Americans live have fewer amenities that promote health equity and more harms that increase the risks of chronic disease and injuries. To improve the health of Black Americans, policymakers must address the inequities they face in the labor and capital markets.

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1.

Introduction

Black Americans have been critical to the economy of the United States from its inception as a collection of 13 colonies to its establishment as the world's dominant superpower.

From the forced labor and ingenuity of enslaved Africans to the international influence of Hip Hop culture created and promulgated by Millennial and Generation Z Black Americans, each generation of Black Americans has contributed substantially to the economic success of America, despite all the pain, trauma, and other harms caused by structural racism (White & Borrell 2011). With a gross domestic product of $26.53 trillion, the United States is the leading economy in the world (Matalone & Picard 2023). However, because of structural racism, bigotry, sexism, and classism, Black Americans have never fully enjoyed their share of the benefits of America. Rev. Dr. Martin L. King, Jr., in his famous "I Have a Dream" speech, argued that racial injustice has denied African Americans the ability to fully enjoy the nation's promise of life, liberty, and the pursuit of happiness, stating, "It is obvious today that America has defaulted on this promissory note insofar as her citizens of color are concerned. Instead of honoring this sacred obligation, America has given the Negro people a bad check, a check which has come back marked insufficient funds" (Carson 1998)

Black Americans continue to face economic inequities in comparison to non-Hispanic White Americans. The 47.1 million Black Americans living in United States today comprise 14% of the total population, yet they only own 4% of the nation's wealth. In 2019, Black family median wealth was only $24,100 which is 15% of the median wealth of non-Hispanic White families of $188,200 (Bhutta et al. 2020). Black families also have lower median household incomes compared to White families, $43,771 versus $71,664. More than 1 in 5 Black Americans live at or below the federal poverty level, as compared to fewer than 1 in 11 non-Hispanic White persons. For Black American children, poverty is a severe problem. One in four Black children live in poverty, compared to only 1 in 12 non-Hispanic White children. Black workers face inequities in the labor market as well. The Black unemployment rate has perpetually been almost twice the White unemployment rate. In 2023, the Black unemployment rate is 5.4%, compared to a rate of 3.1% for non-Hispanic White workers. Even though that rate is a historical low, Black unemployment is still higher than non-Hispanic White unemployment. When employed, Black workers earn 76 cents for every dollar non-Hispanic White workers earn (DoL 2023).

The economic inequities that Black Americans face have implications for their overall health. It is well understood that the social determinants of health, that is, where someone lives, works, and plays, are responsible for up to 50% of an individual's health outcomes (University of Wisconsin Population Health Institute 2023). It is within these contexts that people are exposed to risk factors that harm their health as well having access to protective factors that benefit their health. One's wealth and income are key determinants of the quality of one's economic, social, political, and environmental contexts. Consequently, economic inequities lead to contextual inequities, that is, to inequities in the social determinants of health that produces inequities in Black American health.

The health inequities that impact Black Americans are well documented. The Heckler Report found that Black Americans suffered from higher rates of excess deaths from cancer, cardiovascular diseases, cirrhosis, infant mortality, homicide and accidents, and diabetes (Heckler 1985). Findings from the Heckler Report and subsequent reports, such as *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002) from the National Academy of Medicine (formerly the Institute of Medicine) have motivated policy-makers to create and fund agencies, including the National Institute on Minority Health and Health Disparities (NIMHD) and the Office of Minority Health, as well as state-level offices of minority health (Institute of Medicine 2003). The mission of these government agencies is to improve the health and well-being of Black Americans and other racial and ethnic minority populations and address health inequities. In addition, these reports have encouraged many health care and public health organizations to incorporate health equity as a core value and to implement strategies to improve health outcomes for Black Americans and other people of color.

Over time, the disparity in life expectancy at birth between the Black and Non-Hispanic White populations has declined. In 1970, life expectancy for the Black population was 64.1 years, compared to 71.9 years for the non-Hispanic White population, a disparity of 7.8 years. Over the next 40 years, life expectancy increased for both populations, with the gap narrowing to 3.8 years. In 2010, life expectancy for the Black population was 75.1 years compared to 78.9 years for the White population (Kochanek, Arias, & Anderson 2013). Unfortunately, this progress has not continued in the second decade of the 21st century. By 2021, life expectancy *fell* by 5 years to 70.1 years for the Black population and by 2.5 years to 76.4 years for the non-Hispanic White population, widening the disparity to 6.3 years. The events of the last few years have nearly erased all the gains in reducing the disparity in life expectancy between the Black and non-Hispanic White populations (Arias et al. 2021). The preceding reduction in the disparity in life expectancy between the Black and non-Hispanic White populations has been attributed to lower mortality rates for cancer, homicide, HIV, and causes originating in the fetal and infant period (Schwandt et al. 2021). However, this progress was arrested by rising mortality for diseases related to drug overdoses, cardiometabolic diseases (e.g., diabetes and obesity) and other chronic diseases (Woolf, Masters & Aron 2022).

The health status of Black Americans is below the health aspirations of the nation. A comparison of selected health indicators for the Black population against the nation's Healthy People 2030[1] goals illustrates the challenge of addressing health inequities for Black Americans. The rates for Black Americans for each of these indicators exceed the national rates. The infant mortality rate for the Black population is more than twice the national goal. Mortality, incidence, and prevalence rates for Black Americans for five selected leading causes of death are 33% to 74% higher than the target rates

1 Every 10 years, the U.S. Department of Health and Human Services issues national objectives for improving the national health and well-being. These are measurable objectives that guide individuals, communities and organizations that are committed to address the nation's health needs. Healthy People 2023 is the fifth iteration of this initiative. For more information, see **https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people**

TABLE 1

Comparison of Selected Health Indicators from Healthy People 2030: 2030 Target Rate, 2021 Black Population Rate, and 2021 National Population Rate

Health Indicator	Healthy People 2030 Target	Black Population in 2021	National Population in 2021
Infant Mortality	5.0 per 1,000 live births	10.4 per 1,000 live births	5.6 per 1,000 live births
Diabetes	4.8 new cases of diabetes per 1,000	7.1 new cases of diabetes per 1,000	5.5 new cases of diabetes per 1,000 adults (2019-21)
Coronary Heart Disease Deaths	71.1 coronary heart disease deaths per 100,000 population	107.5 coronary heart disease deaths per 100,000 population (2021)	92.8 coronary heart disease deaths per 100,000 population (2021)
Cancer Deaths	122.7 per 100,000 population	162.4 cancer deaths per 100,000	146.6 cancer deaths per 100,000
High Blood Pressure	42.6 percent of adults	58.0 percent of adults	45.7 percent of adults
Stroke Deaths	33.4 stroke deaths per 100,000	57.8 stroke deaths per 100,000	41.1 stroke deaths per 100,000
Homicide	5.5 per 100,000 population	31.8 homicides per 100,000 population	8.2 homicides per 100,000 population

Note: Rates are age adjusted to the year 2000 standard population. Source: **https://health.gov/healthypeople**

set out in Healthy People 2030, and the homicide rate is almost six times higher. Table 1 offers more details from this comparison.

A naïve hypothesis would propose that the disappointing health profile of Black Americans is due to biological deficiencies rooted in race and unhealthy behaviors rooted in culture. However, race and culture are both social constructs, things that are not immutable but rather conform to life choices available in context and time. For example, persons who are mixed race today would have been designated as Black or Negro a few generations ago. Before the 1970s marriage rates among Black families were comparable to those among White families, and now the race disparity marriage rates is considered to be a social ill that plagues Black households, and the lack of social support is viewed as a health related social risk factor.

2.

Race Disparities in Labor Markets

The labor market outcomes for Black Americans have historically trailed those of White Americans. Black Americans have a higher unemployment rate and lower wages, and they work in lower-quality jobs compared to White Americans.

These discriminatory trends in the labor market have a negative impact on the health of Black Americans in several ways (see Table 2). Their higher unemployment rate limits Black Americans' access to the healthcare delivery system. Access to healthcare in the United States is built on employer-based health insurance, so disparities in the labor market limit Black Americans' access to private health insurance and increase their reliance on public health insurance and the likelihood of being uninsured altogether (Table 2). Black American children and working-age adults are respectively 2.09 and 1.80 times more likely to be covered by public insurance, that is, by Medicaid, compared with White Americans, and Black American children and working-age adults are respectively 1.15 and 1.65 times more likely to be uninsured compared with White Americans.

Employer-based health insurance is better insurance coverage for health care services compared to the public payers, that is, Medicare and Medicaid. Enrollees in private health plans have better access to the high-quality healthcare providers, primarily because these health plans pay more for services and have more market power than public payers. Private health plans can provide their enrollees with superior access to healthcare services. With their disease management programs, population health management tools, and data management systems, they can encourage clinicians to provide better care to their enrollees and help their enrollees better manage their health and healthcare. This is important because the health care system in the United States is fragmented and allows for autonomy for clinicians and patients. A quality health plan can help patients use and coordinate their care across providers.

TABLE 2

Comparison of the Distribution of Health Insurance Coverage for Black and White Populations by Age, 2021

	Total	Children	Working Age Adults	Elderly
Black Population				
Private Insurance	55.8	42.7	62.9	48.7
Public Insurance	45.3	58.7	29.1	94.4
Uninsured	9.6	4.7	13.5	1.1
White Population				
Private Insurance	74.2	73.1	79.9	60.6
Public Insurance	35.7	28.1	16.2	96.5
Uninsured	5.7	4.1	8.2	0.3
Ratio of Black to White				
Private Insurance	0.75	0.58	0.79	0.80
Public Insurance	1.27	2.09	1.80	0.98
Uninsured	1.68	1.15	1.65	3.37

Source: Branch B, Conway D. Health Insurance Coverage by Race and Hispanic Origin: 2021 Issued November 2022 ACSBR-012

Black Americans have lower rates of coverage by private health insurance, 55.8 percent being covered by private insurance compared to 74.2 percent of White Americans. This race disparity is due in part to the race disparity in the labor market. Persons who are unemployed or out of the labor market must rely on Medicaid or other public payers or rely on uncompensated/charity care to cover basic hospital care, physician care, outpatient services, and pharmacy services. This labor market disparity also attenuates the access to dental care, vision care, and other health services that are not routinely reimbursed well or even covered by Medicaid or other public health plans. The Affordable Care Act's (ACA's) creation of federal and state health benefit exchanges and its expansion of Medicaid reduce this disparity in health insurance coverage due to race disparities in the labor market. The health benefit exchanges provide persons who do not have access to employer-based health insurance with an affordable option. Persons who live below 133% of the federal poverty line qualify for Medicaid coverage in 38 states. However, the uneven implementation of the ACA has hindered its ability to reduce the race disparity in coverage. Southern states, where 38.4% of the nation's Black population lives, were reluctant adopters of the ACA. Most of these states declined to establish their own health benefit exchanges and to expand their Medicaid programs, leaving many low-income Black persons with limited health insurance options.

TABLE 3

Percent of Workers Reporting Access to Medical Care Benefits and Distribution of Black and White Workers, by Occupational Category, 2022

	Percent of Workers in Each Category Reporting Access	Percent of Non-Hispanic Black Workers by Occupational Category	Percent of Non-Hispanic White Workers by Occupational Category
All workers, all occupations	73	100	100
Management, professional, and related occupations	90	34.7	43.4
Service	48	21.7	14.5
Sales and office	68	20.9	20.3
Natural resources, construction, and maintenance	78	5.6	10.0
Production, transportation, and material moving	78	17.1	11.8

Source: Medical Care Benefits data from Table 2 Employee Benefits in the United States – March 2022 **https://www.bls.gov/news.release/pdf/ebs2.pdf** access on July 24, 2023. Occupation data reported by the Bureau of Labor Statistics for 2021 at **https://www.bls.gov/opub/reports/race-and-ethnicity/2021/home.htm**

The race disparity in labor market outcomes creates race disparities in Medicare coverage. Many Medicare beneficiaries rely on supplemental insurance to pay for some or all of the Medicare cost sharing requirements, that is, the premiums, copays, deductibles, and coinsurance. Supplemental insurance also pays for health services that Medicare does not cover. Affluent Medicare beneficiaries use employer-sponsored supplement and Medigap supplement plans, while poor Medicare beneficiaries rely on Medicaid to supplement Medicare coverage. Only 11% of Black Medicare beneficiaries have employer-sponsored supplemental insurance, compared to 20% of White Medicare beneficiaries. The race differences in retiree incomes contribute to race disparities in MediGap coverage, which covers only 5% of Black Medicare beneficiaries compared to 25% of White Medicare beneficiaries. Black Medicare beneficiaries who need help paying premiums, copays, deductibles, and coinsurance are more likely to rely on Medicaid for supplemental coverage than White Medicare beneficiaries, 23% compared to 9%. While Medicaid does provide needed coverage for Medicare cost sharing provisions, it requires beneficiaries to be poor to be eligible for this government assistance.

The race disparity in the quality of jobs contributes to the race disparity in health insurance coverage, that is, in medical care benefits. Occupations that non-Hispanic White workers are more likely to have provide better access to medical care benefits than occupations that Black workers are more likely to have. Table 3 displays the access to medical care benefits by occupation in 2022 relative to the distribution of non-Hispanic Black workers and non-Hispanic White workers. This table shows that in comparison to non-Hispanic White workers, non-Hispanic Black workers are more likely to be employed in occupations that do not offer them access to medical care benefits. Workers in the

management, professional, and related occupations had the best access to medical care benefits, with 90% of them being offered such benefits by their employers, as compared to service workers, of whom only 48% are offered these benefits by their employers. Black workers are more likely than non-Hispanic White workers to have service jobs and less likely to have managerial jobs.

The race disparities in earnings are associated with race disparities in health and healthcare. Median usual weekly earnings for full-time wage and salary workers were $794 for Black workers, as compared to $1,003 for White workers. This race difference in earnings reduces Black workers' ability to purchase goods and services that would enable them to maintain good health and use appropriate health care services. Earnings determine the amount and quality of food, housing, neighborhoods, transportation, and recreation that someone can pay for. These goods and services facilitate healthy lifestyles by promoting healthy behaviors (e.g., quality diet and exercise) and reducing exposures to harmful toxins (e.g., air pollution, lead exposure, contaminated water). Earnings also determine how much a person can afford to pay out-of-pocket for health care services. This includes copays, coinsurance, and deductible for services typically covered by health insurance, such as hospital care, physician care, and prescribed medications. Also, earnings determine how much persons can afford to use of services that sometimes are not covered by health insurance (e.g., dental and vision care).

Race disparities in the types of jobs people have impact their health more directly than just through access to healthcare services. Studies have shown that job-related stress is a contributor to higher rates of mortality, coronary heart disease, psychiatric disorders, and chronic diseases (Kivimäki & Kawachi 2015; Mutambudzi & Henkens 2020). Workers in occupations where they have little control over their hours and work conditions and those whose occupations require high effort but offer low rewards (e.g., low compensation in the form of salary, wages, benefits, and job security) have poorer health compared with workers in occupations that allow more control over their time and work conditions. The COVID-19 pandemic brought this phenomenon to the forefront. Persons who worked in service, transportation and factory jobs were at greater risk of contracting COVID-19 than persons in managerial and professional occupations (Baker, Peckham & Seixas 2020). Workers in the former group of occupations could not work from home or practice social distancing as readily as those in the latter group of occupations. Consequently, they could not control the level of their exposure to COVID-19 and had greater risk of become infected with the disease.

3.

Race Disparities in Capital Markets

Race disparities in access to and participation in capital markets are well documented (Conley 1999). Capital markets provide the necessary funds that people use to invest in housing, business, education, and training. Capital markets also provide opportunities to save for retirement.

Historically, Black Americans have had limited access to credit. The banking industry has a long history of discrimination against Black Americans in the housing markets (Conley 1999). When purchasing a home, Black Americans have historically faced predatory lending practices that subjected them to higher interest rates with less favorable terms (i.e., unreasonable fees and payment requirements). Black neighborhoods were subject to redlining, the promulgation of subprime mortgages, and other predatory lending practices. Redlining is when the banking industry designates non-White communities as of higher financial risk relative to White communities. Based on such risk assessments, the banks would lend money to residents in non-White communities at higher interest rates compared to White communities. This effectively lowered the value of homes in non-White communities, making it more difficult to sell them and to maintain them. The discriminatory practices of the banking industry were codified in federal law in the 1930s through the Home Owners' Loan Corporation (1933), the Federal Housing Authority (1934), and the Veterans Administration Service Readjustment Act (1944). These federal programs relied on local real estate agents to assess the financial risks of neighborhoods. Redlining created racial residential segregation, which relegated Black families to under-resourced neighborhoods and stymied their ability to accumulate wealth through home ownership (Katznelson 2005). Many cities in the United States became racially segregated, with few integrated neighborhoods, and integrated neighborhoods became unstable because of these financial pressures. In some cases, Black families

would be driven out or prevented from buying into neighborhoods so that White residents could obtain favorable access to financing. In other cases, White families would abandon neighborhoods—a phenomenon known as "White flight"—creating predominantly Black neighborhoods with limited access to financing (Rothstein 2017) This limited access to private and public financing created communities that were under-resourced regarding the social drivers of health. And these conditions persist today, impacting Black communities.

Residential segregation is the main driver of health disparities (Williams & Collins 2001). Residential segregation impacts the economic, physical, and social environment of a community. The lack of financing and investment in Black communities limits the amount and quality of community-based amenities that help people maintain and improve their health (Massey, Condran & Denton 1987). These amenities include social determinants, namely housing, education, transportation, the availability of healthy foods, the quality of the built environment (e.g., sidewalks and roads), recreational facilities, public safety, and public utilities. Residential segregation leaves Black communities with fewer employment and business opportunities, lower-quality housing, and lower-quality schools and neighborhoods. Also, the availability of healthcare resources such as office-based care from physicians and other health professionals is reduced (Gaskin et al. 2012; Chan et al. 2019).

Small businesses are the economic engines that drive growth and prosperity in nations. However, Black-owned firms have difficulty obtaining the financing necessary to maintain and expand their businesses. Black business owners are more likely than others to use personal funds to respond to financial challenges and less likely to obtain outside financing from lenders or grants. They are less likely to have strong relationships with either large or small banks. For their part, Banks are lending Black business owners less money than they lend business owners from other racial and ethnic groups.[2] This inequity in financing for Black business owners limits their ability to provide goods and services that would potentially benefit the health of residents in their communities. It also hinders Black business owners' ability to provide quality jobs to the residents of their communities.

The lack of private and public investments in Black communities has left these communities with harms such as pollution, crime, vacant and unkempt properties, and food swamps (i.e., establishments that sell primarily unhealthy foods) that are associated with chronic disease and higher death rates. For example, Black neighborhoods have higher levels of air pollution compared to non-Hispanic White neighborhoods. A recent study found that the concentration of fine particulate matter (an air pollutant) was 13 percent greater in Black neighborhoods than in non-Hispanic White neighborhoods (Jbaily et al 2022). Black communities are also characterized by a greater prevalence of liquor stores, an inundation of tobacco products, and easier access to illegal drugs in comparison with White communities (LaVeist & Wallace 2000). They are more likely to be food deserts or food swamps in comparison with White communities (Bower et al. 2014). Black communities have fewer and lower-quality recreational facilities as well, which curtails healthy physical activity (Kegler et al 2022; McKenzie et al 2013). The largest gaps in life expectancy by neighborhood occur in cities with the highest degree of racial and ethnic segregation, and within cities there are neighborhoods where that gap exceeds 20 to 30 years.[3] Some scholars and advocates have concluded that one's zip code is a more important determinant of one's health than one's genetic code (Graham, Ostrowski & Sabina 2016; Columbia University's Mailman School of Public Health, 2019).

2 *Small Business Credit Survey: 2021 Report on Firms Owned By People of Color* (United States Federal Reserve System 10.55350/sbcs-20210415) accessed at **https://www.fedsmallbusiness.org/survey/2021/2021-report-on-firms-owned-by-people-of-color** on June 10, 2023.

3 "Large Life Expectancy Gaps in U.S. Cities Linked to Racial & Ethnic Segregation by Neighborhood" (NYU Langone Health Research Press Release, June 5, 2019) accessed at **https://nyulangone.org/news/large-life-expectancy-gaps-us-cities-linked-racial-ethnic-segregation-neighborhood** on June 10, 2023.

4.

Other Communities of Color

This report has focused on how the unique economic challenges facing Black Americans impact their health and wellness. While other communities of color suffer health inequities associated with economic inequities, their stories are different.

Each community of color deserves to have its story told and analyzed to inform policies that would promote health equity for its members. Any discussion of health inequities for American Indian and Alaska Native populations must discuss the impact of being dispossessed and displaced from their land and the implications of these policies for their health. One must study the role of the Indian Health Service, treaties with the United States government, and policies and practices of different tribal nations in addressing the health needs of American Indians and Alaska Native populations. Similarly, any discussion of health inequities for Asian and Pacific Islander populations must discuss the immigration policies that prevented them from migrating to this country. Attention must be paid to Asian Americans' fight for citizenship and its implication for economic opportunities. Any discussion of health inequities for Hispanic populations must consider the impact of the United States' annexation of Texas and the Mexican American war, which resulted in the annexation of the Southwest region of the United States. The variation in this nation's immigration policies toward different Latin American nations must also be considered. Also, because Latinos can be White, Black, or Indigenous, one must consider how the experience of Latinos can vary by race. The legacies of discriminatory policies and programs of federal, state, and local governments, and the actions of powerful private corporate interests and individuals that have harmed other communities of color throughout U.S. history reverberate today and prevent individuals from these communities from achieving health equity. Any report that simply lumped their experiences with those of Black Americans would have limited usefulness for these community of color.

TABLE 4

Selected Health Indicators by Race and Ethnicity, 2020 and 2021

Health Condition	American Indian and Alaskan Native	Asian	Black American	Hispanic/ Latino	Pacific Islander	White Non-Hispanic
All-Cause Mortality for Males, All Ages, 2021[a]	1,282.7	554.9	1,374.0	884.9	1042.8	1,055.6
All-Cause Mortality for Females, All Ages, 2021[a]	946.6	386.3	917.2	582.7	806.0	751.4
Infant Mortality, 2020[a]	7.7	3.1	10.4	4.7	7.2	4.4
Cancer Mortality for Males, All Ages, 2020[a]	205.7	105.9	199.1	123.1	[b]	176.2
Cancer Mortality for Females, All Ages, 2020[a]	142.7	80.9	138.2	90.7	[b]	128.7
Diabetes Prevalence	17.7%	9.6%	13.2%	10.6%	11.9%	8.8%
Coronary Heart Disease	8.3%	2.9%	5.2%	3.0%	[b]	5.6%
Hypertension	29.2%	20.2%	35.2%	18.8%	25.4%	28.3%

Source: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Vital Statistics System, "Mortality 2018-2021," on CDC WONDER (online database, released in 2021) (data are from the Multiple Cause of Death Files, 2018-2021, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program), accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html on Jun 10, 2023; CDC, Infant Mortality Statistics from the 2020 Period Linked Birth/Infant Death Data Set, *National Vital Statistics Reports*, Table 2., NCI 2022; "U.S. Age-Adjusted Mortality Rates, 2020," *Seer Cancer Statistics Review,* SEER*Explorer; National Center for Health Statistics, "Percentage of diagnosed diabetes/coronary heart disease/hypertension for adults aged 18 and over, United States, 2021"; National Health Interview Survey (generated interactively: June 10, 2023) from **https://wwwn.cdc.gov/NHISDataQueryTool/SHS_adult/index.html**

[a] Denotes rates per 100,000 or 10,000 live births.

[b] Denotes that Pacific Islanders are included in Asian population.

Racial and ethnic inequities vary in nature and their impacts on health vary too. A quick glance at selected health indicators by race and ethnicity reveals that each group's experience is different (see Table 4.) For most health indicators, the Asian and Hispanic populations have better outcomes than the non-Hispanic White population, while for most indicators the American Indian, Alaskan Native, and Pacific Islander populations have worse outcomes compared to the non-Hispanic White population. These differences in health outcomes are not easily explained by economic inequities, nor do the economic inequities faced by these communities of color mirror the inequities faced by Black Americans (see Table 5.) The Asian population in the United States has a higher median income than the non-Hispanic White population, while the Hispanic, Native American, and Alaskan Native populations have lower median incomes. A higher percentage of the Asian population age 25 and older has a 4-year college degree compared to the non-Hispanic White population (55.4% versus 38.1%), while lower percentages of the Pacific Islander, Hispanic, and Native American populations have a 4-year college degree (23.8%, 17.2% and 18.5% respectively). The unemployment rate for Asian workers is

TABLE 5

Selected Socioeconomic Indicators by Race and Ethnicity, 2020 and 2021

Economic Indicator	American Indian and Alaskan Native	Asian	Black American	Hispanic/ Latino	Pacific Islander	White Non-Hispanic
Median Household Income (2021)	$51,097	$101,418	$48,297	$57,987	[a]	$77,999
Percent with 4-year College Degree, 2017	18.5%	55.4%	24.3%	17.2%	23.8%	38.1%
Unemployment Rate, 2021 Annual Average	8.2%	5.0%	8.6%	6.8%	6.9%	4.7%

Source: Income data from U.S. Census Bureau, *Current Population Survey, 2022 Annual Social and Economic Supplements* (CPS ASEC). Education data from U.S. Census Bureau, *Current Population Survey, 2017.* Employment data from U.S. Bureau of Labor Statistics, Current Population Survey, 2021.

[a] Denotes that Pacific Islanders are included in Asian population.

close to the rate for non-Hispanic White workers, while Hispanic workers and American Indian and Alaskan Native workers have unemployment rates that are, respectively, 46.8% and 74.5% higher than those of non-Hispanic White workers. While the Asian population as a whole compares favorably to White populations on these economic indicators, it should be noted that there are Asian subpopulations that perform worse on economic indicators than non-Hispanic Whites. Analysts must study the historic and contemporaneous experiences of each group to understand how the social determinants impact the health and well-being of these communities of color.

5.

Conclusion

Health inequities suffered by Black Americans are rooted in economic inequities that have persisted over generations. Inequities in labor markets devalue Black workers and deprive them of income and earnings. Inequities in capital markets devalue Black homes and businesses and hinder the development of Black talent and creativity. This lack of economic activity has implications for the health of Black Americans and their access to healthcare and other health-promoting goods and services. If Black Americans are going to achieve health equity, in addition to incorporating equity in the implementation of policies and practices to improve the delivery of healthcare and public health services, inequities in the labor market and capital markets must be addressed. Otherwise, these economic inequities will continue to generate inequities in the social determinants of health that lead to health inequities for Black Americans.

This problem is not just a social justice issue, it is an economic issue too. Health inequities for Black Americans cost the U.S. economy $311.5 billion in 2018 (LaVeist et al. 2023). This is a significant drag on the U.S. economy, almost 1.5% of annual gross domestic product. While it may take a significant investment to address the problems in the labor and capital markets Black Americans face, it is probably more costly to ignore these problems and to allow health inequities to persist.

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