An Asset Framework to Guide Nonhealth Policy for Population Health
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There is now copious evidence that economic and social conditions shape population and individual health. An understanding that place, employment, and education are determinants of health (often called social determinants of health [SDOH]) suggests that policy interventions that target these SDOH have important implications for health. This realization poses a challenge to those concerned with promoting health. How can we offer policy solutions that address the SDOH and that may be palatable to nonhealth policymakers?

One approach to guide policy thinking is an assets framework. We propose that there are 3 types of assets that unlock access to resources and shape population health: financial assets, physical assets, and social assets. These assets in turn may be amenable to policy interventions. Understanding how these assets shape health can point to specific nonhealth interventions that can be used to improve the health of populations.

Financial Assets

Financial assets include income, savings, credit, and insurance (e.g., disability insurance, health insurance, and life insurance). Although the income-health gradient has been established across all life stages, there is evidence that wealth is a stronger indicator of financial well-being and predictor of subsequent health. There is also increasing evidence of an association between health and lower debt and higher credit scores. Importantly, gaps in nonincome financial assets between racial and ethnic groups are often wider (and may contribute more to health disparities) than income gaps. For example, the income differential between White families and Black families is 2 to 1, but the wealth ratio, which goes beyond income and includes assets and net worth, is 6 to 1.

Understanding how financial assets influence health shines light on nonmedical interventions that could improve health. For example, wealth accumulation is shaped over generations and is influenced by in-kind payments (such as payment for college) or capital invested in early childhood. This suggests that reconsidering benefits to all children can have substantial health benefits across the life course. Policy efforts to provide baby bonds to newborns (i.e., a savings trust account that can be redeemed when reaching adulthood) have been proposed at the national level and in multiple states including Connecticut, Iowa, and Wisconsin. Providing baby bonds could help low-wealth groups accrue financial assets and commensurate health benefits. Similarly, policy efforts (such as cash transfers and insurance benefits) that can improve wealth could also be associated with improved health.

Physical Assets

Physical assets include material objects that facilitate shelter (homes), mobility (cars), and communication (devices and the internet). Home ownership may provide stable housing, higher-quality living standards, and psychological respite that confer positive health; conversely, an inability to cover mortgage payments may confer negative health effects. Home ownership may also influence health through helping persons accumulate capital and through the potential leverage of homes as collateral to then wield assets to generate health.
Similarly, access to technological devices can facilitate both social interactions and economic opportunities that may improve health; access to telehealth can also enable interaction with health services. This understanding of physical assets and their roles in shaping health points to potential nonhealth policy interventions. In the UK, the Right to Buy policy provided subsidies for home renters to purchase their homes and was met with improvements in objective and subjective health indicators. Similarly, policies that aim to provide high-speed internet to all in the US can facilitate access to health services.

Social Assets

Social assets are attributes that shape an individual’s role and status in society, affecting health directly and conferring privilege and opportunities to access other assets. Social assets include education, marital status, and religious affiliation. Some of these assets influence health directly. For example, education is associated with the positive health behaviors of exercise and eating more nutritious foods and marriage is associated with reduced alcohol consumption and a longer lifespan. Social assets also are associated with health indirectly. Religious group affiliation and being married are both associated with social support, which has been linked to better health across a range of indicators. In addition, being married confers social privilege and access to opportunities for wealth generation and stable housing, further allowing individuals to accrue other assets that contribute to health.

Intergroup gaps in social assets are likely to contribute to health inequalities. For example, there are substantial differences in educational attainment across populations in the US, with racial and ethnic minority groups having less education and commensurately poorer health. Policy actions that influence the attainment of social assets stand to both improve health, and may if applied carefully, narrow health gaps. For example, providing affordable, quality education can have health-promoting effects across the life course. As another example, same-sex marriage legalization allows lesbian, gay, bisexual, transgender, and queer individuals to access health insurance and other benefits afforded through marriage, providing access to benefits that promote health.

One of the central challenges to linking the SDOH to effective policy action is the abstraction that accompanies discussions of social determinants. An asset framework may help identify policy actions that can improve health. For example, finances in and of themselves provide no health benefits, however, they can facilitate access to the resources that are critical for health, ranging from the foundational drivers of health (such as housing, food, education, and employment) to the proximal factors that restore health in the face of illness (access to high-quality health services). Much of health policy focuses on improving access to health services, and though this is critical to ensure that populations receive effective and fair medical intervention, we propose an expansion of health policy to interventions that bolster the assets that produce health.

ARTICLE INFORMATION

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