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Ownership of a bank account and health of older Hispanics

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HIGHLIGHTS

- Hispanics are more likely than non-Hispanic Whites to be unbanked.
- Using the HRS, we study the association between health and bank account ownership.
- Among Hispanics, bank account ownership is associated with improved mental health.
- Hispanics in low SES neighborhoods and below median wealth experience larger benefits.

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ABSTRACT

We study health effects of financial inclusion, particularly ownership of a bank account of older minorities, with focus on Hispanics. Using data from the Health and Retirement Study from 2000 to 2012, we find that, for Hispanics, being banked has a positive effect on mental health but is not associated with effects on physical health. Mental health benefits are likely to be larger for those who face greater hurdles to access formal financial institutions. Hispanics in less well-off neighborhoods and with below-median wealth appear to experience the greatest mental-health benefits associated with ownership of a bank account.

1. Introduction

Previous studies of the United States (US) have found that access to health insurance for the uninsured improves wellbeing by providing financial protection, reducing stress, and, in turn, improving mental health (e.g., Finkelstein et al., 2012). Similarly, Taylor et al. (2009) document a positive relationship between individuals' ability to manage and take control of their finances and their psychological wellbeing.

Ownership of a bank account constitutes a basic step towards promoting financial capability and is likely to have important implications in relation to liquidity constraints and saving behavior (Thaler, 1999), transaction costs (Carbo et al., 2005), financial preparedness for retirement (Clark and d'Ambrosio, 2003), and personal security (Mullainathan and Shafir, 2011). Hence, access to a bank account may increase financial stability, reduce stress, and benefit health, especially among minorities facing cultural and socio-economic barriers that limit their participation in the formal financial sector.

Using panel data techniques, we investigate the extent to which ownership of a bank account is associated with better physical and mental health for different racial and ethnic groups in the US, particularly Hispanics. We focus on individuals age 51–90 since they are likely to face greater hurdles to accessing primary financial services due to their cultural background or lack of acculturation.

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We also explore whether, among Hispanics, the potential health benefits of ownership of a bank account are heterogeneous across different socioeconomic status (SES) groups. While our work is innovative in documenting the relationship between financial access and health, lack of exogenous variation in bank account ownership prevents us from interpreting our estimates as causal. We briefly discuss some of the endogeneity issues we face.

2. Data and methodology

We use data from the Health and Retirement Study (HRS). Our sample includes individuals age 51–90 observed over the period 2000–2012 (7 biennial waves). We construct three health indices – overall, physical, and mental health – using principal component analysis as in Michaud and van Soest (2008). Overall health index includes self-reported health (5-point scale: excellent, very good, good, fair, or poor), severe condition (cancer, chronic lung disease, heart attack or other heart problems, and angina), mild condition (hypertension, diabetes, emotional, nervous, or psychiatric problems, and arthritis or rheumatism), CESD score (Center for Epidemiologic Studies Depression Scale), and difficulty with activities of daily living (ADL). Physical health index includes severe condition, hypertension, diabetes, arthritis or rheumatism, and difficulty with ADL. Mental health index includes CESD score and psychiatric problems. Health indices are standardized and reverted so that higher values correspond to better health.

We classify as "banked" those households who answer the question: "*Do you (or your) (husband/wife/partner) have any checking or savings accounts or money market funds?*" affirmatively.[3] For each household, we consider the financial respondent and estimate individual-specific effects models of the form:

$$HI^j_{it} = \alpha + \beta AF_{it} + \gamma X_{it} + \lambda_i + \delta_t + \varepsilon_{it}, \quad (1)$$

where HI^j_{it} is the health index j for individual i in year t; AF_{it} is an indicator for whether individual i in year t holds a bank account; X_{it} is a vector of time-varying individual characteristics, namely an index of neighborhood SES characteristics, a quadratic polynomial in age, an indicator for couple household, income and wealth in tertiles, indicators for home and vehicle ownership, working status, private pension, health insurance, ever smoked, and obesity. The term λ_i represents time-invariant individual characteristics; δ_t are survey year indicators and ε_{it} idiosyncratic errors.

We estimate Eq. (1) by fixed effects (FE) with robust standard errors. This allows us to control for unobserved individual traits and preferences that are bound to affect both health outcomes and financial behavior. Since we are interested in the effect of financial-sector participation on the health of racial groups, we estimate Eq. (1) for the entire sample and, separately, for Whites, Blacks, and Hispanics (excluding other racial/ethnic groups). The FE estimator exploits within-individual variation in ownership of a bank account to identify the parameter of interest. While changes over time in bank account ownership are relatively common among minorities (especially Hispanics), we check the robustness of our results to the source of identifying variation by estimating equation (1) with random effects (RE). In the RE specification, we include time-invariant individual characteristics, such as gender, education, race and ethnicity, ever received Social Security benefits, and individuals' initial health to account for unobserved determinants of health status potentially correlated with financial behavior.

[3] FDIC (2014) indicates that 67% of unbanked and underbanked Hispanics own a checking account, but only 26% own a savings account.

We exploit the restricted HRS geo codes to link census tracts of sampled households with data from Census 2000 and the 2009–12 American Community Survey. We construct an index of neighborhood socioeconomic status (*NSES*) characteristics using principal component analysis as in Diez Roux et al. (2001). The index includes neighborhood-level information about residents' income, housing, education and occupation (see Blanco et al. (2016) for more details). Summary statistics are available in Table A.1 of the online appendix (see Appendix A).

3. Results

Table 1 shows the estimated relationship between health and ownership of a bank account for the entire sample and, separately, for Whites, Blacks and Hispanics. The FE estimates in columns (1)–(3) indicate that having a bank account is associated with an improvement in overall and mental health, while there is no effect on physical health. When we split the sample by race/ethnicity, we see that mental health benefits are driven primarily by Hispanics, for whom ownership of a bank account increases the mental health index by nearly 0.06 standard deviations. For Whites and Blacks, we observe a marginally significant association between bank account ownership and overall health.

Columns (4)–(6) present the RE results. These confirm the stronger association between mental health and ownership of a bank account for Hispanics in comparison to the other two racial groups. The RE estimation also reveals significant positive health effects for Whites (overall and mental health) and Blacks (overall health). While we control for initial health in our RE regressions, this may not fully account for unobserved individual-specific characteristics that correlate with both health outcomes and ownership of a bank account. For this reason, we prefer FE specifications, which we will use below when exploring heterogeneity across SES groups.

Controlling for ownership of home, vehicle and private pension, which could proxy for financial inclusion, might lead to underestimate the association between bank account ownership and health outcomes. When we exclude such variables we obtain slightly larger parameter estimates (see Tables A.4 and A.5 in the online Appendix, see Appendix A). Yet, in the reminder of the paper we maintain a more conservative specification where these variables are controlled for.

In Table 2, we analyze whether the effect of bank account ownership on health varies by SES. Here we consider only Hispanics, for whom mental health benefits of financial-sector participation appear to be greatest. We hypothesize that ownership of a bank account increases financial security, reduces stress, and through this, improves mental health. We expect the positive effect of owning a bank account on mental health to be more apparent for relatively more disadvantaged groups, especially within minorities that face access barriers related to language proficiency, culture, and legal status, among others. Below, we test this hypothesis using a one-sided test.

In columns (1) and (2) of Table 2, we separate Hispanic households depending on whether they answer the questionnaire in Spanish or English. We consider the former to be less proficient in English and to have limited acculturation. As a consequence, they may find it more difficult to open a bank account because of language as well as cultural barriers. We compute that, while 72% of Hispanics answering the HRS in English own a bank account, only 40% of those answering in Spanish do so. We find that, for those Hispanics who answer in Spanish, ownership of a bank account improves mental health by nearly 0.08 standard deviations. For those who answer in English, the estimated effect is smaller and not statistically different from zero. Yet, a one-sided