Studies: US life expectancy drops as mortality rises among younger adults

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While most high-income countries experienced a drop in life expectancy in 2015 for the first time in decades, only the United States and the United Kingdom saw that disturbing trend continue into 2016.

The recent declines in American life expectancy are due in part, but not exclusively, to drug overdoses, suicides and alcoholism. Deaths among middle-aged Americans over the past decade and a half were also attributed to heart, lung and other organ diseases, as well as to mental and behavioral disorders.

These were the findings of two studies published last week in the BMJ (formerly the *British Medical Journal*). The continuing decline in US life expectancy—and the increase in mortality among younger adults and across all ethnic groups—points to systemic social causes driving this crisis.

The first study, by sociologists Jessica Ho of the University of Southern California and Arun Hendi of Princeton University, examined trends in life expectancy across 18 so-called high-income countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Italy, Japan, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, the US and the UK.

The study focused on 2014 to 2016, because previous research has shown life expectancy dropping significantly between those years. Ho and Hendi found that 14 of the countries experienced declines in life expectancy for both men and women from 2014 to 2015. Only Australia, Japan, Denmark and Norway did not.

The decline in life-expectancy was generally attributable to an unusually severe influenza season in 2014–2015. Leading causes of non-US deaths in this period included influenza and pneumonia, respiratory disease, cardiovascular disease, Alzheimer's disease, as well as mental and nervous system disorders. Most of these deaths occurred in the over-65 population.

But while many of the countries saw a rebound in life expectancy in 2016, the US and the UK saw declines for two consecutive years. While the opioid epidemic—along with alcohol-related liver disease and suicides—were seen as key contributors to these declines in the US, mortality rates increased across a broad spectrum of diseases involving multiple body systems. Injuries involving motor vehicles were also key contributors.

While the study was not designed to determine the reasons for the decline in life expectancy in the US and UK, the authors speculate that increasing social and economic inequality and declining access to quality health care among some groups in the population may be strong contributing factors. Ho and Hendi write, "It is possible that greater inequality within a country renders that country more vulnerable to declines in life expectancy."

While other high-income countries are also experiencing income inequality, it has been growing at a far more rapid pace in the US. The authors add that this burgeoning inequality may explain why the US "has the lowest life expectancy among high income developed countries, and Americans fare poorly across a broad set of ages, health conditions, and causes of death compared with their counterparts in these countries."

The second BMJ study was led by Dr. Steven Woolf, a social epidemiologist at Virginia Commonwealth University. This study examined death rates among Americans aged 25 to 64 across racial and ethnic groups between 1999 and 2016.

Previous research has shown "deaths of despair"—from overdoses, alcoholism and suicides—were the main drivers over the past decade and a half of an increase in mortality among middle-aged Americans. However, Woolf's research also found a significant increase in deaths of heart, lung and other organ diseases, as well as from mental and behavioral disorders. Woolf said in a statement released by the BMJ: "The opioid epidemic is

the tip of an iceberg."

The researchers found that between 1999 and 2016, midlife all-cause mortality in the US increased by a statistically significant 5.6 percent among non-Hispanic whites. All-cause mortality rates showed a decline during the first half of this time period: declining until 2009 among Non-Hispanic American Indians and Pacific Islanders; until 2010 among non-Hispanic blacks, until 2011 among Hispanics, and until 2012 among non-Hispanic whites.

These mortality rates then began to plateau or increase among all groups. The progress made in reducing midlife mortality from heart disease, cancer, HIV and other diseases was offset by statistically significant increases in deaths from external causes: drug overdoses, alcohol poisoning, suicides and a variety of organ diseases.

Woolf's team notes: "The unfavorable mortality pattern that began for some groups in the 1990s is now unfolding among Hispanics and non-Hispanic blacks, a development made more consequential" by the fact that Hispanics and blacks have had higher death rates to begin with.

The researchers also found that the gender gap is narrowing. While middle-aged men still have higher overall death rates than middle-aged women, the relative increase from fatal drug overdoses and suicides was higher among women.

Research on life expectancy has focused recently on white mortality in depressed rural areas. However, the BMJ study documents that non-Hispanic whites and Hispanics experienced the largest proportional increases in drug overdose deaths in suburban fringe areas, while the largest increases for non-Hispanic blacks occurred in small cities. American Indians and Alaska natives living in metropolitan areas experienced a larger relative increase in suicides than those in rural areas.

The researchers warn that the increasing death rate among middle-aged Americans "signals a systemic cause and warrants prompt action by policy makers to tackle the factors responsible for declining health in the US." The authors of the first BMJ study correctly note that "it is possible that greater inequality within a country renders that country more vulnerable to declines in life expectancy."

They suggest that solutions to the drug overdose epidemic could include better prescription drug monitoring programs, expanding access to substance misuse treatments, establishing supervised injection centers and needle-exchange programs, and increasing the availability of naloxone to counter overdoses.

The researchers also say corrective social policies should address "the underlying social and economic conditions that may underpin drug use." It is precisely these underlying conditions that have worsened under successive US administrations and through a bipartisan assault on social programs upon which millions of workers and their families depend.

Cash welfare assistance was all but eliminated under Bill Clinton. Cuts to food stamps, intensified under the Obama administration, have continued under Donald Trump. The current president, while declaring the opioid epidemic a "public health emergency," has allocated no new funding to the states to address the crisis.

It is notable that the first BMJ study found that between 2010 and 2016 life expectancy in the US stagnated and decreased, while other high-income countries saw modest but steady increases. In the wake of the Great Recession, the working class continued to see its living conditions worsen while the two big business parties bailed out the banks and the super-rich continued to pad their bank accounts at the expense of the vast majority.

While new declining US life expectancy rates should sound the alarm bells, no such response has been elicited from the White House or Congress. They remained similarly silent at the recent release of a CDC report that estimated 72,000 people died from drug overdoses in 2017 in the US.

Life expectancy is one of the most important measures of the social health of society. An increase in mortality rates—unheard of in modern times except from disease epidemics or world war—is a warning to the working class that it must develop a socialist response to this health emergency.

The hundreds of billions of dollars allocated to the US military for its myriad wars must be diverted to fund rehabilitation centers, mental health centers, and hospitals and clinics utilizing the latest scientific methods and treatments. The wealth of the pharmaceutical corporations, giant hospital chains and private insurance companies should be expropriated and placed under workers' control. A socialized health care system must be established that provides free health care of the highest quality for all.