Prepared Testimony

Nicholas Eberstadt, Ph.D.

Henry Wendt Chair in Political Economy

American Enterprise Institute

eberstadt@aei.org

Hearing on

"Dying Young: Why Your Social and Economic Status May Be a Death Sentence in America"

U.S. Senate Committee on Health, Education, Labor and Pensions

Subcommittee on Primary Care and Aging

November 20, 2013

Mr. Chairman, distinguished Members, esteemed co-panelists and guests,

In these august chambers, as in other policymaking circles in Washington and around the nation, a policy syllogism is gaining currency and receiving increasingly respectful attention. The syllogism runs something like this: health progress is faltering in America today; faltering health progress is the consequence of social and economic disparities; therefore government must intervene to reduce disparities if health progress is to be revitalized.

Influential as this syllogism has come to be nowadays, I submit that it is empirically flawed, and therefore requires serious qualification and re-examination.

The problem with the syllogism lies not in its assertion that health progress in modern America is disappointing. For the national as a whole, the evidence to this effect is, unfortunately, overwhelming.

Rather, the trouble lies with the proposition that social and economic disparities are the cause of America's disappointing health performance today.

To be clear: this is not to ignore the great corpus of data pointing to a widening of income differences and other economic differences in America over the past generation. Nor is it to suggest that it is not better to be affluent, educated, and well insured. Obviously it is: and not just for reasons bearing on health.

Yet the perhaps curious fact of the matter is that real existing social and economic disparities are just not that good in predicting real existing health disparities in our real existing modern America. In fact, it is commonplace today for poorer, less educated groups to enjoy substantially

better health outcomes than those who would appear to enjoy distinctly greater socioeconomic advantages. The surprising—but also hopeful—fact is that it is possible for groups suffering what might be described as both social and economic disadvantage to achieve very good health outcomes in America today. And that is not just a technical, arcane, theoretical possibility: it is a main street reality, ratified by the survival profiles of millions upon millions of Americans today.

We manifestly need to understand exactly how it is that so many Americans today manage to achieve good or excellent health outcomes with limited incomes, educational backgrounds, and other socioeconomic resources. But manifestly, the mental straitjacket that the "social disparities" mindset imposes on public health research is incapable of helping us in this critical task.

The tables and graphs that accompany this written statement offer data and analysis that underscore, and expand upon, the summary points offered telegraphically in the preceding paragraphs.

Let us begin with the question of America's health record over the postwar era. There is really no question at this point as to the at-best mediocre results we as a society have garnered over the past half century and more. While our country has achieved continuing incremental improvements in overall health conditions (as reflected in the mirror of mortality), our progress has been decidedly slower than in other affluent Western democracies—and thus our ranking in this roster has gradually but steadily declined.

We can see this in Figures 1 and 2 of the attachment to this written statement. [SEE FIGURES 1 AND 2] The graphics trace out the trends in years of combined male and female life expectancy at birth on the one hand, and infant mortality rates per thousand live births on the other hand, for the United States and 23 other never-communist members of the OECD (Organization for Economic Cooperation and Development), an association of aid-dispensing Western industrialized democracies.

These estimates come from the Human Mortality Database, a project undertaken by the University of California at Berkeley and the Max Planck Institute for Demographic Research in Germany—since experts in this network have carefully examined the underlying data from all these countries and offered their own corrections or reconstructions as warranted, we get an "apples to apples" comparison here.

As can be seen in Figures 1 and 2, despite continuing progress in reducing mortality levels, America has gone from a more or less middling ranking in this pack of 24 countries shortly after the end of World War II (1950) to the very poorest ranking among these 24 countries today (circa 2010). Life expectancy at birth is now estimated by the Human Mortality Database researchers to be lower in the USA than in any of the other 23 comparators—and infant mortality conversely is placed highest in the USA for any country in this same group. Trend lines for the odds of surviving from birth to say age 65, or any other measure for the risk of premature mortality, would tell a roughly similar story for America's health performance over the postwar era.

What accounts for this long-term relative decline in US health performance?

Over the past half century, America has become an increasingly multiethnic society, and it has also seen the emergence of growing economic differences. (Admittedly, rising measured economic differences have also been characteristic of almost all other affluent Western democracies over these same decades—but measured income dispersion in the USA today appears to be greater than in almost all of the comparator countries in Figures 1 and 2).

It is tempting to link these big changes in American society and economy with our disappointing health performance. This impulse, indeed, is at the heart of the current popularity of the "social disparities" paradigm, so widely utilized in public health research on America today. There is no gainsaying the general insight that more prosperous and better educated people should be expected to have more favorable health outcomes than those who are less well-to-do. But as a practical matter, socio-economic disparities do not seem to offer us all that much help in understanding the big health differentials we see in our society today.

Table 1 makes the point. [SEE TABLE 1] It presents figures for America's major ethnic groups on the one hand for major indices of social and economic disparity—poverty rates; proportions of the adult population without high school education; income distribution for families; percentages of persons without health insurance; percentages of adults with no health care visits over the previous 12 months—and on the other for age-standardized mortality.

If the "social disparities" model has much predictive power in the modern American context, we would expect these major disparities to track with differential in mortality. We should bear this in mind when we examine the findings in Table 1.

Consider what this table reveals for the "non-Hispanic white" (i.e. "Anglo") population in contemporary America (i.e., around the year 2010). By all indicators in this table—poverty, education, income distribution, access to health insurance, use of health services in the past 12 months—the "Anglo" community or population appears to be decidedly better off on average than Americans as a whole. But age standardized mortality for Anglos is no better than for the USA as whole. Indeed, age standardized mortality is reportedly slightly *higher* for Anglos than for the nation as a whole.

Needless to say, if social and economic disparities were the dominant factor in determining health outcomes in the United States, the improbable correspondence between relative socioeconomic privilege and slightly less-than-average health results for Anglo America today would be unfathomable. But the situation is even more striking than this one comparison would suggest.

Consider next the circumstances for our Asian minority (officially, Asian and Pacific Islanders). On all of the social and economic indicators in Table 1, the Asian population fares less favorably than the Anglos. Yet age-standardized mortality levels for our Asian-Pacific population are officially estimated to be over 40 percent below the national average.

Finally, consider the situation for the Hispanic population in America today. By a number of measures, it would appear to be *the* most socio-economically disadvantaged major ethnic group in America today. Nearly 40 percent of Hispanic American adults, for example, have no high school degree (2009); over 30 percent of all have no health insurance (2010); and nearly 30 percent of Hispanic adults did not report even a single visit to get health care over the previous

year (2010). Even so: the age-standardized mortality level for Hispanic Americans is estimated to be fully 25 percent lower than the average for the nation as a whole!

Thus the striking paradox of health in modern America is this: minority groups reporting higher incidences of poverty and income inequality, lower educational attainment, less health insurance coverage, and greater likelihood of no treatment by medical professionals than our Anglo majority also report significantly lower mortality (and thus longer life expectancy) than our Anglos—indeed, significantly better mortality levels than for America as a whole. And this paradox is not new: as Figures 3 and 4 attest, for males and females alike, mortality rates for our Asian and Hispanic minorities have been superior to those of non-Hispanic Whites for many decades—in fact, for as long as such numbers have been compiled. Non-Hispanic Blacks or African-Americans are the only ethnic minority whose health profile appears to be poorer nowadays than our Anglos.

The phenomenon of superior health performance by ostensibly disadvantaged minorities can be seen from sea to shining sea. Consider first Los Angeles County: with nearly 10 million inhabitants, the nation's most populous jurisdiction, fewer than 30 percent of whose residents are Anglos. [SEE FIGURE 5] According to the LA County Department of Public Health, total male and female life expectancy at birth for these non-Hispanic White residents in 2010 was actually a bit below the countywide average (80.8 years vs. 81.5 years). But the official poverty rate for the Anglo population in LA County is well below the countrywide average. On the other hand, Hispanics and Asians both suffered higher poverty rates than Anglos—the rate for Latinos was over twice as high as for non-Hispanic Whites—yet their life expectancies were also markedly higher. In 2010, the Latino edge in life expectancy over Anglos in LA County amounted to roughly 2.4 years; for Asians, the premium was fully 5 years. Is "your social and economic status" a "death sentence in America", as the title of our hearing today avers? Evidently, not in Los Angeles.

Now consider New York City, the nation's biggest urban jurisdiction. [SEE FIGURE 6] As we all know, the "Hispanic" designation encompasses a wide variety of backgrounds. In terms of country or place of origin, the Latino population of New York City is quite different from Los Angeles County. No matter: according to the New York Department of Health, Hispanics still edge out Whites in life expectancy in New York City, and have been doing so for many years, even though the Hispanic population's poverty rate in 2010 was over twice as high as the rate for Whites.

If we look at age-standardized mortality in New York City, we see our national health paradox instantiated locally. [SEE FIGURE 7] Here again, mortality levels are lower for Hispanics and for Asians than for Whites, even though their official poverty rates are higher. It is true that mortality levels for New York's Black population is dramatically higher than for its White population—and poverty rates for Blacks in New York were about twice as high as for non-Hispanic Whites in the period under consideration. But the Hispanic poverty rate in New York was very appreciably higher than the Black rate, even as the Hispanic age-adjusted mortality levels were fully one third lower than Black levels.

In and of itself, poverty just isn't that good a predictor of health outcomes in New York City. That point is further emphasized in an analysis by the New York City Department of Health on life expectancy, ethnicity, and neighborhoods. [SEE FIGURE 8] It is true that the very lowest

life expectancy was recorded for Black New Yorkers who lived in the City's poorest neighborhoods. It is also true that life expectancy generally tended to increase for City residents as the affluence of their neighborhood increased. So far, so good for the "social disparity" model. But the biggest differences in health outcome in New York City just can't be predicted by this proxy of affluence or disadvantage. Note that life expectancy for African Americans in the City's most affluent neighborhoods was notably lower than for Hispanics in the City's poorest neighborhoods. Note as well that there was no "poverty neighborhood" effect whatever for New York's Asian population. Indeed: according to this analysis, the very healthiest group in New York City was Asians who lived in New York's poorest neighborhoods. These people enjoyed life expectancies roughly five years higher than for Whites from the City's wealthiest neighborhoods.

Let us return to our international comparison of America's health performance. The disappointing picture painted in Figure 1 turns out to be much more interesting, and somewhat more promising, when we disaggregate life expectancy by state and by ethnicity. We can do so with the aid of research by the "Measure of America" project from the Social Science Research Council (SSRC), which permits us to compare state-level life expectancy at birth by ethnicity with US Census Bureau estimates for life expectancy at birth for the rest of the OECD. [SEE FIGURES 9-12] As we can see, America's international health standing depends very much on which group and region we are talking about.

For African Americans, the story is pretty dispiriting—the nationwide average for life expectancy for American Blacks is lower than the life expectancy of all but three of the OECD's 34 countries, and even the highest calculated state-level African American life expectancy (Rhode Island) is lower than 20 of the OECD's country-level averages.

For US Whites, the situation looks better, but only to a degree. By these SSRC calculations, the nationwide life expectancy at birth for America's Whites ranks below the life expectancy at birth of fully 20 OECD countries, as estimated by the US Census Bureau. The dispersion of life expectancy by state for America's whites is noteworthy. Among US Whites, life expectancy for the longest living region (Washington DC) is higher than for any country in the OECD—but life expectancy for the lowest region (West Virginia) is worse than for all but 4 OECD nations.

When we place Hispanic America's health in international perspective, the contrast is dramatic. To many viewers, the results are likely to be unexpected. By themselves, Hispanic Americans today are estimated to enjoy a life expectancy higher than for any country in the OECD—higher even than Japan, the world's healthiest society by the yardstick of life expectancy.

And America's Asian population is almost off the chart. By the SSRC's reckoning, Asian Americans nationwide can expect to live about 5 years longer than citizens of Japan; life expectancy for Asian Americans in their lowest-health state (Hawaii) would be a bit higher than life expectancy in Switzerland; and in at least six states. Asian-American life expectancy at birth nowadays is placed above 90 years.

Viewed from this perspective, America's health problem looks a little different from the conventional formulations. If the United States were a nation composed solely of its Hispanic and Asian Pacific minorities—populations, as we have seen, where conventionally described "social disparities" weigh heavier than on the nation as a whole—we would be the healthiest

country on earth. Our nationwide health problem is a problem within our African American population—a group that suffers disproportionately from poverty and other conventional metrics of socioeconomic disadvantage—and our Anglo population—a group that suffers *less* from poverty and other conventional metric of socioeconomic disadvantage than the nation as a whole.

As should by now be apparent, health outcomes in modern America are a consequence of something beyond abstract social forces. Seeming victims of "social disparities" regularly achieve high levels of life expectancy—very often, levels better than those with seemingly greater social and economic advantages. If we are truly interested in improving our country's public health conditions, we should be asking what is going *right* in these populations and these communities. Is it behavior? Lifestyles? Outlook and attitudes? Some combination of these things? We should desperately want to know. We will not—indeed cannot—learn the answers to this critically important question to our nation's wellbeing if we insist on attempting to protect the conclusion that social inequality is really what ails us.