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THE DECLINE IN LIFE EXPECTANCY IN THE UNITED STATES: SOME CAUSES AND POTENTIAL REMEDIES

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Abstract

Life expectancy in the United States declined in 2015 for the first time in nearly a century, a trend that continued in 2017. This paper explores three central reasons for this reversal: a spike in fatal opioid overdoses; the long-term public health implications of overweight and obesity; and an uptick in suicide. The causes behind each of these are considered. Increased fatality due to the consumption of narcotics is linked both to practices of the pharmaceutical distribution industry that have made opioids widely available and to broad transformations in the US economy over the past forty years that have generated chronic insecurity in many people's lives. Multiple reasons for the overweight and obesity epidemic are presented, including changes in people's work lives as the US economy has shifted from manufacturing to service employment; advertising and widespread availability of unhealthy food; and influence of industry on national policy governing the food supply. The troubling spike in suicide is attributed in part to the relative ease with which people in the United States are able to gain access to firearms and bullets. The paper concludes with some suggestions on how this decline in life expectancy can be turned around.

Keywords: life expectancy; opioids; obesity; suicide; pharmaceutical industry; food industry; firearms;

1. INTRODUCTION

In 2018, The United States Centers for Disease Control and Prevention reported that in the previous year life expectancy in the United States had dropped for the second time in three years. In 2017, the average American could expect to live 78.6 years in contrast to the 78.7 years that had been the case in 2016. Although this decline appears infinitesimal, it is in reality significant because it was only the second time in nearly a century that a drop in life expectancy occurred in the US. Prior to a decline in 2015 as well of 0.1 years, the last time life expectancy went down was in 1918 due to an influenza pandemic (Devitt 2018). (As of this writing, statistics for 2018 had not been release.)

Determining the causes of the recent declines is very challenging. In this brief paper, I probe three probable sources: a spike in fatalities as a result of drug overdoses; the negative health implications of the overweight and obesity epidemic; and an increase in suicides partly attributable to the ease with

which people in the US have access to firearms. In addition to providing some statistics on these public health crises, I consider potential reasons for their development and ways in which they might be remedied. The manifold consequences of this drop in life expectancy are not examined in this paper in part because further research is needed in order to fully bring them to light.

2. OVERDOSE FATALITIES

In 2017, 70,237 people – or more than 192.43 per day – died of drug overdoses in the US, which was a nearly 10% increase over 2016. Alarming enough on its own, the growth in overdose fatalities is even more troubling when viewed with a deeper historical perspective: 21.7 out of 100,000 people died of drug overdoses in the US in 2017 while the figure for 1999 was 6.1 out of 100,000. There was significant regional variation in the number of fatalities, West Virginia, Pennsylvania and Ohio being, in that order, the states with the highest frequencies and Nebraska, North Dakota and South Dakota, as well in that order, having the lowest frequencies – this geographical variation is not without significance, a point to which I return (Centers for Disease Control and Prevention 2018a). Furthermore, these fatalities are not only urban but also suburban and rural and have grown among most social classes and races (Realuyo 2019). In regards to age of fatality, people 25 to 54 were more likely to die from drug overdoses than people of other age categories, meaning that loss of life was greatest at ages at which the majority of people are typically their most productive.

47,600 of the deaths resulted from the consumption of opioids, a class of drugs that includes heroin; synthetic substances such as fentanyl, carfentanyl and tramadol; and pain relievers that can be composed of natural and/or synthetic substances, such as oxycodone (OxyContin), hydrocodone (Vicodin), codeine, morphine, and numerous others. In 2017, the greatest number of people – approximately 28,500 – died from overdoses of synthetic opioids, a figure that is, however, imperfect because synthetic opioids are at times mixed with heroin in order to make them more potent, but they also as a result become potentially more lethal (Scholl et al. 2019).

3. PHARMACEUTICAL DISTRIBUTION INDUSTRY

The multiple social and economic forces behind this loss in human life are prompting considerable investigation. One about which we are increasingly learning is white-collar crime within the highest echelons of the corporate world. In April of this year – for the first time in US history – felony drug-trafficking charges were brought against the sixth largest pharmaceutical distributor in the US – Rochester Drug Cooperative – and two of its executives, Laurence F. Doud III and William Pietruszewski. (In the past, civil suits have been brought against drug distributors, all of which have been settled out of court at sums that were of little financial consequence to these corporations.) Prosecutors argue that the executives distributed tens of millions of oxycodone pills and fentanyl products to pharmacies that they were aware were illegally selling the drugs (Sanders 2019, Mulvey 2019).

In another recent example, on May 2, 2019 a federal jury found high-level executives, including the founder and former chairperson, of Insys Therapeutics Incorporated guilty of racketeering. Specifically, the chairperson, John Kapoor, and four of his colleagues, were found guilty of bribing doctors to prescribe Subsys, a fentanyl sublingual spray, and defrauding insurers who did not want to pay for the drug. The drug was approved by the FDA for use by cancer patients suffering from severe pain, but the company pushed for it to be prescribed much more broadly (Raymond 2019).

Other civil suits by the attorneys general of New York, Vermont and Washington are pending against other major players in the pharmaceutical distribution industry, including Cardinal Health, McKesson and AmerisourceBergen, all of which are by revenue among the 15 largest American companies. They distribute greater than 90 percent of drug and medical supplies within the United States. The suits allege that these distributors created means by which federal regulation could be avoided. For example, they are accused of alerting pharmacies of the possibility of being reported to the Drug Enforcement Administration; of assisting others in raising and getting around stipulated limits on the number of opioids they could purchase; and of informing yet others about impending audits (Hakim, Rashbaum and Rabin 2019).

Underlying these cases – and thus the opioid crisis itself – is at best piecemeal regulation of industry by state authorities, a common practice in the US, where freedom from regulation is championed

as central to fostering a viable economy. This ethos has in the long run repeatedly had gravely damaging side effects, the Great Recession, which nearly led to an economic depression in the US and slowed global economy activity, being a particularly striking, but hardly unprecedented, example of this. The New York Bureau of Narcotics Enforcement that was ultimately responsible for supervising activity at the Rochester Drug Cooperative was therefore poorly equipped to do so. It had fewer than 20 trained employees to scrutinize not only its activities but also the actions of other distributors, manufacturers, over 5,500 pharmacies and approximately 120,000 prescribers. Legislation has typically entrusted oversight of opioid sales to the distributors, essentially giving the responsibility of safeguarding the sale of pharmaceutical drugs to a part of this highly lucrative commodity chain that generously profits from it.

These practices of encouraging doctors to widely prescribe opioids without concern for their addictive qualities and of allowing even dubious pharmacies to purchase large quantities of the drugs have been rewarding to the distributors because of the presence of a sizeable number of vulnerable people in the United States, especially in certain parts of the country. Here we return to the geographical variation in cases of overdose deaths. A drugstore in rural West Virginia, for example, was at one point inundated with opioids, 4,000 pills a day from Cardinal and 5,000 from McKesson (Hakim, Rashbaum and Rabin 2019). As noted earlier, West Virginia is the state that has seen the greatest number of fatalities. It and the other two states with the highest rates of fatality (Pennsylvania and Ohio) not only have comparatively large working-class populations – people who perform jobs that are more likely than white-collar occupations to lead to injuries that result in chronic pain – but they also have large numbers of people who have served in the military, in some cases performing multiple tours in places such as Iraq and Afghanistan, work that as well can lead to bodily harm that causes persistent pain.

4. ECONOMIC TRANSFORMATION

There are other ways in which some sectors of the American population have been made susceptible to the use of opioids that are perhaps less well understood. They include fundamental changes to the American economy since the 1970s. That is, we need to call attention to how neoliberal capitalism has transformed the American economy in ways that have negatively affected many people's lives, stimulating a market for opioids.

One change has been the evaporation of well-paid occupations with ample benefits in broad segments of the economy. True, employment is at record levels now and recently we have even heard about increases in wages in the United States. Yet we need to look closely at what kinds of jobs people have and how much they earn from those positions, including in entitlements such as retirement benefits. What we discover is that a lot of the work is low or modestly paid service employment, and we also learn that we remain below the wage peak of January 1973 when average hourly wages were $4.03, an amount, when adjusted for inflation, which comes to $23.68 today. But even when wages have increased, they have largely gone to the highest earners. Since 2000, for example, usual weekly wages have risen 3% (in real terms) to $426 per week among workers in the lowest tenth of the earnings distribution while among people in the highest tenth of the distribution, real wages have risen 15.7%, to $2,112 a week – an amount that is nearly five times greater than that of the lowest tenth (Desilver 2018). This trend matches a broader one of increasing economic inequality across the United States in this period.

No single explanation can be isolated for this decline in well-paid work. One is likely the drop in union membership since the 1970s – while in that decade approximately a third of all workers were represented by a union, today the figure is around 10%. Consequently, the vast majority of American workers do not benefit from collective bargaining and therefore hold limited power to raise their income, not to mention to improve their working conditions, schedules and more. Another likely explanation as already noted is the loss of manufacturing employment over this period and its replacement by service sector work that is chronically poorly paid.

Continuous cutbacks in the public sector of the economy have as well played a role. One place where this is sharply evident is in education. Recent organizing and striking by teachers' unions – e.g., the Los Angeles Unified School District strike of January 2019 and a second strike in two years by West Virginia teachers in February of this year – in many parts of the country provide insight into this reduction (Goldstein 2019).

The City University of New York, the second largest public university system in the country, also provides evidence of the impact of this. CUNY was essentially free-of-charge until the 1970s, and even though there are now a number of programs – The Excelsior Scholarship and Accelerated Study in Associates Programs – that for some students reduce or even eliminate the costs of getting an education at CUNY, the expense can be a deterrent for others. And even for those who do get support the challenge to complete a degree can be insurmountable because there may be pressure within families – many of which are made up of recent immigrants to the country who are non-native speakers of English – to work for wages and to provide social support to other family members. For example, I have encountered students who need to look after younger siblings because childcare services are too expensive or no afterschool programs exist – this work cuts into their class attendance and ability to study and complete assignments. For those who do complete a degree and in fact for many who do not, an added burden can be the debt that has to be paid off, which typically has very high interest rates. This has had an impact on both the housing and the labor markets, making it difficult for many to pay for rent or a mortgage, both of which can be exorbitant, and consequently to move to different locations for work.

There have been other fundamental changes to the economy as a result of neoliberalism (Harvey 2005, 2010), but I believe these alone give a sense of the matter. What are the connections between these "antisocial" transformations since the 1970s and the opioid crisis, however? As an anthropologist who is interested in studying the work lives of people in different societies, I inevitably see the opioid crisis in relation to employment prospects that exist within an economy. It is important to recognize the role that the production and distribution of opioids plays in filling an employment gap left by the changes to the economy on which I have only touched here. Producing and selling opioids is a form of work, however illegal and discredited, that for some can be undeniably profitable and for others minimally fills a void. We can consider here the dissipation of well-remunerated blue-collar employment in places such as West Virginia that has not been replaced by gainful options, or, if we move beyond the borders of the US, we see processes such as heroin production and distribution filling vast employment chasms in places such as Mexico that were created, for example, by free trade agreements such as the former NAFTA (North American Free Trade Agreement).

We need also to weigh the psychosocial implications of transformations to the US economy in order to fully understand the emergence of the opioid crisis. Opioids are not only powerful and addictive, but they can also serve as an escape from a harsh reality for some people. Unable to find decent-paying, meaningful work; to afford an education that would lead to secure employment; to pay for essential medical and dental services; and to do much else, at least some people can be drawn into using narcotics for the break, however temporary, that they provide. This has become even more likely with the ease of access to opioids, and their relatively low cost, in many parts of the country.

5. POTENTIAL SOLUTIONS

What are some potential solutions to this crisis? First, wages need to be raised and entitlements need to be expanded in the jobs that currently exist in the economy. We also need to invest much more heavily in education and to make access free or at least inexpensive to the entire population. Furthermore, greater investment in technology, including for example renewable forms of energy, would provide employment to many people while also addressing other costly problems, such as climate change. Meanwhile, we need to make a better effort at requiring corporations and the superrich to make financial contributions to the economy. A recent report showed that many major corporations paid no taxes on their wealth in 2018 or that they even received rebates (Saul and Cohen 2019).

Research has shown that the idea that all of this wealth ultimately leads to innovation and job creation is a falsehood. Instead, what we have been witness to is a small class of people accumulating vast sums of wealth for personal consumption and aggrandizement while many sectors of the US population go without – or turn to opioids.

6. PUBLIC HEALTH AND OBESITY

Obesity and overweight have also played a role in the decline in life expectancy. Obesity is defined by the Centers for Disease Control and Prevention as having a BMI (Body Mass Index) of greater than or equal to 30. Overweight is defined as having a BMI within a range of greater than or equal to 25

to 29.9. Data that the CDC have accumulated on obesity show the following: From 1988 to 1994, 22.9% of Americans were calculated as obese. From 1999 to 2002, the figure was 30.4%; from 2003 to 2006, it was 33.4%; from 2007 to 2010, 34.7%; and from 2013 to 2016, 38.8%. (The differences in number of years represented by the figures results from a change in the way in which the CDC recorded its statistics.) Hence, we see a continuous uptick, so much so that by 2016 close to 40% of adults in the US were obese. The same trend exists for overweight in the United States (Hales et al. 2017, Centers for Disease Control and Prevention 2017).

As with the opioid epidemic, there are significant differences in the incidence of obesity and overweight in the US. The problem is most acute in the southern states of Alabama, Mississippi, Louisiana and Arkansas, but Iowa and West Virginia also have very high rates, while Colorado and Hawaii have the lowest rates. There is also much variation according to social class, one indication of this being that the likelihood of a person suffering from obesity goes down with increases in education. At the same time, considerable difference in rates of obesity and overweight exists racially and ethnically, non-Hispanic blacks reporting from 2015 to 2017 that the suffered from obesity at a rate of 38.4%; Hispanics at a rate of 32.6% and non-Hispanic whites at a rate of 28.6%. Obesity and overweight are also significant problems within Native American populations (See CDC Overweight & Obesity: Adult Obesity Maps available at https://www.cdc.gov/obesity/data/ prevalence-maps.html.).

A number of illnesses have been attributed to overweight and obesity, including type 2 diabetes mellitus, heart disease, hypertension, stroke, some forms of cancer, poor health-related quality of life and disability (Haomiao Jia, Matthew M. Zack and William W. Thompson 2016). Statistics show, for example, an increase in diabetes in the US over this period. According to one published article, "Between 1990 and 2010 the number of people living with diabetes tripled" (Rowley, et al. 2017). Diabetes in itself has myriad health implications, including kidney disease, neuropathy, skin and eye complications, high blood pressure, disability and much more. (See the American Diabetes Association at www.diabetes.org for further information.)

7. SOCIAL CONTEXT OF OVERWEIGHT AND OBESITY

It is not unusual for people who are obese to be ridiculed and blamed for their weight or for it to be associated with cultural practices. These reactions fail, however, to appreciate the numerous social, economic and political forces that have led to the current epidemic. We need to understand, for example, how much sodium, sugar, hydrogenated oil (such as palm oil) and other potential threats to public health are in the global food supply, and how industry gains from our consumption of them. The power of advertising to shape our consumption patterns and the often low cost of poor-quality food and drink – consider carbonated beverages filled with high-fructose corn syrup – as well demand our attention. We need also to measure the impact of changes in people's work lives as a result of the transformation through which the US economy has passed. This includes the kinds of work Americans perform and the schedules they maintain. In general, work today is much more sedentary than it was in the immediate post-World War II decades, and today people are more likely to have work schedules that can make it comparatively difficult to exercise and to prepare their own meals, which makes eating out attractive. And let's not forget that today many people spend considerable amounts of time sitting in their cars getting to work or other locations sometimes because the housing costs near the places where they work are too expensive. Then there is the issue of how well society properly educates the population about healthy eating habits, the degree of access that people have to healthy food options and other factors. For further details, see Albritton (2009) and other scholarship.

There is no single solution to this epidemic given its multiple sources. However, greater control by the government of the food supply would arguably move us in a more positive direction. This has of course already taken place with considerable success on many occasions throughout history. One prominent recent example was the ban imposed by the federal Food and Drug Administration in 2015 that went into effect about one year ago on the use of artificial trans fats in food. Along with this approach, it would likely be effective to also raise prices at the national level on unhealthy foods. Local measures, such as the recent decisions in Berkeley and Philadelphia to raise taxes on sugary carbonated beverages can be ineffective. Although declines in purchases of these products occurred in those localities, reportedly some people also began shopping outside the city limits purportedly to avoid the sugar tax. Still, a decline in sales was recorded (Ducharme 2019).

8. INCREASE IN SUICIDE

In addition to the impact of opioid overdoses and obesity and overweight on life expectancy, the US has seen a very troubling increase in suicides over recent years. According to the Centers for Disease Control and Prevention, the suicide rate in the US went up 30% from 2000 to 2016, an increase from 10.4 people out of 100,000 to 13.5 out of 100,000 (Centers for Disease Control and Prevention 2018b). Viewed differently, 47,000 people committed suicide in 2017 or approximately 129 per day, more than twice the number of homicides. The increase has occurred among men and women, among all racial and ethnic groups and among people of all ages, except the very old. Among girls and women, the increase has been particularly dramatic, from 4 to 6 per 100,000. This made suicide the tenth leading cause of death in the US in 2016. Among people aged 10 to 34, it was the second leading cause of death after unintentional injuries (Winerman 2019).

As with the obesity epidemic and the increase in opioid usage, there is no single explanation for the rise in suicide within the US. A reasonably accurate one emerges, however, when we observe the methods people use to take their own lives. Suicide by firearm is the most common means: According to the National Institute of Mental Health, in 2017 nearly 24,000 suicides (23,854) – or about 50% – involved the use of guns, while about 13,000 (13,075) were suffocations, about 6,500 (6,554) were poisonings, and the remaining nearly 4,000 (3,690) were by other means. Among men, the use of firearms was especially common at 56.0%, while among women it was 31.2%, only slightly lower than poisoning. (See National Institute of Mental Health 2019). Ease of access to firearms means people can act on impulses that may be triggered by economic duress to a greater extent than would be the case were it not so simple and affordable for people to obtain a weapon and bullets. Thus, we can make a compelling argument that access to guns and bullets is a public health dilemma in the US, which the Centers for Disease Control and Prevention should have the power to control. In fact, suicide is a far greater concern than mass shootings, which, although alarming and horrifying, do not take nearly as many lives annually as suicides.

9. CONCLUSIONS

These are very destabilizing times in the United States as evident from data we have accumulated on drug overdoses, obesity and overweight and suicides. Gone appears to be the dream that each new generation would be better off than the previous one. Instead, we appear to be moving backward if these data on life expectancy are accurate and if they persist. I have already given some specific suggestions on how these crises can be abated. On a more general note, I strongly believe that we need to make the US a much more balanced society economically. This involves addressing the fact that decent-paying work is elusive to a portion of the society, that many families have difficulty paying for basics such as food, a mortgage or rent, transportation, medical treatment, childcare services and more and that education comes at a steep cost for many families. Only by admitting that these problems create an unhealthy society can we move toward improvement and perhaps even greater happiness in the US.

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