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What Makes America Sick

Economic Opportunity and America's Population Health Crisis

By Rourke O'Brien

The United States is in the midst of a population health crisis. Americans born today are projected to die three years younger than peers born in other wealthy democracies – and that's before accounting for the effects of the Covid-19 pandemic. This decline in longevity is unprecedented and worrying. Particularly as data reveal these trends are driven not by changes in the health or mortality of the young or old, but instead by deteriorating health among working-age adults – best evidenced by the rise of so-called 'deaths of despair' due to drug overdose, alcohol poisoning and suicide among men and women in this age group.

Declining economic opportunity as one key driver

How can we explain this dramatic reversal in America's population health trajectory? Although there are many contributing factors, a fast-growing body of research points to declining economic opportunity as one key driver. Of course, social scientists have long examined the relationship between health and the economy: we know, for example, that unemployment exacts a toll on individual health and well-being, even if, in the aggregate, the effect of economic downturns on population health are mixed. But my colleagues and I argue we need to think about this differently, and take seriously how the collapse of economic opportunity is making Americans sick.

That's the mission of our **Opportunity for Health Research Lab**, led by my colleague **Atheendar Venkataramani** at the University of Pennsylvania. Our goal is to integrate insights from across the social sciences to advance a new framework for understanding the how the opportunity structure of a society impacts individual health behaviors and population health outcomes. And, importantly, to identify the public policies and institutional practices that can and do make a difference.

What do we mean by opportunity? In our research we operationalize this idea a few different ways. One measure of opportunity in a society is the amount of upward economic mobility, that is, the extent to which children from low-income families are able to move up the income ladder in adulthood. Recent estimates using administrative tax records show a steady decline over time in the fraction of Americans who achieve the 'American Dream' of doing better than their parents. These new data also underscore that your odds of being upwardly mobility differ depending on where you live.

We use these place-based estimates of economic mobility as a measure of economic opportunity in a local area. And find they help us make sense of spatial patterns in population health. For example, **in one study we find** that working-age mortality increased more in parts of the country characterized by low-levels of opportunity. This is consistent with analyses of survey data where we show that people who live in areas with more opportunity report better health and are less likely to drink alcohol or use drugs than otherwise similar peers in lower opportunity locales. Coming of age in an area with less opportunity, it appears, dims hope for the future and reduces the incentive to invest in human capital, including health.

We can also examine the health consequences of declining opportunity that result from changes in the economy. Deindustrialization, in particular, has fundamentally altered economic opportunity in the United States. Consider that in 1980 nearly one in four U.S. workers was employed in a goods-producing industry whereas today that number is just one in ten. But it's not just the loss of jobs, it's the loss of jobs that paid well and often came with benefits, including pensions and health insurance coverage. For American workers without a university degree, collapse of the manufacturing sector wiped out a pathway to upward mobility and middle-class security. And devastated not just workers and their families but entire communities, as many cities and towns lost their largest, and sometimes only, major employer. When jobs disappear, the health of the entire community is impacted. **In one study we show** that the closure of automotive-assembly plants led to a causal increase in opioid overdose mortality in the nearby area.

And it's not just acute shocks like plant closures that impact health. One driver of manufacturing job loss in the U.S. is the rise of automation, specifically the use of industrial robots that displace human workers. Previous research found the increased use of industrial robots over the 1990s and 2000s led to the loss of more than seven hundred thousand jobs; those lucky enough to keep their jobs still saw their real wages fall. **We examined the secondary consequences of automation on population health** and found the increased use of industrial robots led to an increase in working-age

mortality, again driven largely by deaths of despair, particularly drug overdose deaths. Notably, the strength of this relationship varies across policy contexts. We find that automation increased mortality less in states with more generous income support polices.

At the same time, we find automation increased mortality more in states with 'right to work' laws that inhibit unionization. This underscores why policy matters, particularly labor market policies that improve opportunity by increasing the number, type and quality of jobs as well as safety net policies that help households cope with precarity.

Yet it's not just safety net and labor market policies that make a difference. A major aim of our research program is to document the health consequences of policies that impact opportunity. For example, in recent years several U.S. states banned the use of affirmative action in university admissions, a policy change that reduced the admission prospects of racial and ethnic minority students. We found that this policy change led to a causal increase in alcohol use and smoking among minority high school students, with no effect on white students. Perhaps most distressing is these elevated smoking levels persist through age 30. A policy change in adolescence that stymied hopes for the future impacting health behaviors over the life course.

Policies that promote opportunity also promote health

But just as policies that reduce opportunity can negatively impact health, policies that increase opportunity can improve it. Consider the **Deferred Action for Childhood Arrivals or DACA program**, an Obama-era policy that blocked deportation of undocumented persons who entered the U.S. as children. In an instant, this policy had a profound impact on the opportunity of these young people, allowing them to come out of the shadows to pursue work and education. We find this policy shock to opportunity also had measurable, positive effects on health; a finding corroborated by other research teams using different data and measures. Policies that promote opportunity also promote health.

Of course, it is important to underscore that this relationship goes both ways. That is, opportunity doesn't just shape health, health also shapes opportunity. **In other work we find** that children whose mothers during pregnancy received public health insurance had higher rates of upward mobility when measured in adulthood. At the same time, **we also find that cohorts exposed to higher levels of air pollution during the prenatal period achieved less upward mobility in adulthood**, as do cohorts with higher incidence of low-weight births. These studies echo a large literature that finds a positive correlation between individual health and economic outcomes. And suggests that an investment in America's health is also an investment in opportunity.

We argue that America's population health crisis is both a cause and a consequence of the fading American Dream. This diagnosis, while depressing, does offer hope – **and a plan for action**. To start, we must tackle the problem holistically, recognizing that opportunity policies and income support policies are also health policies. And, conversely, that population health investments also serve to reduce precarity and

promote upward mobility. Beyond rhetoric, this research motivates integrating health outcomes into cost benefit analyses of economic policies and economic outcomes into analyses of health investments. Our findings also underscore the need to make place-based investments – in education, in jobs, in infrastructure, in healthcare resources – targeted to communities hardest hit and stuck in a downward spiral of fewer jobs, less tax revenue and government spending, and deteriorating health.

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