COMMENTARY: WILL 'DEATHS OF DESPAIR' AMONG WHITES CHANGE HOW WE TALK ABOUT RACIAL/ETHNIC HEALTH DISPARITIES?

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The recent trend of premature death among Whites in the United States has garnered attention in both the popular and academic literature. This attention has focused on the plight of low socioeconomic status Whites in non-urban areas. The population health literature in general and the health disparities literature more specifically has struggled to describe differences in health when White groups present worse health outcomes or worsening trends compared with racial/ethnic minority groups. There remain many open questions as population health/health disparities research attempts to explain the increasing mortality rates for low socioeconomic status Whites in non-urban areas in relationship to other racial/ethnic groups. As the conversation in the academic and popular literature continues to unfold, a key question for population health research and practice is how will the 'deaths of despair' phenomenon among Whites influence our measuring of, and reporting and intervening on, race/ethnic health disparities? *Ethn Dis.* 2018;28(2):123-128; doi:10.18865/ed.28.2.123.

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COMMENTARY

In 2015, economists Anne Case and Angus Deaton published results from their study[1] suggesting that, for the first time in contemporary American history, mortality rates were increasing for working-class White, middle-aged Americans. Historically, Whites have been the beneficiary of one of the lowest mortality rates in the country, yet the death rate for non-Hispanic Whites aged 50-54 with only a high school degree increased by more than 20% between 1999 and 2015.[1] This is unique since every other demographic group across developed countries has consistently seen a decline in mortality— an established trend of a lower percentage of people dying at every age in rich nations. In follow-up analyses, Case and Deaton found the increase in White mortality was consistent across 5-year age groups among those aged 25-64 years and only among Whites without a college degree.[2] The sudden rise, they found, was largely a result of 'deaths of despair'— or death due to drugs (opioid and heroin abuse primarily), alcohol poisoning, suicide, and alcohol-related liver disease.[2]

The results from the Case and Deaton studies received substantial media attention and widespread popular consumption, with two main criticisms emerging. First, researchers were critical of the magnitude of the increase in White mortality rates, suggesting Case and Deaton's results were overstated. Gelman and Auerbach[3] re-analyzed the data from Case and Deaton[1] and included in their analysis an age adjustment due to the changing composition of those in the 45-54 age group from 1999 to 2015. Their findings showed that, after adjusting for age, there was not a steady increase in mortality rates for Whites aged 45-54 years across the early 2000's. Instead, there was an increasing trend from 1999 to 2005 and a constant or stable trend thereafter. Additionally, they noted that when they stratified these age-adjusted mortality rates by sex, there was only a mortality increase among White women with less than a college degree.[3] Consistent with Angus and Deaton, they reaffirmed the trajectory of mortality among Whites in the United States was still divergent relative to all other groups across developed nations.

The second criticism, and perhaps more relevant for research and practice on health disparities, was in Case and Deaton's emphasis on White Americans and the comparison of mortality trajectories to European Whites, US-born Hispanics, and African Americans. National popular press publications like the *Washington Post* included headlines like: 'How dare you work on Whites: Professors under fire for research on White mortality.' The criticisms largely centered on the notion of highlighting issues for White Americans that have long been issues for racial/ethnic minority groups, especially African Americans. Critics suggested Case and Deaton were drawing attention away from more persistent problems like the consistently higher rates of Black mortality.[4,5] Case and Deaton's findings unexpectedly positioned working-class Whites as the new face of disadvantage, despite racial/ethnic minority groups in the United States having long histories of deprivation and high rates of mortality. American Indians and Alaskan Natives, who have endured a legacy of injustice and discrimination, report consistently higher overall mortality rates than Whites with a disproportionate amount of deaths due to 'deaths of despair,'[6] but are often entirely neglected from this discussion. What some found most troubling was the collective national response and attention paid to the 'deaths of despair' phenomenon once the face of disadvantage was now White.[5]

In their 2017 follow-up, Case and Deaton compared US Whites with European Whites to explore possible explanations of the increase in mortality found in their 2015 analyses. Their exploration suggested that perhaps there was something inherent to the [White] American experience— that is, something unique in the way the social and economic systems had been steadily changing [and declining], that was killing this group of middle-aged Whites in the United States— but not similarly affecting the White population of any other European, Canadian, Australian or predominately White country. The authors stated, life in the US was becoming "more difficult for less-educated [White] people, not only in their employment opportunities, but in their marriages, and in the lives of, and prospects for their children."[2]

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But, what specifically was happening to Whites with low educational attainment in the United States that was driving them to 'deaths of despair'— either slowly with drugs and alcohol or more deliberately with acts of self-violence? Case and Deaton hypothesized that lower educated middle-class Whites were experiencing a sort of cumulative disadvantage due to the dissolution of the labor force and subsequently the blue collar, White middle-class lifestyle. This group, they suggested, was seeing less return for their job experience as they age— or "diminishing returns to experience," as economists say— that spiral into other social and economic consequences.[2] Marriage rates were on the decline; they weren't going to church as frequently; their jobs were less stable; and more kids were being had outside of wedlock. In response to their changing and ignored role in society, Whites had become hopeless, leading them to cope with this despair by abusing drugs/alcohol or committing suicide. Political scientist Justin Best powerfully calls them 'the new minority' in his recent book[7] and historian Jefferson Cowie calls it the 'last days' of the working-class Whites in *Stayin' Alive.*[8] Both documented the disintegration of the blue-collar identity and the slow collapse of the White working class that has been occurring since the 1970s.

If disenfranchised middle-aged Whites with low educational attainment are dying at such startling rates due to the spiral of diminishing returns on experience, a dissolving labor force, financial insecurity, and low marriage rates, why then do we not see similar trends among Hispanics or African Americans? Case and Deaton compared mortality rates among all Hispanics aged 45-54 years to this aged-matched group of working-class Whites. Hispanics, the largest growing subgroup in the United States, have on average, lower education and income levels than their White peers. Yet, they show Hispanics continue to make progress against mortality at a rate of improvement that is similar in other rich, developed countries.[1] Historically, Hispanics have outperformed Whites in the United States on some measures of health (eg, lower rates of cancer and cardiovascular disease mortality). An oversimplified idiom used to describe this phenomenon of Hispanics generally having worse economic circumstances than Whites but showing better outcomes for some health measures has been called the Hispanic (or Latino) paradox. The Hispanic paradox has been heavily criticized since it entirely discounts the health outcomes where Hispanics perform worse than Whites (eg hypertension and diabetes)[9] while also disregarding the within-group heterogeneity masked by the label of Hispanic ethnicity, failing to discern any differences between Mexicans, Puerto Ricans, Central Americans, and Cubans.[10-12] The Hispanic paradox remains a problematic term since it misrepresents Hispanics as a comparatively healthy group when it is only a paradox because Whites are not outperforming Hispanics on all measures of health. The term positions Whites as the gold standard in the measuring and reporting of health outcomes.

For decades, researchers have shown that Blacks rate their health worse,[13] live a greater proportion of life with disability,[14] have higher rates of many of the leading causes of death such as cancer and heart disease,[15,16] and have shorter life expectancies[4] relative to any other demographic group in the United States. In 2015, Blacks still had higher death rates than Whites in all age groups under aged 65 years.[4] However, Black mortality rates have been on a steady decline over the last 15 years, narrowing the White-Black disparity from 33% in 1999 to 16% in 2015.[4] Still, the decline in Black mortality was not the only contributing factor closing the White-Black mortality gap. Case and Deaton suggested that increasing mortality among middle-aged Whites without a college degree was adding to the disparity reduction. It appeared that poorly educated middle-aged Whites were—in the last 15 years— unexpectedly losing ground in the mortality race, even to African Americans.

Yet, haven't other racial/ethnic groups in the United States historically experienced gaps between their social and economic aspirations and realized outcomes? The recent economic downturn has been noticeably hard on all Americans with less than a college degree, especially so for Blacks and Hispanics; yet, throughout US history, racial/ethnic minorities have consistently reported worse outcomes on every economic metric relative to Whites (eg, education,[4] income,[17] wealth,[17] homeownership[4]). Blacks and Hispanics have unfailingly lived a diminishing return to experience in the United States; yet, they are experiencing overall improvements in rates of mortality. Case and Deaton offer an explanation, suggesting that perhaps it is that racial/ethnic minority groups have historically been exposed to adversity, and that earlier and more frequent exposure to adversity may confer Blacks and Hispanics an advantage in dealing with unfavorable circumstances. Additionally, racial/ethnic minority groups in the United States have seen a larger variance in individual labor market outcomes as generations of these groups get further away from historical and overt forms of racial oppression.[18] Perhaps this conjures up a perspective that relative improvements for people of color are at the expense of working-class Whites. Working-class Whites may be experiencing an increasing gap between their expectations of social and economic systems that have typically benefited them and their current ability to reach those expectations.[7]

The mechanisms causing the increase in working-class White mortality will likely be the source of much future research. But, how do we situate the reduction in White life expectancy within the health disparities literature? Health disparities have been generally understood to refer to systematic differences in health outcomes and their determinants resulting from social and economic disadvantage.[17,19] Federal and state public health efforts have focused on the reduction of race/ethnic disparities through programs such as Healthy People and Racial and Ethnic Approaches to Community Health (REACH), particularly targeting Blacks.[19,20] A challenge for 21st century scholarship is to make sense of the implications of growing intragroup diversity and what this means for racial/ethnic cross-group comparison. While it is true that middle-aged, working-class Whites have a relatively contemporary increasing trajectory of mortality and there is less disparity between Whites and Blacks, Whites still have lower death rates than their Black peers of the same age and educational status.[2] What does it mean then, in our measuring and reporting of health disparities, that within the group that has historically reported the best health outcomes (Whites), there is now a subset that is driving the reduction in disparities between groups? And in so doing, causing the mortality trends among Whites to look unexpected. Does this mean we consider White working-class experiencing the 'deaths of despair' phenomenon a 'health disparities population'?

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James Jackson's Environmental Affordances Model (EAM), while not specifically dealing with 'deaths of despair,' attempts to reconcile differences in physical and mental health among African Americans and Whites. The understudied paradox in this line of research is that, while Blacks have higher risk of stress exposure, morbidity, and mortality relative to Whites, Blacks report lower rates of common stress-related forms of psychopathology such as major depression and anxiety disorders. The EAM is a life-course framework that aims to better understand the complex processes by which race, stress and individual coping behaviors may interact to produce the mental and physical health disparities we observe at the end of life. A key premise of the EAM is that race/ethnicity does not just simply represent skin tone or ancestry, it is a social construction that codifies a set of experiences throughout the life course. The EAM theorizes that if Whites and Blacks had similar lived experiences or resided, worked, and grew up in comparable environments, the differences in mental and physical health would not exist.[21] While Whites seldomly live in contexts identical to Blacks, even when both have incomes below the poverty level,[22] the current discussion about 'deaths of despair' suggests that Whites are not necessarily immune to the downstream health outcomes that can result from perceived stress and unhealthy coping behaviors. Situating the 'deaths of despair' within the EAM framework highlights the need to better understand the complex interaction among distressing social contexts, coping strategies/behaviors, and the social construction of White race.

The Case and Deaton findings[1,2] encourage a conversation about the underexplored concept of "Whiteness" and what White race means for health. How is it that Whites are the default referent group in the literature, yet the meaning or interpretation of this comparison remains largely unexplained and unchallenged?[23] As population demographics in the United States shift, with current racial/ethnic minority groups assuming the majority,[24] deferring to Whites as the uniform reference group may need to be qualified. Increasing working-class White mortality may represent the first marker that White American exceptionalism is fading and traditional paradigms in population health research that center Whites as the universal subject[25] will need to reflect this new demographic reality. Thus, researchers are going to have to be more explicit in the justification for their choice of reference groups in analyses where we are comparing outcomes across racial/ethnic groups. What does it look like to remove the White lens from our health disparities framework? What happens when we stop using terms like paradox to refer to health patterns when Whites underperform relative to other groups? Can we remove the underlying assumption that Whites will always do better? Can we be more explicit about the factors along the pathway laid by historical discrimination that shape not only the health outcomes of people of color but also that created the concept of "Whiteness"?

Finally, Case and Deaton's work highlights that in explicating factors contributing to racial/ethnic disparities, race, class/socioeconomic status, and place *all* matter; and not just as single demographic categories, but their intersection matters for the measuring, reporting and intervening on health disparities. Additionally, the results of the Case and Deaton studies should encourage more intragroup racial/ethnic investigations in health and health care-related research to understand heterogeneity among groups, highlighting the differential influence of determinants of health across group members. Moving past the description of these results to intervention, challenges researchers to differentiate between changes in overall mortality rates, changes in the differences between groups (eg, reductions/increases in disparities), and changes among a subset of group members. Meeting this challenge in the United States necessitates adopting research practices that capture the intersectionality and intragroup variability that defines the American population.

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Conflict of Interest

No conflicts of interest to report.

Author Contributions

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