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Supplement Article: Why Does Health in the US Continue to Lag Behind?

Socioeconomic Disparities Do Not Explain the U.S. International Disadvantage in Mortality

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Abstract

Objectives: The articles examines the contribution of internal socioeconomic disparities in mortality to the U.S. international disadvantage in life expectancy at birth.

Methods: Using individual death records from the U.S. national vital statistics system for years 1982–2019 and data for other countries from the Human Mortality Database, we compare age-specific death rates and life expectancy between counties classified into 10 socioeconomic categories and 20 high-income countries. We also calculate the number of years of life lost in each socioeconomic decile in relation to the comparison set.

Results: There is a clear and increasing socioeconomic gradient of mortality in the United States, but the growing divergence in internal mortality trends does not explain the rising gap between the country and its peers. In 2019, even American women in the most socioeconomically advantaged decile lived shorter lives, while only 10% of men in the most affluent decile fared better than their peers. The long-standing U.S. disadvantage in young adult mortality has been growing and the country's previous advantage in mortality at ages 75 years and older has virtually disappeared for all but for Americans in the most affluent counties.

Discussion: The similar age pattern of differences in mortality rates between each socioeconomic deciles and the comparison group suggests that the underlying factors might be the same. The role of external causes (including drug overdoses) for middle-aged adults and a slowing down in progress to control cardiovascular diseases at older ages at the national level are consistent with this pattern.

Keywords: Demography, Health disparities, International comparison, Life expectancy, Socioeconomic status

This special issue brings new light to the shortfall in mortality improvement in the United States compared to other high-income countries. A common question is whether this shortfall is due to heterogeneity in the United States. The suggestion is that because the United States is so large in population and area, some parts are doing well while the overall mortality experience is being held back by low-performing areas and subpopulations. Here, we examine this more closely by splitting all 3,143 counties in the United States into socioeconomic deciles and tracking life expectancy in each decile over time. We find that since the early 1980s, the shortfall cannot be explained by heterogeneity in socioeconomic status. There are differences in the trends in life expectancy among the deciles, but even the most privileged decile of counties performs only about as well as the average of all other high-income countries; all other deciles perform more poorly. The U.S. disadvantage in mortality is not limited to small, specific, groups—it is systematic and systemic.

Background

Economic inequalities in the United States have been growing since around 1980 after a period of convergence, and the trend has coincided with increasing disparities in mortality within the population (Bor et al., 2017; Elo, 2009). Because information on the level of education is readily available on the death certificate and in most representative surveys with mortality follow-up, educational disparities in adult mortality have been particularly well documented. Studies typically find a 10- to 15-year gap in life expectancy between individuals without a high school degree and those with a college diploma (Sasson, 2016). Evidence also shows that this type of disparity has been growing since the 1980s due to rising levels of mortality among low-educated adults, while mortality among the most educated continued to decline (Case & Deaton, 2021; Sasson & Hayward, 2019). Other research has demonstrated that education alone is insufficient to explain all of the variations in mortality across the U.S. population, with a fairly consistent trend of continuously declining risks of death for the highly educated but inconsistent patterns (decrease, increase, or stable levels) among the lower-educated, thus suggesting the need to take additional characteristics into account (Montez et al., 2019). Income is an important covariate and its association with survival has been demonstrated by a study combining tax records and mortality data from the Social Security Administration (Chetty et al., 2016). Both types of studies have yielded important results, complementing and reinforcing each other as they describe from various angles the rising inequalities in mortality within the U.S. population and identify some of the mechanisms at play. They have also shown the need to take geographic variation into account when investigating the strength of the relationship between education or income and mortality. Due to data limitations, a weakness of these (and similar) studies is that they could only focus on older age populations. Individual-level analyses also suffer from issues of changing composition, reverse causality, and the increasing selection in the most disadvantaged categories over time (Currie et al., 2018).

Another string of studies has relied on aggregated rather than individual-level analyses, by grouping counties or other geographic units based on their socioeconomic characteristics or metropolitan status and investigating differences in mortality across groupings. Previous research has demonstrated the value of using area-level measures of socioeconomic factors to investigate mortality disparities (Currie & Schwandt, 2016; Elo et al., 2019; Ezzati et al., 2008). The superiority of composite indices that combine multiple aspects of socioeconomic deprivation over single measures such as poverty or education has also been documented (Glassman, 2019; Singh, 2003; Singh & Siahpush, 2002; Townsend, 1987). Historically, areal multidimensional indices have been widely used to study health and mortality differentials in Europe, especially in the United Kingdom where the approach was initially developed to better allocate health care resources (Benach & Yasui, 1999; Carstairs & Morris, 1989; Meijer et al., 2013; Townsend, 1987). Work relying on this approach in the United States found growing mortality disparities resulting from a continuous improvement in survival for the best-off communities and a deterioration for the most deprived. The finding is consistent with the increasing geographic variations demonstrated by others (Montez et al., 2020; Vierboom et al., 2019). Whatever the type of disparities investigated, the early 1980s appears to have marked a turning point, initiating diverging trends in survival within the U.S. population and across communities.

Also around 1980, the U.S.'s previously small lag in life expectancy behind other high-income countries started increasing. The phenomenon has generated a large body of literature, including two comprehensive reports by the National Research Council (2011, 2013) and a more recent study by the National Academies of Sciences, Engineering, and Medicine (Harris et al., 2021). These and other works have highlighted various characteristics of the U.S. shortfall in survival. They demonstrated that the United States experiences higher mortality at every age, with older ages (65 years and older) contributing disproportionately to the growing gap in life expectancy at birth and younger ages (especially below 50 years) to the divergence in age-specific mortality rates (Ho, 2013; Ho & Preston, 2010; Manton & Vaupel, 1995). The increasing internal disparities and the divergence in survival between the United States and similar countries begged the following question: Could that excess U.S. mortality be attributable to higher socioeconomic disparities? A recent comparison of France, Canada, and the United States found a greater poverty gradient in mortality in the United States and suggested that "in a very real sense, higher overall US death rates [compared to other countries] are a reflection of inequality between rich and poor" (Baker et al., 2021). An older study also indicated that comparatively large geographic disparities within the United States partly explained the increasing gap in life expectancy at age 50 from 1980 to 2000 with Japan, Germany, France, and Canada (with an effect in the order of 30%–50% for men, 10%–30% for women; Wilmoth et al., 2011). Here we revisit this issue with a more systematic comparison of U.S. socioeconomic inequalities in mortality at all ages using recent data on national trends in a group of 20 high-income countries.

Data and Methods

We constructed life tables by calendar year and by sex for all U.S. counties grouped into deciles based on their socioeconomic characteristics. Using data from the 2000 census, which corresponds to the mid-point of the study period, we calculated a county-level socioeconomic score (SES). We also experimented with an alternative approach to take into account the possible lack of consistency of area characteristics over time. In this alternative approach, instead of classifying counties across SES decile at one point in time, county-level SESs were calculated for each year when data are available, that is, using the 1980 and 1990 Censuses in addition to the 2000 Census as well as the 5-year American Community Survey data for each period 2005–2009 to 2015–2019. The results of this analysis were very close to those obtained when keeping the county classification fixed over the whole period. Differences in life expectancy at birth between the two approaches were for instance in the order of 0.2 years and similarly for the life expectancy gap between the two extreme SES deciles (see Supplementary Table S1 and Supplementary Figure S1 for additional details). These differences have no impact on the main conclusions of our study. For the sake of simplicity and ease of interpretation, we chose to present here the results of the analysis based on the counties classified into SES deciles fixed for the entire study period. The lifetable series was calculated for all years 1982 (the first year when county-level population estimates are available from the Census Bureau) to 2019 (the last year when mortality data are available at the county level at the time of this analysis).

Following an approach proposed by Singh et al. (2002) and further developed by Barbieri (2020), the SESs were derived from area-level information on county level of education (percent population aged 25 years and older with less than 9 years of education, and percent with at least 4 years of college education), median household income adjusted for state median gross rent, unemployment rate, occupation (percent of the labor force population in white-collar occupations), income inequalities (ratio of the median household income in the first to fifth quintile), poverty (percent population below the Federal Poverty Threshold), housing value (median home value for owner-occupied units), median gross rent, and equipment (percent housing units with no telephone, and percent with no or incomplete plumbing). Small counties were combined with demographically similar contiguous counties within each state so that each geographic unit counted at least 10,000 people during the period 1982–2019 to limit the large fluctuations associated with small numbers. There are 3,143 counties in the United States; the final sample includes a total of 2,473 units of which 2,072 are single counties and 401 are county aggregates.

The SESs were calculated from the aggregated socioeconomic variables at the county level through the implementation of a Principal Component Analysis (PCA). PCA is a statistical method implemented to reduce the amount of information in a large data set into a small number of variables (or principal components, also called factors). In our analysis, the eigenvalue on the first dimension is 55%, representing the proportion of the total variance explained by the first component (Supplementary Table S2a). Contributions to the first component are highest for income disparities (12%), the proportion of the population below the Federal Poverty Threshold (12%), the proportion of housing units without a telephone (11%), the median gross rent (11%), the median home value (10%), and the proportion of the population with 4 years or more of college education (10%). They are lowest for the proportion in the labor force in white-collar occupations (9%), the percent of the population with less than 9 years of education (9%), the median-adjusted household income (9%), the unemployment rate (6%), and the proportion of housing units with no or incomplete plumbing (2%; Supplementary Table S2b). The correlations on the first component of the PCA were used to determine the weights allocated to each variable summed over to create the SESs (Supplementary Table S2c). Further standardization was carried out so that the mean of the SESs was equal to 100 and their standard deviations to 20. Counties and county aggregates were then ranked based on their SESs, weighed by their populations, and distributed into 10 groups (deciles). Each socioeconomic category (SES decile) thus represents about 10% of the total U.S. population (not 10% of counties). The SESs range from −4 to 178. The spread in the SESs is largest for the two extreme deciles (from −4 to 91 in the first decile and from 142 to 178 in the tenth) and smallest for the middle deciles (only 3.7 in the fifth and sixth deciles). These middle deciles include some of the largest and most heterogeneous counties in the country. For instance, with 9.5 million people in 2000, Los Angeles county represented 32% of the population in the fifth decile and with 5.4 million, Cook county represented 18% of the population in the sixth. Overall, the most deprived deciles included a large number of small, rural counties compared to the most privileged: The first decile includes 1,029 counties or county aggregates for an average proportion of the rural population of 49%, while the tenth decile includes 68 counties with an average 95% urban population. Counties in the most deprived deciles are particularly concentrated in the South and Southeastern regions of the United States. The reader can refer to Supplementary Table S3 and Supplementary Figure S2 for more details on the socioeconomic characteristics of the counties in each decile and their geographic locations.

Next, we extracted tabulations of death counts by sex, single year of age, and county for every calendar year from 1982 to 2019 from the restricted-access Multiple Cause of Death Data Files provided by the National Center for Health Statistics at the Centers for Disease Control and Prevention (National Center for Health Statistics, 2021). We also collected July 1st population estimates by sex and single year of age and by county from the Census Bureau for all years since 1982 (Census Bureau, 2021). The death counts and populations were aggregated over all counties within each SES decile to serve as the numerators and denominators of the sex- and age-specific death rates, respectively. Complete lifetables were calculated by sex and SES decile using these tabulations by implementing the Human Mortality Database (HMD) methods protocol (Barbieri et al., 2015; HMD, 2021; Wilmoth et al., 2007); 95% confidence intervals were calculated around the lifetable values following a set of methods proposed by Chiang (1984). Our main outcome measures are the age-specific mortality rates and the expectations of life at each age. Supplementary Tables S4a and S4b present the life expectancy at birth by sex for each socioeconomic decile for all years 1982–2019.

We compared mortality levels and trends in the United States to a subset of countries most comparable to the United States with information available from the HMD over the period from 1982 to at least 2017. All these countries belong to the Organization for Economic Co-operation and Development (OECD), an intergovernmental economic organization which includes a total of 38 high-income countries, only a subset of which we used in for comparison. Our comparison group contains 20 OECD countries located in Norther Europe (Denmark, Finland, Iceland, Norway and Sweden), Western Europe (Austria, Belgium, France, Ireland, Luxembourg, the Netherlands, Switzerland, the United Kingdom, and Germany), and Southern Europe (Italy, Portugal, and Spain) as well as Canada, Japan, and Australia. These are all high-income democracies with demographic data of excellent quality. For countries with no data for 2018 or 2019, we substituted the last available data point (2017 if both 2018 and 2019 were missing, 2018 if 2019 was missing).

We calculated a lifetable series for all the comparison countries pooled together using a population-weighted average of the death rates in the HMD lifetables for each sex and age in each calendar year. Japan (with about 23% of the overall number of person-years lived in the peer countries), Germany (15%), France, Italy, and the United Kingdom (11% each) contribute the most to the weighted average. The smallest countries (<1%) are Denmark, Finland, Ireland, Iceland, Luxembourg, and Norway. Given the overrepresentation of the largest countries in the comparison group and to ensure that a few very low-mortality countries among them did not drive the diverging pattern, we also calculated a lifetable series for the countries unweighted by population size. We found that the difference between the two was small (from 0.5 years of life expectancy at birth in 1982 to 0 in 2019 for men and from 0.4 to 0.3 for women) because many of the least populated countries in the group experience levels of mortality very much on par with the most populated (Supplementary Tables S5a and S5b). To follow standard practice, we thus only present results for the pool of peer countries using the lifetables based on the population-weighted mean.

We used several mortality measures to describe the difference in mortality between the U.S. population in each SES decile and the comparison countries taken collectively. First, we examined the ratio of the age-specific death rates in the lifetables corresponding to each SES decile relative to those in the pooled comparison countries. Next, we assessed the difference in life expectancy at birth across each SES decile and the comparison countries as well as the contribution of each age group to these differences. To calculate the age group contributions, we relied on a decomposition technique proposed by Andreev et al. (2002). Finally, following an approach suggested by Preston and Vierboom (2021), we estimated the number of deaths that could have been averted in each SES decile under the mortality conditions of the OECD composite and the associated number of years of life lost within each decile in 2019, by applying the mortality rates and remaining years of life in the pooled lifetables for the peer countries to the U.S. population by sex and age in each SES decile.

Results

There is a very clear and increasing gradient of mortality across the 10 deciles of U.S. counties (Figure 1A and B). In every calendar year, life expectancy at birth increases progressively from one socioeconomic decile to the next, except for the middle deciles (4, 5, and 6 especially) that exhibit some interweaving.

Life expectancy at birth ranged from 68.8 years in the lowest SES decile to 72.5 years in the highest in 1982 and from 73.0 years to 80.2 years in 2019 for men. For women, it ranged from 77.2 to 78.8 years in 1982 and from 78.7 to 84.5 years in 2019. Between 1982 and 2019, the gap between the lowest and highest deciles increased from 3.7 to 7.2 years for men and from 1.6 to 5.8 years for women. The deteriorating trend in survival observed at the national level since 2010 appears to have affected Americans in all socioeconomic deciles, translating into much slower progress than previously for the most privileged men and for all women and into a reversal for the 80% men in the least privileged counties.

Over the same period, life expectancy at birth in the pooled OECD countries increased from 72.0 to 80.1 years for men and from 78.4 to 84.9 years for women, an increase of 8.1 and 6.5 years, respectively (Figure 2A and B), with Japan ranking systematically the highest for both sexes combined. In 1982, life expectancy at birth in the United States was just below the value for the pooled OECD countries (70.8 vs. 72.0 years for men, 78.1 vs. 78.4 years for women). During the following 35 years, the country

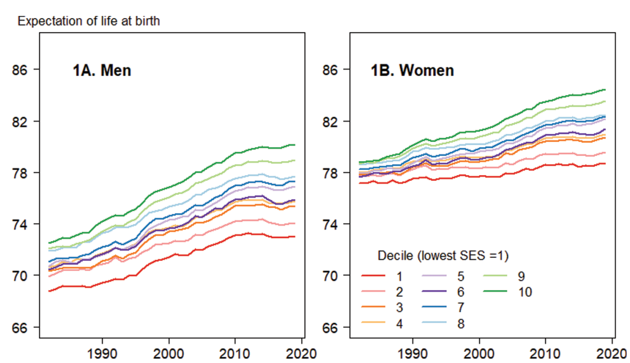

Figure 1. (A and B) Trends in life expectancy at birth in the 10 U.S. socioeconomic deciles, 1982–2019, each sex.

position eroded progressively for both sexes over time and by 2019, the length of life was lower in the United States overall compared with the comparison pool by 3.5 years for men and 3.1 years for women.

Our most striking finding, however, is that by 2019, the average life expectancy at birth in the comparison countries ranked higher than for American women in all 10 socioeconomic deciles and higher than for men in the first nine socioeconomic deciles (Figure 2C and D). Only the top decile of men in the most advantaged counties had longer life expectancy at birth, on average, than the pooled OECD, and only by a fraction of a year. The gap between Americans in the lowest socioeconomic decile and the OECD average increased from 3.2 years in 1982 to 7.1 years in 2019 for men and from 1.2 to 6.1 years for women. Americans in the highest socioeconomic decile had a 0.5 and 0.4 years advantage, for men and women, respectively, in 1982, declining to 0.1 years for men and transforming into a handicap of 0.4 years for women in 2019. By the end of the period, male life expectancy at birth was higher in Australia, Switzerland, Spain, Iceland, Italy, Japan, the Netherlands, Norway, and Sweden than for American men in the highest socioeconomic decile and it was very close (less than 1 year) in Austria, Belgium, Canada, Denmark, France, Ireland, the United Kingdom, and Luxembourg. Female life expectancy at birth was higher in Australia, Switzerland, Spain, Finland, France, Italy, Japan, Luxembourg, Norway, Portugal, and Sweden and very close in Austria, Belgium, Canada, Ireland, Iceland, and the Netherlands compared with American women in the highest socioeconomic decile. The only countries with at least 1 year of difference in the length of life compared to the 10% Americans in the most affluent decile were Portugal (with a life expectancy of 78.6 years) for men and Germany (83.3 years), Denmark (83.4), and the United Kingdom (83.0) for women.

In 1982, Americans in all 10 SES deciles had higher death rates at young adult ages (20–35 years) and, for women, at older adult ages (50–70 years) as well, but this disadvantage was compensated by lower mortality rates at all ages 70 years and older (Figure 3A and B). The rate for American men in the most disadvantaged decile was more than twice as high as that for their OECD peers between ages 20 and 35 years. For women, the peak reached just below 2 at age 25. Those in the lowest 5 SES deciles had higher mortality at all ages below 70 years than their average OECD peers. However, American men in the highest three SES deciles experienced rates that were either lower than or very close to those in the pooled comparison countries at all ages other than young adults. American women in the most privileged deciles only experienced an advantage

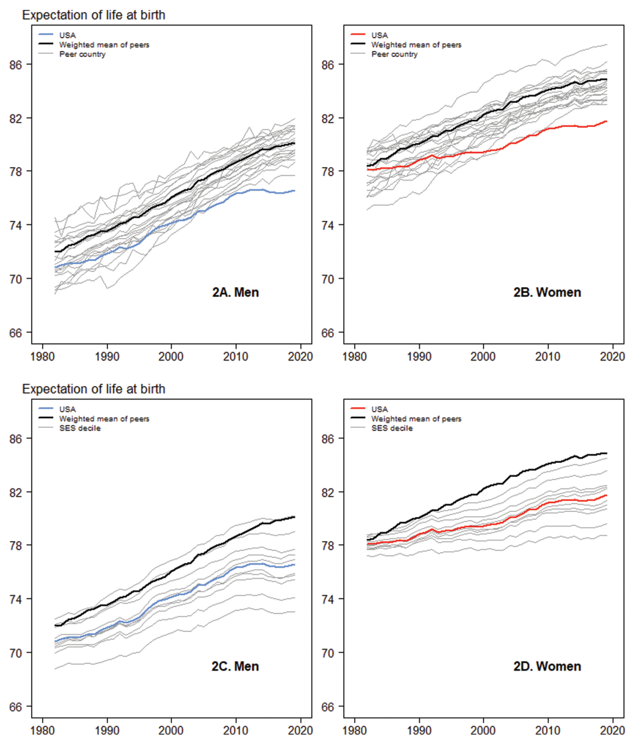

Figure 2. (A–D) 1982–2019 Trends in life expectancy at birth in the United States, in 20 peer countries* with population-weighted mean, men (A), women (B), and in the 10 U.S. socioeconomic deciles, men (C), women (D). *Peer countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom.

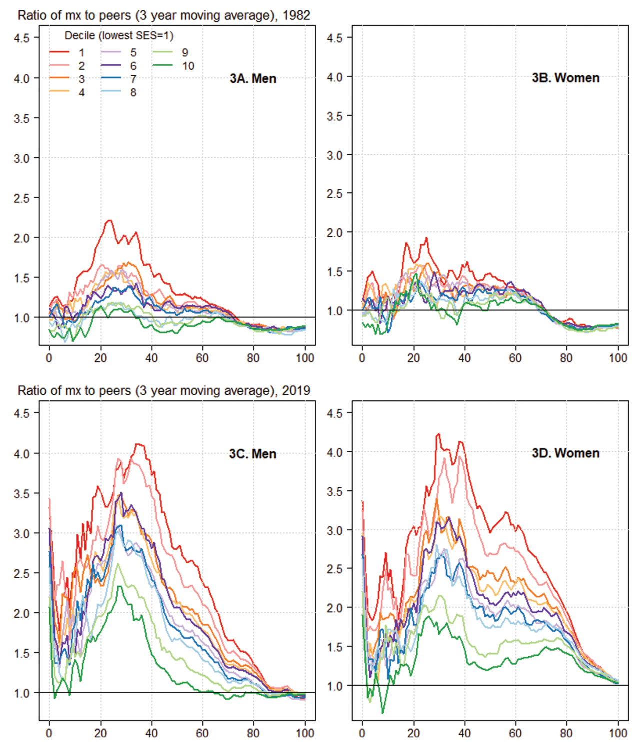

Figure.3. (A–D) Ratio of the age-specific death rates (mx) in each SES decile to the population-weighted mean for the 20 peer countries*, 1982 (men, A; women, B) and 2019 (men, C; women, D). *Peer countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Iceland, Ireland, Italy, Japan, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland, and the United Kingdom.

over their peers during childhood (below age 15) and, like all others, around age 40 and over age 70 years.

In 2019, the relative position of all Americans had deteriorated in every respect (Figure 3C and D). The previously large disadvantage exhibited by young adults had increased further and spread to surrounding age groups. Between ages 20 and 40, the 20% of American men and women in the two lowest deciles experienced death rates that were about four times higher than in the pooled OECD countries. The rates for American children around the ages of 5–15 years in the first three deciles were 2.5 times as high as their peers in the comparison countries. Equally striking is that the most privileged Americans of both sexes exhibited a pattern of excess mortality virtually identical to what the most disadvantaged Americans experienced in 1982 compared to peer countries, with mortality rates at young adult ages (around 20–30 years) twice as high for men and only slightly less for women. Furthermore, in 2019, the previous advantage in mortality at ages 70 years and older had disappeared for all except for men in the most privileged decile.

Though the gap in the mortality rates of Americans in the lowest SES decile with their OECD peers was largest for young adults, the contribution of ages younger than 45 to the difference in life expectancy at birth in 2019 was smaller than that of the age group 45–75 years (Supplementary Figures S3a and S3b). This is because rates are much smaller below age 45 years than above and a large difference in small rates contributes less to the gap in life expectancy than a small difference in high rates. For men, the higher death rates at ages 0–44 years contribute 37% to the 7.1 years of difference between the United States and peer countries in the length of life, while those at ages 45–74 years contribute 56%. For women, these proportions stand at 24% and 57%, respectively, of the 6.1 years of difference in life expectancy at birth. The oldest age group (75 years and older) only contributes 7.5% to this difference for men but 19.5% for women. In 1982, however, because mortality at older ages was lower for Americans in all SES deciles than for their OECD counterparts, the difference in life expectancy at birth was entirely attributable to higher mortality at ages younger than 70 years (Supplementary Figures 3a and b).

For American men in the highest SES deciles, the comparatively large advantage in mortality at older ages (70+ years in 1982, 60+ years in 2019) compensated the low relative mortality at younger ages (15–49 years in 2019). For American women in the same SES decile, the relative advantage at ages 75 and older years in 1982 has completely eroded by 2019, so that the small though favorable difference in life expectancy with their OECD peers (0.4 years) they experienced in 1982 had transformed into a disadvantage (of 0.4 years) in 2019. No single age group contributed particularly to the disadvantage; rather, it was spread out throughout the life span.

With the mortality rates and the remaining years of life of the average lifetable for peer countries in 2019, a total of 446,400 deaths would have been averted in the United States: 274,687 for men and 171,713 for women. All of these decedents would have collectively lived an additional 14.5 million years. These values are highly consistent with those calculated by Preston and Vierboom (2021) who estimated the excess deaths at 400,700 and the total number of years of life lost at 13 million using a slightly different set of comparison countries and the lifetables for 2017. In our study, American men lost many more years of life than women (8.3 million vs. 6.2 million). The lowest SES decile which, like all other deciles, represents about 10% of the overall U.S. population, contributed about one fifth of the total number of years of life lost (18% for men, 19% for women). The contribution of each decile declined progressively to reach only 1% for the most privileged. The 50% most deprived Americans contributed 69% for men and 70% for women to the total number of years of life lost by the United States compared to peer countries.

Discussion

Though there has been a clear and increasing socioeconomic gradient of mortality in the United States over at least the past 35 years, internal inequalities in mortality only partly explain the growing disadvantage in life expectancy relative to peer countries. If the worse-off counties had experienced levels of mortality closer to the national average, the gap in life expectancy between the United States and other countries would be smaller. However, the fact that even the 10% of Americans in the most socioeconomically privileged counties are not doing better than the average of their peers in other high-income democracies indicates that the gap would remain. The country has experienced increasingly higher relative rates of mortality in the working-age population in all SES county groupings, including the most affluent, relative to the comparison countries. Furthermore, the U.S. previous advantage in mortality at ages 75 years and older has progressively eroded and had virtually disappeared by 2019, except for the 20% of American men in the two highest SES deciles.

That even Americans in the most advantaged communities are doing poorly in terms of mortality compared to their peers in other countries is consistent with results from previous studies. Banks et al. (2006, 2010) showed that (White) Americans in the highest wealth quintile had poorer health status than their British counterparts despite benefiting from a much steeper economic gradient. Although we would have liked to compare socioeconomic disparities in mortality in the United States with those in other countries, it would be very difficult to bring Banks et al.'s studies up to scale because sources of data are very diverse across countries (Banks et al., 2006, 2010). However, scattered evidence suggests that the increasing mortality disparities experienced by the U.S. population are unique to this country. For instance, a recent string of analyses on area-level poverty and mortality in several European countries showed that in many, inequalities in mortality have been declining since the 1990s, especially for children and working-age adults (Cloyne et al., 2021).

Additional research is necessary to understand whether the factors driving the growing disadvantage in U.S. life expectancy are the same across all SES deciles. That the age pattern of the difference in mortality between each SES decile and their OECD peers is very similar suggests that it could very well be so, albeit more strongly for the lowest deciles. As indicated by other studies on the U.S. life expectancy shortfall, external causes of death for middle-aged adults (and, in the recent past, the drug overdose epidemic in particular) appear to have played an important role, together with the slowing of progress to control the impact of cardiovascular diseases at higher ages, in part due to the disproportionate prevalence of obesity (Barbieri, 2019; Harris et al., 2021; Ho, 2019; Ho & Hendi, 2018; Ho & Preston, 2010). Examining the causes of death that have most contributed to the growing disadvantage in life expectancy between each SES decile and the comparison countries would improve our understanding of the mechanisms at play. However, we strongly suspect that the explanations for the overall difference between the United States and other high-income countries are multifactorial. Previous research has emphasized more specifically the systemic failure of American society and the role of structural factors (including economic and racial inequality) and public policy to explain both mortality disparities within the United States and the country's shortfall in life expectancy (Avendano & Kawachi, 2014; Beckfield & Bambra, 2016; Case & Deaton, 2020; National Academies of Sciences, Engineering, and Medicine, 2021; National Research Council, 2013). Additional studies should concentrate on identifying the mechanisms mediating the impact of these upstream factors on the observed disparities, whether they operate through compositional factors (differences in the characteristics of individuals and in the ways those affect individual behavior), through contextual variables (and the associated opportunities permitted by the immediate or more distal physical and social environment), or through the cultural and historical features of populations (Cummins et al. 2007; Macintyre et al., 1993, 2002). A determination should then be made as to which of these mechanisms would be easier to address, given the available resources and the political climate, to improve the U.S.'s poor performance compared to its peers.

In the mean time, the divergence is going to continue. It appears that the United States has been more severely hit than its OECD peers by the recent coronavirus disease 2019 epidemic. The widening gap in mortality across SES groupings of counties during the health crisis (Case & Deaton, 2021) combined with the larger impact of the disease on life expectancy at birth in the United States relative to peer countries (Aburto et al., 2021; Woolf et al. (2021) suggests that the observed trend may have further deteriorated in 2020 and 2021.

Supplementary Material

Supplementary data are available at *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences* online.

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Conflict of Interest

None declared.

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Author Contributions

M. Barbieri is the sole author of this article. She has developed the initial concept and research design for the study; she has established the specific methods implemented; she has collected, processed, and analyzed the data; she has written and revised the manuscript, reviewed and approved the final version of the manuscript.

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