Since the 1980s, the U.S. has declined precipitously in life expectancy and mortality rankings, particularly among other high-income states. This decline has occurred despite life expectancy and mortality improving over the past 40 years; instead we see that while the U.S. has improved, other high-income states have improved much more rapidly.

Obesity and smoking, as well as related conditions such as diabetes play a large role in keeping U.S. mortality higher than other countries. Diabetes and Obesity are twice as prevalent in the U.S. as the OECD average[[1]](#footnote-1) and if American obesity and smoking patterns matched the rest of the rich world, the U.S. would have been above average until very recently.[[2]](#footnote-2) However, other studies argue that smoking is not a plausible explanation.[[3]](#footnote-3) A review article found that for the following outcomes, the U.S. had an advantage: percent of population taking lipid lowering drugs, screening rates for breast, cervical, colorectal, and prostate cancers, five year breast cancer survival, fatality rates from acute myocardial infarction, week and month long hospital fatality rates, percent receiving treatment for high blood pressure and diabetes, and the use of cardiac procedures.[[4]](#footnote-4)

High rates of death from firearms and transportation accidents are uniquely American phenomena. Deaths from transportation accidents have declined in peer countries at a much slower rate than in peer countries; in 1975, the U.S. had one of the lowest fatalities per kilometer driven but by 2005, it had one of the highest.[[5]](#footnote-5) Risks from these causes is particularly concentrated in teens and young adults. Among 15-19 YOs, firearms and transportation accidents are among the leading causes of death and 15-19 YOs are 82 times more likely to die from getting shot in the U.S. relative to an average of 19 OECD countries.

Aside from the aforementioned effects that firearms and transportation accidents have on youth mortality, the U.S. continues to show deviations from the OECD mean by age categories. When looking at all cause child mortality, we see that while the U.S. has improved over the past several decades, other countries have improved more. Childhood mortality from intentional injuries started at similar levels in 1960 but has grown significantly since the 1960s, driven almost exclusively by U.S. males.[[6]](#footnote-6) American childhood mortality from unintentional injuries started and ended at higher levels.[[7]](#footnote-7) By 2010, there was not all categories studied (infectious diseases, perinatal conditions, cardiovascular diseases, congenital anomalies, malignant neoplasms, neuropsychiatric conditions, other noncommunicable diseases, intentional injuries, and unintentional injuries) where the U.S. had better outcomes. [[8]](#footnote-8) When we expand the scope to include adults as well, one study shows that mortality under age 50 accounts for two thirds of the life expectancy gap for U.S. males and two fifths for females.[[9]](#footnote-9) Within this group, the top five contributers for this gap among males are homicide, transportation and non-transportation injuries, perinatal condition, and non-communicable diseases excluding cardio vascular diseases. For women, the top five were noncommunicable diseases excluding cardiovascular diseases, perinatal conditions, transportation and non-transportation injuries, and homicide. For the people aged between 40-75, one study observes that the U.S. has the poorest all cause mortality rates but that they improve dramatically 75+.[[10]](#footnote-10) Unusually aggressive treatment is likely to be contributing to this age pattern, though health insurance and smoking are not plausible explanations.[[11]](#footnote-11) While much of the literature cites the U.S. old age advantage, one study questions that finding. The authors find that crossover age has been rising linearly and that but 2010, there is only a small advantage for females over 75 and no advantage for males.[[12]](#footnote-12) The authors also observe no consistent U.S. superiority in survival at older ages between 1955 and 2010.[[13]](#footnote-13)

The effects of economic conditions are also far reaching on health. In the short term, recession is associated with an increase in mortality from mental health issues and communicable diseases, but a decrease in mortality from car accidents and cardiovascular related diseases. [[14]](#footnote-14) A large literature supports the assertion that mortality fluctuates procyclically.[[15]](#footnote-15) Economic crises also have a significant effect on infant mortality and the effects of economic crisis hurt countries with higher rates more than those at the median.[[16]](#footnote-16) A study that examines the effect of unemployment on suicide rates found a positive and significant relationship between per capita GDP and suicide rates, an inverse relationship between suicide rates and economic growth, and a negative relationship between fertility and suicide.[[17]](#footnote-17) Relative income correlates more strongly with suicide incidence than absolute incidence, which is also supported by a wealth of literature on happiness.[[18]](#footnote-18) Downturns and austerity are also associated with deteriorating mental health. [[19]](#footnote-19)When examining mortality more generally, relationships between income and mortality can be difficult to pin down.[[20]](#footnote-20)

The effects of education often manifest themselves through inequality. The U.S. has bifurcated into college educated and not college educated and the least educated are getting hit the hardest by premature mortality generally, as well as from deaths of despair.[[21]](#footnote-21) The authors find that mortality for non-Hispanic whites without a college degree is rising while mortality for whites with a college degree is falling.[[22]](#footnote-22) Blacks’ and Hispanics’ mortality rates have fallen regardless of education and the authors argue that a cumulative disadvantage between successive birth cohorts builds up as a result of worsening labor market opportunities for uneducated whites.[[23]](#footnote-23) A study comparing U.S. and Germany followed two cohorts and found that there was a higher risk of dying for minimum and medium skilled unemployed Americans but no association among similarly skilled German.[[24]](#footnote-24) The authors argue this is partially due to stronger unemployment and labor protections.[[25]](#footnote-25) Education can also serve as a mediator between behaviors that affect health. The experimental and quasi-experimental evidence is less conclusive.

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