Congressional Testimony to the House Budget Committee

Angus Deaton, Princeton University and University of Southern California

June 23rd, 2020

Health and wealth inequality in America: how COVID-19 makes clear the need for change

Chairman Yarmuth, Ranking Member Womack, and Committee members, thank you for inviting me to talk about inequalities and the COVID-19 pandemic. It is a privilege to meet with you at this critical juncture in American history, indeed in world history.

The pandemic is exposing and exaggerating longstanding inequalities in health and wealth. It will worsen the inequalities between black and white, between the more and the less educated, and between ordinary people and the well off. Enlightened policy can moderate these effects, as has already been the case. But we are not done

This pandemic, like other pandemics before it, lights up anew the fault lines in society. Inequalities that we knew about, like racial and ethnic inequalities, are more starkly visible. Inequalities in work and in living conditions have become salient in new ways, as people are sorted into essential and inessential workers, as jobs, transportation, and activities that once were safe become unsafe, and as access to the internet becomes the difference between learning or not learning, or working safely or not working at all.

The pandemic may turn tolerable inequalities into intolerable inequalities. There is a danger of social unrest, but there are also opportunities to address long-standing problems. The need to repair our policing has already become urgent. Other outstanding issues include healthcare, antitrust policy, and our system of unemployment benefits.

I want to start by describing inequalities in the US before the pandemic struck. I shall then discuss how these inequalities shaped the experience of the pandemic, often amplifying them, and then I shall go on to discuss issues for the future.

My guess is that, left to itself, the pandemic will worsen inequalities in the US, between blacks and white, between the more and the less educated, and between ordinary people and the very well off. Enlightened policy can moderate the worsening, or there could be serious disruption. But we have been here before; the income and wealth inequalities of 2000, if they had seen from 1960, would have seemed intolerable, but tolerated they were.

BEFORE THE PANDEMIC

Educational attainment, race, and unequal lives

In the past half century, the lives of Americans have become increasingly divided according to whether or not people have a four-year college degree; those with a BA are prospering and living longer, while those without are foundering. Not only are the gaps widening in the outcomes that make for a good life, but for less-educated Americans, life is getting worse. The American economy is not delivering for less-educated Americans.

In our recent book, *Deaths of despair and the future of capitalism*, Anne Case and I document the disaster and the divide. Most stunningly, mortality rates in midlife, which had been declining for a century since the last pandemic, began to rise in the mid-1990s, driven by increases in suicides, drug overdoses and alcoholic liver disease (what we call "deaths of despair") as well as by a reversal of progress against mortality from heart disease. There were 158,000 deaths of despair in 2018 (the latest year we have data) compared with 65,000 in the mid-1990s. The increase was almost entirely among the two-thirds of white non-Hispanics who do not have a bachelor's degree. Until 2013, black non-Hispanics, who had suffered their own catastrophe in the 1970s and 80s, escaped this epidemic. After 2013, when illegal fentanyl hit the streets of eastern cities, black deaths of despair began to rise too, again almost exclusively among African Americans without a bachelor's degree. Other rich countries appear to be exempt from deaths of despair, at least for now, although here are much smaller epidemics in other English-speaking rich countries, most notably in Britain.

There has also been a surge of pain, of disability, of difficulty in socializing, and in loneliness, again largely confined to the less-educated. The fraction of men in employment has fallen for many decades and, since 2000, for women too. Yet labor force participation has held steady for educated men and women. Median earnings of less-educated men have fallen for half a century; if benefits are included, especially employer-provided health insurance, the decline is moderated, but, as I argue below, these "benefits" are worth much less than they cost, and are harming working people in other ways. The earnings premium between those with at least a BA and those without has now risen to an astonishing 80 percent.

Community and social lives of the less-educated have deteriorated, creating a widening gap with the more educated. For those without a BA, divorce has risen, as has out of wedlock childbearing, and many never marry, though they participate in serial cohabitations that often bring children, many of whom lose touch with their fathers. The decline in unions has depleted an important social and community resource, and rates of churchgoing have fallen. Again, these dysfunctions are confined to less-educated Americans, whose lives are getting worse, and whose lives are diverging from the third of the population with a BA or more.

African American mortality rates have long been higher than those of whites; it is true today, and it has been true for as long as we have data. In the 1930s, midlife mortality rates for blacks were two-and-a-half times those for whites. The gap has diminished steadily, closing particularly rapidly when white mortality rates began to rise in the mid-1990s. This convergence came to a halt after 2013, with the rise in fentanyl deaths among blacks; blacks with a BA—22.5 percent of the black population—were largely exempt.

In our book, we argue that the disintegration of life among inner-city African Americans in the 1960s and 1970s, culminating in the crack epidemic, was echoed forty years later by the epidemic of deaths of despair among whites. Black Americans, then among the least-skilled workers, faced the leading-edge of globalization as manufacturing jobs in cities were lost.

In the last thirty years, globalization and automation has eliminated many more jobs, especially for less-skilled workers. Wages fell along with employment as good jobs vanished and workers relocated to less well-paying jobs, gig jobs, or jobs in labor supply firms, or dropped out of the labor force altogether. Some of the worst jobs like chicken processing plants in rural America, or meat packing plants—where many immigrants work—have become danger zones in the COVID-19 epidemic.

Good, stable, jobs with high wages became scarcer, undermining the foundations of community and social life. In many of the worst-affected communities, where despair ran deep, pharma companies pushed doctors to prescribe huge numbers of opioids—essentially FDA approved heroin—a ladder from despair to addiction and death. Meanwhile, globalization opened up new worlds of opportunities for the educated elite, who prospered as never before, some quite spectacularly so.

African Americans have long done worse than whites on almost all positive outcomes, in unemployment, wages, wealth, housing, health insurance and access to quality healthcare, and especially in rates of imprisonment. On some indicators, such as self-reported pain, or life-satisfaction, education now appears to be as important a divide as race. However, while a third of white Americans have a BA or more, less than a quarter of blacks Americans do.

Health insurance and healthcare pre-COVID

American healthcare played an important role in the disaster even before COVID-19. There are three key facts: American health care is exorbitantly expensive; much of it is financed through employer provided health insurance; and it delivers relatively poor outcomes. It is a major driver of income inequality, because it transfers unnecessarily large sums upward from the general public to providers, some of whom are very wealthy, and it lowers wages and destroys good jobs for lower paid workers. An average family (single) policy cost $20,000 ($10,000) in 2019 which has to come out of what the worker is worth to the firm. This means lower wages, or often for the least skilled, elimination of the job. Outsourcing firms can provide the same work, but often without benefits, and at lower wages; few large firms now hire their own janitors, security guards, drivers, or food-service workers. Those low-level jobs—the proverbial mailroom worker—often provided the sense of being part of an important firm, and for some, the opportunity for promotion. The rapid increase in the cost of healthcare—now twice as expensive as in any other country—has lowered wages, destroyed jobs for the less-educated, and enriched hospital executives, pharmaceutical companies, device manufacturers, insurance executives, and a minority of physicians—the most common occupation among the top one percent.

All of this harm is over and above the role of the system in the opioid epidemic.

DURING THE PANDEMIC

The quick and the dead: age, sex, race, and ethnicity

Death does not come equally to all, especially not COVID deaths. COVID infections and death are structured by sex, by age, by race and ethnicity, by education, and by geography. Pre-existing inequalities shape who dies and who lives, just as the pandemic itself creates new inequalities.

In some cases, the odds of dying are *approximately* (and only approximately) proportionally elevated for everyone so that the epidemic reinforces pre-existing health inequalities. Men are more likely to die than women from COVID; by June 10, 51,397 men had died, and 44,209 women. In 2018, with no COVID, 1.5 million men died and 1.4 million women; the normal disadvantage of men is has been exaggerated by COVID. Older people were more likely to die at baseline, and are more likely to die in the pandemic. By June 10, the ratio of COVID deaths for those aged 85 and over to deaths for those aged 55 to 64 was 2.8 to 1; in 2018, that ratio was 2.3 to 1. Once again, COVID somewhat exaggerates the mortality inequalities by age and sex that already exist.

While we are used to the fact that the old are more likely to die than the young, and that men are more likely to die than women, we do not fully understand why these differences exist, and if, as seems likely, they are influenced in part by social arrangements, they are potentially correctable. The mechanisms of COVID are even less well understood. It could be that, like a predator in the wild, it singles out the weak. Or it could be something more specific, like older people are less likely to have had another childhood vaccine that is partially protective—like rubella. Old people who live in nursing homes have been heavily affected. There is also evidence that women are more likely than men to accept and observe social distancing restrictions.

The exaggeration of pre-existing mortalities is much larger for African Americans relative to whites, while, for Hispanics, a pre-existing mortality *advantage* (the so-called Hispanic paradox) has changed into a mortality *disadvantage* with more Hispanics dying than their proportion in the population. In 2018, relative to white non-Hispanics, blacks' death rates were 18 percent higher, and white Hispanic death rates a third lower. During the pandemic, and up to June 10, blacks' mortality rates from COVID were 84 percent higher than for whites, and Hispanics four percent higher. It is important to note that these differences have already changed and will change more with time and as the geographic composition of the epidemic changes. As the pandemic spreads to more places that are predominately white, the white advantage will diminish, although it almost certainly will not vanish.

Death rates have been disturbingly high among native Americans. In Arizona, AIANs account for 22 percent of COVID deaths, but are only four percent of the population. In New Mexico, they are 50 percent of deaths, but are only nine percent of the population.

What explains these racial and ethnic differentials? We will not have definitive answers for some time, but we know something.

Where and how people live matters a great deal for any infectious disease, including COVID. The disease has not yet reached some areas, many of them predominately white. Many minorities live in segregated communities, with high population density and multifamily living arrangements. Segregated communities are often less well-served by healthcare. These inequalities have long been known, but have a new significance with COVID.

Transportation seems to have been important in New York City, as people commuted in crowded subway trains to Manhattan from the ethnic and racially structured communities in which they lived. The patterns of mortality by race and ethnicity are quite different in New Jersey and Massachusetts than in New York, showing less or no white advantage. Geography, transportation, and segregation all help control the spread of an infectious disease.

Pre-existing conditions make COVID more deadly. Patients who suffer from underlying health conditions, particularly cardiovascular disease, diabetes, or chronic lung disease, are six times more likely to be hospitalized, and once hospitalized twelve times more likely to die from COVID. Because underlying health conditions are more common among the less educated, and among African Americans, they contribute to the COVID mortality differences among those groups.

Minority workers are disproportionately represented in services and in healthcare. The CDC reports that 25 percent of Hispanics and non-Hispanic blacks work in services occupations, compared with

only 16 percent of whites. African Americans are 12 percent of all employment but 30 percent of nurses.

African Americans are disproportionately incarcerated, and prisons have become hotspots for COVID.

The patterns we document in *Deaths of despair*, with mortality and income gaps expanding simultaneously, will be further exaggerated by the pandemic, or rather by the measures that have been taken to moderate and control it. Many educated people get to stay at home, continue to earn their salaries, communicate with colleagues and friends electronically. Their health is protected along with their incomes. Their children take zoom classes and their attendance is monitored by their parents.

People without a college degree keep their jobs, if they are essential workers, but may risk infection, or, if they are not essential, lose their jobs and risk their earnings, but stay safe. Essential occupations include food and agriculture (including retail and the infamous meatpacking jobs) where only 14 percent of workers have a BA, and where about half of workers are people of color. For non-essential workers who lose their jobs, most have been at least temporarily covered by emergency payments. In the longer term, some jobs may never return, and some workers may feel they have to return to work, even when they do not feel safe. Otherwise, they risk not having money to buy food, or to pay rent.

Under these conditions, the gaps by education in both health and earnings will surely expand.

Healthcare is supposed to be met by the money paid to hospitals in the CARE act, and insurers are largely foregoing copays and deductibles. But the situation remains murky, and many people may face hospital charges. A quarter of a million people have been hospitalized with COVID since the pandemic began, and that number could more than double by the end. If insurers pay now, they will have to recoup later. There is scope here for enormous popular discontent as this situation unwinds. If so, there will also be demands for reform.

Other issues and looking forward to post-COVID

The Constitution of the US embodies sharp inequalities in political representation in the Senate. The largest four states, California, Texas, Florida, and New York, have a third of the population, but only eight percent of the Senate. In contrast, Wyoming, Vermont, Alaska, and South Dakota comprise less than one percent of the population but also have eight Senate seats. The distribution of COVID cases, hospitalizations and deaths are more concentrated than population and have even fewer Senate votes. The four states with the highest number of deaths, New York, New Jersey, Massachusetts, and Michigan have half of all deaths so far, and, once again, eight percent of Senate votes.

This inequality will narrow as the pandemic moves across the country and into more rural areas. But, for the present, the inequality of representation makes it harder to provide financial relief to the states that are hardest hit.

In the gilded age, with vast material inequalities, antitrust laws were introduced to break up trusts and to make capitalism fairer to workers and consumers. Many commentators and researchers have

recently been concerned about increasing industrial concentration today: hospitals are an important example, airlines another, though the champion is retail, with Amazon and Walmart. A related but distinct concern is about big tech, their quasi monopoly position, and whether they are a net benefits or threats to society. At the same time, the share of labor in GDP—long thought to be an immutable constant—has been falling, not only in the US but around the world. If there is prolonged unemployment post-COVID, the position of labor will weaken further. Many have argued that government anti-trust enforcers, and the courts, have lost interest in antitrust enforcement. Prices of many goods and services that used to be cheaper in the US than in Europe are now more expensive, arguably because the EC has been a more effective regulator than the US.

All this can be argued both ways. Big tech, and retailers like Amazon and Walmart have brought great benefits to us all. Yet there is a level of discomfort that is growing to something like alarm as COVID causes greater consolidation. Many bricks and mortar facilities have been closed, whether inessential retail or manufacturing, while anything with an e- in front of it has been open. Many stores have gone bankrupt. Big tech has money to purchase firms in difficulties, as does private equity.

One thing that I do not worry about is that the unemployment we see now, and that may last for a while, will bring an epidemic of deaths of despair. Our book argues that deaths of despair are the consequence of a prolonged, half-century undermining of the supports of working-class life in America. These deaths do not respond to the ups and downs of employment and unemployment. Deaths of despair were rising before the Great Recession, they rose during the Great Recession, and they continued to rise after the Great Recession. We expect deaths of despair to continue through the pandemic, but not to spike in response to the unemployment that has been generated as a part of social distancing.