

Response to Dr. Clarfield

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I would like to thank Dr. Clarfield for providing an enlightening essay on trends in healthy life expectancy (HLE).¹ He opened my eyes to alternative ways of thinking about these metrics, but before I get into this important issue, it is worth clarifying one main point raised during this debate.

Dr. Clarfield states, “Life expectancy is increasing at all ages in the developed world and has been for quite a while now.” Let us be clear—this is a false narrative that a handful of demographers have perpetuated for many years now² and that nondemographers often have repeated. The overall trend in life expectancy over more than a century has been upward, but in many developed countries, life expectancy at birth has dropped in approximately 30 of the last 100 years from one year to the next.³ In the United States, life expectancy at older ages (especially women aged ≥ 65) has largely stagnated since the mid-1980s,⁴ and at extreme old age, there has been little movement in mortality at all. “Best practice life expectancy” is often used as the basis for this view of continuously rising LE, but this metric is an artificial construct, newly created, for the purpose of highlighting the extreme distribution of LE in the world from one year to the next. It is equivalent to concluding that, because the world record for running 1 mile has been declining steadily for the last 150 years, this decline will not only continue into the future, but also everyone can achieve this world record running speed.

Furthermore, population subgroups (especially those that are less educated) have experienced notable reductions in LE in the last quarter century.^{5,6} Finally, and most importantly, since 2010, increase in LE at birth has decelerated or stagnated in many developed nations—leading many actuaries and demographers to wonder whether some new global trend in health and LE has emerged.⁷ This reality of observed human mortality—unlike artificial metrics designed to highlight extremes—is likely to have an influence on trends in HLE, so we might as well begin by dispelling this long perpetuated myth.

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This is a response to the article by Clarfield.

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One critically important point that Dr. Clarfield makes is that, regardless of the diseases that accumulate and are expressed in aging bodies, we need to be careful about how we use the metric of HLE when thinking of individuals rather than populations. Although the increased expression of frailty and disease influences the HLE metric in an unfavorable way, people have become better at adapting to changing conditions in body and mind, and many can live relatively healthy, happy, productive lives with the conditions that limit HLE. This is not an effort to sugarcoat aging and the health conditions that appear at later ages; it is a simple realization that, just because HLE may be decreasing, it does not necessarily follow that the overall health of the population is worsening.

In this regard, I think Dr. Clarfield has made an extremely important point that needs careful consideration any time the question of population health metrics emerges. We must not lose sight of our ability to learn and adapt to aging bodies—as glasses, canes, joint replacements, hearing aids, pacemakers, lens replacement, and countless other gadgets enable us to navigate the normal breaking down of our bodies with time. Humanity will no doubt become better at this form of personal adaptation, so even if our national health statistics point to the rising prevalence of frailty and disability, we must remember to consider how people actually feel and function rather than just listening to what our national vital statistics suggest.

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