#246: Deaths of despair / Effective altruism (Angus Deaton)

Julia Galef: Welcome to Rationally Speaking, the podcast where we explore the borderlands between reason and nonsense. I'm your host, Julia Galef, and my guest today is Angus Deaton. He is a professor of economics at Princeton who won the Nobel Prize in economics in 2015.

You may have seen his name in the media most recently because he and his colleague and wife, Anne Case, at Princeton, wrote a very widely discussed paper on the alarming rise in the US of "deaths of despair," which is their term for deaths from drug abuse, alcohol abuse, and suicide. That paper came out a few years ago, but just this year, they published a book on the topic, titled *Deaths of Despair and the Future of Capitalism*.

So that is the first thing that I wanted to speak to Angus about. Why are deaths of despair increasing, and how do we know?

Then, the second half of the episode is about a topic that's especially close to my heart -- effective altruism, which is a movement based around using logic and evidence to figure out how to do the most good. And a few years ago, Angus wrote an essay that was pretty critical of effective altruism. So, of course, I couldn't resist the opportunity to talk to him about it.

Those are the two halves of this episode. Then, at the end, I spend a few minutes talking about my reaction to the arguments that Angus made.

So let's jump in. Here is Angus Deaton on deaths of despair. As we enter the conversation, he's giving the background context that, for most of the 20th century, people were living longer and longer, at least until deaths of despair started to take off.

Angus Deaton: We really have data starting in the 1930s, when all the states started collecting information on deaths. We can project beyond that, but it's pretty clear that throughout the 20th century, mortality rates were falling at almost all ages and life expectancy was rising.

There are interruptions in that. The most obvious of which is the last pandemic at the end of the First World War, the influenza pandemic. But until the turn of the century, we've got this sort of steady progress. What was causing the progress was different at different times, but nevertheless, life expectancy kept going up, we were living longer. A great benefit to mankind.

Julia Galef: So what you and Anne Case discovered is that those trends begin to change around 1999, 2000?

Angus Deaton: Yeah. In the late nineties. It's clear that that steady progress just sort of comes to a pretty shuddering halt. We have to be a little bit careful here, because mortality and life expectancy are not the same thing. Mortality is age specific. There are deaths at five or deaths at 55. They can all behave a little differently.

But what we discovered was, initially, in the age group mid-life, 45 and 54, that the steady progress over the past century had just come to a halt. It was going up in some years or just steady in other years. But this steady progress that we'd seen for the century before really just stopped.

And the most remarkable thing was that when we did that for other countries, other countries had been sharing this mortality decline, about 2% a year, and they didn't stop. They went straight on. So the US just left the herd. It became egregious, to use the word in its technical sense.

Julia Galef: What is the technical sense of egregious? I don't think I know.

Angus Deaton: Outside the flock. I think the word-

Julia Galef: Outside the flock?

Julia Galef: Oh.

Angus Deaton: Grex. G. R. E. X. is Latin for a flock. So egregious means you're outside the flock. Whether sheep or birds, but ... Whatever.

Julia Galef: I will be using that in a sentence as soon as possible.

So you attribute this sudden halt in progress on falling mortality rates, to something you call deaths of despair. Could you describe what that entails? Like what are you defining as a death of despair?

Angus Deaton: Well, let me back up a little bit.

Julia Galef: Okay, sure.

Angus Deaton: So when we discovered this great benefit to mankind, it stopped giving benefits. The first thing we wanted to know was, what causes of death are making this happen? We discovered this accidentally while looking at suicide. So we knew suicides at mid-life were rising quite rapidly. Then we looked for the other things that were rising rapidly. What we found were deaths from alcoholic liver disease and also deaths from drug overdoses.

So those were the two most rapidly rising causes of death. And we thought, "Oh, wow, look at these things." I think it was Anne who thought of the term talking to a journalist, that all three of these deaths, whether deaths from alcoholic liver disease, or deaths from drug overdose or suicides, were self-inflicted in some ways. As she likes to put it... they kill yourself quickly or kill yourself slowly, but it's not like an infectious

disease or a virus, or it's not like a failure of the medical system. It's sort of self-inflicted.

Now just to ... The question here is attributing this. In a comment that was posted very shortly after our paper was published, the Dartmouth researchers, Meara and Skinner pointed out that the upturn would not have happened except for what was happening to mortality from cardiovascular disease.

So mortality from heart disease had been the big thing that had been driving down mortality since the 1970s. And basically it had stopped and was beginning to turn around. So, that was not rapidly rising, but it's a very big item. The fact that it had been declining for so long and had stopped declining was a big, important part of the story as to why deaths had stopped falling.

Julia Galef: The story about the causes of deaths of despair that I had absorbed, from when it was first in the media several years ago, and which I bet many of my listeners also have in their heads, is an economic story. That around the US in especially rural areas, wages have been stagnating, people are losing their jobs, costs of healthcare are going up, and so on. And so people are struggling economically more than they used to, and this is what's driving them to drink and to drugs.

But in your book, you kind of explicitly say, this is not what you see as the main culprit for deaths of despair. That's right?

Angus Deaton: Almost.

Julia Galef: Okay. Correct me.

Angus Deaton: I mean, well, in the book, what we talk about is a long slow process in which wages are going down, jobs are getting less good. The good jobs that people used to have, have turned into not very good jobs. They don't belong to unions anymore. And that this fuel for the working class that used to be so important has really been choked off to the point where the working class is really struggling. That's a long slow process.

When we talked about that, people wanted to say, "Well, there's a recession. Isn't that going to cause lots of deaths of despair?" And the answer is, well, no. And in fact, there's a graph in our book and even in our Brookings paper, which was 2017, we show that if you look at The Great Recession in 2008, which was the biggest recession since The Great Depression up until now, deaths of despair were rising before The Great Recession, they were rising during The Great Recession and they were rising after The Great Recession. You just can't see any point at which The Great Recession has any effect on those deaths at all.

So, we don't want to tie this ... When you said it's tied to economic factors, that's right... but not directly and not on a day to day or month to month basis, like over the business cycle.

Julia Galef: I see.

Angus Deaton: We're talking about a long term sort of gutting of the working class.

There's something very important we haven't talked about though. And that is that these deaths of despair are only happening to people who don't have a four year college degree.

Julia Galef: Right.

Angus Deaton: That's a very important part of this story, because if it was just the drug epidemic, why would you pick those people? If it was suicide, again, suicide is usually higher among more educated people. That's the opposite of what's happening now. So there's really something else going on, which is very important.

Julia Galef: Okay. So we covered the fact that economic conditions are an indirect cause of deaths of despair, but we didn't talk about what your leading candidate for the direct cause was.

Angus Deaton: I'm a bit worried about indirect cause. I mean, I think of the failures in the labor market as being a sort of fundamental, the deepest cause, if you like. But I don't like this way causal language tends to be used in the sense that there is a cause or there's things along the causal chain.

But what happened here is, as the labor market disintegrated, lots of other bad things happened. So unions went away, social structures begin to fall apart. Bob Putnam's guy who was bowling alone, was bowling alone in a union hall. Now he's not bowling at all because there's no union anymore.

People don't go to church. All of this is people without a BA. Their marriages are coming apart, which is not true for people who have a BA. People who have a BA stay married, and marriage rates are falling among people without a BA.

What's more is the huge rise in pain. All sorts of pain. Face pain, neck pain, sciatic pain, back pain, you list it. And it's all ... the reports of that are going up and up and up among less educated people -- something that's not happening in other rich countries, in Europe for example. So there's this unwinding catastrophe.

Now, if you tell me, what is it that made me think it was a good idea to hit the bottle, or what was it that made a good idea to think drugs – well, the proximate cause might've been my back pain. The proximate cause would be, I don't have any friends anymore. People report they have trouble socializing.

But way back at the root of that is what's happening in the labor market. The pulling out the props for a good working class life for people who don't have a four year degree.

Julia Galef: You know, there's one additional demographic qualifier to who gets deaths of despair, that we haven't talked about yet, in addition to level of education.

That is race. That it's not just, non-college educated people in general, but non-college educated *whites* in particular who are seeing this rise in deaths of despair, as opposed to minorities, right?

Angus Deaton: But that's even more complicated. Because when we first started doing this work, which was in the summer of 2013, what was very noticeable was that these deaths of despair were only among white people, men and women who do not have a four year degree.

Blacks were doing just fine. Or not really ... I have to be very careful how I say this. Blacks have always had higher mortality rates than whites, but the mortality rates of blacks have been falling for quite a long time, and were continuing to fall. So the mortality gap between whites and blacks was narrowing -- which is a very welcome thing, but a lot of it was narrowing because more whites were dying, rather than that there was also an improvement among blacks.

So when we first wrote about it, these deaths of despair were just not happening to blacks at all. [There are] two aspects to that. One is, that if you go back to the sixties and seventies, there was an episode when the inner cities really disintegrated, when the first wave of globalization came. When there was a terrible episode of African-American poverty, a flight from the cities, of what at the time was called cultural problems with the Negro family, to quote Daniel Patrick Monahan...

That episode, which was seen at the time as being sort of a one-off thing that happened to the African-American community, is very similar -- not perfectly similar, but very similar -- to what was happening to whites after the mid-nineties.

So it was like the horrible things that happened to blacks in the sixties and seventies were now happening to less educated whites. That's a very uncomfortable parallel because it suggests that there's some feature of capitalism which is shedding the least skilled workers first.

It's also true that the cultural critics from the right have used exactly the same rhetoric about white loss of virtue, this time around, that they used about black loss of virtue in the earlier episode.

Julia Galef: Well, at least they're consistent, I guess that's some small comfort.

Angus Deaton: Yeah. Except the story doesn't work so well now, because if it was peculiar to blacks, why is it happening to whites? It's pretty clear that we've seen this falling labor force participation at the same time that wages have been falling for less educated whites. That's got to be ... that's not a pulling back of supply. That's got to be a failure of demand.

But the other part about the black story is: We didn't know this when we were writing, because it hadn't happened yet, but after 2013, black mortality started to rise too. Most people, including us, attribute that to the spread of fentanyl into the inner cities. So blacks and whites, less educated whites, began to share the same tracks after that.

Julia Galef: I wanted to ask about the racial gap in deaths of despair because it wasn't clear to me whether your theory can account for that gap well.

So, the factors that you've been pointing to that reduce meaning in people's lives and that are kind of the main cause of deaths of despair are things like the loss of good jobs for people without college educations and related metrics like the decline in labor force participation, the decline in unionization, and some other metrics of strong communities and social ties. All of those things, as far as I've seen, apply just as much to minorities as they do to whites. Yet we've only seen this strong rise in deaths of despair, at least until more recent years, among whites and not minorities.

Angus Deaton: Well, except we've seen the black deaths already. So in some sense they've gone through that.

Julia Galef: But your theory wouldn't predict that as those causes of deaths of despair continue to mount, we wouldn't see more deaths of despair in the last 20 years?

Angus Deaton: Well, we are now. I mean, so the-

Julia Galef: I mean, among blacks --

Angus Deaton: We are now, since 2013. It turned out just to be delayed.

But in some sense you could say, well, the shakeout for African Americans already happened. And so they were sort of exempt for a while until you get this thing among whites. But there are other factors-

Julia Galef: Why would they be exempt?

Angus Deaton: Because they'd already ... Their jobs had already been destroyed.

Julia Galef: Presumably, if it gets worse, then ...

Angus Deaton: Yeah, no, absolutely. But there are other things happening in the white community, which were not happening in the black community.

Julia Galef: Oh, like what?

Angus Deaton: Well, a lot of people have written about this, but there's this sense in which the loss of white privilege is very important. The people who do the ethnographic work, when they interview people, when they talk to what's bothering people, a lot of what's bothering people is they feel that they're being left behind, that their jobs are being taken away by black people, that the privilege they used to have [is gone].

As many people have said, "If you've had this privilege for so long and you've been unconscious of it, then when it's taken away, the removal of a privilege looks more like oppression than just the removal of a longterm privilege." I think that's been a very important thing, too.

I also think that, in spite of what's happened this year, and what's happened this year is long overdue, there's been a huge change in attitudes towards race in the United States, and I think that's been hugely beneficial to African-Americans at a time when the opposite is happening to whites, or they see it as the opposite happening.

Julia Galef: I see. So the theory is that there are a number of destructive forces that were affecting both whites and minorities, like the hollowing out of the job market for people without college education, and a decline in marriage rates and a decline in unionization and other sources of meaning for people...

Angus Deaton: Yes.

Julia Galef: ... But this didn't result in a spike in deaths of despair among minorities the way it did among whites because, A, they kind of already had that spike two decades ago, and so they were exempt in a sense. And B, they had countervailing forces such as long-term fall in discrimination-

Angus Deaton: I think that's right.

Julia Galef: ... that protected them from the negative effects of this.

Angus Deaton: I wouldn't say they were exempt, though maybe I did say that, but-

Julia Galef: You can amend it. You can always amend your comments on this podcast.

Angus Deaton: I think a lot of what had happened was at the end of the crack epidemic the African-American communities decided they'd had enough of drugs and were much less susceptible for a while.

Some of the stories of fentanyl is that, at the end of the crack epidemic, there were a fairly large number of people in inner cities who were regular users of heroin or cocaine, but stable users. No one really knows those numbers, but there are numbers suggesting that, even before any of this

started, there were more than a million Americans using heroin on a regular basis.

This story is that fentanyl got into the supply, so illegal dealers who were illegally dealing heroin and cocaine were putting fentanyl into the supply in order to make it more powerful. Sometimes people would die because they didn't know what they were using.

Julia Galef: Yeah. I wanted to ask about the chronic pain issue that you mentioned, because as I was reading your book, I think I was a third of the way through, and it suddenly hit me, "Whoa, I bet chronic pain is the cause of deaths of despair."

And this theory was very appealing to me, because it just seemed to fit the data so cleanly. Because chronic pain has been increasing significantly for the last two decades, which is the same timeframe as deaths of despair, and the biggest predictors of having chronic pain are being rural, white, and non-college educated, which are also the strongest factors predicting who experiences death of despair.

Also, there's a pretty clear causal connection between being in a lot of pain and turning to alcohol or drugs.

Angus Deaton: Or suicide.

Julia Galef: Or suicide, yeah.

You do devote a chapter to chronic pain, but, unless I'm misreading you, your interpretation was different from mine. In your read, pain is downstream of the loss of meaning factors that we talked about, like a loss of good jobs, decline in marriage rates, decline in unionization, things like that.

So I guess it wasn't clear to me why your model wouldn't simply be chronic pain is the main cause, as opposed to being --

Angus Deaton: But you still have to explain where the chronic pain comes from. There's no chronic pain among people who don't have a BA. Sorry. No rise in chronic pain among people who *do* have a BA, and there's no rise in chronic pain among Europeans. We have a paper just a couple of weeks ago in the Proceedings of the National Academy of Sciences showing that.

I'm quite sympathetic to what you say. I think that pain is a big factor in driving people to deaths of despair. That's part of the causal story. But you still have to tell a story of where the pain is coming from.

Julia Galef: Yeah, that's true. I don't have a good story to explain that, and certainly not about why it would be specifically a larger rise among whites than minorities. That is surprising and confusing. It just seems like having --

Angus Deaton: Actually, there's been quite an upsurge in pain among blacks, too. We don't emphasize that in the book, but --

Julia Galef: Oh, really. Since when?

Angus Deaton: I think around the same period. We haven't looked at that very carefully, but I don't think, in the pain measures, there's such a big difference between blacks and whites. Which would go nicely with your story about the labor market in recent years, because we tend to think of the labor market -- not directly, because working at McDonald's is not going to give you more pain than working on an assembly line. Though working in Amazon warehouse might well.

We think of it, and that's why we quote the neuroscience literature, where lots of people are thinking that being excluded can be a source of things like lower back pain. But it's all very mysterious, no one really knows what's driving that. Some people think the drugs are driving it.

Julia Galef: I guess it could be that I'm mistaken about the racial component to chronic pain. I was pretty sure I had read that the rise was much stronger among whites than among blacks, but assuming for a moment that I'm right about that...

Angus Deaton: Okay. You might be right. I'm not being definitive about that.

Julia Galef: Well, neither am I. We'll just provisionally imagine I'm right for the moment.

If that were the case, then it seems like, if you add this additional piece to your model where there's this underlying cause of the chronic pain stemming from loss of meaning -- but the elements of loss of meaning are not differentially bad for whites as opposed to blacks -- It just seems like it makes the model more complicated. And it fits the data less well than just the simple
"Chronic pain causes..."

Angus Deaton: Complicated models will always fit the data better than less complicated models.

Julia Galef: No, no, I think this one fits the data worse!

Because... I mean, am I wrong? Because things like falling marriage rates and employment-to-population ratio and unionization, et cetera, apply to both whites and blacks and Hispanics, but we only see the rise in chronic pain and deaths of despair among whites.

Angus Deaton: I don't know all these things. Because a lot of the things we look at in the book about coming apart at home, and coming apart at work, we know those things are true for whites without a college degree. I haven't worked through them in detail for the black community and the Hispanics.

But remember, I do think this thing is very important, that African-Americans are treated better than they used to be. There's a Gallup statistic we quote in there, how almost the whole population thought intermarriage was immoral and bad and shouldn't happen, and then within 25 years it's switched the other way.

Some more recent work we've been doing, if you have a BA, whether you're black or white matters much less than whether you have the BA or not. It's still true that blacks with a BA have lower life expectancy than whites with a BA, but that gap is tiny compared with the gaps between whites who do and do not have a BA or blacks who do and do not have a BA. Bob Putnam has written about this, too. There's a sense in which these racial differences are being in part replaced by education or class differences, if you think of class in terms of education.

Julia Galef: Yeah. That actually reminds me of another question I had, which is, if more people are going to college over time, then could it be that, if we're looking at the group of non-college-educated people over time, that's actually a different group of people as we go through the years? It's a smaller group of people who are maybe less...

Angus Deaton: Yeah, that's true.

Julia Galef: Whatever causes people to go to college, the people who are left out of the college-educated pool by 2010 are worse on those measures than non-college educated people were on average in 1980.

Angus Deaton: That's right. I'm sure there's some such fact. But remember, it brings down, it makes health worse for the more educated, too.

Julia Galef: What makes health worse?

Angus Deaton: If you have fewer people not going to college, then the people who are not going to college are more negatively selected, which is the word we tend to use in the profession. They're less healthier, maybe less smart, whatever you'd like to think. But then those people who were in that group have now moved up into the educated group, and they were not so healthy before and they're still not so healthy. It brings down both groups.

Is it the Will Rogers Effect? You know: If you transfer the smartest person at Harvard to Princeton, the IQ in both places goes down.

Julia Galef: Oh... that's a Princeton joke. I get it. That's an important piece of context for the joke.

Angus Deaton: I may even have got it the wrong way around, but if you have two sets of people, one of whom is faster or smarter or whatever you like, than the other, and you move people from the less good to the good group, it brings down both groups.

Julia Galef: Yeah, I think that's a well-known paradox whose name I'm forgetting...

Angus Deaton: I think it's called the Will Rogers Paradox, but I'm not sure.

Julia Galef: Oh, okay. Yeah, yeah.

Angus Deaton: Yeah. It's one of those things. It doesn't explain the expanding gap quite as well, but we're not resistant to that interpretation.

The first group we looked at, which was the midlife whites... If you look between 1990 and 2015, I think we were looking then, there was very little difference in the fraction of them that had a college degree. But more broadly, that has been increasing over time. Not as fast as you might think given how much you get rewarded for having a college degree. But I'm sure there's some such effect.

But if you look at, for instance, life expectancy for people without a BA -- or life expectancy at 25, because at birth you can't tell whether they have a BA or not -- then what happened was that rose until about 2010 and then it started going down, and it's been going down ever since. It's a bit hard to explain that sharp curvature by a steady increase in the fraction of people going to college. But I'm sure someone very clever could tell that story.

I just wanted to come back to your pain story, because I think this marriage thing, in the book we talk about Sarah McClanahan's work on fragile families for instance, and how marriage rates have gone down but people are still shacking up with each other and having kids. Those are fragile relationships which move on, so you could get people like a guy in his 50s who might have had three sets of kids but he doesn't know any of them.

I think when you get to your 50s, for me, that would make me quite prone to alcohol or suicide, that sort of thing. Because a lot of the things that are good for your life in late middle age or in middle age are from having had a stable family life, and not having that is likely to engender pain too.

I think Daniel Patrick Moynihan used the term, "A tangle of pathologies." Looking for simple causal effects in here, I don't think it's terribly productive. But it's not so surprising these lives would lead to more pain and then from more pain to more suicide, more drugs, more alcohol.

Julia Galef: Yeah. I'm very sympathetic to the idea that the real world is in fact very complicated and messy, and any theory that just has one simple cause is going to be pretty wrong.

But at the same time, I'm also worried about this problem of adding epicycles to theories where, if the theory doesn't quite fit the data, then you can always add an explanation for why, “Well, we didn't see the rise in this group because there was this other countervailing factor.” Those

explanations may be true, it just feels like you can kind of infinitely fool yourself. Because there's no way to actually prove you wrong.

Angus Deaton: I agree with that, but I think we have a pretty simple story here, which is the labor market disintegration, and then through marriage and through pain, towards all these other things.

I think you do have to overlay on this the withdrawal of white privilege.

Julia Galef: Yeah. That is definitely one of the asymmetric-by-race factors, I agree.

I guess it just sounds like you're less concerned about mismatches in timing and across races than I am. Does that make sense? It had seemed to me that there were a lot of mismatches between factors that your theory should have predicted would cause a rise in minorities as well but didn't. And factors that we would have expected to cause a rise in deaths of despair earlier, but didn't.

But it sounds like these mismatches seem small to you in the grand scheme of the theory's power?

Angus Deaton: Well, you haven't talked about Hispanics, which is the one that people usually do talk about, and say you can't explain Hispanics. But Hispanics are clearly very different. Hispanics, they're healthier than whites by quite a lot.

Julia Galef: Oh, I didn't know that.

Angus Deaton: Yeah. No, people do get upset about that.

Julia Galef: I'm not upset, I'm happy for them!

Angus Deaton: No, but some people call it the Hispanic paradox. A lot of Hispanics are immigrants, and to us, this makes perfect sense in our story. Because when you think of whites, they're doing worse than their parents did. For Hispanics, that's just not true at all, because a lot of them weren't here in 1970. [They weren't here] to see what the old world used to be like. So for us, I think that works okay.

One of the things that's interesting is that, during the COVID epidemic, Hispanics are being hurt at higher rates than they ought to be, along with blacks. In Britain, it's interesting, blacks and other minorities, as they call them, they had better health than whites in Britain before COVID, but now have worse.

So it seems that the blacks and other minority ethnicities in Britain are rather like Hispanics here.

Julia Galef: So it's the immigrant factor, that the types of people who immigrate to a country are going to be on average more well-protected? Is that the common factor?

Angus Deaton: Yes. Well, they're not as deeply affected by this disintegration of a class to which they didn't use to belong. Also, there's a huge amount of health selection on immigration too.

Julia Galef: That more healthy people are more likely to immigrate?

Angus Deaton: Yes.

Julia Galef: Yeah, that makes sense.

Angus Deaton: So they may be coming from countries where there's high infant mortality, but if you immigrate to the United States from Nigeria, for instance, you obviously didn't die as an infant. So you got through that part of it. And those people tend to be very ambitious, very well put together, do very well.

Julia Galef: All right. Well, let's move on now to the other thing I was itching to talk to you about, which is effective altruism.

I don't know if I made this clear actually, but I'm a big fan of effective altruism. I've been involved with various effective altruist organizations over the years.

And so like any good effective altruist, I was very excited to see a critique of effective altruism that you had written a few years ago in the Boston Review. This was 2015. It was titled The Logic of Effective Altruism. Do you remember this?

Angus Deaton: I'm not sure.

Julia Galef: I mean, I'm sure you write many things, which is why I didn't assume you'd remember, but I can remind you of what you said so that I can ask you about it.

It was a response to... I guess it was kind of like a symposium, and you were responding directly to Peter Singer. But you were talking more broadly about effective altruism and critiquing the kind of GiveWell style of helping people, which is funding charities who do things like distributing antimalarial bed nets or de-worming, or sometimes doing cash transfers. Those are some of the top charities that GiveWell recommends.

So just to dive into one of the first criticisms that you made... it sounded like from your perspective, a big problem with the GiveWell approach is that it casts poor people, the recipients of the charity, in kind of a passive role. That they're not "asked if they want to participate in effective

altruism." And in fact, you write that polls by Gallup and Afrobarometer suggest that poor people in Africa, their priorities lie elsewhere.

So I was just curious for you to elaborate on that. And possibly you don't remember the details of the polls, but if you do, I'd be curious. Is your view that people in places like Africa aren't interested in the kinds of interventions that GiveWell offers, like antimalarial bed nets?

Angus Deaton: No, I'm sure they're interested in antimalarial bed nets.

Sorry, just to back off a little bit, I have no objection to altruism at all. And I also think, and I spent a lot of my life studying, that there are a lot of people around the world living in very dire poverty. And I also agree with the proposition that we have an obligation to do what we can to help those people.

And I dealt with this more fully in the last chapter of my previous book, The Great Escape.

Julia Galef: About the problems with foreign aid, or [aid to governments]?

Angus Deaton: Yes. Yeah, exactly.

So I have no problem with altruism. It's the effectiveness that I have [issue with].

And when I listened to Peter talking about how easy it is to do these things, and the only thing that people have been doing wrong before was they weren't doing randomized controlled trials, then phase two randomized controlled trials, then we can find out what works… and to me that's just nonsense. And I don't think randomized controlled trials are capable of doing that.

I don't like the way GiveWell uses them. But what you said is more fundamental. I think giving aid in other countries from outside is almost always a mistake.

Julia Galef: And are you talking about aid to governments, or are you talking about also aid to individuals?

Angus Deaton: Both.

Julia Galef: Oh, okay.

Angus Deaton: I mean, there's not as sharp distinction as you might think there. And that's because one of the analogies I'd like to give is suppose that you're living somewhere, and someone moves in next door. And this person who moves in next door, who has a wife who lives with them, is someone really detestable. And he treats his wife like a slave, and gives her just enough to

eat, makes her life totally miserable, and sort of behaves to her like Borat likes to tell you the Kazakhs behave to their women.

Julia Galef: Poor Kazakhstan.

Angus Deaton: I'm sure Kazakhs don't behave that way. Poor Kazakhstan. Apparently it's been celebrating recently.

Julia Galef: Yeah, I heard they decided to lean into it, and their slogan is now “Very nice!”

Angus Deaton: So a guy like Borat moves in next door with his wife, and he hasn't learned that Kazakhstan has changed its tune. Then the question is: You would really like to help this woman, who's truly miserable. And you ask yourself, "Okay, I have a randomized control trial that shows when I give women money, they do better.”

Well, do you think it would be a good idea to give this woman money? Well, of course not, because her husband would just say, "Thank you very much,” and take it.

Now, you might be able to do better by giving *him* money, which is the opposite of what the effective altruists like to say. The husband is like the government here, because the government has control over its people. And so if you give any significantly large sums to poor people, it's just one more source of revenue for the government, because the government is in business of extracting and exploiting from its own people. They're not trying to help them. If they were trying to help them, the woman wouldn't be miserable in the first place, and these people would not be so poor.

So a lot of the problems in a lot of those countries is government that is dictatorial, extractive, and is basically plundering its own people. And the danger of giving aid to either the people or to the country is you make that worse, not better.

Julia Galef: And you're saying that that happens even in the case of, say, giving out antimalarial bed nets? How would that happen?

Angus Deaton: Well, I've always argued the health side of this is probably less subject to this critique, but the government is providing health services anyway. And you're only going to have a healthy society and the good health system in those countries if the government provides it, and if there's a consensus by the people that they want it provided. So the big problem with providing health services from outside is that they make the indigenous health services much worse.

Julia Galef: And is that a conjecture that sounds plausible, or is that something we have evidence of?

Angus Deaton: I think there's plenty of evidence of it over the years, because there's always been this debate in the global health community between these external innovations where people parachute in and inject people, or maybe you give them bed nets. So the bed nets are a sort of intermediate case.

Julia Galef: By inject, you mean give vaccines?

Angus Deaton: Vaccines to kids, for instance. So they fly in on helicopters with the help of local people, and they do this external intervention over a relatively short period of time, and maybe they help clean up a swamp. There are things like that.

The antimalarial campaigns after the second World War were temporarily very effective. But in none of those countries has outside funds, I think, ever being able to provide a functioning health service with good maternal child and maternal care. I mean, this sort of thing.

Julia Galef: Are you saying then that we shouldn't try to save lives in the present with vaccines and benefits and so on until we can figure out the underlying --

Angus Deaton: No, I'm not saying that. I'm not saying that.

Julia Galef: Oh, so you're saying that these interventions are helpful, they just didn't solve the biggest problem?

Angus Deaton: That's right. Well, they solved a big problem. Life expectancy went up by leaps and bounds in poor countries after the second World War, largely because of these external innovations. And so we credit those with [a lot].

But if you're trying to provide healthcare... And remember, providing healthcare is incredibly difficult. We're really bad at it in this country, let alone in countries that just don't have the resources we do. And so it's a very difficult problem, but I think interventions from the outside of providing clinics and manning clinics and so on are likely to have unmeasured side effects, and those side effects are never taken into account in the randomized controlled trials either.

Julia Galef: And it seems likely to you that those side effects would be bad enough that it would outweigh the good done by the lives saved from a vaccine?

Angus Deaton: Well, we could colonialize those countries.

Julia Galef: Sorry, what'd you say?

Angus Deaton: We could re-colonialize some of those countries and then do it to them.

Julia Galef: With vaccines?

Angus Deaton: Well, no, but we can give them health services... I mean, that's what Paul Romer, at NYU, used to argue. He was going to get the Canadian government to set up a sort of part of Honduras as a separate country, and basically make people do what was good for them.

Julia Galef: Okay. I'm not signing my name to that plan, to be clear. I don't think that falls under the EA, effective altruist umbrella of recommended --

Angus Deaton: Well, but you say – what's "effective"? Let's focus on effective. You have to find out what is actually effective.

Julia Galef: Yes, no, I do want to talk about that.

Angus Deaton: You have to do a much more serious job of looking at what happens. And that's why in my book, The Great Escape, what I argue for is that there's a huge number of things that we could do to help those people.

For instance, how about the arms trade? When I talked to Peter Singer, I said, "Why didn't you ever say anything about the arms trade?" He said, "Well, that's too hard."

Well, maybe. But if Peter and all the other effective altruists were to go to Canberra or go to Washington or go to London or go to the cities where they have some standing to speak, and speak up against the arms trade, then I think we'd do a lot more good than digging wells in the Sahel.

Julia Galef: I see. So your view is that... it's not that effective altruist interventions don't do good. You just think that we could do more good if the people attracted to effective altruism would turn to political influence and activism.

Angus Deaton: Well, that's true, but it's more specific than that. I think Jagdish Bhagwati was the first to use the phrase. He said, "I believe in giving help for Africa, not help in Africa."

Julia Galef: What does help "for" Africa consist of?

Angus Deaton: Trade policy, for instance, making it easier for African countries to sell their goods here, not putting punitive patents on drugs. There's whole lot of things.

The secret is not to go in there with money which will screw up the equilibrium between the government and the governed. You're not going to get development unless there's a government that voluntarily raises money from its people and uses it to benefit them. Most aid from the outside will severely interfere with that. There are lots of countries in Africa where more than 100% of government revenue is coming from abroad. There's no accountability of their own citizens.

And effective altruists make that worse.

Julia Galef: Well, the thing that's still unclear to me is whether... I don't really disagree with your picture of aid in general, but it seems to me that the specific, targeted interventions that effective altruists tend to favor don't have the baggage attached, and the problems that you're talking about, that apply to most aid over time.

I guess it's just hard for me to see how giving out antimalarial bed nets is really that damaging, even if we could be doing more.

Angus Deaton: Well, I'm not against giving antimalarial bed nets, though I've read some work and talked to some people who are skeptical about the long-run effectiveness of those. But that's not the point. I mean, I'm all for giving vaccines. I'm not against vaccination-

Julia Galef: But isn't this exactly the question? Those are the interventions, maybe it wasn't clear, but those are the interventions that I was meaning to ask about. Were you thinking of a different kind of intervention?

Angus Deaton: If you read the global public health literature, especially on the left, they've always been against those sort of innovations, because they say we have to build health systems in countries so as to look after maternal and child health.

Julia Galef: Okay... Well, maybe we should talk now about your critique of randomized controlled trials, or RCTs, because that type of evidence is one of the big things that effective altruists like GiveWell base their judgements on, their judgments about how to help people. And you've pretty famously written about why RCTs aren't so trustworthy.

Before reading your op-ed, I would have thought you would actually approve of the way GiveWell uses RCTs. So let me describe to you the way I see them using RCTs, and you can tell me if you actually do approve or not.

So GiveWell's view is that most... I mean, I can't officially speak for them, but my perception of their view is that most research is pretty flawed, including the vast majority of randomized controlled trials. But that occasionally, you can have enough RCTs that are well done, in enough different contexts, that are looking at lots of different outcome measures, with a large enough effect size, that at that point you can be pretty confident that there's a real benefit there.

Angus Deaton: You're making my hair stand --

Julia Galef: Okay, well let me finish, and maybe I'll make it better. Or maybe I'll make it worse.

Angus Deaton: You're making my hair stand on end.

Julia Galef: So, you can't be 100% sure, but if you have a lot of different RCTs in different contexts with large effect sizes, then you can be probably confident enough to act on that.

And so the small selection of charities that GiveWell recommends on their website are the exceptions to the rule. They're the cases where GiveWell thinks, "Okay, in this case, there actually is enough evidence that we feel comfortable recommending that people act on it, even though that is usually not the case."

Maybe the way I misconstrued your view is that you don't think you can ever do that? Whereas in GiveWell's case, they think you can sometimes, occasionally do that.

Angus Deaton: Well, I'm sure you can sometimes occasionally do it, but your language drives me bananas.

Julia Galef: Okay, why? Which aspect?

Angus Deaton: Well, for instance, replication tells you nothing. Think of all the white swans that there were in the world before the first black swan turned up. Read about Bertrand Russell's chicken.

Julia Galef: What doesn't it...

Angus Deaton: You know Bertrand Russell's chicken?

Julia Galef: Is it the chicken that thought... or was it a turkey?

Angus Deaton: No. Well, it was in the poorer days when people only had chickens for Christmas instead of turkey.

Julia Galef: Okay. Well, I was thinking of the right example at least, not the right fowl.

Angus Deaton: But the point is that chicken hears the farmer coming every day and realizes after 300 or 400 replications, that every time the chicken hears the footsteps it's going to get fed, and gets very happy it hears the footsteps until Christmas Eve and when the farmer wrings his neck.

And the moral of that story is, which I think maybe I can paraphrase Bertrand Russell's words: a deeper understanding of the nature of the world would have been useful to the chicken under these circumstances. The point is, replication doesn't tell you anything.

Julia Galef: So even if you did a thousand RCTs, in tons of different countries, and every time you found that cash transfers increased people's consumption and made them happier -- you would claim that you haven't learned *anything*? Because you can never be sure that in the “thousand and oneth” case that you wouldn’t find a negative effect?

Angus Deaton: That's right. That's right.

Julia Galef: I see. So, I think we have different --

Angus Deaton: Well, unless you could tell me why it's happening. I don't need a randomized controlled trial to tell me that if people get better off, they get happier. Which is what a lot of what the RCTs on cash transfers are doing.

Julia Galef: I thought that actually *was* an open empirical question, where it seems very common sense, but we've done research and it wasn't obviously going to turn out to be true.

Angus Deaton: I don't think so. I think those are RCTs on cash transfers are really silly.

Julia Galef: Oh, you think they're silly because you think it's obvious the cash transfers *do* make people better off?

Angus Deaton: Well, I'd be prepared to work on that, and have worked on that basis. But none of those experiments ever include the people who are going to have to pay for the cash transfer.

Julia Galef: Which people?

Angus Deaton: The people who are going to have to pay for them.

Julia Galef: Sorry, which people are those though?

Angus Deaton: Well, if people are talking about cash transfers in America, which was an issue in the election, for example, taxpayers have to fund those.

Julia Galef: Oh, what I was describing is just a charity where donors give money, and then the charity gives out that money in cash payments to recipients.

Angus Deaton: But we're going around in circles here. The problem is that in some environments that's going to make people better off; in other environments it's not. And you're not going to get at that by doing replications of randomized controlled trials.

Because in some governments, they'd let people enjoy the money, in other places they wouldn't let them enjoy the money. And lots of other contingencies that are not taken into account. So you have to have a basic structure mechanism of what you think is going on here.

I'm not against randomized, controlled trials, but this idea that if you do them often enough, like the graduation experiment, that somehow it always works, is really preposterous, both logically and in practice.

And then you use the term effect sizes. Effect sizes is a completely disreputable statistical concept.

Julia Galef: Why is that?

Angus Deaton: Because you're not interested in the effect size. The effect size is to do with the standard error. No, it's how big an effect it has on people.

Julia Galef: Wait, how is that not the effect size? When I said effect size, I meant to refer to things like “How big is the mean effect on people's life expectancy, if you –"

Angus Deaton: That's not the effect size. The effect size is what you just talked about, divided by some sort of standard deviation. Anyway, I could give you lots of literature to read on that.

But these people are using effect size all the time, because they want to compare things across countries. And you can't compare things across countries if they're in different currencies and if they're in different places.

So they use effect sizes, and effect sizes robs the whole thing of meaning. You do a training program for people, a training program for dogs, and you could look at the effect size --

Julia Galef: Well, I don't know what the people you're complaining about are doing, but I imagine if you're testing a specific intervention -- like giving out anti-malarial bed nets -- the cases in different countries or different regions aren't going to be identical, but it's still pretty similar, what you're doing from one region to the other. You're giving out bed nets.

Angus Deaton: I don't agree, because all the side effects, which are the things we're talking about, are going to be different in each case.

And also, just to take a case -- we know what reduces poverty, what makes people better off: it's school teachers, it's malaria pills, it's all these things.

Julia Galef: How do we know that, though?

Angus Deaton: Oh, come on.

Julia Galef: No, I'm sorry, that was not a rhetorical or a troll question.

Angus Deaton: Really? I don't know how you get out of bed in the morning. How do you know that when you stand up, you won't fall over? I mean, there's been no experiments on that. There's never been an experiment on aspirin. Have you ever taken an aspirin?

Julia Galef: So, sorry, you think that increasing the number of schoolteachers -- or paying them better, or some intervention on school teachers causes people to be better off -- that that claim is as obvious as *gravity*?

Angus Deaton: It's pretty obvious. But that's not the point I'm trying to make. The point I'm trying to make is if you send a bunch of people who do experiments,

students from MIT or wherever, you do experiments in these countries, then, and I don't know if you know about the graduation program, but the graduation program is regarded as one of the great stars in the firmament of this thing. And they say they got the same effect sizes. In my sense, not yours --

Julia Galef: Could you just summarize what the graduation program is?

Angus Deaton: You should read the paper that Nancy Cartwright and I wrote in Social Science & Medicine, which is on my website.

Julia Galef: No, that's great, but if you wouldn't mind just giving a quick summary for my listeners --

Angus Deaton: The graduation program is a program in a bunch of different countries, in which people are given some capital in the form of Guinea pigs, or chickens or sheep or something. They're also given advice on how to farm. And then they're revisited. Maybe they're given some money. I forget exactly the details.

And then you come back after a year or two years and see whether they're better off, whether they're earning more money, whether their enterprise is working and so on. So the idea is to try and get people over the hump, which otherwise is keeping them trapped in a poverty trap.

And they got pretty positive results in all but a couple of countries, and so they put a great weight on the replication. They do the standardized effect size, which I think is nonsense.

But the point there is, the question is not whether those things can work. We're pretty sure that these things can work. The question is whether government civil servants or government employees working under all the usual constraints of employing workers and all the incentives that go with that, can actually do that.

And that comes to the crux of the matter, really. It's really whether the countries can do this for themselves. Because if we can develop general methods, of things that look like they're promising, then local people have to adapt them for themselves.

So this takes us back to where you started, which is this question, we've got to use local knowledge. We can send blueprints to places, they can look at it and say, "This is interesting, maybe this would work in our context if we adapted this." And that to me makes sense.

I'm just not persuaded by any number of randomized controlled trials, as they're usually run at least.

[Musical interlude]

Julia Galef: I wanted to share a few of my takeaways and updates from my conversation with Angus. And of course, he's not here to respond right now, so it's possible I'm misunderstanding or mischaracterizing him somehow. So just keep that in mind.

With that caveat, my reaction to the second half of our conversation about effective altruism was... I went into this call assuming that Angus's problem with effective altruism was basically that first, he's focusing on the problems with foreign aid, and he doesn't realize that that is not what EAs are talking about.

And second, that he's focused on the danger of trusting randomized controlled trials too blindly, and he doesn't realize that EAs agree with that, and they have a pretty high bar for how good the evidence has to be in order to have confidence in a given intervention. That was my expectation of his view.

But in fact, from our conversation, I was surprised to learn that his view seems to be not that we need to use RCTs more carefully, but rather that we're better off relying on our common sense intuitions about how to reduce poverty. Which to me just seems not reliable enough. Our common sense intuitions are often wrong. And I think we have to test them with data, with RCTs.

And then my other big disagreement with Angus in that part of the conversation was something like, I felt he was basically holding charity to a very high bar of evidence. Where you can never be positive that your well-intentioned intervention, like giving people bednets to save them from malaria, isn't going to somehow have a negative side effect you couldn't anticipate. And if you can never be positive, then you shouldn't do it.

And you can do a thousand studies that all find the same thing, but you can never be sure that the next study isn't going to find something different. And that's true, it just seems to me like setting an impossibly high threshold for doing anything. And a much higher bar than we would apply to anything else.

So, that was my take after our talk.

But I can certainly agree with him about the dangers of trusting RCTs too blindly. And I think it's a good thing that people are critiquing effective altruism. That is an important check on any philosophy or ideology or movement.

Although... the specific examples that I brought up multiple times of EA interventions, like cash transfers or anti-malarial bed nets or vaccines -- which isn't something GiveWell does, but that's just because it's been pretty well covered by other organizations by now -- he didn't really seem

to think those were worrisome or harmful. And the examples he did give of aid with harmful side effects were not things that EAs advocate.

And yet I don't think that I succeeded in changing his picture of what EA is or how good it is. So I guess I still have a fair amount of uncertainty about what he thinks about what EA actually is. I'm not sure.

Then to go back to the first half of our conversation about deaths of despair, this is a really important trend. And I am glad that Angus and Anne Case noticed it, and are calling attention to it and studying it. I just, as you may have inferred from my questions, I'm less convinced about their causal explanation for deaths of despair. Which is roughly that it's the result of a loss of meaning in people's lives, caused by a decline in good jobs for people without college educations, and a breakdown of support systems, social support systems like union memberships and marriages, and so on.

And my problem was basically that there are these two big facts about the rise in deaths of despair. That it started in the late nineties, and that it's been mostly limited to white people until the last few years. And it didn't really seem to me like the story about loss of meaning accounts for those two facts.

But maybe he's right about a decline in racism being a protective factor for minorities against deaths of despair. I just don't know. It's an additional piece we're adding onto the theory at this point, and it's hard to test. And so I don't know. But again, these are important and interesting questions. I'm very glad he's writing about them, even if I have lots to disagree with him about.

So, if this conversation whet your interest, you can read more about deaths of despair in Angus and Anne Case's new book, *Deaths of Despair and the Future of Capitalism*. And you can also read Angus's criticisms of effective altruism in the piece that he wrote for the Boston Review, which I was talking to him about. It's called “The Logic of Effective Altruism.” And I'll link to both of those things and a few more on the podcast website.

That’s all for this episode. I hope you'll join me again next time, for more explorations on the borderlands between reason and nonsense.