Commentary: Should we not go further than descriptions of avoidable mortality?

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The paper by Andreev and his colleagues is an interesting and thought-provoking article. It examines, in some detail, both trends and variations in the certified causes of death of a number of conditions which are considered to reflect either the quality and effectiveness of clinical care or the presence, and application, of national policies intended to reduce mortality from a number of behavioural risks, e.g. smoking, road accidents, and alcohol. The authors demonstrate that while death rates from these conditions were falling in the UK, between the mid 1960s and the mid 1980s the rates were stable in Russia and then began to increase in the 1990s, reaching a peak in 1994. There are similar marked variations between Russian regions, as has been described in other European Countries.

The authors comment that ‘the concept of avoidable mortality has become established as a way of identifying the contribution of health care to population health’. It is worthwhile considering this statement.

Concern with the performance of health services is a relatively recent, but logical development, given the apparently inexhaustible demand for health care. An example of this was the controversial WHO Report which compared national health systems but, as Andreev et al. point out, was not concerned with outcome. Donabedian, the most scholarly and one of the first workers in this field, identified three components of health care—its structure or organization, its process, and outcomes—about which it is necessary to obtain information in an assessment of health care quality. Doll, in this journal, recognized three major components to evaluation—economic efficiency, social acceptability, and medical efficiency. Although infant mortality rates have long been used in global assessments of a country or region’s health services, it was not until a working group chaired by Rutstein first published their proposed list in 1976, it was not until 1983 that it was applied to examining the performance of a national health service. As Andreev et al. illustrate, it has since that time been used in many countries in Europe, the Americas, and Asia, with a steady increase in number of publications since the late 1980s.

Although there have been some critical publications, (e.g. Carr Hill) the concept has continued in use. It is, however, worrying that little progress has been made in advancing the original concept.

In choosing the conditions included in the concept ‘avoidable’ the authors who first applied it consulted and discussed these, at length, with clinical colleagues and, in a number of instances, limited the age ranges analysed, e.g. 5–49 for pneumonia and bronchitis, and 5–34 for Hodgkin’s disease. Subsequent authors, e.g. Andreev, have both extended the list and age ranges, e.g. Hodgkin’s ages 0–74, pneumonia/influenza 0–74, nephritis and nephrosis ages 0–74.

Although it is usually stated that in some of the categories, e.g. cancer, only some deaths are avoidable, looking at trends over time for these conditions allows advances in the application of effective treatment to be identified. Andreev et al. in contrast to some other workers, were careful to consult with local health professionals to ensure the validity and acceptability of the classification. Nonetheless, in spite of advice for an upper age limit of 60 years, this was rejected as ‘…it would underestimate what could be achieved …’. But this ignores the possible errors in death certification particularly in the elderly, where death may be due to multiple causes and certification has often been shown to be fallible.

Of far greater concern has been the neglect by epidemiological researchers of both the validity of the findings and their application to improving clinical services.

Death rates from ‘causes amenable to intersectoral health policies’ such as cancer of the lung and motor vehicle accidents, and those from conditions prevented by immunization such as whooping cough, measles, and diphtheria, have long been used to influence health policies at central level. Apart from maternal and infant mortality there are, however, relatively few examples of systematic investigation, locally or nationally, to identify the possible causes for failure and what can be done to improve outcome. This is of particular importance at local levels and can identify bad practice which can be easily remedied.

The concept of avoidable/amenable mortality is an interesting example of the use of descriptive epidemiology which can influence the delivery of both health and clinical services. It now deserves closer analytical, systematic scrutiny, and investigation at both local and national level so it can contribute to the remedy of the failures it describes.

References


