THE ROLE OF AVOIDABLE MORTALITY IN HEALTH ASSESSMENT

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Measuring the health status of the population is difficult, since many aspects have to be considered. In present, the emphasis is on using tools that includes as many dimensions of health as is possible; also, calculating synthetic and comprehensive indicators covering many aspects of health has become a common practice. Avoidable mortality (with its two components: treatable and preventable causes) is useful in measuring the health status of the population, but also in planning and assessing the healthcare services.

In Romania, the avoidable mortality is less studied and data existing at international level require deepening in researching this phenomenon, in order to identify potential weaknesses of the health system and healthcare impact of different policies. For Romania, the level (first place in the EU countries) and increasing trend of phenomenon (mainly for diseases that are treatable) should alert policy makers and politicians. Scientific evidence must accurately reflect reality and decision making process must be supported by a good understanding of the phenomenon.

Keywords: measurement of health status of population, avoidable mortality, treatable and preventable causes of death.

The health of the populations is determined by aggregating data collected on individual level.

An individual health status is more easily defined than population health. The population health is placed on a continuous scale ranging from perfect health to death. Over time, health was defined under different aspects, and currently the most accepted and commonly used definition is the WHO definition where health is regarded in a positive perspective (“complete physical, mental and social well-being”) not only in a negative one (“absence of disease”) [1]. Other definitions are more comprehensive and detailed and include the two components/concepts: positive and negative health.

Also, health is one of the main components defining the concept of "quality of life", along with other aspects of social, economic, cultural.

Several determinants of health
The difficulty in establishing a standard method is determined, in large part, by many factors influencing the health of the population. According to classical models for classifying the health status determinants, the four categories of determinants act synergistically on health and by approaching them at political level, one can affect the population health status [2,3].

Age, sex and heredity are considered as basic determinants of health. They are however, factors over which individuals have little control. Community and social networks (which family is included in), play a considerable role in improving the health status of population.
**Health Determinants**

Often, the local facilities provide services to individuals or communities through which they receive information about health and health services. Thus, they receive the needed support in order to play an active role in improving their health. Other determinants of health include education, employment, living conditions, working conditions, agriculture, food production, water and sanitation, and health services. Behavioral factors are ones of the attributes that can be heavily influenced by both the personal and system interventions. Therefore, to achieve full health potential depends not only on delivery of health services. Many other factors and many individuals, groups, public or private institutions should play a role in the overall effort to improve health and to achieve the high level of health [2,3].

**Specificity of “health status indicators”**

Also, the health status indicators of the population have specific characteristics, namely: multiple possibilities for defining them (what leads to a limited comparability); long response time (the effects of measures are visible after a long period of time); multiple etiology (the same effect can be attributed to several causes influencing more or less directly).

In the absence of a comprehensive or absolute measurement of health, 1) life expectancy; 2) disease prevalence; 3) frequency of preventable deaths (crude, specific and standardized rates, avoidable deaths, etc.); and 4) availability of medical services; serve as health indicators. Judgments regarding the health of a particular population are usually performed by a comparison with other populations or by studying trends in the level of health indicators.

Over time, the health of a population was assessed by using specific indicators (Box 1), and mainly by indicators such as: age-specific death rates, causes of death or life expectancy (LE).

As the mortality pattern has changed going from acute diseases (first place in the hierarchy of causes of death) to chronic and degenerative diseases, we can say that the mortality rates and life expectancy were not able to adequately reflect reality any more. The preponderance of chronic disease leads to a number of years lived in disability. For this reason, other means for expressing the health have appeared, including synthetic indicators combining those measuring morbidity and mortality.

These indicators are divided into two major classes: 1) “health expectancies” combining the mortality and morbidity rates in order to calculate life expectancy lived in full health without any disability; 2) “health gap”, taking into account the number of years of life expectancy lost by premature deaths and morbidity.

The first category “Health expectancies” includes: DFLE - disability free life expectancy; ALE - Active life expectancy; DALE - Adjusted life expectancy.

The second category “Health Gap” includes indicators such as: DALY - Disability Adjusted Life Years; HALE - Heath Adjusted Life Expectancy.

By broadening the classical indicators (negative) describing the health status of a population, we should take into account the list of five ’D-indicators” of health assessment: 1) death; 2) disease; 3) disability or dysfunctional; 4) discomfort; and 5) dissatisfaction. However, there are positive indicators that can describe health. Positive health is a concept with a growing use, comprising not only the absence of disease but also mental and physical well-being, full functionality, individual ability, social support and mind and body performance. All these positive status were defined in the literature as positive health, social health and health related with quality of life.

**Box 1**

The most frequently used indicators for measuring the health status of the population [3]:

- Percentage of new-born with low weight at birth
- Percentage of children with age and standards-appropriate weight
- Indicators of psychosocial development in children
- Infant mortality rate (under 5)
- Mortality rate in young people
- Life expectancy at a given age
- Maternal mortality
- Specific mortality
- Specific morbidity
- Level of disability
- Social and mental illness indicators: the rate of suicide, drug addiction, crime, juvenile delinquency, alcoholism, smoking and consumption of tranquilizers
Table 1. Measuring tools for health associated with quality of life

<table>
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<th>INDEX</th>
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Self-assessment of health status

Health status can be appreciated both in an objective (ie: collecting and analysing clinical and biological parameters included in a research/assessment file, at individual level), and a subjective manner.

The most common method for subjective assessing of the health status is represented by self-evaluation. Satisfaction questionnaires and assessment of their health status are methods quite commonly used, and usually they are applied complementary to the objective assessment of health. The main benefit of the subjective measurement of health is that the patient's subjective response may be associated to biological parameters of the patient. Measuring health subjectively may be used for: monitoring patient care; improving inter-relationship between doctor and patient; informing doctors on patient wellness throughout the healthcare process; performing clinical trials of two or more different treatments; evaluating health gain in different population groups when the most valuable healthcare services are considered; monitoring the health of the population in general.

Questionnaires assessing the quality of life

The concern for questionnaires development to measure quality of life (a broader concept that includes health) dates from 1970 and is based on psychometric principles.

Instruments used to measure quality of life can be broadly grouped into four groups according to two characteristics: type of questionnaire - can include general questions about quality of life, can be applied to the general population or patients, can address specific disease or not; all questions are designed to assess quality of life of patients with a certain condition; and type of data provided by the tool. The questions in questionnaire are quantified in order to obtain a single score of health related to the quality of life (Table 1).

Quite often, the instruments (questionnaires) provide a profile of health status with scores for various dimensions of health, presented separately. Eg: the questionnaire “SF 36 Short Form” calculates eight scores on health status (physical functioning (PF), role-physical (RP), bodily pain (BP), general health (GH), vitality (VT), social functioning (SF), role-emotional (RE), and mental health (MH)).

The average scores for health profile associated with quality of life may vary on a scale ranging from 0 representing total absence of health (vitality zero, physical functionality is missing, person is totally immobile, mental health is missing etc.) to 100 representing perfect health (maximum vitality, overall physical functionality, perfect mental health, etc.). In this way health is measured using different types of questionnaires, which responses are quantified on a scale ranging from 0 to 100 percent. The instrument can be applied to different populations and comparisons can be made due to the equivalence of the measurement units which are expressed as a percentage.

AVOIDABLE MORTALITY

As presented previously, the measurement of the health status of population involves using a variety of indicators, each being able to reflect different facets of the concept. The question that arises frequently when considering health is: "How much healthcare/health services contribute to human health?"

Providing health services has been designed for the improvement of health. The question is “How health can be assessed so that it can be stated if medical services are effective or not?”. While health services are not only ones that can influence the health status of population, a determinant role is attributed to socio, economic and environmental factors.

Graph No.1 presents the relationship between health and its determinants. In the context of a poor financing of healthcare, the question is whether an additional amount of money spent on an "input" would be more productive in terms of improving health and reducing mortality.

The question “Healthcare can be significant in influencing health?”, was a subject of debate for a long time. Since 1970, different authors [4] have argued that medical care has contributed a little to mortality decline occurred in industrialized countries in the XIXth century and mid of the XXth century. Affirmation is accompanied by presentation of the decline in mortality rates by tuberculosis, in England and Wales, between 1838 and 1970.
The largest reduction of mortality by tuberculosis was realized before the introduction of immunization or chemotherapy. It was assumed that this reduction was due to the influence of factors outside the health system, particularly through improving nutrition and environmental conditions. It is true that the introduction of immunization and chemotherapy had a remarkable impact on the death rates, but not as large as previous one.

The rapid change of the healthcare’s scope makes that the affirmation "Medical care contributes little to reducing mortality" to be no longer current.

In the second half of the twentieth century, the purpose of healthcare was changed greatly. The changing has occurred not only in visible areas such as new pharmaceuticals and new technologies but also new ways of organizing more effective care have appeared. Even if, in the past, medical care had a small contribution to the health of the population, this is no longer accepted, nowadays. Various attempts were undertaken to quantify the healthcare/health services contribution on the health status of the population. The most frequently used methods is calculation of the avoidable mortality which is called also as „mortality amenable to medical/health care”: its measurement is based on analysing those causes of death and ageing groups for which death can be avoided by providing timely the proper and efficient healthcare.

The term “avoidable mortality” was used since the 1960s, following the work of David D. Rutstein and his colleagues to develop a measurement of quality of healthcare. This concept has been subject for comments and reviews by different authors, most notable of which was Charlton JR, Holland, Mackenbach and Westerling.

A list of causes of death and certain age groups, for which a proper and timely provided healthcare should be given time and preventable death, was elaborated. The list is presented in Table 2. This list of causes of death reflects the consensus of different specialties on what can be done through an effective care that is given at a particular point in time. This list may vary over time due to multiple changes in medical and technical progress and in organizing and functioning of healthcare units. Thus, some causes of death that previously were considered to be unpreventable, can be now considered as preventable because of the medical progress. Similarly, age groups considered in the list were subject of changing over time, together with the prolonging the life expectancy.

If we regard the avoidable mortality from the perspective of different types of causes for death, we can distinguish for avoidable mortality two components:

- Mortality caused by treatable disorders (causes of death that could be prevented by medical intervention and secondary prevention). Eg: malignancy of the cervix, blood hypertension, appendicitis, tuberculosis
- Mortality caused by preventable disorders (which interventions that are usually outside of a direct control of medical services, like inter-sectoral health policies are responsible for). Eg: lung cancer (prevention through smoking reducing policies), chronic liver disease and cirrhosis (preventable by policies to reduce alcohol consumption), accidents (preventable by legal actions regarding speed limits and/or wearing belts safety, etc.)

Avoidable mortality has never intended to be more than one potential indicator of health system weakness, and of the means for healthcare providing.

Today, to compare the performance of health systems is on the international political agenda, especially since when the 2000 World Health Report was published. By including the concept of avoidable mortality in the methodology used in this report, the attempt to assess performance using also the avoidable mortality, could be considered as an anticipation for a new ranking of the health systems performance.

### HEALTH STATUS OF THE POPULATION IN ROMANIA

Romania is ranking on one of the the last places regarding the performance of the health system, regardless of what classification is made. In this sense, The European Health Consumer Index - EHCI (a comparative research of the European health systems) has situated Romania on the 27th place of 31 analyzed countries. Besides the 27 EU members, this classification has considered also countries such as: Norway, Switzerland, Croatia, and FYROM. This situation is not encouraging at all, especially due to the fact that Romania had occupied a lower place in comparison with the previous years (eg: place 25th in 2007).
In terms of health, the report "A health system focused on citizen’s needs" elaborated by The Presidential Commission for Romanian Public Health Policies Analysis and Development of Romania, presents Romania as the country with some of the worst indicators in the entire European region, not only in the EU. The first indicator drawing the attention is the average life expectancy (71.7 years) that despite a slight improvement, remains among the lowest in the European region. In terms of morbidity and mortality rates, it is noted that in Romania the set of indicators presents a mix of indicators that are specific to developed countries (increasing in cardio-vascular mortality rates and cancer morbidity rates), with indicators that are specific to developing countries (increasing of the communicable diseases such as tuberculosis and sexually transmitted diseases). In terms of indicators for which a strong correlation with health system performance was proved such as infant and maternal mortality, Romania is situated on the last places among the EU countries. The main causes of death in Romania are represented by cardio-vascular diseases, followed by cancer, digestive diseases, injuries and poisoning, and respiratory diseases.

Also, if we analyze the overall performance of the Romanian health system in an international context and taking into account the concept of performance of WHO [1] which is focused around three main pillars: (1) the health status of the population; (2) the capacity to meet the expectations of population; (3) the fairness concerning the financial contribution) - we note that Romania is ranked 99 worldwide, after countries such as Albania (55), Slovakia (62), Hungary (66), Turkey (70), Estonia (77) [2,3].

The position occupied by Romania in this classification is associated with a low health status of population. In Romania, the frequency of the national surveys/barometers on health status of population is low (eg: the last survey of the Ministry of Health that was conducted on a nationally representative sample is dated in 1997), and the most frequent method remains the measurement of the statistical health indicators.

The latest appreciation on the health status of the Romanian population is made by “The Presidential Commission for Romanian Public Health Policies Analysis and Development of Romania”, whose strategy is a milestone for public health policy that aims to improve the Romanian health system.

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As a global assessment, the report stresses that the patterns of morbidity and mortality have undergone important changes in recent decades in Romania, by increasing mortality and prevalence of chronic diseases, and in association with ageing of population, and in the context of a multiple action and influence of the biological, environmental and behavioral risk factors, and health care and socio-economic conditions.

In national context, the current situation can be explained by a complex of factors: the contribution of different health determinants, the disparities in availability and accessing to medical services (higher in rural than in urban areas), the inefficient health system response to major health problems (more focused on curative hospital care than on preventive primary care), inadequate funding and inefficient use (under-financing and lack of continuity in financing), weak management of human resources, lack of health services integration to ensure continuity of care, weak management of information in health, weak inter-sectorial collaboration, etc.) [2,3].

In terms of health determinants, their contribution for health is different; a significant role in the argumentation of this low level of the health status of population in Romania, in comparison with the European countries, can be attributed to a weak development of the social and community networks, and to the socio-economic, cultural and environmental conditions.
In Romania, the behavioral factors are important and among these, the most impact on the health of the population is due to: smoking, alcohol consumption, drug use, diet and physical inactivity. In Romania, in 2007, over five million smokers were recorded; among these, about 38,000 people die every year from diseases due to tobacco consumption; most of them dye before reaching the age of 65 [2,3].

Health reforms led to numerous organizational and operational changes, but these changes did not result in improving the health status of the population in Romania. Instead, we notice a trend of increasing in mortality rates and an increasing in number of deaths from preventable causes.

In Romania, there are a few researches on avoidable mortality, and most evidence come from international statistics. According to these statistics, the higher avoidable mortality in the 25 EU member states is recorded in Romania [4]. Thus, in 2002, mortality from preventable causes of death in Romania was five times higher (for men) and 3.5 times higher (for women) than in Sweden. Moreover, in the last decade, in Romania has been an increase in avoidable deaths, in contrast to the downward trend recorded in other European countries.

The over time analysis shows an increase in mortality caused by treatable diseases in Romania in the ‘90s and also after 2000; a slight decrease was recorded in 1997-2000. The deaths caused by preventable causes of death represent 11% of total death [5].

The Presidential Commission Report notes that, in contrast to the situation in most EU states (notably Western European countries where there is a downward trend), in Romania there is a strong uptrend in cardiovascular mortality. As regards deaths from malignant tumors, we can notice that their frequency is below the EU average, but a high level of avoidable deaths is noted; in this regard, the high number of deaths from cervix cancer should draw attention to the decision-makers on the inadequacy of the health system to the real needs of the population.

EU analysis on avoidable deaths due to health system shows that Romania ranks first in the EU, both in mortality in women as in men; moreover, despite the trend is significant decreasing in all other EU countries, in Romania it is either reduced (for women) or stationary (for men).

**CONCLUSIONS**

Technological and scientific progress in the field of medicine and society in general has led to new and more effective and efficient treatment and prevention methods for illness and death.

The immediate consequence is evident in the worldwide increasing trend of average life expectancy. Thus, in the context of life prolonging, one of the current public health concerns is the assurance of the "quality of life"; in this respect, the focus is also on scientific approaching of the avoidable events, and terms such as "avoidable morbidity" and "avoidable mortality" are becoming current concepts.

Among the multitude of the methods, none is a standard for measuring health. To measure avoidable mortality is useful both in assessing the health of the population, but also in planning and evaluating health care performance. The level of the phenomenon (measured by counting the avoidable causes of death) can be considered as one of the indicators for assessing the quality of care and outcome of health care [7].

Avoidable mortality may be considered an important indicator of health system performance by referring to diseases that can be treated through proper and timely medical care or prevented by inter-sectorial policy.

In Romania, the avoidable mortality is less studied and data existing at international level require deepening in researching this phenomenon, in order to identify potential weaknesses of the health system and healthcare impact of different policies.

For Romania, the level (first place in the EU countries) and increasing trend of phenomenon (mainly for diseases that are treatable) should alert policy makers and politicians. Scientific evidence must accurately reflect reality and decision making process must be supported by a good understanding of the phenomenon.

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