The Politics of Achievable Mortality

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The article by Kindig and colleagues[1] in this issue of *Public Health Reports* is a noteworthy contribution in a line of research that seems highly relevant for policy but violates unwritten rules of politics, especially, but not exclusively, in the United States. Beginning with William Farr in Britain in the 1850s,[2] many investigators have used epidemiologic methods to estimate the extent to which rates of mortality could be reduced within countries and their political subdivisions.[3–5] Most of these studies have calculated mortality that could be avoided by appropriate health care. Some studies have also estimated mortality that could be avoided as a result of some combination of reducing high-risk behavior by individuals, ameliorating deleterious social and economic circumstances, and reducing or eliminating environmental stressors. The authors of studies of avoidable mortality, as well as their funders and devoted readers have, however, frequently been disappointed by the reluctance of most policy makers to accord high priority to reducing unwarranted mortality—particularly when reducing it requires coordination across government departments, economic sectors, and civil society.

Kindig and colleagues attribute the weak influence of research on avoidable mortality to its methodological limitations. As relationships such as those described in this article gain better causal certainty, "they should be of substantial guidance to policy makers."[1] Similarly, Walter Holland, lead author of three editions of the *European Community Atlas of Avoidable Death* in the 1980s and 1990s, wrote in 2003 that the "concept of avoidable/amenable mortality . . . deserves closer analytical, systematic scrutiny, and investigation at both local and national levels so it can contribute to the remedy of the failures it describes."[6]

These statements are professions of faith in a causal relationship between progress in science and effective policy. But they ignore what I call the epidemiology of politics. The primary data for this epidemiology by analogy are experiential knowledge about career risk among men and women who hold elected office, staff members who report directly to them, and senior officials of executive branch agencies whom elected officials appoint or confirm. In the epidemiology of politics, losing office is the equivalent of morbidity (if their party loses power) and mortality (if they are defeated or, for appointees, fired for cause). Policy makers everywhere devise rules to reduce their risk of these

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adverse events. These rules often require them to contain personal sympathy for avoiding mortality among voters and their families.[7]

Academic practitioners of political science and public administration occasionally allude to some of these rules. But they usually discuss the rules in abstract words that fail to communicate the intense and exhausting analytical and rhetorical work of public life, and the emotional strain of thinking and arguing in settings that are always pressured and often hostile. Besides, the education of most researchers of population health rarely includes academic study of the politics of policy-making.

Three of the rules that political professionals apply to avoid career risk impede making policy to address avoidable mortality. The first rule is that policy makers, their staffs, and their appointees risk failing and, worse, risk failing in public when they try to coordinate budgets and policies across agencies of government and sectors of the economy and civil society. The second is that they avoid career risk by distancing themselves from controversies that a significant number of voters perceive as controversial scientific challenges to widely held values. The third is that invidious comparisons among jurisdictions invariably cause problems for them.

Much of the daily work of government and politics consists of addressing pleas from interest and advocacy groups that compete for scarce resources and often have some support or sympathy from voters. Each interest and advocacy group, including advocates for population health, wants more money and authority; each also defends what it has acquired. To achieve lower rates of mortality, for instance, resources could be transferred from clinical health services to community-based prevention, from tax subsidies for industry to programs that reduce exposure to environmental toxins, from transportation infrastructure to education, or from institutional long-term care to services for people living alone. Any such transfer creates losers and, hence, career risks that public officials balance against support from winners.

Despite the constraints of career risks, policy makers have often used findings from research on achievable mortality. They have done so when they could focus policy on a single objective and use strong research findings to embarrass opponents of change. Policy makers have cited research to justify, for example, reducing the effects of smoking cigarettes, the number and severity of injuries from automobile and motorcycle crashes, and unnecessary maternal and infant mortality.

Controversies about immunization illustrate the career risk to policy makers of conflict between science and values. Many parents resist mandatory immunization for their school-aged children. Many health workers and their unions recently challenged mandated vaccination against H1N1. Most policy makers accept the strong evidence in favor of mass immunization and fund health officials to promote it. But few elected officials make public statements about the risks and benefits of immunization. Similarly, few policy makers are eager to challenge the high proportion of their constituents who believe that health care is by far the most important cause of avoidable mortality.

Ranking jurisdictions has been another source of career risk because policy makers cannot afford to be accused of neglecting duty. The ranking of any jurisdiction on any metric usually causes a governmental crisis. As soon as senior elected and appointed officials learn about a ranking, they demand that relevant agencies accord the highest priority to explain or challenge it. Within hours or days, their political adversaries and leaders of interest and advocacy groups loudly demand increased spending to repair the deficiencies that make the jurisdiction a laggard. Even high rankings have caused problems for policy makers because lobbyists use them as grounds for opposing policy to contain the growth of any spending they can plausibly associate with the jurisdiction's success.

Because rankings rankle, they have a long shelf life. In October 2009, for example, the *Wall Street Journal* reprised a 2000 study by the World Health Organization that ranked the U.S. 37th in the world in health care. The article emphasized the considerable disagreement among researchers about the study's methodology.[8]

Policy makers have strong reasons to avoid taking sides in such conflicts among experts. Contrary to conventional wisdom, everyone in elected office has a working knowledge of fundamental principles of population-based research as a result of commissioning and interpreting opinion polls. They know the sources of systematic bias and the mathematical conventions of statistical significance. They also know that many people, including many scientists, use research findings to advance their own careers and to promote policy.

In contrast to the limited influence of research on achievable mortality on policy for public and population health, its methodology has informed policy to improve the quality of health services. An influential article in 1976 calculated the reduction in mortality that could be achieved by increasing the quality of clinical services to address 80 causes of death.[9] In the ensuing decades, the science of evaluating the effectiveness of interventions became more precise and persuasive. Moreover, evidence accumulated about the underuse, overuse, and misuse of services and of unwarranted

geographical variation in the incidence of interventions. Policy makers in the public and private sectors, as well as many physician leaders, now had strong justification for new clinical and reimbursement policy to improve the quality and efficiency of care. They also had evidence with which to confront resistance to the new policy from manufacturers of prescription drugs and medical devices, advocacy groups, and reluctant physicians.

The relatively recent success of applying "quality science" to practice and policy suggests that Kindig and colleagues may be correct when they describe the "job of population health research [as getting] as close to causal understanding [of the determinants of health] as is possible to guide political or managerial efforts."[1] Until 2009, the U.S. lagged behind many other industrial countries in sponsoring and applying rigorous research on the effectiveness of interventions to improve health. The appropriation of $1.1 billion for comparative effectiveness research in the American Recovery and Reinvestment Act of 2009 could yield new opportunities to evaluate and compare interventions to address a broad array of biological, behavioral, economic, and social causes of avoidable mortality. A shift in focus from ranking jurisdictions to ranking interventions would enable policy makers to more effectively manage their career risk from applying science in the public interest.

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