



Services for liver disease in the United Kingdom

Roger Williams

BMJ 2005;331:858-859
doi:10.1136/bmj.331.7521.858

Updated information and services can be found at:
<http://bmj.com/cgi/content/full/331/7521/858>

These include:

Rapid responses

You can respond to this article at:
<http://bmj.com/cgi/eletter-submit/331/7521/858>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Topic collections

Articles on similar topics can be found in the following collections

[Liver, including hepatitis and cirrhosis](#) (819 articles)

Notes

To order reprints of this article go to:
<http://www.bmjournals.com/cgi/reprintform>

To subscribe to *BMJ* go to:
<http://bmj.bmjournals.com/subscriptions/subscribe.shtml>

health, Morris et al have identified several basic needs for health and wellbeing and have calculated a minimum income for healthy living.⁷ They based their calculations on the needs of a healthy single man aged 18-30 who has left the family home,⁷ although a single healthy woman may have been a more appropriate choice because two out of three beneficiaries of the minimum wage in 1999 were women.⁸

To calculate the minimum income for healthy living, Morris et al derived minimum prices for nutritional requirements from consensus guidelines on diet. They budgeted for physical activity, choosing the least expensive dynamic aerobic exercise but including expenditure spread over a year for items such as training shoes or a bicycle, helmet, and cycling kit. The psychosocial budget covered a variety of expenditures for social participation: on telephone bills, postage, the occasional gift, and subscriptions for clubs and trade unions. For essential items such as clothing and the costs of renting a home the researchers used data from the Office for National Statistics' family expenditure survey on average weekly expenditure by the 30% of the population on the lowest incomes. The minimum income for healthy living was £132.00, but the take home pay of the average young single man working 37.5 hours a week on the minimum wage was £120.00. Hence there was a shortfall of £12.00 each week between what such a man earned and what he needed to stay healthy (April 1999 prices).

The researchers point out that their budget has some gaps and excludes any allowance for personal choice and development, contingencies, or emergencies. Thus, their budget is an underestimate of the real minimal costs for healthy living. Inevitably too, there are inefficiencies in purchasing. For example William Beveridge, the British economist and social reformer whose recommendations paved the way for the NHS,

allowed 6% for inefficiencies when he was setting social security budgets in 1942.⁹ Allowing for these margins and bringing the calculations up to date by correcting for inflation, a single healthy man aged 18-21 working a 37.5 hour week (the national median) on the lower rate of national minimum wage currently has £20.00 less a week, on average, than he needs to live healthily. Those aged 22-24 on the main rate may just about manage. A single man aged 25-30, if he gets working tax credits, should receive an income sufficient to maintain health—on average £11.00 above the basic amount.

Of course the government also has to consider economic implications when setting the national minimum wage. Given that the government has recently committed to helping people to achieve healthier lifestyles,¹⁰ can politicians afford to ignore the evidence for a minimum income standard that would offer all those in low paid work a better opportunity for choosing health?^{11 12}

Christopher Deeming *PhD student*

School for Policy Studies, University of Bristol, Bristol, BSS 1TZ
(christopher.deeming@bristol.ac.uk)

Competing interests: None declared.

- 1 Webb S, Webb B. *Industrial democracy*. London: Longmans, 1897.
- 2 Milton, J. Low pay estimates for 2004. *Labour Market Trends* 2004;112:481-3.
- 3 Sutherland H, Sefton T, Piachaud D. *Poverty in Britain: the impact of government policy since 1997*. York: Joseph Rowntree Foundation, 2003.
- 4 Dickens R, Manning A. Has the national minimum wage reduced UK wage inequality? *J R Stat Soc: Series A* 2004;167:613-26.
- 5 Morris JN. Are we promoting health? *Lancet* 2002;359:1622.
- 6 Morris JN. Commentary: Minimum incomes for healthy living: then, now—and tomorrow? *Int J Epidemiol* 2003;32:498-9.
- 7 Morris JN, Donkin AJM, Wonderling D, Wilkinson P, Dowler E. A minimum income for healthy living. *J Epidemiol Community Health* 2000;54:885-9.
- 8 Heasman D. Patterns of low pay. *Labour market trends* 2003;111:171-179.
- 9 Beveridge W. *Social insurance and allied services*. London: HMSO, 1942. (Cmd 6404.)
- 10 Department of Health. *Choosing health: Making healthy choices easier*. London: Stationery Office, 2004. (CM 6374.)
- 11 Morris JN, Deeming C. Minimum incomes for healthy living (MIHL): next thrust in UK social policy? *Policy Politics* 2004;32:441-54.
- 12 Zacchaeus 2000 Trust. *Memorandum to the prime minister on minimum income standards*. London: Zacchaeus 2000 Trust, 2004.

Services for liver disease in the United Kingdom

Need improving urgently as hepatic morbidity and mortality rise

Mortality from liver disease is increasing in the United Kingdom. In 2000 liver disease killed more men than Parkinson's disease and more women than cancer of the cervix. The average mortality among patients admitted to hospital with a diagnosis of liver disease was 18.2% in 2004 with a large range, which suggests (once clinical factors have been accounted for) that the standard of care may vary widely from place to place.¹

Liver disease has many causes, almost all of them increasing in prevalence. Mortality from alcoholic liver disease has doubled in the past 10 years and, as the chief medical officer pointed out in 2001,² these deaths occur mainly among men aged 40-60. Fewer than 10% of an estimated 300 000 cases of infection with hepatitis C virus have been diagnosed and the prevalence of the related chronic liver disease is expected to treble by 2020. Moreover 6000 people who are hepatitis B positive are coming into the United Kingdom each year through legal immigration alone. The incidence of primary hepatocellular cancer is increasing, and so is that

of cholangiocarcinoma. Steatohepatitis arising from obesity and diabetes—both increasingly prevalent—is also becoming more common and is being referred to in the United States as the new epidemic of cirrhosis.³

But are there enough specialist staff and facilities in the United Kingdom to manage these projected increases in liver disease, or even the current workload? One fifth of the 15 000 cases of cancer seen each year with liver metastases may be suitable for resectional surgery, but too few surgeons have expertise in hepatic resections. Management with new antiviral agents of chronic infections with hepatitis C and B viruses is increasingly complex, and in a recent survey only 40% of consultants were providing a fully comprehensive service for people with hepatitis C infection (W Rosenberg, personal communication, 2003). Despite national recommendations on treating hepatitis B and C, practice still varies substantially around the country (so called postcode prescribing). Moreover, the managed clinical networks for delivering care for people with

BMJ 2005;331:858-9

hepatitis C, heralded by the chief medical officer last year,⁴ have not been adequately implemented.

In 2004 I conducted a questionnaire survey on the staffing and facilities of 28 English hospital trusts identified as running hepatology services and known as "liver centres." Relatively few were able to provide a full range of liver services.⁵ There were serious shortages of staff at all levels: a third of the centres lacked a designated consultant hepatologist, and in 11 of the 28 units general physicians were sharing the workload with gastroenterologists. Five centres did not have a single specialist nurse for hepatitis, and in four centres the only specialist nurses were for people with alcohol related disorders. Lack of dedicated beds for patients with liver disease was one of the most common limitations to the service. Waiting times for outpatient appointments were generally unacceptable too—more than 20 weeks in three hospitals, and between 11 and 20 weeks in 14. Only seven hospitals were able to offer an urgent appointment within two weeks. An earlier questionnaire survey on training by Ramage⁶ also showed the need for a substantial increase in consultant hepatologists.

How can staffing in the United Kingdom be improved? The recent designation of hepatology as a subspecialty of gastroenterology, with one year of the current five years' training spent in a liver centre, is a step forward. So are the integrated training pathways proposed for academic doctors through the Modernising Medical Careers programme⁷—and the initiatives of the UK Clinical Research Collaboration,⁸ which should both bring new recruits into academic hepatology.

Liver services need better funding as well as better staffing. The considerable costs of drug treatment and specialised procedures for treatment underline the need for an appropriate funding mechanism within the new national tariff system.⁹ And much remains to be done in the commissioning of specialised liver services by primary care trusts.¹⁰ The National Plan for Liver Services UK envisaged that some 10-15 hospital centres would provide specialised services through a series of managed clinical networks, evenly distributed around the country.³ This is considerably less than the number of hospitals currently identified as liver centres, and these serve a variable number of primary care trusts (range of 1-14, median 6).

The six centres for liver transplantation in the United Kingdom—which receive dedicated funding—fared better than liver centres in last year's survey, with considerably more facilities for investigation and availability of expert staff.⁶ Patients referred to these centres with liver disease not requiring transplantation (which accounted for 30-60% of the total referrals) will benefit from the better facilities. Increasing the number of transplant centres would be one way to provide liver services more widely in the United Kingdom. Large areas of the country currently lack a transplant centre, notably north west England (including Manchester and Liverpool) and the south west peninsula. Clearly, specialised services for liver disease and transplantation will have to improve substantially to meet the considerably increased burden of liver disease that is predicted for the next 20 years.

Roger Williams *director*

University College London, UCL Institute of Hepatology, London WC1E 6HX
(roger.williams@ucl.ac.uk)

Competing interests: None declared.

- 1 Handlip P, Swindells M, Allan C, Clifton M, Thomas H. Information-clinical analysis. The data today. Real-time monitoring can alert trusts to clinical performance problems—before the star-ratings do it for them. *Health Serv J* 2004 Sep 2;114(suppl):6-8.
- 2 Department of Health. *Annual report 2001/2*. www.doh.gov.za/docs/reports/annual/2001-02/contents.html (accessed 4 Oct 2005).
- 3 Moore K, Thursz M, Mirza DF. *National plan for liver services—specialised services for hepatology, hepatobiliary and pancreatic surgery*. 2003. Report prepared for the British Association for the Study of the Liver. www.basl.org.uk/National%20Plan%20for%20Liver%20Services%20UK%20Final-May04.pdf (accessed 4 Oct 2005).
- 4 Department of Health. *Hepatitis C: action plan for England*. July 2004. www.hepc.nhs.uk/resources/documents/ACTIONPLAN.pdf (accessed 4 Oct 2005).
- 5 Williams R. Provision of specialist liver services in England. July 2004. www.bsg.org.uk/pdf_word_docs/hepservices.doc (accessed 4 Oct 2005).
- 6 Ramage J. Results of hepatology training questionnaire, 2002. www.bsg.org.uk/pdf_word_docs/hep_survey.doc (accessed 10 Oct 2005).
- 7 National Health Service. *Modernising medical careers: foundation programmes*. www.mmc.nhs.uk/pages/foundation (accessed 3 October 2005).
- 8 Department of Health, UK Clinical Research Collaboration. Government agrees new pathway to create the medical researchers of tomorrow. Press release, 30 March 2005. www.ukcrc.org/Documents/UKCRC_MMC_Report_Press_Release_30_March_2005.PDF.pdf (accessed 4 Oct 2005).
- 9 Department of Health. *Reforming NHS financial flows: introducing payment by results*. London: DOH, 2002. www.dh.gov.uk/assetRoot/04/06/04/76/04060476.pdf (accessed 4 Oct 2005).
- 10 Williams R. Direct and indirect constraints on commissioning specialist medical care. In: Grimley Evans J, Pollard S, Sikora K, Williams R, eds. *They've had a good innings: can the NHS cope with an ageing population?* London: CIVITAS, 2003:50-69.

ASCOT: a tale of two treatment regimens

Better blood pressure, fewer deaths, and less diabetes with newer antihypertensive agents

Papers p 873

Each year in the United Kingdom alone there are 20 000 preventable deaths from cardiovascular disease attributable to hypertension. Much of the excess mortality and associated morbidity arises from poor control of blood pressure among people known to have hypertension. For the past two years in the United Kingdom, general practitioners have had the prime responsibility for tackling this problem, along with financial incentives to meet targets for detecting and controlling high blood pressure. Yet, despite many clinical trials and guidelines, they may be unsure about which antihypertensive drug to use first and how to combine treatments.

In 2004 the National Institute for Health and Clinical Excellence (NICE) recommended thiazide or thiazide-like diuretics as the first line treatment for most patients, with the addition of β blockers as the next step.^{w1} This echoed the advice given in the US Joint National Committee's guidelines the previous year.^{w2} Near simultaneous guidance from the British Hypertension Society, however, recommended for the first time drugs acting on the renin-angiotensin system—angiotensin converting enzyme (ACE) inhibi-

References w1-w12 are on bmj.com