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equivalent to paroxetine, costs only 82p, compared with £1.62 for paroxetine. His case studies suggest that complementary and alternative programmes can lead to savings in direct costs, but these savings will be greatly diminished or abolished when set against the overall costs of providing these services. The provision of specific complementary and alternative interventions by members of existing primary healthcare teams might offer scope for cost savings in such settings.

The report concludes that complementary and alternative therapies should be targeted at the “effectiveness gaps” of conventional health care, particularly in managing chronic pain and mental disorders, and in palliative care. We think this is a useful concept but were perplexed by Smallwood including asthma, for which conventional treatment is generally effective and safe.

Despite its limitations and the likelihood of bias in its conclusions, we believe that the Smallwood report fulfills a useful political function. It should promote more investment in research on the cost effectiveness of complementary and alternative treatments. Nevertheless, the report’s principal recommendation—that NICE (the National Institute for Health and Clinical Excellence) carries out a full assessment of the cost effectiveness of these therapies—is ill advised.

A more sensible recommendation to NICE would be that, in developing the scope of new guidelines on chronic conditions, the institute pays greater attention to reviewing complementary therapies. Therapists with particular expertise in complementary and alternative treatments for each specific condition should be invited to join guideline development groups. These groups can wrestle with the philosophical and methodological dilemmas over what study designs should be included in the evidence base of the guidelines. Uncertain evidence of effectiveness does not preclude a positive recommendation in a guideline, and original modelling of cost effectiveness can be part of guideline development.

Lastly, those making decisions about integrated medicine in the NHS should consider each complementary or alternative therapy on its merits, using a broad range of appropriate scientific evidence including data on cost effectiveness. Such decision making, if done transparently, may change the public perception of scientific medicine for the better.

**Editorials**

**Keeping healthy on a minimum wage**

*Is not easy in the United Kingdom*

The national minimum wage was a flagship policy of the United Kingdom’s Labour Party during the 1997 election campaign—a century after Fabians Sidney and Beatrice Webb first advanced the idea.1 From April 1999 the policy set a minimum wage of £3.60 per hour for those aged 22 and older and a lower rate of £3.00 for those aged 18-21. Reviewed annually, the main rate now stands at £5.05 and the youth rate at £4.25 per hour. People aged 25 or over and working at least 30 hours a week can also receive working tax credits after means testing. Has the policy reduced poverty and, in turn, improved public health?

The minimum wage and working tax credits are important policies in the government’s anti-poverty strategy. Yet the latest estimate shows that wages in 250 000 jobs held by people aged 18 or over in the United Kingdom are still below the minimum rates.2 Furthermore, although these “welfare to work” policies stemmed from beliefs in social justice and in “making work pay,” the overall effect of the minimum rates on income inequality appears small.3,4

The national minimum wage and working tax credits have raised the earnings of the lowest paid workers. However, progress towards a minimum income for healthy living has been slow and patchy. The health community did not participate in decisions on setting minimum incomes and calculations to set the rates did not consider requirements for personal health.5

Arguing that policies on social welfare should take account of the minimum income needed to maintain
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


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