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equivalent to paroxetine,¹⁰ 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,¹¹ 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.¹²

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.

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- 1 Kaptchuk TJ, Eisenberg DM. Competing medical systems in North America. *Varieties of healing. 1: medical pluralism in the United States. Ann Intern Med* 2001;135:189-95.
- 2 Thomas KJ, Nicholl JP, Coleman P. Use and expenditure on complementary medicine in England: a population based survey. *Complement Ther Med* 2001;9:2-11.
- 3 Manheimer E, Berman B, Dubnick H, Beckner W. Cochrane reviews of complementary and alternative therapies: evaluating the strength of the evidence. 2004. www.cochrane.org/colloquia/abstracts/ottawa/P-094.htm (accessed 10 Oct 2005).
- 4 Campbell M, Fitzpatrick R, Haines A, Kinmonth AL, Sandercock P, Spiegelhalter D, et al. Framework for design and evaluation of complex interventions to improve health. *BMJ* 2000;321:694-6.
- 5 Jonas WB. The evidence house: how to build an inclusive base for complementary medicine. *West J Med* 2001;175:79-80.
- 6 Canter PH, Coon JT, Ernst E. Cost effectiveness of complementary treatments in the United Kingdom: systematic review. *BMJ* 2005;331:880-1.
- 7 Hulme C, Long AF. Square pegs and round holes? A review of economic evaluation in complementary and alternative medicine. *J Altern Complement Med* 2005;11:179-88.
- 8 Smallwood C. *The role of complementary and alternative medicine in the NHS*. London: FreshMinds, 2005. www.freshminds.co.uk/PDF/THE%20REPORT.pdf (accessed 10 Oct 2005).
- 9 House of Lords Select Committee on Science and Technology. *Complementary and alternative medicine*. London: Stationery Office, 2000. www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldscitech/123/12301.htm (accessed 10 Oct 2005).
- 10 Szegeidi A, Kohnen R, Dienel A, Kieser M. Acute treatment of moderate to severe depression with hypericum extract WS 5570 (St John’s wort): randomised controlled double blind non-inferiority trial versus paroxetine. *BMJ* 2005;330:503.
- 11 Fisher P, van HR, Hardy K, Berkovitz S, McCarney R. Effectiveness gaps: a new concept for evaluating health service and research needs applied to complementary and alternative medicine. *J Altern Complement Med* 2004;10:627-32.
- 12 National Institute for Health and Clinical Excellence. *Incorporating health economics in guidelines and assessing resource impact. Guideline development methods: information for national collaborating centres*. London: NICE 2005. www.nice.org.uk/pdf/GDM_Allchapters_0305.pdf (accessed 10 Oct 2005).

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 main 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 6}

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

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}

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- 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

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