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EDITORIAL

Travel time disparities in access to liver transplantation in the United Kingdom: An argument for adding another center

Geographic disparities in access to liver transplantation are a significant focus in the debate over liver allocation in the United States and the United Kingdom. The most recent proposed United Network for Organ Sharing (UNOS) allocation policy recommends expanding geographic sharing of livers on the basis of a 150–nautical mile radius sharing circle around the donor hospital. Proponents of expanding geographic sharing suggest that it might equalize waiting time across the country and reduce waitlist deaths in areas with long waits. On the other hand, data showing a high burden of end-stage liver disease (ESLD), lower listing rates, higher risk of dying on the waitlist, and lower chance of receiving a liver transplant in certain rural or impoverished areas suggest that maintaining local primacy for liver allocation policies may protect these groups. Recently, the United Kingdom converted from a zone-based to a national wait-primacy for liver allocation policies may protect these groups. Recently, the United Kingdom converted from a zone-based to a national wait-list for liver transplant, taking local primacy off the table except in some unique circumstances (eg, donors after circulatory determination of death), allowing for the comparison of outcomes between the 2 systems.

With this background, Webb et al examined the UK national registry for geographic disparities based on distance from a transplant center and found an increased risk of dying on the liver transplant waitlist for patients living >60 minutes from the nearest transplant center, as well as decreased chance of receiving a transplant or recovering without a transplant. The authors hypothesize that delay in referral for transplant, regional variations in the behavior and general approach to liver disease by clinicians and/or patients, and less available and less frequent pretransplant follow-up may in part explain the disparities. The current data were used to demonstrate that adding a liver transplant center in Bristol, UK, would improve access, reduce travel time differences, and perhaps improve outcomes.

Interestingly, there was not an adverse impact of travel time on posttransplant survival as has been shown in the United States. Although in the United Kingdom about 55.1% (33.8 million people) live >1 hour from a liver transplant center and 12.5% (7.6 million people) live >2 hours away, the distances are still not as great as they are in the United States. For example, London and Edinburgh, the southernmost and northernmost cities with transplant centers, are only 417 miles apart, so patients are generally closer to a transplant center than in some areas of the United States. This may explain the differences between the US and the UK data.

Geographic disparities in liver transplantation may be due to both supply and demand-side factors. First, geographic disparities are manifest in centers that have longer waiting times, lower transplant rates, and higher waitlist mortality because of a larger gap in supply and demand than at other centers. This might have to do with donor potential and organ procurement organization performance (supply) or disease incidence, market competition, access to health care, or referral patterns (demand). Second, geographic disparities exist because of long distances to a transplant center, particularly in rural portions of the United States. Goldberg et al showed that veterans who received care greater than 100 miles from a Veterans Administration transplant center were less likely to be placed on a transplant list, had a lower transplant rate, and had an increased mortality among waitlisted veterans. Similar to the authors’ suggestion of opening a new center in Bristol, some in the United States have proposed opening additional VA transplant centers.

Unfortunately, the authors do not provide data on whether patients living farther from a transplant center experience a lower chance of being listed, a significant source of geographic disparities. Higher ESLD mortality in areas that are far from transplant centers and underserved undermines equity and reinforces the importance of improving access to multidisciplinary clinical teams and of adding centers to serve patients where travel times are disproportionately long. Moreover, a shift away from a zone-based system toward a national system may further disadvantage patients in impoverished areas, where greater supply of organs may reflect sociodemographic disadvantage. Ladin et al showed that higher mortality leading to greater organs supply may partly result from disproportionate risks incurred at the local level due to disparities in public safety laws, healthcare infrastructure, and public funding. They pointed out that changing organ distribution from high- to low-supply regions might exacerbate existing social and health inequalities by redistributing the single benefit (greater organ availability) of greater exposure to environmental risks (eg, violent death, healthcare scarcity).

The authors were also not able to analyze the impact of rurality or socioeconomic status on outcomes with longer travel time. It is likely that such an analysis would have uncovered greater disparities in outcomes. The recent availability of the Neighborhood Atlas that shows the distribution of neighborhood disadvantage throughout the United States will be a powerful tool to examine these questions in diverse patient populations in the United States. Perhaps a solution to the travel time disparities in the United States might also include the establishment of additional liver transplant centers as has been shown in the United Kingdom.

DISCLOSURE

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