

ON THE CONTRARY **Tony Delamothe**

# Migrant healthcare: public health versus politics

What can doctors do about the sorry state of migrants' access to UK healthcare?

As an excellent new book makes clear, migrants are a force for good.<sup>1</sup> This is just as well: all of us are descended from the migrants who left Africa 50 000 to 60 000 years ago. But there's a downside. If migration is nearly as old as humanity itself, so is the hostility that outsiders face.

The United Kingdom distinguishes itself by being more opposed to immigration than similar countries with higher proportions of foreign born citizens. Underpinning this attitude is a host of assumptions that don't fit the facts. A recent report contradicts the widespread belief that immigrants "cost jobs."<sup>2</sup> Migrants are actually less likely to claim working age benefits than British nationals. A Migration Observatory poll found that asylum seekers loom large when the British public thinks about migrants coming to Britain, yet applications for asylum made up just 3% of immigrant numbers in 2010. Despite its daily contact with the NHS, the British public seems oblivious to the fact that 37% of its doctors and 13% of its nurses are foreign born (figures from European Observatory on Health Systems and Policies). If they all went home tomorrow the NHS would collapse. No one—least of all the mainstream press—seems interested in correcting the public's misunderstandings.

Instead, bowing to anti-migrant sentiment, Britain's three main political parties pledged to cut the numbers of migrants at the last election. Last week the immigration minister, Damian Green, described how the government hopes to shrink net migration from a record high of 252 000 in 2010 to "the tens of thousands" by being more selective. Meanwhile, the Department of Health has begun another review of charging non-residents for healthcare. (Non-residents include people who have overstayed their visas, who have been refused asylum, or who are completely "undocumented.")

It's not a conducive atmosphere in which to hold a generous hearted discussion about the healthcare needs

of migrants. But to its credit that's what the Health Protection Agency attempted recently at a conference at Cumberland Lodge. My conclusion, although I'm not sure that the Health Protection Agency would have put it like this, is that the agency wishes that it could tackle the healthcare needs of migrants without having to take the politics into account.

The UK has signed up to various international conventions guaranteeing migrants access to healthcare, but these are silent about who should pay. There are several options. At one extreme is Portugal's policy of inclusiveness: all migrants are guaranteed healthcare regardless of their immigration status.

The UK currently mixes inclusiveness and exclusiveness. Theoretically, at least, nobody in the UK is excluded from treatment in primary care on the basis of his or her immigration status. However, secondary care must be paid for unless the patient is "ordinarily resident." There are exceptions to this rule, most notably treatment for a wide range of infectious diseases, which includes sexually transmitted infections but, oddly, not HIV. The health service will pay for the diagnosis but not the treatment of HIV. The *BMJ* has learnt of cases of HIV positive patients left untreated until they've been admitted as emergencies to intensive treatment units. By then they qualify for admission on the grounds that hospital treatment has become "urgent and immediately necessary."

Emergency care is the most expensive way of providing healthcare; it's better to treat illness as early as possible. Paradoxically, while the UK's Department of International Development is proselytising for the early use of antiretrovirals globally, the UK is avoiding best practice at home. Similarly odd is the refusal to provide free formula milk to HIV positive mothers who have been refused asylum, given that replacing breast milk with formula is known to reduce viral transmission from mother to child.



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When not actually dangerous to individual patients, excluding various groups from optimal healthcare seems petty. It's unlikely to deter potential migrants, as healthcare comes way down most migrants' reasons for migrating. The observation that "enforced discomfort" characterises the UK's policy towards unwanted migrants seems about right.

What can doctors do about this sorry state? For hospital doctors, not a lot. Eligibility for secondary care is usually decided before doctors see a patient.

Primary care should be different. The law states that nobody is excluded from GP treatment on the basis of immigration status. If GPs close their list to foreign nationals, while continuing to register British citizens, this is likely to be unlawful discrimination. And yet agencies that work with migrants say that this is happening. Last year "Project:London," Médecins du Monde's healthcare project in east London, reported that 545 of the 1288 people they saw had tried and failed to register with a local GP. Other agencies have used "mystery shoppers" to approach general practices that have recently declined to register a migrant. Someone with an English accent and surname is usually successful. Education of general practice staff is obviously the way forward, but a well publicised court case or two could usefully concentrate minds in the short term.

What might the government do? There's the precedent of the Home Office handing the healthcare of prisoners to the NHS. The NHS already provides healthcare to individuals, but the Home Office has a large say in decisions about migrant patients as a group. Since public health is hardly its forte, it would do better to hand this role over to those better qualified.

Tony Delamothe is deputy editor, *BMJ*  
[tdelamothe@bmj.com](mailto:tdelamothe@bmj.com)

**Competing interests:** I am a migrant and the son and grandson of migrants.

References are in the version on [bmj.com](http://bmj.com).

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MEDICINE AND THE MEDIA Margaret McCartney

# Would you like your telomeres tested?

A US company claims that the length of people's telomeres indicates their general state of health, but is its test reliable?

A company that is based in the United States, Life Length, is offering “telomere testing and services” from its laboratory in Spain, with the aim of “making it easy for physicians and their patients to take our biomarker test,” says its press release.<sup>1</sup> It adds, “Telomeres are best predictors of biological age and excellent general health indicators, highly related to the emergence of age-related diseases. This test will likely become standard in checks-up and preventive healthcare. US doctors can now incorporate Life Length's telomere test easily into their practice.”

Telomeres are repeated sequences of DNA at the end of chromosomes that stabilise the chromosomes and prevent them being identified by cells as broken DNA. For some time it has been known that abnormal or shortened telomeres cause chromosomal problems, which in turn have been related to some disorders, including tumorigenesis. Life Length says that it can test anyone, no matter where they are, although the blood sample to be tested must be analysed within 48 hours and kept at 4°C in transit to the laboratory in Spain. The company says that it has already tested samples from UK and other European citizens, at a cost to each of about \$700 (£450; €540). In the US the test is offered with a “physician consultative fee” that takes the total to about \$1000.

What kind of independent information about the test is available to patients before testing? María Blasco, the company's chief scientific adviser, and Stephen Matlin, its chief executive said in an email, “We do not provide medical advice to patients . . . This is something for the individuals' physicians to handle, but generally none. We have found that most people that want to do this test are already well informed about telomeres and their importance, often more than their doctors.”

So how useful is the test? Dr Blasco and Mr Matlin say, “As a biomarker of general health the test offers information of interest. If there is a negative finding (that is, biological age significantly above chronological age) it is a tap on the shoulder that we are probably not doing something right (perhaps excessive stress, poor sleep habits, too much smoking or drinking, obesity, insufficient exercise, etc) and that a change in lifestyle habits would be opportune. There are of course specific situations; say a woman who cannot have children that is chronologically in her late 20s.

If the test shows that she is in fact a 50 year old from the point of view of her telomeres, that will likely help her physician in selecting possible treatment (personalised medicine).”

But this raises more questions than it answers. How reliable are telomeres? Is advice about lifestyle and avoiding risk factors not the same advice we would give to people regardless of the length of their telomeres? And how evidence based or practical is use of this information for “personalised” medicine?

In fact, there is no good quality research evidence on the harms and benefits of testing telomere length in asymptomatic individuals. Peter Lansdorp is the scientific director of the European Institute on the Biology of Ageing at the University of Groningen, in the Netherlands, and professor of medicine at the University of British Columbia, Vancouver. He also founded the company Repeat Diagnostics, in 2005, which is based in Canada and which offers telomere length testing. He says that the test has limited usefulness for people who are well.

“We know there is large variation in telomere

length in normal individuals: a teenager might have shorter telomeres compared with a 70 year old. What are we going to tell such a teenager? That he or she should be concerned or do things differently based on the telomere test results? There are a number of diseases where short telomeres are directly implicated—but, as far as we know at this point, it's a minor fraction of the population who are affected by genetic telomere pathways. We can't assume that all will benefit from this information—going to the gym or a change in diet seems a better way to spend the money.”

Instead, he thinks that telomere testing is likely to be useful only in specific situations of illness that runs in families. “Our samples are typically sent by specialists from patients with bone marrow failure or pulmonary fibrosis, when they are making decisions about treatment including transplantation and so on.” His company primarily offers the service to doctors rather than directly to members of the public.

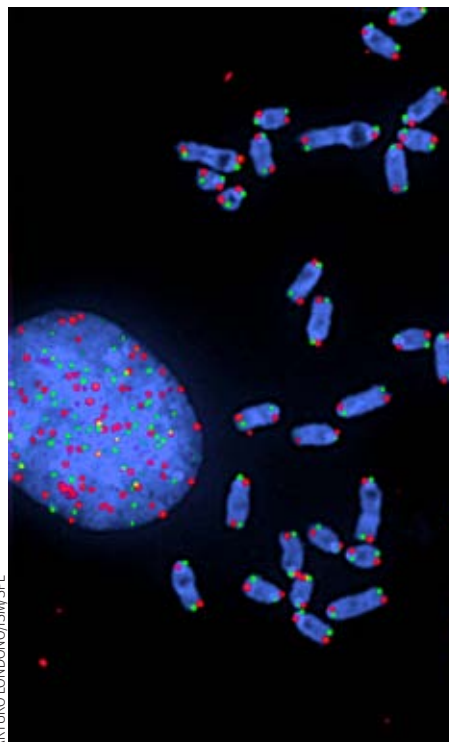
Life Length, however, under the heading, “Want to know your biological age?” suggests to people who want to know what they can do if they get a “bad” result: “Knowing that you have a higher than average percentage of short telomeres is like knowing that you have high cholesterol or other conditions which are influenced by life-style choices; it affords you, following professional advice, the opportunity to make those changes that may allow you to reduce your rate of telomere aging proactively. Currently there is no prescription medication available that allows individuals to medically control telomere loss but it is likely that in the future there will be.”

It also recommends “repeating the measurement every 3 or 6 months instead of the usual annual measurement.” These recommendations are not based on evidence and serve to distract us from the true causes of ill health and proved interventions in preventive healthcare. Media coverage of telomere testing is likely to be encouraged with such press released commercial hype, which serves patients and doctors poorly.

Margaret McCartney is a general practitioner, Glasgow [margaret@margaretmccartney.com](mailto:margaret@margaretmccartney.com)

1 PR Newswire. Life Length telomere test available nationwide. 8 Dec 2011. [www.prnewswire.com/news-releases/life-length-telomere-test-available-nationwide-135241698.html](http://www.prnewswire.com/news-releases/life-length-telomere-test-available-nationwide-135241698.html).

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