LETTERS

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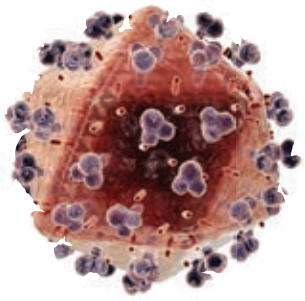

MIGRANT PATIENTS

HIV testing should always be free to migrant patients

Arie reported the extent to which migrant patients are a drain on NHS resources.[1] The problem of HIV tourism by people who are known to be infected with HIV is minimal. Moreover, whereas some visitors are tested for HIV at sexually transmitted disease (STD) clinics, the numbers are modest and early diagnosis and treatment reduces the costs of care and infectiousness.

Of 65 240 adults seen for HIV care in 2010, only 170-340 (0.5%) people were short term visitors (see full response for details of our calculations).

HIV testing of those at higher risk occurs predominantly at open access STD clinics. In 2011 and 2012, 11.5% of 2.03 million clinic HIV tests were done in attendees born outside Europe, including 193 215 in heterosexuals and 24 175 in men who have sex with men. Almost all HIV tested attendees born outside Europe were described as UK residents. Only 6629 (0.3%) were either known to be visitors or of unknown residence, 79 of them being diagnosed with HIV infection. Over 90% of those diagnosed with HIV infection will have started anti-retroviral treatment and become non-infectious within a few months of diagnosis.

The data show that the receipt of specialist HIV care by short term visitors is rare and may reflect unplanned emergency care. In contrast, open access to STD clinics is an essential service providing earlier diagnosis of infectious HIV in visitors. Treatment of a sexually transmitted disease at an STD clinic is excluded from charging,[2] but charging for an STD investigation, including HIV testing of symptom-free people, is currently ambiguous.[3] This ambiguity should be resolved now that routine HIV testing is recommended for general medical admissions and new registrants at GP practices in high HIV prevalence areas of the UK.[4 5] To incentivise the early testing and diagnosis that is essential for HIV control, all possible information must be conveyed to healthcare professionals and migrant patients that HIV and STD testing and treatment is free.

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Full response at:
www.bmj.com/content/347/bmj.f6444/rr/673918.

1 Arie S. Are migrants a drain on health systems? *BMJ* 2013;347:f6444. (29 October.)
2 Department of Health. HIV treatment for overseas visitors in England from 1 October 2012. https://www.gov.uk/government/publications/hiv-treatment-for-overseas-visitors-in-england-from-1-october-2012.
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4 National Institute for Health and Care Excellence. Increasing the uptake of HIV testing among men who have sex with men. March 2011. http://publications.nice.org.uk/increasing-the-uptake-of-hiv-testing-among-men-who-have-sex-with-men-ph34.
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RECONFIGURATION IN THE NHS

Data from two London hospitals' urgent care centres, 2009-12

Charing Cross and Hammersmith Hospitals' accident and emergency services will be reconfigured under current plans.[1] Both hospitals currently possess a GP led urgent care centre co-located with an emergency department; self referred patients are unable to access emergency departments without being seen by a GP or emergency nurse practitioner in an urgent care centre. We present administrative data recorded in the urgent care centres.

From 1 October 2009 to 31 December 2012, 282 947 unplanned attendances occurred at these centres, 63.2% of them at Charing Cross Hospital. The annual number of attendances increased by 9.4% (7911) from 2010 to 2012 (92 303 in 2012).

Most attending patients (85.3%) were registered with a general practice, and 47.7% of attendances occurred outside of general practice core hours. The most common category of primary diagnosis was "injury" (24.1%).

Patients were referred to the co-located emergency departments in 18.0% of attendances (13.4% self referred; 4.6% referred by GP). The risk of referral in patients aged ≥65 years (33.2% of attendances) was significantly greater (P<0.001) than in those aged 0-15 (8.2%), 16-24 (12.9%), 25-49 (16.5%), and 50-64 years (25.9%).

Most patients were discharged with GP follow-up (36.1%) or with no follow-up (31.9%). Some patients were also referred to a hospital specialist (8.9%), although not all referrals were urgent.

To conclude, most patients attending these centres can be managed by a GP or emergency nurse practitioner. However, it is unclear how patients who do require emergency department services will be affected by the planned reconfiguration.

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1 O'Dowd A. Doctors support biggest local reconfiguration in NHS, says Hunt. *BMJ* 2013;347:f6593. (1 November.)

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TAX ON SOFT DRINKS TO REDUCE OBESITY

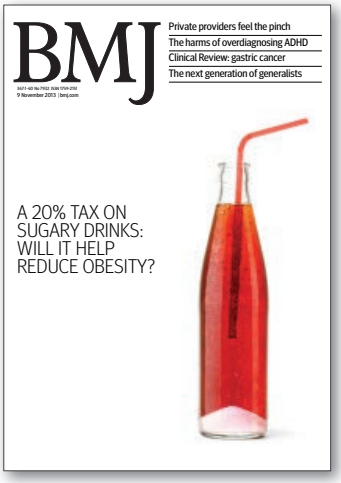
Reduce "good" food prices instead of taxing "bad" foods

It is a positive development that public health specialists now research price policies on obesity.[1] This is the sixth UK proposal for taxes

on "bad" foods in 18 months. It is the most ambitious, estimating effects on health as well as consumption.

However, none of the other five proposals has been seriously considered by policy makers. This suggestion, for a 20% tax on soft drinks, is also unlikely to be implemented and would make little difference if it were. The reasons are economic ineffectiveness and political unacceptability.

The authors are admirably clear about methods. But this is just another modelling exercise, reworking poor primary data. And it confirms earlier studies—benefits are tiny.



The best they claim is that consumption would fall by 16.7 kJ/person/day—one gram of sugar. A can of cola contains 35 g. That would reduce the number of overweight/obese people by 1% when over 60% of British adults weigh too much.

Such meagre benefits explain why tax proposals founder. After the March 2012 budget, popular resistance swelled against a planned "pasty tax." The government backed down.

After that, no rational politician would antagonise voters by supporting taxes on popular products for such negligible gains.

Still less will they be attracted to Block's supporting proposal—that governments introduce taxes on a trial basis so academics can conduct "quasi-experiments" to gather "real world evidence" on whether they work.[2] There are less risky ways to raise the price of sugar.[3]

Both articles combine methodological sophistication with political naiveté. Unlike model makers, policy makers will not find soft drinks taxes "promising," but impotent and improbable.

The new interest in price instruments has concentrated on raising the cost of "bad" foods. But taxes will not work.[4] We need instruments that lower the prices of "good" foods.[5]

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Full response at: www.bmj.com/content/347/bmj.f6189/rr/669996.

1 Briggs ADM, Mytton OT, Kehlbacher A, Scarborough P. Overall and income specific effect on prevalence of overweight and obesity of 20% sugar sweetened drink tax in UK: econometric and comparative risk assessment modelling study. *BMJ* 2013;347:f6189. (31 October.)
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5 Winkler J. Brutal pragmatism on food. *BMJ* 2013;346:f3728.

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Too bitter to swallow?

Briggs and colleagues' study is a useful addition to the evidence on the potential health impact of taxes on sugar sweetened drinks.[1] But to convince policy makers of the effectiveness of such taxes we urgently need experimental studies that allow stronger causal inference than modelled projections based on historic consumption data. Furthermore, non-economic determinants of food consumption such as taste, preference, and environmental cues have been largely overlooked. These taxes target people who may not find them acceptable and without support from voters, policy actions are less likely. The modest modelled effects of such taxes may not be sufficient to convince policy makers or the wider public of their value.

We need to reflect on the bigger picture of food policies and gain a better understanding of the food industry's behaviour. For example, a 36% reduction in the reference price of sugar over 2006-10, owing to EU reforms, was associated with a 1.7-6.5% decrease in the price of sugary drinks in France.[2] The Department for Environment, Food and Rural Affairs estimates that upcoming European Common Agricultural Policy reforms will decrease the price of sugar by 20-35%.[3] How much of this reduction will be transmitted to consumers, and how much of any taxes on sugary drinks will the food industry be able to absorb and not pass on to consumers? There is a clear contradiction here between the potential effects of economic and health policies.

We do not want to imply that there is no place for taxes on sugary drinks. Theoretically they could reduce obesity, albeit by only a little. They may have a cumulative effect over time, but probably only if the message that accompanies them convinces people of real health benefits.

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DO WE NEED GPs?

Diabetes UK defends its type 2 diabetes awareness campaign

Spence describes Diabetes UK's type 2 diabetes awareness campaign as "hysterical, tear stained, and intellectual schmaltz" and suggests that we did not consider "the harm it might do."[1]

This is unfair. Spence may not like the advertisements and may think they play on fear. But the problem is that people do not understand how serious type 2 diabetes is, why people at high risk must try to prevent it, or why those who already have it need to be diagnosed.

We needed strong imagery to try to deal with this, and our decision to use this imagery was not taken lightly. The campaign was developed through focus groups of people with type 2 diabetes. They told us that highlighting the condition's emotional impact on families is the best way to make people think seriously about their own risk. We then tested this approach in quantitative market research, and the results clearly showed that this was the approach that most resonated.

Above all, the campaign worked. Public understanding of the seriousness of type 2 diabetes increased immensely. Most importantly, more than 30 000 people carried out an online risk assessment, and many others had their risk assessed at pharmacies and GP surgeries.

The campaign can make a real difference by identifying people at high risk, who can then start to make the healthy lifestyle changes that will help prevent the disease. It will also identify some of the estimated 850 000 people with undiagnosed type 2 diabetes and improve their chances of good health outcomes by ensuring they get the support and drugs that they need to manage their condition effectively.

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1 Spence D. Do we need GPs? *BMJ* 2013;347:f6589. (1 November.)

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