**Migrant health charges: a scandal amidst the crisis**

This editorial highlights some of the public health hazards implicit within the government's treatment of migrants and locates these within a wider frame of mental health. In the midst of a pandemic threatening countless lives and a belated lockdown inducing widespread mental stress, the Government continues to pursue a Hostile Environment policy. This involves various legislative and administrative measures aimed at making it as difficult as possible for people without full rights to remain in the UK to actually stay in the country. One aspect of this involves charging migrants for treatment and reporting debt to the Home Office, undermining public health objectives and community solidarity. Anyone can be infected, so everyone must feel confident to use the NHS, and participate in eventual contact tracing to control COVID-19.

Against the backdrop of global health, social care and other workers' heroic struggles against the COVID-19 pandemic, within shamefully ill-prepared systems hobbled from the outset by some nakedly partisan, ideological and downright stupid government decisions and lies, is hidden a scandal of tragic and existential proportions. As the majority of citizens strive through lockdown and social distancing to create an environment inimical to the spread of this deadly disease, the original *hostile environment* immigration policy works against key public health objectives and poses fundamental questions for our democracy and our very identity as citizens upholding it. When one group of fellow human beings, indeed a group much in need of compassion and support, is so severely cast as 'other'; when they are rendered outsider to our most strongly held values and norms; effectively excluded from the systems of health and welfare of which we are rightly most proud – just who do we think <u>we</u> are?

We are living through a crisis at one and the same time replete with mental health as well as the more obvious physical health concerns. Migrant mental health is an important issue, with substantial threats to wellbeing posed by the circumstances which precipitate migration (including war, persecution, extreme poverty, natural disasters), the risky and often drawn-out process of migration itself, and the intimidating and discriminatory reception that many immigrants experience in their new 'homelands'. The hostility has been stoked in a number of western nations; a paradigm case being the UK government's *hostile environment* policy, announced by Home Secretary Theresa May in 2012, although Labour had already used the phrase in a consultation document in 2007.

Politicians and their media allies exacerbate this by tapping into and spreading xenophobic and racist stereotypical representations of migrants as a drain on local resources, depicting them as human swarms poised to swamp public institutions which thus require protecting for the use of an indigenous population fired up to mistrust, demonise and scapegoat incomers and outsiders as 'the other'.

All of this mistaken and misguided misrepresentation ignores evidence of the positive contribution migrants make to communities, economies and public services. Indeed, the NHS that the public holds so dear, and our bulwark against COVID-19 and its potential aftermath, would not exist without the contributions of waves of migrant labour. It is perhaps the ultimate irony of this present emergency that migrant workers or those of migrant heritage, having built the NHS and sustained it from its inception, are now fighting and, for some, dying in the front line of defence against COVID-19. The two nurses most prominently associated with the recent intensive care of Boris Johnson are respectively from New Zealand and Portugal.

At this point in time, disproportionate numbers of the NHS staff who we know have sadly died of COVID-19 are of immigrant heritage or are migrant workers. Official statistics have been criticised for failing to refer to ethnicity but independent analyses make sobering reading. The Intensive Care National Audit and Research Centre (2020) report for April 17th, showed 34% of all critically ill patients with COVID-19 were identified as identified as black, Asian or minority ethnic. Even higher proportionality for NHS workers is evident: with 63% of deceased nurses, 64% of deceased support workers, and 95% of deceased doctors being BAME as of April 22nd (Cook et al. 2020). Even now, asylum seekers with valuable nursing, medical and other qualifications are legally excluded from the workforce under inflexible rules that are a further impediment to an intelligent response to this crisis and longer-term deficits in the NHS workforce (Mayblin et al. 2020).

The hostile environment gave us the disgrace of Windrush generation deportations and exclusions from health care rights; a scandalous targeting of the original migrant facilitators of our welfare state and post-war economic growth. And now we have escalating migrant health charges, which are antithetical to our universalist, free-at-the-point-of-need health service and threaten to turn health care workers into policers of entitlement, refusers of care, and enablers of incarceration and deportation. The charges have been around in law since 1977 at least, but only really implemented

since 2015, with upfront charges since 2017. In the middle of a pandemic, hostile environment policies such as health charges make even less sense. Indeed, from a public health perspective they are profoundly absurd, with particular concerns regarding vulnerable groups such as the disabled, people with mental health difficulties and in relation to maternal and child health (see Murphy et al. 2020). Thus, even if there is an immediate promise that people will not be charged for treatment of COVID-19, there is a huge disincentive to seek treatment given the mistrust and exclusions that are already established within the hostile environment. Moreover, if testing proves COVID-19 is not the cause of a person's health problems, they may then be caught up in the previous traps of lack of entitlement, charging and reporting to immigration authorities. All of this amounts to a clear and present hazard to the health of migrants, and with regard to COVID, to wider public health. The World Health Organisation has urged the UK to implement comprehensive contact tracing, which government now says will be restarted after being stopped in early March. This, however, will require the involvement and co-operation of everyone at risk. A cross-sectional alliance of health care workers, communities and representative organisations has begun a local campaign in Liverpool to end the hostile environment as a means of fighting the pandemic with an open letter to Merseyside NHS Trusts and an online petition (Avaaz 2020). At a national level campaigning against migrant health charges has the support of the trade union Unison, professional bodies such as the BMA, campaigning groups such as Doctors of the World and a letter to Government coordinated by MPs Apsana Begum, Bell Ribeiro-Addy, and Zarah Sultana has been signed by 60 cross party MPs (Bulman 2020).

The wholesale denigration and adverse treatment of migrants within a hostile environment is obviously detrimental to their health and wellbeing, with particularly savage impact on the mental health of previously traumatised individuals. The discourse around migration that breathes life into the hostile environment is reflexively poisonous and dehumanising. As such, the hostile environment makes a mockery of professional ideals of person-centredness, recovery and trauma informed care. Not to recognise this is a particularly cruel professional delusion. As we know, mental health care already has a chequered history in its relationship to race and ethnicity, with extant and enduring exclusions and anomalies in care provision (Fernando 2014). Moreover, the iniquities of othering extend to considerations of mental distress itself, with service users of mental health care amongst the most stigmatised and socially excluded groups in society. Indeed, aspects of such exclusion have been linked to wider public fear of madness and the mentally distressed, not dissimilar to anxieties regarding contagion (Jodelet 1991).

A process of othering may offer some short-term gains in self-worth for the in-group, but, ultimately, it demeans us all. To be on the perpetrator side of the othering divide is corrosive of our very humanity, eating away at that aspect of ourselves concerned with active, benevolent regard for others. Denial of this dimension of our being by leaving unchallenged discriminatory and stigmatising policies such as the hostile environment, and the noxious rhetoric that sustains it, is thus harmful for all concerned.

We can get out of these traps, overturn the hostile environment, and imagine a more inclusive, relational society (Haigh & Benefield 2019). Indeed, the logical shortcomings of a hostile environment are fatally exposed in the ironies and paradoxes of the COVID-19 crisis. The failings of neoliberalism at large are apparent in the turn to wholesale state, public and community responses and intervention on the part of politicians previously beholden to the assumed virtues of the market and privatisation. As mental health nurses we also possess knowledge and skills relevant to forging wider social change. These can help us to better relate to our global and local sisters and brothers, and it is worth noting a true spirit of cooperation, community solidarity and appreciation for each other taking hold amidst all the social distancing. Making a virtue of the relational, various commentators on mental health have noted the latter-day importance of Axel Honneth's notion of recognition (P. Fisher 2008, Rashed 2019) and the value of dialogue and democracy both for improving care and transforming society. Notably, Danny Taggart (2008), draws on the philosopher Emmanuel Levinas to make a case for trauma informed mental health care to commence with a responsibility to 'the other'.

So, when we ask, 'who do we think we are?', let us all be in a position to answer, paraphrasing Sivanandan (2002): we are they, they are us; who we are is what we do. Let us do the right thing and stand up as healthcare workers, against the hostile environment, as our comrades stand so valiantly against COVID-19.

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