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Race, Immigration and Health:

The Hostile Environment and Public Health Responses to Covid-19

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ABSTRACT

This paper examines the impact of governmental management of the pandemic on the morbidity and mortality of migrants, gendered and racialised groups by focussing on the relation of its public health message campaign to accommodation, health and survival. The Hostile Environment immigration policies have restricted the ability of these groups to adhere to Government's public health guidelines, increasing risks of their contracting coronavirus. These policies exacerbate existing health inequalities in intersectional ways. The Covid virus, in its socially reproductive capacity, can thus be understood as a biological descriptor for a political crisis of intersectional inequality in the politics of health.

KEYWORDS: Covid-19; Hostile Environment; health inequalities, public health; migrants; asylum seekers; gendered and racialised minorities

Introduction

Dispelling the public "myth" that coronavirus is the great equaliser, growing evidence points to the disproportionate impacts of Covid-19 on the health, survival and livelihoods of ethnic, migrant and marginalised communities (Atchison et al. 2020; Platt and Warwick 2020; Rosenthal et al 2020). Whereas these racialised direct impacts are rightly considered, the indirect consequences of the government's response to the pandemic on racialised and gendered individuals have received less attention (Devakumar et al. 2020). The government's management of its Covid-

response can also be discriminatory: unequal distribution of resources determines not only who is at greater risk of contracting or dying from the virus but also the ability of individuals to follow the recommendations to control the pandemic (Van Bavel et al. 2020). This paper argues that Covid-19 has not only directly impacted on the morbidity and mortality of migrant and ethnic communities in the UK, but also disproportionally prejudiced their ability to adhere to the Government's public health guidelines, thus putting them doubly at increased risk from coronavirus than the general population. This amounts to a form of structural violence (Devakumar et al. 2020).

The detrimental outcomes of the pandemic, and its management, are experienced differently along intersectional lines of class, gender, ethnicity and generation (Bhala et al. 2020; Paton et al. 2020). These intersectional lines are intertwined and are given presence, force and shape by past intersectional histories of discrimination. Similarly to the ways in which during the pandemic the "vulnerable", the "at risk" patients and the elderly occupy an ambiguous place in social and medical hierarchies (Moore 2020), the position of gendered and racialised individuals and communities relates to complex histories whose place in social and medical hierarchies at the time of the pandemic is intricate and ambiguous. In addition to its biomedical properties, Covid must thus be understood as a profoundly social and political pathogen (Fagan 2020). This paper shows that in addition to the literal reproductive capacity of the virus, which is biological, the virus has a secondary repetition, which is social: it reproduces and amplifies the scale and intensity of existing structural and intersectional inequalities in public health, thus differentially impacting the most vulnerable groups. The pathogen must therefore also be understood as a biological descriptor for a political crisis of intersectional inequalities in the politics of health, in which a constellation of agencies of liberal society generate relations of multi-faceted hosting through which the virus registers its effects differentially. Thusly understood, the force and effect of the pathogen is intersectional with reference to categories of migration, race and gender. Not only the virus but also the Government's response to the pandemic is likely to increase existing socio-economic differences and to intensify racial and ethnic discrimination that exacerbate health inequalities (Chouhan and Nazroo 2020). This is because the same living and working conditions experienced by members of ethnic and racial minorities that lead to chronic ill health are the same ones that persist to make it difficult for these individuals to protect themselves from the virus (Meer at al. 2020). This is particularly significant for migrants, asylum seekers and racialised non-citizens who are subjected to the Government's Hostile Environment immigration policies.

The Hostile Environment and public health responses to Covid-19

Recent changes in UK immigration policy have created an intentionally "hostile environment" for irregular migrants. The impact of this environment has spilled into other categories of non-citizens. The 2014 and 2016 Immigration Acts have restricted access to housing, healthcare, banking and legal representation, limited access to services, facilities and employment by reference to immigration status, and increased penalties for unauthorised working (Lewis, Waite and Hodkinson 2018; Targarona and Donà 2021). These punitive measures, aimed at irregular migrants, have negatively impacted upon other categories of migrants, such as individuals in the asylum system and migrants with precarious status (Meier and Doná, 2021). They have also affected long-term residents, most notably the Windrush generation of Caribbean migrants who arrived in the UK between 1948 and 1973. As Commonwealth citizens, these migrants have the right to indefinitely reside and work in the UK. However, hundreds of them have been wrongly placed in detention centres, deported to countries that many left as children, and denied legal rights to remain or return to the UK (de Noronha 2019). New restrictions for European citizens were introduced in November 2020, when the Immigration and Social Security Co-ordination (EU Withdrawal) Act was passed into law. The Act has ended free movement for European migrants and paved the way for the government's new Points-Based Immigration System.

The Hostile Environment has become an explicit immigration strategy of the UK Conservative government since it took power in 2010. It has become a major "governmental technology in the control and disciplining of diversity and discourses on migrants and racialised minorities" (SSAHE 2020, 1). However this approach marks a rhetorical rather than qualitative shift away from anti-immigrant policies of previous governments (Weisz 2018) that have longer histories than the Coalition/Conservative governments (SSAHE 2020). Racism is implicit in UK immigration policies, which disproportionately impact people of colour (Goodfellow 2018).

Covid has exposed the ways in which the Hostile Environment interacts with the pandemic and its management to exacerbate existing health inequalities for racialised, gendered and citizenship-based categories. Individuals in the asylum system, migrants with insecure immigration status and residents without the "right" papers suffer not only the direct impacts of Covid-19 on their health, lives and livelihoods (Mleya 2020) but also see that opportunities to access health services, availability of information and eligibility for welfare support are restricted by immigration status (Rosenthal et al. 2020). Additionally, their ability to adhere to

the public health guidelines implemented by the Government to respond to the pandemic are constrained (Meer at al. 2020; Paton et al. 2020). Thus, the UK Government's Hostile Environment immigration policies serve as a means of further diminishing health equalities for racialised, gendered and non-citizens' groups at the time of the pandemic. These increased health inequalities are detrimental not only to the well being of racialised migrants and minorities but also to a broader national public health agenda for recovering from Covid-19.

On March 23, 2020, Prime Minister Boris Johnson announced a new set of guidelines to delay the Covid pandemic. Lockdown was introduced, requiring the public to stay at home except for absolutely necessary trips to buy food or medicine, to go to work or exercise. The government's announcement was captured by the slogan "STAY HOME – PROTECT THE NHS – SAVE LIVES". Yet, this message presumes that accommodation is safe for all, admission to health services is accessible and free at point of use, and that all residents in the country can follow the guidelines to reduce mortality rates. On May 10, 2020, the message changed to the more ambiguous "STAY ALERT – CONTROL THE VIRUS – SAVE LIVES", in line with the easing of the lockdown. While the content of this message is partially new it also relies on continuities with the rules of lockdown, including social distancing and self-isolation, to avoid the recurrence of another spike. Since the easing of restrictions in June and July, local actions were put in place to contain the spread of the virus where infection rates were high. On October 14, the Government announced a 3-tier system, which saw areas with the highest number of cases being placed in tier three and subjected to the tightest measures. On November 5, a second national lockdown was announced that lasted till December 2 when it was followed by the return of a tiered system of restrictions, and the new message 'wash HANDS, wear a MASK, and keep social DISTANCE'. As the vaccination program got underway, with the first vaccination taking place on December 8, a new and more easily transmissible variant of the virus was identified as the cause of the sharp rising of infections in the latter part of 2020. This discovery led the Government to put into place a third national lockdown on January 6 2021. This measure also saw the re-introduction of the previous STAY HOME – PROTECT THE NHS – SAVE LIVES slogan.

Focussing on the government's key public health message "STAY HOME-PROTECT THE NHS-SAVE LIVES", and to a lesser extent on ensuing related communication messages, this piece examines the impact of the Hostile Environment on compliance with public health guidelines in three areas - accommodation, health, and survival. These interrelated spheres are chosen because they are at the core of the

government's public health call to stay home during lockdown, to maintain hygiene to protect the NHS and to maintain social distance and other measures to save lives. An overview of these intersections show the pervasive impacts of the Hostile Environment on the ability of racialised and gendered individuals to adhere to public health guidelines during the pandemic that highlight the relationship between race, immigration and health inequalities.

"STAY HOME": Accommodation

The government's guideline to "STAY HOME" is predicated on a number of assumptions: that home is a safe space for all, that individuals residing in the UK have a home to stay in, and that the public has autonomy in the decision to stay home. The Institute for Race Relations published a report in which it criticises the dreadfully overcrowded and unhygienic housing that is provided to asylum seeking families and their children, which increases their risk of contracting Covid-19 (Institute for Race Relations 2020). Asylum seekers who reside in temporary accommodation have to share their spaces with strangers during lockdown, and its easing, in breach of strict measures to contain coronavirus. Speaking on Radio 4's Today programme about the accommodation he has been staying in for the past four months, where people share rooms with two or even three others, John says: "This is risky. In this Covid 19 pandemic my life is at risk. I cannot control their movements. I might bring the infection to them, they might bring it to me. We are very scared. Every day we have new people coming. From where we do not know."(BBC 2020) Similarly, individuals subjected to the Hostile Environment in asylum detentions, which have been identified as likely hotspots for spikes following the easing of the lockdown, continue to share their cells with strangers in overcrowded conditions, where they have limited agency on preventing infections, placing everyone there at risk (Gardner 2020).

The government asks individuals exhibiting symptoms and those who have had contact with infected individuals, to self-isolate. The Test, Track and Trace programme relies on individuals, even those with no symptoms, to self-isolate for between ten and fourteen days. While asylum seekers and other migrants in precarious conditions are willing to follow the guidelines, self-isolation and social distancing are unfeasible in over-crowded accommodation shared with strangers.

The gendered impacts of the coronavirus pandemic are ongoing and crises exacerbate pre-existing gender inequalities. Domestic violence in the home has worsened during lockdown (Norris 2020). Yet, for women whose immigration status is linked to that of their partner, the likelihood of leaving an unsafe home is further

restricted because of the additional fear of putting their immigration status at risk due to Hostile Environment policies. Asylum-seeking women fleeing domestic abuse are also blocked from accessing help when services are in lockdown (Norris 2020), and fear for their safety in over-crowded refuges for asylum seeking-women (Mleya 2020a).

Children who entered the country as unaccompanied minors and those in refugee families are entitled to formal education, which during lockdown has become "home schooling". Unsuitable accommodation and limited access to technology (internet access is not provided in temporary accommodation), together with language barriers and other challenges regularly faced by newcomers, constitute significant obstacles to "home schooling" as well as children's engagements with blended learning platforms in the foreseeable future (Nanton 2020).

Migrants with no recourse to public funds, asylum seekers living below the poverty level, and those with precarious status are at high risk of being or becoming destitute as a result of the Hostile Environment. A situational analysis conducted by Refugee Action with forty organisations indicates that a key challenge faced by people seeking asylum, refugees and other migrants during lockdown is destitution, as "many city centre hotels have refused to support asylum seekers or homeless. They'd rather close and receive government support" (Refugee Action 2020). Refugee Action's partners continue to encounter problems, and they call attention to areas of real concern for increased risks of rough sleeping, which they attribute to recurrent delays in the legal system, on-going changes of rules and constant uncertainty around immigration status. These migrants, who are already in extremely vulnerable circumstances, are unlikely to be able to follow the government's advice to "stay at home". To not be able to stay in a regular place during lockdown, and its easing, has public health consequences for all.

On Thursday evenings during the first lockdown, the public clapped to celebrate the front line staff in the health and care services. Many of the new sung and unsung heroes in the health, social care, public transport, delivery and other sectors, who kept the economy going during lockdown and continue to do so, are migrants or come from migrant backgrounds (Bhala et al. 2020). For Fagan (2020) the "opportunity to work from home is, one might say, a particular privilege which Covid-19 has underlined. Many others, of course, do not enjoy this privilege" (p. 154). Covid has made visible the existence of societal and structural inequalities that have existed in the country for a long time. Not only do these racialised and gendered migrants risk their lives every day when using public transport and working in unsafe environments, but their efforts to follow public health guidelines

are hindered when social distancing is not practiced and protective equipment is not available (Thomas 2020).

Migrants such as domestic workers, outsourced cleaners and security guards, who are in low-paid and insecure jobs, are not in a position to refuse to do non-essential work for fear of losing their jobs and those employed in the gig economy have no sick pay (Mason and Booth 2020), while migrants working in the undocumented sector where many are subjected to modern day slavery conditions cannot afford to "stay home". These gendered and racialised migrants have no rights, including the right to "home", and they do not have the autonomy to follow the guideline to "STAY HOME".

The transition from the "STAY HOME" message to the more ambiguous "STAY ALERT" message is equally problematic for migrants with insecure status and those in the asylum system. For the reasons outlined above, Hostile Environment regulations force migrants to maintain a heightened sense of awareness – to stay extra "alert" while thwarting their rights to levels of protection experienced by the rest of the population and constraining migrants' ability to follow the guidelines like the general public.

"PROTECT THE NHS" – Access to Health

During the pandemic, the general public was reminded of its responsibility to follow the message, "PROTECT THE NHS". However, this message has different meanings and implications for individuals subjected to Hostile Environment practices. The Hostile Environment policy creates barriers to accessing the health service, such as the data sharing of a patient's non-clinical information from the NHS to the Home Office (Hiam et al. 2018). Another Hostile Environment policy that the government introduced in 2018 is the NHS charge, whereby non-EU patients are made to pay fifty per cent more than it costs the NHS to treat them and hospital staff are required to demand proof of entitlement to free healthcare (Bulman 2020a). Defaulting on the payment of bills has serious consequences for migrants and asylum seekers, who can be reported to the Home Office and have their application for settled status rejected due to non-payment. The system of immigration enforcement, which continued during the pandemic, threatens migrants' ability to remain in the country and thus actively discourages them from seeking healthcare (Puntis 2020). Such hostile environment measures undermine the government's response to the pandemic in different ways: they not only have a detrimental effect on the health, welfare and wellbeing of migrants but they also undermine the

ethical standards and professional responsibilities of health staff and negatively impact on the national health system more generally (Mahrasingam 2020).

The government has attempted to adapt the immigration system to the realities of the Covid emergency. However, these concessions are conditional. It has made testing for Covid-19 exempt from charges usually payable by migrants for using the NHS, but it maintains charges for other health conditions. The Home Office has scrapped the surcharge for health professionals but not for others. Similarly, it automatically renews the visas of doctors and nurses for a year but other stuff whose visa expire, including those occupying essential roles, are not given extensions. These conditional changes not only reproduce existing inequalities but reinforce downward equality, lifting restrictions for some groups but not others.

Personal hygiene is another core element of the campaign to protect the NHS. A key public health message during the easing of the second lockdown was to 'WASH HANDS'. Yet, soaps and sanitisers are not made available for many migrants in vulnerable circumstances. For example, these essential items are not automatically provided to individuals in immigration detention facilities, who must purchase them using vouchers earned by working under exploitative conditions. The same applies to the wearing of masks and face coverings that were made compulsory in shops and other public places in England on 24 July with £100 fines for non-compliance (Sparrow 2020). The wearing of masks has become central to the public health communication strategy during the second lockdown. Yet, people in the asylum system who live on £5.39 per day, a rate that is below the national poverty level, cannot afford the costs of these extra items, creating a "support gap" (Bulman 2020b) that disadvantages them in their ability to adhere to public health guidelines.

The pandemic and the government's response to the crisis are taking a toll on the mental health of the nation. Mental health charities have seen a spike in the number of requests for support since the lockdown (BBC 2020). Many individuals seeking asylum have experienced war and displacement, and have been exposed to multiple losses. In the UK they face loneliness, concerns about the status of their application process and ongoing worries about their survival (Donà 2010). Anxieties caused by the Hostile Environment towards non-citizens are exacerbated by the impossibility to follow government's guidelines such as social distancing and self-isolation. According to Refugee Action, mental health is a key issue, and "there are real issues for people in Houses of Multiple Occupancy. If others don't observe the rules, it creates tensions." (Refugee Action 2020).

The Hostile Environment has fostered a milieu in which migrants wishing to follow public health guidelines to protect the NHS are subjected to exclusionary policies. The government's change of message, from "PROTECT THE NHS" to "CONTROL THE VIRUS", is perplexing. A major impact of the Hostile Environment rests in its restriction of individual autonomy. To control an invisible parasite may not resonate closely with those subjected to stringent regulatory requirements and punitive monitoring mechanisms that constrain their ability to have control over their lives.

While waiting for the vaccine, the country relies on widespread testing, contact and tracing to reduce the impact of the second wave of Covid-19. For this programme to be viable, all sections of the population must be willing to be contacted by the NHS or public health staff (Dropkin 2020). Dodds et al. (2020)'s detailed investigation among black Africans and community health professionals has uncovered mistrust of self-sampling technologies. Historic and contemporary discrimination and racial inequality are generally associated with distrust in social institutions, including the healthcare system (Vand Bavel et al. 2020). Members of these communities are likely to be wary about the public health information they receive, less able to understand the messages because of language proficiency and less willing to adopt recommendations. As new treatments are developed and vaccines are rolled out, there is a need to collect information on ethnic minorities, who are usually inadequately represented in clinical trials and longitudinal health cohort investigations (Bentley 2020). Inclusive policies that guarantee equal access for everyone to the care system, including to testing, new therapies and vaccines are vital for the welfare of the population as a whole.

"SAVE LIVES" – Mortality

As of January 2021, the UK death toll has risen to almost 90,000, the highest number of confirmed coronavirus fatalities in Europe and one of the highest in the world (Johns Hopkins University 2021). The government's policies and public health guidelines put in place to respond to the pandemic have all increased the risk of poor health and the gravity of the illness for migrants and black, Asian and minority ethnic people (Devakumar et al. 2020). Increased mortality risks are linked not only to intersectional variables such as race, poverty and immigration status but equally important housing conditions, ability to access health care and to survive below poverty levels, all of which are seriously constrained by the Hostile Environment. The Trussell Trust, which coordinates a network of food banks, has documented an 89 per cent rise in the number of deliveries of emergency food parcels and a 107 per cent increase in parcels donated to children since the inception of the pandemic (Sandhu 2020). Individuals living below the poverty level in the asylum system, migrants with no recourse to public funds, and those heavily reliant on welfare

support are at higher risk of coronavirus-related food starvation than the general population. This of course has implications on their ability to contribute to the government's message to "SAVE LIVES", when their own lives are at risk.

The intersectionality of gender, class and occupations is a risk factor in mortality rates, with males working in low paid occupations being at higher risk of losing their lives due to Covid-19 (Aljazeera 2020). Migrants with insecure status and those working in the undocumented sector are disproportionally represented in low paid occupations and have limited rights and protections. Migrants, especially those without documents, are also less likely to report symptoms, go to the hospital, seek help, or may seek help later, with the onset of more advanced disease (Devakumar et al. 2020), putting them at higher risk of getting ill and dying of Covid-19 and non Covid-19 illnesses.

As the UK continues to fluctuate between total and partial lockdowns, it is even more vital for the population to continue to follow public heath guidelines in order to "SAVE LIVES", the third component of the government's slogan. It is then fitting to ask whose lives the government has in mind when urging the nation to "SAVE LIVES" while its Hostile Environment policies are responsible for destroying lives and constraining asylum seekers' and migrants' ability to follow public health guidelines. As one migrant said: "While I've tried to follow government guidance, the asylum system isn't set up to protect our health" (Mleya 2020). One could argue, by extension, that government guidance isn't set up to save migrant, gendered and racialised lives. While charities and activists have longed called for the Hostile Environment policies to be scrapped, this imperative is even more relevant to the government's strategy to "SAVE LIVES" during and after the pandemic. This is important not only for racialised migrants and minorities but also for a broader national public health agenda for recovering from Covid.

Conclusion

Covid is not just a viral disease but also a social and political pathogen in the politics of health. Most researchers examine the direct effects of Covid on the morbidity and mortality of migrants and racialised groups. This paper focused on the indirect impact of governmental management of the pandemic through an analysis of the Hostile Environment, and the ways in which immigration policies have restricted the ability of racialised, gendered and citizenship-based categories to adhere to the Government's public health guidelines. The analysis of

accommodation, health and survival unravelled the interactions between race and migration, and governance and public health by showing that the Covid virus, in its social reproductive capacity, can be understood as a biological descriptor for a political crisis of intersectional inequality.

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