

## **Whose space is it anyway? The architecture of social exclusion and why it is bad for the public's health.**

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### **Abstract**

Over the past decade there has been a significant upsurge in nationalist politics and sentiment in both Europe and the USA. Ideas of nationhood and sovereignty have become dominant themes within political discourse, and there has been a rise in the popularity of right wing parties that espouse strict immigration control. In the UK, the concept of 'health tourism' has become an issue in relation to the underfunded National Health Service (NHS), with legislation being passed in 2017 with the aim of charging people who were defined as ineligible to use health services. This Act has already begun to have a negative impact on the health of the most vulnerable people in our society, not least undocumented migrants, rough sleepers, and others with insecure status. Many people in these groups are fearful of accessing health services because they cannot afford the upfront treatment charges, while others are deterred because they believe that their contact details will be passed to the UK Border Agency. Public health implications include missed prevention and early stage disease treatment, untreated infectious diseases, reduction in screening and vaccination coverage and an increase in health inequalities.

The 2016 presidential election in the USA, and the UK referendum on EU membership, in the same year, both focused on taking direct action against inward migration, which was characterised as having an adverse effect on the economies, infrastructures, social values and health status of both countries. While Mexicans and Muslims were targeted in the USA, in the UK blame was directed at the free movement of EU citizens, especially those from eastern European countries such as Poland, Romania, Bulgaria and the Baltic states. Autochthonous populations (predominantly white and Christian) have become increasingly vocal in their rhetoric of fear: migrants taking your jobs, Muslims threatening your culture and security, political correctness restricting your liberty to speak your mind, migrants importing diseases and, in the UK, the "deliberate attempt to water down the British identity" (UKIP, 2010) have all contributed to the creation of a hostile environment towards 'others' and 'otherness'. This paper will look at the role of populist politics and contemporary architecture in assisting the demonization of the homeless and migrant populations, and will use the endemic levels of tuberculosis in the UK's capital city, London, to exemplify the consequences for public health and the health of the public.

**Key words:** Public health, migrants, hostile environment, tuberculosis

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## **Introduction**

Recent elections show a political sharp turn to the right in North America, Europe, Australia, and the UK. Analysis of the 2016 Brexit vote in the UK shows that ideas of 'uncontrolled' immigration from the EU in the form of freedom of movement was a dominant reason for voting to leave the EU, with 'taking back control of our borders', and regaining national 'sovereignty' well up the agenda (Chu, 2017). Older voters were more inclined to vote to leave the EU, and this has been attributed to a reconstruction or re-emphasis of British identity and values, with much mention of the Second World War. In addition, the Leave campaign claimed that if the UK remained in the EU, 88 million Turks would flood into Britain, thus reawakening a barely nascent fear of 'otherness'. Donald Trump ran a similar campaign in the 2016 American Presidential election with his emphasis on 'put America first', and make America 'great again', whilst demonising Mexicans and Muslims.

Official government figures for England show that there has been a 51% increase in the number of people sleeping rough in the last two years and a rise of 134% since 2010 (Gov.UK, 2017). Two UK charities, Crisis and the Joseph Rowntree Foundation (JRF), report that UK homeless numbers have increased by a third in the last five years (Crisis 2017; JRF, 2018). The politics of austerity and benefit sanctions are cited as a major reason: 'in this context of depressed wages and soaring living costs, reduced services and lack of housing, we are facing a humanitarian disaster. The Red Cross is involved in food aid in the UK for the first time since the Second World War'. London, as a region, has the highest percentage of rough sleepers: between 2015-2016 there has been an increase in rough sleeping in London of 16% (Homeless Link, 2015). However, as the Chief Executive of Crisis has pointed out, 'behind these statistics are thousands of desperate people, sleeping in doorways, bin shelters, stations and parks – anywhere they can find to stay safe and escape the elements' (Crisis Newsletter, 2017). Although anyone can become homeless, certain groups are more likely to find themselves with nowhere safe to live, notably single men and recent migrants, especially those from conflict zones. A recent report disclosed that 50% of the increase in rough sleepers was due to greater numbers of migrants becoming homeless (O'Neill, 2017). Levels of homelessness reflect social inequalities including shortened life expectancy, higher use of emergency services, and general levels of deprivation, which in turn create social problems and diminish social capital.

### ***Inverse care and social inequalities***

In 1971, the Welsh GP Julian Tudor Hart described his 'inverse care law' in an article in *The Lancet*, which proposed that those most in need of health and social care tend to have least access to it. Wilkinson (2010) and Marmot (2013) have posited that there is a social gradient in health in the UK, whereby the lower a person's social position, the worse his or her health and life expectancy. They propose that health inequalities result from social inequalities, and that this requires action across all the social determinants of health. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently, whereas reducing the steepness of the social gradient will, and thus benefit society socially and economically (Marmot, 2013.) Socially, the cost of health inequalities can be measured in human terms, years of life lost and years of active life lost; and in economic terms, by the cost to the economy of additional illness and high levels of demand on emergency services.

In the UK in 2018, homelessness is once again on the political agenda. The Homelessness Reduction Act (2017) now places a duty on local authorities to intervene before households and individuals become homeless, while during the 2017 election campaign, British Prime Minister Theresa May promised that her party will "support the most ambitious councils" and housing associations to overturn the decline in social housing if she was re-elected (Harley,

2017). There are currently 300,000 fewer homes for social rent than 20 years ago and around 1.2 million families on local authority waiting lists for a social tenancy, as the ability for local authorities to build housing has declined (Harley, 2017). However, anti-homelessness initiatives only apply to those who are eligible for local authority support, while local authorities can only provide support to a limited number of 'priority' cases because of scarce resources. There remains a whole swathe of rough sleepers who have sunk beneath the radar and do not qualify for help as they are deemed not in 'priority need', despite sleeping rough. Crisis Chief executive Jon Sparkes describes these people as at risk of being "hidden from help and trapped in horrifying situations" (Crisis, 2017).

Rough sleeping is the most visible manifestation of homelessness, but evidence from various reports suggests that a significant proportion remain invisible and uncounted. Irregular migrants, for example, are rarely included in population censuses, which remain the main statistical source of information about the UK Population. All forms of hidden homelessness offer extremely insecure, vulnerable and precarious accommodation. While entitlement to welfare benefits is one key to accessing temporary housing, those ineligible for benefits - including many EU 'A8' nationals (from the newer, eastern European EU member states), some other foreign nationals, failed asylum seekers, young, single people under the age of 18 and those with no recourse to public funds (NRPF), especially visa over stayers and failed asylum seekers are the 'hidden' in hidden homelessness, out of sight from support, advice and official statistics, and fearful of accessing health services.

### **Health risks of homelessness**

Research shows that failed asylum seekers, undocumented migrants and other members of the homeless population have diverse and additional health needs to host populations (BMA, 2002) but tend only to access health services such as A&E when need becomes urgent. This has significant implications for health protection; despite exemptions for charging for many infectious diseases the NHS charging regulations mean that there is a genuine risk of undertreating and underdiagnosing infectious disease, which in turn will present a risk to the general population (FPH, 2018). In a 2017 report, the WHO announced that tuberculosis (TB) remains the greatest infectious disease killer and that progress [towards eradication] in most countries is stalling or is not fast enough to reach the global "End TB" targets. A Comment column in *The Lancet Global Health* (2107) stated that currently there is a 'dearth of innovative approaches that enable reaching the high-risk groups and susceptible populations...[and] there is no truly multisectoral tuberculosis response, which is essential to address the drivers and determinants of the epidemic' (Brooks-Pollack, 2017, e361). TB remains a public health issue throughout the world and requires a wide range of resources to be mobilised and financed in order to combat not just the disease, but simultaneously the parallel health-related and other conditions which sustain it.

In the UK, TB remains obstinately embedded in large urban areas. London is known as the TB capital of western Europe: parts of London have higher rates than Iraq or Rwanda (London Assembly Health Committee, 2015). Prevention is poor, and drug resistant TB is becoming more common with expensive, complicated and gruelling treatment regimens lasting for up to 2 years and costing more than £500,000 per patient. In the years immediately after the Second World War, the UK Department of Health and the newly formed NHS formed the Mass Miniature Radiography (MMR) programme, which used mobile units, in vans, to take x-ray equipment to communities, in order to screen for tuberculosis. This proactive screening campaign drew to an end in the late 1950s as notification rates fell and there was a higher rate of recovery with modern treatment methods and drugs. However, in 2007, a new mobile x-ray unit was financed with the purpose of screening London's underserved populations, focusing on soup kitchens, prisons and hostels for the homeless. While notification rates in some areas of London are falling, in other areas they remain stubbornly high, but the reasons remain

complex and unclear. The increase at this time in TB cases was predominantly among people born outside the UK, but who appeared to have been infected here, rather than in their country of origin. TB is also known to occur more often in areas of deprivation, whereby poor living conditions, poor nutrition and poorer health, overcrowding and homelessness are all significant risk factors for the disease (Adams, 2010).

## **Urban planning, environmental architecture and public health**

When discussing public health today, architecture is not generally the first thing that springs to mind, yet its influence on us is difficult to ignore. The quality of the built environment is something that affects us all. The houses we live in can directly impinge on both mental and physical health, and poor domestic housing exacerbates health inequalities. Architects can, and do, play a critical role in shaping the qualities of our environment and this can be for the better, especially if they work in collaboration with end users and try to address their needs and ambitions. Good architecture has the capacity to be people-centred, to promote community cohesion, and be a source of pleasure. As Carol (2014) comments, 'a strong relationship exists between the design of the built urban environment and public well-being'.

In mid-nineteenth century Britain, the new fields of urban planning and public health worked closely together, with common goals of eliminating poverty and decreasing infectious diseases, especially in the emerging cities of an industrialising nation. These new, unregulated towns and cities had grown extremely rapidly in size and population, sucking in vast numbers of people from the countryside to work in the factories and mills. By 1851, the census recorded half of the population of Britain as living in towns, the first society in human history to do so (Law, 1967). Building was unregulated and most of these new towns had only minimal sanitary infrastructure. The wealthy urban elite felt concern at both the unprecedented population growth (by 1900 the population of Great Britain was almost 37 million) and the concentration of so many people in the relatively small spaces of towns and cities. As early as 1840, the iconic water fountains in London's Trafalgar Square were built as a way of reducing the size of the square to prevent the assembly of too many people. Railings were constructed around the gardens in the elegant squares of west London, sometimes topped with a *cheval de frise*, while brick walls would be topped off with a layer of mortar with glass shards embedded in it, restricting their use to residential key holders only, as the better off began to segregate themselves from contact with the unhealthy masses (Fee, 2005).

By the 1860s urban conditions had become a serious public health issue; inadequate sanitation led to ill-health and death for the rich as well as the poor. The towns and cities were desperately unhealthy and plagued by epidemics of cholera, typhoid, typhus and 'summer diarrhoea' because too little had been invested in the urban environment, in terms of sewers, street paving and cleansing, and in pure water and decent housing. The second half of the nineteenth century saw the birth of a powerful sanitary reform movement and urban planning policy; and by 1875 a Public Health Act regulated house building and ensured public investment in sewers and clean water supplies and a massive increase in the level of investment in public health. The mid-nineteenth century also saw the deliberate development of London's 'green lungs' in the form open spaces and public parks for all to use for fresh air and recreation (Jones, 2018).

### ***From 'defensible' to 'defensive': architecture, destitution and the creation of the hostile, urban environment***

At the beginning of the twentieth century, new structural building materials such as plate glass, reinforced concrete and cast iron provided the inspiration for the modernist movements that dominated architecture until the 1980s. A more functional and demotic philosophy began to emerge in the work of architects such as Berthold Lubetkin who believed in an architecture of

social responsibility, and that architecture could improve society by transforming it: 'nothing is too good for ordinary people' (Heath, 2009). Le Corbusier's Unité d'Habitation in Marseilles (1953) and Neave Brown's Alexander Road Estate in London (1970's) were developments that attempted to accommodate an entire community and which included not only apartments, but shopping streets, community centres, open spaces and other amenities. In the 1970s, the journalist Charles Nevitt created the term 'community architecture', while in the USA Oscar Newman published his 'defensible space' theory (Rustin, 1989). This was originally concerned with crime prevention and neighbourhood safety, by promoting community cohesion, lowering crime rates such as burglary, and developing crime prevention through environmental design (CPTED), and was rooted in the community architecture movement that maintained that user participation in the development of housing and other public projects led to greater satisfaction and produced psychological and social benefits.

Recently in the face of increasing urbanization and globalization, the fields of public health and urban planning have begun to reconnect. There is a renewed recognition of the need for leaders to understand both disciplines in order to effectively influence planning and policy, and improve and protect the public's health (Ige, 2018). However, in a paradoxical inversion of J.K. Galbraith's 1950s observation of 'private affluence and public squalor' - that is, a society in which privately owned resources were generally clean, efficient, well-maintained, and of good quality, while public spaces were dirty, overcrowded, and unsafe, there is today a move to claim back public spaces from universal use. Increasingly, defensible space theory is incorporated into new buildings and spaces, especially in the centre of our cities, not in the spirit of Newman but rather as a way of defining legitimate and non-legitimate users of public space. It is now 'defensive architecture', openly hostile towards the destitute, rough sleepers, the homeless (and skate boarders), and is creating a new perception, of legitimate and non-legitimate users of 'public' spaces. This is further reinforced by the use of ASBOs (Anti-Social Behaviour Orders) and PSPOs (Public Spaces Protection Orders). While an ASBO is an order given out by a court, to stop a person from behaving in certain ways or doing certain things, PSPOs propose to deal with a particular nuisance in a particular area that is considered to be having a detrimental effect on the quality of life for those in the local community. Thus both place and person can be controlled through coercion and punishment.

### ***The hostile environment and public health – why does it matter?***

In his speech to the Labour Party conference on becoming leader, Ed Miliband stated that 'the gap between rich and poor does matter. It doesn't just harm the poor, it harms us all' (28 September 2010). However, the health system in the UK remains reactive rather than proactive, despite evidence to show that this is an expensive and ultimately ineffective way to deliver meaningful health care. Systems are still designed to react to emergencies, especially when dealing with the health of the most vulnerable: 'Homeless shelters, hospital emergency rooms, jails, prisons – these are expensive and ineffective ways to intervene [sustaining the] cycle of continued suffering' (Earley, 2010). Lack of available healthcare for underserved and vulnerable groups contributes to the burden of ill health, which is already greater within these groups. Immunisation and screening programmes benefit both the individual and society, while the impact of health status on a country's economy should not be underestimated. A society with a large burden of ill-health is less economically productive.

### ***TB as a barometer of health and social inequalities:***

TB is an illness associated with health inequalities and social exclusion, but also in the public mind with dirt, disease and poverty. However, the causes of TB are complex and far from simply medical. Although anyone can catch TB, it particularly affects those who are marginalised from society: migrants, the elderly, prisoners, and homeless people. It has a

strong relationship with poverty and deprivation, and among these groups in particular, prevention strategies can be poor, and awareness low. These groups are also, by definition, difficult to reach. Adherence to treatment is also a problem for groups such as the homeless, street sex workers, and drug and alcohol users. Their daily priorities tend to be about shelter and survival, and compliance to a six-month course of quite unpleasant drugs is difficult for them to achieve. Furthermore, these risk groups tend to present with quite advanced disease; their non-completion rates are high, and this creates the conditions for new strains of drug resistant TB to emerge (Story, 2006).

In England TB is embedded in large urban areas, despite decades-long attempts to eradicate it. There is significant regional and local variation in rates of TB in England, depending on population characteristics, socioeconomic factors and level of local risk. In London one third of boroughs have a 'high incidence' threshold with more than 40:100,000 cases, and it is now more widely recognised that TB control requires a combination of medical and social interventions to address its underlying determinants. Public Health England (PHE) has developed a Collaborative Tuberculosis Control Strategy for England 2015-2020, in order to 'bring together best practice in clinical care, social support and public health to strengthen TB control, with the aim of achieving a year-on year decrease in incidence, a reduction in health inequalities and, ultimately, the elimination of TB as a public health problem in England'. Importantly, the strategy's second equality statement acknowledges 'the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities' (PHE, 2015). The implementation of the strategy will include a significant role for local government in ensuring that the wider social determinants of TB are addressed and that people affected by TB are supported to take their treatment. PHE and NHS England together with local government and a range of partners must work together to make sure all aspects are implemented (Abubakar, 2015).

There is a clear evidence that rates of TB increase as deprivation grows. In 2015, the rate was 20.5 per 100,000 in the 10% of the population living in the most deprived areas compared with only 3.6 per 100,000 in the 10% of the population living in the least deprived areas (PHE, 2016). In 2016, the rate of TB was 21.5 per 100,000 in the 10% of the population living in the most deprived areas compared with only 3.4 per 100,000 in the 10% of the population living in the least deprived areas, with a clear trend of an increasing rate of TB with increasing deprivation (PHE, 2017). TB patients with social risk factors have a greater potential for infecting others, and have poorer treatment completion as well as a greater risk of having drug resistance, and are also at greater risk of having pulmonary disease. They tend to be diagnosed at a much later stage of the disease, and have poorer outcomes in terms of treatment completion and mortality. Any control and eradication strategy must maintain focus on the social factors associated with TB and ensure an integrated approach to the specific needs of under-served populations (PHE, 2017).

Many major studies, including the Whitehall Studies (Marmot, et al., 1991; Marmot and Shipley, 1996), alongside major reviews of the social determinants of health (Department of Health and Social Security, 1980; Townsend, et al., 1986; Acheson, 1998; Marmot, 2010), have demonstrated a clear link between socio-economic background (such as income or occupation) and health. The most recent of these, the Marmot Review, found that in England, people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods (Marmot, 2010). These health inequalities are not just limited to life expectancy but also infant mortality, mental health, physical health and so on. For rough sleepers, the mortality figures are even more shocking: average age of death for women is 43, and for men 47 (Aldridge, 2018).

### ***Paradoxical imperatives?***

‘As housing supply dwindles and rents outstrip wages and benefits, 70% of local authorities surveyed for [this] report said they had difficulties finding social housing for homeless people last year, while a striking 89% reported difficulties in finding private rented accommodation’ (JRF, 2018). Following the financial crisis of 2007–2008 a period of economic recession began in the UK; by 2010 austerity measures in the form of deep cutbacks to public spending and a reduction in the role of the welfare state were adopted by the coalition and subsequent Conservative governments as way out of the economic recession. By 2017, welfare cuts in the form of universal credit (UC) rollout, including the six-week waiting period for payments, were forecast by the Child Poverty Action Group (CPAG) to be about to push one million children into poverty by the end of the current parliament. Cuts to the National Health Service (NHS) in England left it £4 billion short over the following year. Reductions in local government budgets have pushed children’s services, already overwhelmed by demand, to breaking point. The public service work force has ‘seen their pay crumble away. House building has fallen to its lowest level since the 1920s. Homelessness is up more than 50 per cent since 2010’ (McDonnell, 2017). This is a strategy that over the previous decade has harmed the most vulnerable, creating a cost-of-living crisis in the world’s seventh richest country. A million people have been forced to rely on food banks, disabled people have been stripped of essential financial support and benefits to the low-paid and unemployed have been severely reduced.

### **The ‘hostile environment’**

Throughout this period, immigrants, criminals and welfare claimants in particular have been offered up by press and politicians as scapegoats for the many social and economic problems created by the failing economy. Public opinion on issues such as benefit fraud, crime and immigration focused blame on vulnerable groups. Polls showed that the public believed 24 per cent of welfare was claimed fraudulently, while the actual figure is 0.7 per cent; that more welfare was going to the unemployed than to pensioners – in fact, fifteen times more is spent on pensions; that crime was rising – in fact, the figures show it had dropped significantly; and that 31 per cent of the population were recent immigrants - the actual figure is 13 per cent. Media portrayals still represent the endemic TB problem in this country as caused by immigrants who enter the country with active disease and pose a threat to inhabitants (the ‘importation’ of active TB is only a minor part of the total TB burden), which fosters a popular perception that border control is the best and only response to disease control. Meanwhile, the government is making deep cuts to the welfare state, while simultaneously exhorting the much diminished public services to address inequalities in health, education and social care.

### ***‘It’s the economy, stupid’ (Carville, 1992)***

Is the current rise of populism due to growing economic inequalities? One of the areas in England that voted most strongly to Leave the EU was Boston, in Lincolnshire, with a 76% vote to exit. This is a predominantly agricultural, rural area which produces significant quantities of seasonal fruit and vegetables for the domestic and foreign markets. About 90% of British fruit, vegetables and salads are picked, graded and packed by 60,000 to 70,000 workers from overseas, mostly from eastern Europe. Some rural communities in particular have felt overwhelmed by the rapid inward migration of EU citizens to work in this industry and there is a strong sense of dispossession amongst British people living in these rural towns and villages, despite the fact that it is evident that local economies have been reinvigorated by these new arrivals. A local senior police officer talked about the concept of ‘floating hate’, hiding in plain sight until, “for some people, the referendum vote gave them licence to spread their hate”. Research into the Brexit voting patterns in the UK indicate that economically disadvantaged and low-skilled, ‘left behind’ communities, characterised by poor levels of education, minimal skills, bad health, deprivation and poverty are struggling in a post-industrial

and increasingly global economy (JRF, 2016). Communities that over the past decade had experienced an inflow of migrants and refugees, especially from eastern Europe, were more likely to vote Leave.

***'No public health without migrant health' (Hurley, 2018)***

There are estimated to be more than 400,000 undocumented migrants in London alone, many of whom will be working within the 'shadow economy' where work is done for cash, taxes are not paid and workplace regulations not adhered to. In 2013, Britain's shadow economy was estimated to be worth £150bn a year (Elliot, 2013). The shadow economy is pervasive and made up of a huge number of small and highly dispersed transactions. By 2017, this estimate had risen to £222 billion. Workers in the shadow economy tend to live in overcrowded, illegally sublet accommodation in the most deprived urban areas, or sleep rough because they cannot afford rent. They avoid all contact with any form of perceived authority, be it health services, schools, banks and anywhere that they fear their status might be questioned. However, the widespread ownership of mobile phones and other digital communication methods now help undocumented migrants to exchange information about risks and dangers, both during their migration and once they arrive in a host country. Consequently, when the Home Office developed a Memorandum of Understanding with the NHS which required hospitals to share patients' details with it, as a means of detecting and detaining undocumented migrants attempting to use secondary health services, this information spread rapidly and has acted as a barrier to accessing health services. This controversial arrangement has been rescinded for the time being, but the damage has already been done, in terms of the NHS's status as a safe place for undocumented migrants. The UK government's reversal of this key element of its "hostile environment" approach to immigration came after MPs, doctors' groups and health charities warned that the policy was scaring some patients from seeking NHS care for medical problems, with reports of pregnant women only attending hospital once they had gone into labour, of another woman with a persistent cough dying because she was too frightened to seek health care, and the wider risk it posed to the public health through conditions such as tuberculosis and Hepatitis C going untreated, and children not receiving vital vaccinations.

TB is a reliable indicator of deprivation and indeed thrives on people enduring poor socio-economic circumstances. In England in 2017, 12.6% of people notified with TB had at least one social risk factor (SRF). This is the highest proportion since data collection began in 2010. Drug resistant TB was almost two times higher in people with a social risk factor compared to those without a social risk factor. In addition, the rate of TB in the most deprived 10% of the population of England was 18.4 per 100,000, more than 7 times higher than in the least deprived (2.5 per 100,000) (PHE, 2018). People with SRFs are also at greater risk of having pulmonary disease, are typically diagnosed at a later stage of disease progression, and have poorer outcomes in terms of treatment completion and mortality. The undocumented migrant population is difficult to count, but contributes significantly to the number of homeless people living either on the streets or in insecure, overcrowded and substandard accommodation. These are the people who delay seeking healthcare for fear of immigration repercussions, or simply never make it. Ultimately, however, policies that discourage undocumented immigrants from obtaining health care can both increase costs and have serious public health consequences. Patients with TB both delay seeking care for infectious symptoms, as well as contribute to spread of the disease. When the delay is longer than two months, the person with TB potentially exposes an average of 10 others during the course of this delay.

***‘Defensive architecture [consists of]...structures...installed in spaces of public use in order to render them unusable in certain ways or by certain groups’ (Petty, 2016).***

In his 2015 *Guardian* newspaper essay, ‘Anti-homeless spikes: sleeping rough opened my eyes to the city’s barbed cruelty’ Alex Andreou asks, ‘can our response as a civilised society really be limited to moving people on from our doorsteps?’ He asks, have we now perhaps as a society come dangerously close to accepting the homeless situation as a problem that we just can’t solve? ‘Rough sleeping is the traumatic, health-destroying tip of the homelessness iceberg. It is also the most visible form of this social ill, one that crashes uncomfortably into the sightline of the comfortable and secure as they go about their business. Street sleepers are, as one government minister once allegedly put it, the people you step over when you come out of the opera’.

In the UK, a combination of factors, political, social and architectural, have come together to create the perfect storm known widely as the ‘hostile environment’. It is premised upon a populist target supported by both major political parties over the previous decade, to reduce the numbers of migrants entering the UK, and has enabled and facilitated an environment that in essence discriminates against the most vulnerable people in the UK. Non-clinical NHS data sharing with immigration enforcement agencies, the NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017, the attrition wrought upon the Windrush generation and their children, and other proposals such as the de-prioritisation of school places for the children of undocumented migrants and the powers of landlords, banks and education institutions to check on the status of potential tenants, clients and students have combined to create an unregulated, undocumented shadow population, with almost no rights. While the policy was developed in order to deter new immigration and force others to leave the UK, it is in reality creating a hidden population at the extreme end of health inequalities, with a potentially huge burden of preventable morbidity and mortality from infectious and non-infectious diseases (Aldridge 2018).

‘It’s difficult to ever justify hostile architecture. It draws such a harsh line between the public and the private in cities: it shows you exactly where people ought and ought not to be. Hostile architecture is not an attempt to solve societal ills, it just moves them out of sight’ (Beanland, 2018). The evidence suggests that the constituent parts of the ‘hostile environment’ are creating an illegal underclass highly vulnerable to exploitation and with no access to the social and welfare safety net — access to a doctor when ill, access to a school for children, access to the police and to legal protections. It is critically important that high vaccination rates are maintained, and that conditions such as AIDS or tuberculosis are identified and treated. By denying healthcare to afflicted individuals, and making them scared of using health services, it is arguable that the hostile environment represents a risk not just to individuals but to public health. There is no evidence that it has achieved a reduction in undocumented migrants and rough sleeping, or has deterred the numbers unlawfully entering the UK. What the policy has done is to drive isolated and marginalised people further underground, while appearing to turn a blind eye to open expressions of malice, hatred and fear towards them. The Government needs to carry out a full and independent review, to examine the damaging effect the policies of the hostile environment are having on the whole of our society.

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## **Biographical Notes**

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