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Richard E Ashcroft

When denial of medical treatment is being used as a lever to move people out of the country, ethicists and healthcare professionals should speak out.

An ugly feature of political life throughout the Western world, and beyond, is the suspicion towards, and maltreatment of, migrants from poor to rich countries. People who would otherwise be horrified at being labelled racist nevertheless find it acceptable to support practices which can range from stigmatisation (for instance through requiring failed asylum seekers to pay for basic necessities not with money but with vouchers) to confinement in brutalising conditions in "reception" and "removal" centres.¹⁻⁵

An hour spent searching through government and NGO websites concerned with the treatment of asylum seekers and refugees in developed world countries is an hour well spent – but profoundly depressing. This is not only because of the frankly Orwellian language used by the governments of the UK and Australia (for instance), or because of the conditions and treatment meted out, but also because of the apparent support these practices have among the voting public. In the pointedly optimistic reports of Her Majesty's Inspector of Prisons, for example, one can find praise for the fact that at one removal centre "routine strip searches" have now stopped, alongside recognition that accommodation conditions were "simply unacceptable" (HMIP Report on IRC Haslar, p 5)³ Yet the UK government's "Myth Busting Leaflet" is *exclusively* concerned with the worries of those who think asylum seekers are being treated too well: assuring citizens that adult asylum seekers are given less benefits than permanent residents, and do not receive better housing or material goods.⁶ Similarly, in Australia, the current government has consistently made political capital from being seen to be "tough" on asylum seekers.^{4,7}

The issue of migration between countries has been politically contentious now for many years in most developed countries, as they have been forced to confront the legacy of the conditions under which they became developed,

and the dramatic inequalities in wealth between developed and underdeveloped countries. Some have argued that for a variety of reasons, including economic growth, restorative justice, and difficulties in consistently holding both that liberal democracy is the only morally legitimate form of government and that barriers on immigration are justifiable, we should abandon our current restrictions on free movement between countries.^{8,9} Yet even if, on mature reflection, one does not share this position, it is shaming to live in a country which not only mistreats migrants in these ways, but even sees political parties appeal for votes on the basis that the public actively support them in doing so.

The treatment of asylum seekers is a medical ethical issue. Firstly, the conditions of detention of some asylum seekers, especially those whose application for asylum has been refused, are not only distressing to us, they can induce or worsen pre-existing psychiatric disorders in them.^{10,11} Secondly, not only do doctors with care of asylum seekers have a responsibility to do the best they can for their patients, they also have responsibilities to ensure that detainees in reception and removal centres, and asylum seekers in the community, have proper access to the health care they need, and to speak out about the conditions which worsen their patients' health, and the public health implications of inadequate or inhumane treatment.^{3,12} Thirdly, the social and ethical issues relating to the treatment of asylum seekers are issues which have a resonance with general issues about the human right to health, and the economic and social right to health-care.^{13,14}

The UK government has recently "tightened up" the rules regarding access to free treatment on the National Health Service by overseas visitors, including asylum seekers and illegal immigrants. From April 1st 2004, asylum seekers whose application has been refused and for whom all appeals

have been exhausted are to be charged for all non-emergency care, with some specified exceptions concerning compulsory psychiatric treatment and a list of infectious diseases (not including HIV).¹⁵ Since they are not permitted to work, and may be receiving no other benefits, it is hard to see how this is possible.¹⁶ Although this has been official policy so far as hospital care is concerned since 1989, it has been applied only haphazardly. While the extension of this policy to primary care is currently merely under consultation, the extended guidelines are already in place, and with some fanfare the government has announced its intention to apply this policy rigorously even before this consultation.^{17,18} Laughably, the official guidance to NHS Trusts states that to avoid claims of race discrimination, everyone should be asked the same questions about where they have lived for the past 12 months, and whether they can show the right to live here.¹⁹ It is more important to appear non-discriminatory than actually to be non-discriminatory. More seriously still, doctors are being put into the position of having to decide whether or not to treat a patient, not on medical grounds, but on the grounds of whether the patient has the right papers and or the right illness.²⁰

Critics of laxity asylum rules will argue that all this is as it should be. Yet when denial of medical treatment, even to people with genuine medical need, is being used as a lever to move people out of the country, ethicists and healthcare professionals should speak out. Systems which ensure poor quality or denial of service to one vulnerable group, merely *pour encourager les autres*, diminish and threaten us all.

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