



## The UCL–Lancet Commission on Migration and Health: the health of a world on the move

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### Executive summary

With one billion people on the move or having moved in 2018, migration is a global reality, which has also become a political lightning rod. Although estimates indicate that the majority of global migration occurs within low-income and middle-income countries (LMICs), the most prominent dialogue focuses almost exclusively on migration from LMICs to high-income countries (HICs). Nowadays, populist discourse demonises the very same individuals who uphold economies, bolster social services, and contribute to health services in both origin and destination locations. Those in positions of political and economic power continue to restrict or publicly condemn migration to promote their own interests. Meanwhile nationalist movements assert so-called cultural sovereignty by delineating an us versus them rhetoric, creating a moral emergency.

In response to these issues, the UCL–Lancet Commission on Migration and Health was convened to articulate evidence-based approaches to inform public discourse and policy. The Commission undertook analyses and consulted widely, with diverse international evidence and expertise

spanning sociology, politics, public health science, law, humanitarianism, and anthropology. The result of this work is a report that aims to be a call to action for civil society, health leaders, academics, and policy makers to maximise the benefits and reduce the costs of migration on health locally and globally. The outputs of our work relate to five overarching goals that we thread throughout the report.

First, we provide the latest evidence on migration and health outcomes. This evidence challenges common myths and highlights the diversity, dynamics, and benefits of modern migration and how it relates to population and individual health. Migrants generally contribute more to the wealth of host societies than they cost. Our Article shows that international migrants in HICs have, on average, lower mortality than the host country population. However, increased morbidity was found for some conditions and among certain subgroups of migrants, (eg, increased rates of mental illness in victims of trafficking and people fleeing conflict) and in populations left behind in the location of origin. Currently, in 2018, the full range of migrants' health needs are difficult to assess because of poor quality data.

Published Online  
December 5, 2018  
[http://dx.doi.org/10.1016/S0140-6736\(18\)32114-7](http://dx.doi.org/10.1016/S0140-6736(18)32114-7)

See Online/Comment  
[http://dx.doi.org/10.1016/S0140-6736\(18\)32935-0](http://dx.doi.org/10.1016/S0140-6736(18)32935-0),  
[http://dx.doi.org/10.1016/S0140-6736\(18\)32753-3](http://dx.doi.org/10.1016/S0140-6736(18)32753-3),  
[http://dx.doi.org/10.1016/S0140-6736\(18\)32617-5](http://dx.doi.org/10.1016/S0140-6736(18)32617-5),  
[http://dx.doi.org/10.1016/S0140-6736\(18\)32855-1](http://dx.doi.org/10.1016/S0140-6736(18)32855-1), and  
[http://dx.doi.org/10.1016/S0140-6736\(18\)32780-6](http://dx.doi.org/10.1016/S0140-6736(18)32780-6)

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### Key messages

- We call on nation states, multilateral agencies, non-governmental organisations, and civil society to positively and effectively address the health of migrants by improving leadership and accountability. First, we urge the UN to appoint a Special Envoy on Migration and Health and national governments to have a country-level focal point for migration and health. This would enable much needed coordination and also ensure that migrants are included in all decisions about their health. Second, we propose that a Global Migration and Health Observatory is established to develop evidence-based migration and health indicators to ensure better reporting, monitoring, transparency, and accountability on the implementation of the Global Compact for Migration and the Global Compact on Refugees.
- International and regional bodies and states should re-balance policy making in migration to give greater prominence to health by inviting health representatives to high level policy making forums on migration. Health leaders and practitioners should fully engage in dialogues on the macroeconomic forces that affect population mobility and participate in multisector budgeting and programme planning for migrants.
- Racism and prejudice should be confronted with a zero tolerance approach. Public leaders and elected officials have a political, social, and legal responsibility to oppose xenophobia and racism that fuels prejudice and exclusion of migrant populations. Health professionals' and organisations' awareness of racism and prejudice should be strengthened through regulatory and training bodies including accreditation, educational courses, and continuous professional development. Civil society organisations should hold leaders to account to ensure the implementation of these obligations.
- Universal and equitable access to health services and to all determinants of the highest attainable standard of health within the scope of universal health coverage needs to be provided by governments to migrant populations, regardless of age, gender, or legal status. Solutions should include input from migrants and be specific to the diverse migrant populations. For those exposed to disaster or conflict, or both, mobility models and Disaster Risk Reduction systems should be integrated. Targeted interventions to improve the rights of migrant workers, their knowledge of workplace health and safety, and entitlement to health care are needed.

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We know very little, for example, about the health of undocumented migrants, people with disabilities, or lesbian, gay, bisexual, transsexual, or intersex (LGBTI) individuals who migrate or who are unable to move.

Second, we examine multisector determinants of health and consider the implication of the current sector-siloed approaches. The health of people who migrate depends greatly on structural and political factors that determine the impetus for migration, the conditions of their journey, and their destination. Discrimination, gender inequalities, and exclusion from health and social services repeatedly emerge as negative health influences for migrants that require cross-sector responses.

Third, we critically review key challenges to healthy migration. Population mobility provides economic, social, and cultural dividends for those who migrate and their host communities. Furthermore, the right to the highest attainable standard of health, regardless of location or migration status, is enshrined in numerous human rights instruments. However, national sovereignty concerns overshadow these benefits and legal norms. Attention to migration focuses largely on security concerns. When there is conjoining of the words health and migration, it is either focused on small subsets of society and policy, or negatively construed. International agreements, such as the UN Global Compact for Migration and the UN Global Compact on Refugees, represent an opportunity to ensure that

international solidarity, unity of intent, and our shared humanity triumphs over nationalist and exclusionary policies, leading to concrete actions to protect the health of migrants.

Fourth, we examine equity in access to health and health services and offer evidence-based solutions to improve the health of migrants. Migrants should be explicitly included in universal health coverage commitments. Ultimately, the cost of failing to be health-inclusive could be more expensive to national economies, health security, and global health than the modest investments required.

Finally, we look ahead to outline how our evidence can contribute to synergistic and equitable health, social, and economic policies, and feasible strategies to inform and inspire action by migrants, policy makers, and civil society. We conclude that migration should be treated as a central feature of 21st century health and development. Commitments to the health of migrating populations should be considered across all Sustainable Development Goals (SDGs) and in the implementation of the Global Compact for Migration and Global Compact on Refugees. This Commission offers recommendations that view population mobility as an asset to global health by showing the meaning and reality of good health for all. We present four key messages that provide a focus for future action.

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