Peer-reviewed / Review, meta-analysis, opinion

**Embargo: 23.30 [UK time] Wednesday 5th December 2018**

***The Lancet:* Harmful, unfounded myths about migration and health have become accepted, used to justify policies of exclusion**

* ***Stereotypes that migrants are disease carriers who present a risk to public health and are a burden on services are some of the most prevalent and harmful myths about migration.***
* ***Evidence from a comprehensive new report, including new international data analysis, shows these myths to be unfounded, yet they continue to be used to deny migrants entry, restrict access to healthcare, or detain people unlawfully.***
* ***Migration benefits national and global economies, and more must be done to counter racism, improve migrants’ access to services, and uphold the rights of migrants.***

Myths about migration and health – including that migrants are disease carriers and are a burden on services – are pervasive and harmful to individuals and society. The normalisation of these myths in popular discourse has allowed governments to introduce hostile and restrictive policies in many countries around the world – including the detention of migrants at US borders, and the denial of treatment to migrants in the UK’s NHS.

Public health protection and cost savings are often used as reasons to restrict migrants’ access to health care, or to deny them entry. Yet, as the new UCL-***Lancet*** Commission on Migration and Health lays out with new international data and analysis, the most common myths about migration and health are not supported by the available evidence and ignore the important contribution of migration to global economies.

In 2018, there were more than one billion people on the move, a quarter of whom were migrants crossing international borders. The Commission is the result of a two-year project led by 20 leading experts from 13 countries, and includes new data analysis, with two original research papers, and represents the most comprehensive review of the available evidence to date. The report, including its recommendations to improve the public health response to migration, will be launched on 8th December at the UN Intergovernmental Conference to adopt the Global Compact for safe, orderly and regular migration in Marrakech. [1]

“Populist discourse demonises the very same individuals who uphold economies and bolster social care and health services. Questioning the deservingness of migrants for health care on the basis of inaccurate beliefs supports practices of exclusion, harming the health of individuals, our society, and our economies,” says Commission Chair Professor Ibrahim Abubakar, UCL (UK). “Migration is the defining issue of our time. How the world addresses human mobility will determine public health and social cohesion for decades ahead. Creating health systems that integrate migrant populations will benefit entire communities with better health access for all and positive gains for local populations. Failing to do so could be more expensive to national economies, health security, and global health than the modest investments required to protect migrants’ right to health, and ensure migrants can be productive members of society.” [2]

***The Lancet***editor Dr Richard Horton adds: “In too many countries, the issue of migration is used to divide societies and advance a populist agenda. With one billion people on the move today, growing populations in many regions of the world, and the rising aspirations of a new generation of young people, migration is not going away. Migrants commonly contribute more to the economy than they cost, and how we shape their health and wellbeing today will impact our societies for generations to come. There is no more pressing issue in global health.” [2]

**Myths about migration and health not supported by the available evidence**

***Are high income countries being overwhelmed by migrants?***

Discussions about migration often focus on rising numbers of people crossing international borders and overwhelming high-income countries, but changes in migration are more complex. Although international migration receives the most political and public attention, most movement globally is internal migration. A quarter of all migrants (an estimated 258 million people) are international migrants. In the past four decades, the percentage of the world’s population that is considered an international migrant has changed very little – from 2.9% in 1990 to 3.4% in 2017 globally.

Most international migrants are labour migrants (approximately 65%) – and a much smaller proportion are refugees and asylum seekers [3].

While high-income countries have seen a greater rise in the percentage of international migrants (from 7.6% in 1990 to 13.4% in 2017), they are more likely to be students who pay for their education or labour migrants who are net contributors to the economy. Refugees make up a larger proportion of the total population in low income countries compared to high income countries (0.7% vs 0.2%).

***Are migrants damaging economies?***

An overwhelming consensus of evidence exists on the positive economic benefits of migration, which is insufficiently acknowledged. In advanced economies, each 1% increase in migrants in the adult population increases the gross domestic product per person by up to 2%. Additionally, migration contributes to global wealth distribution. An estimated US$613 billion was sent by migrants to their families at origin in 2017. Approximately three quarters of these remittances are to low- and middle-income countries – an amount three-times larger than official development assistance.

***Are migrants a burden on health services?***

Migrants constitute a substantial proportion of the health care workforce in many high-income countries. Rather than being a burden, migrants are more likely to bolster services by providing medical care, teaching children, caring for older people, and supporting understaffed services. In the UK, 37% of doctors received their medical qualification in another country.

A new, comprehensive systematic review and meta-analysis [4] concludes that international migrants in high-income countries have lower rates of mortality compared to general populations across the majority of disease categories. The study used mortality estimates on more than 15.2 million migrants from 92 countries and found that international migrants had lower rates of deaths for cardiovascular, digestive, endocrine, neoplasms, nervous and respiratory diseases, mental and behavioural disorders and injuries than people in the general population in the receiving country. There was no evidence of a difference for blood, genitourinary, or musculoskeletal disorders.

The only two exceptions were for infections such as viral hepatitis, tuberculosis, and HIV, and external causes, such as assault, where migrants had increased rates of mortality. However, as the report also highlights, several studies (eg on tuberculosis) have shown that the risk of transmission of infections is elevated only within migrant communities, and is negligible in host populations.

The findings are most likely to apply to international migrants in high income countries who are studying, working, or have joined family members in these countries. Vulnerable groups, such as refugees, asylum seekers, and undocumented migrants, may have different health needs, but, as the authors note, rather than form policies based on exceptions, evidence about the healthy benefits of migration should be at the forefront of decisions.

***Are migrants disease carriers that pose risks to resident populations?***

The stereotype of migrants as disease carriers is perhaps one of the most prevalent, and the most harmful. However, there is no systematic association between migration and importation of infectious diseases, and the evidence shows that the risk of transmission from migrating populations to host populations is generally low. Studies on tuberculosis suggest that the risk of transmission is elevated within migrant households and communities, but not in host populations.

Migrants may come from regions with higher disease burden, especially if they come from regions of conflict, with weak public health systems. But illness and infection can also be acquired or during transit – for example air travel can facilitate the rapid spread of infection. Indeed, recent examples of spread of resistant pathogens was driven mainly by international travel, tourism, and the movement of livestock rather than migration.

Strong public health systems are needed to prevent outbreaks of disease, whether associated with migration or not.

***Do migrants have higher fertility rates than among host populations?***

Populist rhetoric often claims that migrants have many more children than host populations. The Commission collates data from several long-term studies that suggest the birth rates among migrants are barely at the level of population replacement (2.1 births per woman) and often falling. A study of six European countries found that fertility rates among migrant women were, in general, lower than host populations.

Studies in India and Ethiopia, for example, have shown that internal migrants are more likely to use contraception than host populations. Ensuring access to services is key to ensuring the sexual and reproductive healthcare of migrant women and girls.

**Unfounded myths: harmful to individuals and society**

Unfounded myths about migration have wide ranging impacts on how migrants are treated within society. Despite evidence that migrants have positive health benefit to societies, many men and women who migrate are subjected to laws, restrictions, and discrimination that put them at risk of ill-health. Protection of the public is often invoked as a reason for the denial of entry, detention or deportation, but too often these policies leave migrants facing worse health situations.

The Commission calls for governments to improve migrants’ access to services, strengthen migrants’ right to health and tackle the wider determinants of migrant health, including taking a zero-tolerance approach to racism and discrimination.

Restricting entry based on health status is increasingly common. In Australia, permanent residency application can be rejected because the applicant has a health condition – the five most common reasons were intellectual or functional impairment, HIV, cancer and renal disease. 35 countries have imposed some form of travel ban on people with HIV [5]. Too often, policies are not based on the overall contribution of migrants to host societies, but only in terms of costs to the state. Restrictions on entry or deportation for diseases with low risk of casual transmission are impermissible on both public health and human rights grounds.

Linking health status to migration enforcement also reinforces distrust in the health profession, and Iimits migrants’ ability to access health care on a non-discriminatory basis. The fear of deportation can mean migrants will not seek health care or assistance when needed, hindering individual and public health. In practice, health-related enforcement regimes can pressure health workers to act as immigration control agents. The Commission points to a growing trend of states limiting access to health care for migrants, despite commitments to provide “health for all.” In the UK, the hostile environment policy was highlighted in the Windrush scandal of 2018 with long-term migrants being deported midway through medical treatment. Upfront charging regulations are still in place.

“Migrants are healthier and contribute to our economy and the NHS. There is no evidence that migrants are a drain on the NHS or that they spread infectious disease. Exclusion of migrants in health systems and the increasing negative rhetoric is political and not evidence based.  The hostile environment towards migrants in the UK has led directly to migrants and British citizens being denied health care, with direct severe public health and health economic consequences. Migrants constitute a considerable portion of the heath care workforce in the UK, making important contributions to the country which should be recognised,” says Professor Abubakar. [2]

States are increasingly treating unauthorised border crossings as a criminal offense, leading to detention, at times indefinitely. Indefinite offshore detention of migrants on Nauru island was introduced as an immigration policy in Australia in 2013, and the USA recently announced a zero-tolerance policy, resulting in migrants arrested or jailed and children separated from their parents. Detention poses clear violations of international law, and findings from a systematic review of 38 studies shows that detention is associated with negative health outcomes, especially mental health.

“Contrary to the current political narrative portraying migrants as disease carriers who are a blight on society, migrants are an essential part of economic stability in the US. The separation of migrant children from their parents creates long term psychological damage—and is a cruel and unnecessary aspect of US policy. The criminalization and detention of migrants seeking internationally protected refuge violates international law, and puts them at greater risk of ill health. Migrants are vital to our wellbeing as a society. Addressing the healthcare needs of migrant populations is an essential strategy to stemming costs associated with any avoidable disease burden in these populations,” says co-author Professor Terry McGovern, Columbia University, USA. [2]

Finally, the health of migrants depends on the social and structural context of their journey, and destination. Migrant related discrimination is a profound determinant of health, especially mental health and social wellbeing. Access to justice, and education are important determinants of health. Yet a study of 28 developed and developing countries found that nearly half did not allow immediate access to education for irregular migrant children, and migrants face many barriers accessing justice, through poor information, employer intimidation, language barriers or unfamiliarity with the system.

Professor Bernadette Kumar, Norwegian Institute for Public Health (Norway) adds: “Too often, government policies prioritise the politics of xenophobia and racism over their responsibilities to act forcefully to counter them. Racial and ethnic discrimination fuel the exclusion of migrant populations, not only violating the rights of individuals, but hindering social cohesion and progress of society at large. Racism and prejudice should be confronted with a zero-tolerance approach.” [2]

The Commission is accompanied by four linked Comments, including by Louise Arbour, UN Special Representative for International Migration; David Miliband and Mesfin Teklu Tessema, International Rescue Committee; Kolitha Wickramage, International Organization for Migration, and Giuseppe Annunziata, Regional Office for Europe, WHO; and Walid Ammar, Director General of the Lebanese Ministry of Public Health.

Commission co-author Dr Nyovani Madise, African Institute for Development Policy (Kenya), adds: “Africans have always been highly mobile people, moving mostly within national and regional borders. The Commission’s report confirms that migrants boost the economies of their destination countries while many also remit money back to their places of origin. Most African countries find themselves as host to refugees and displaced people running away from conflicts in neighbouring countries. Migration policies in Africa must take on board the Commission’s recommendations to provide good healthcare for all people on the move and to acknowledge the positive benefits of migration when formulating and implementing development policies.” [2]

"“Health for all” will mean nothing without reaching the hardest to reach, including those who are forcibly displaced. This means urgently scaling up investments in providing health services for refugees and internationally displaced people to ensure all people can access quality health services," says David Miliband, President and CEO, International Rescue Committee, co-author of the linked Comment [2].

NOTES TO EDITORS

The Commission received funding from the Wellcome Trust, Rockefeller Foundation, UK National Institute for Health Research, the UCL Grand Challenges in Global Health, and the EU’s Health Programme.

The labels have been added to this press release as part of a project run by the Academy of Medical Sciences seeking to improve the communication of evidence. For more information, please see: http://www.sciencemediacentre.org/wp-content/uploads/2018/01/AMS-press-release-labelling-system-GUIDANCE.pdf if you have any questions or feedback, please contact The Lancet press office [pressoffice@lancet.com](mailto:pressoffice@lancet.com)

[1] The Commission will be launched at an official side-event to the UN conference on December 8th. For more information, please see: <https://www.migrationandhealth.org/> or <http://www.un.org/en/conf/migration/> - to attend the launch, please email [info@migrationandhealth.org](mailto:info@migrationandhealth.org)

[2] Quote direct from authors and cannot be found in the text of the Commission.

[3] Most recent global data on labour migration is from 2013 (International Labour Organization).

[4] See Article published alongside the Commission (Aldridge et al.), available under embargo at: <http://www.thelancet-press.com/embargo/migration1.pdf>

[5] UNAIDS data from 2015

**FOR INTERVIEWS:**

**For interviews with the following authors, please contact Rowan Walker in the UCL press office E)** [**rowan.walker@ucl.ac.uk**](mailto:rowan.walker@ucl.ac.uk) **M) +44 7769 141006**

**[UK] Professor Ibrahim Abubakar, Commission Chair, University College London, UK**

**[UK] Dr Davide Mosca, Honorary Associate Professor, Institute for Global Health, University College London; Previous Director, Migration Health Department, International Organization of Migration**

**[UK] Dr Rob Aldridge, (Author of Paper 1 – Global patterns of mortality in international migrants) University College London, UK**

**[UK] Dr Delan Devakumar, (Author of Paper 2 – Health impacts of migration on left-behind children) University College London, UK**

**[USA] For Professor Terry McGovern, Colombia University, USA please contact directly E)** [**tm457@cumc.columbia.edu**](mailto:tm457@cumc.columbia.edu) **or via Stephanie Berger in the Columbia media team E)** [**sb2247@cumc.columbia.edu**](mailto:sb2247@cumc.columbia.edu)

**[GERMANY] For Dr Michael Knipper, University Justus Liebig, Giessen, Germany, please contact directly E)** [**Michael.Knipper@histor.med.uni-giessen.de**](mailto:Michael.Knipper@histor.med.uni-giessen.de) **T) +49-176-99998846**

**[NORWAY/NEPAL] For Professor Bernadette Kumar, Norwegian Institute for Public Health, Norway please contact directly E)** [**BernadetteNirmal.Kumar@fhi.no**](mailto:BernadetteNirmal.Kumar@fhi.no) **T) +4799640321 (Norway) or +9779801014227 (Nepal)**

**[KENYA] For Dr Nyovani Madise, African Institute for Development Policy (Kenya) please contact directly E)** [**nyovani.madise@afidep.org**](mailto:nyovani.madise@afidep.org) **or via Elizabeth Kahurani in the communications office E)** [**Elizabeth.Kahurani@afidep.org**](mailto:Elizabeth.Kahurani@afidep.org)

**For interviews with Comment authors, David Miliband and Mesfin Teklu Tessema, International Rescue Committee, please contact Bianca Wachtel E)** [**Bianca.Wachtel@rescue.org**](mailto:Bianca.Wachtel@rescue.org)

**For interviews with Dr Richard Horton, Editor-in-Chief, *The Lancet,* please contact Seil Collins** [**seil.collins@lancet.com**](mailto:seil.collins@lancet.com) **or Emily Head** [**Emily.head@lancet.com**](mailto:Emily.head@lancet.com)

**FOR EMBARGOED COPIES OF THE REPORT:**

Commission & introductory Comments: <http://www.thelancet-press.com/embargo/migration.pdf>

Commission appendix: <http://www.thelancet-press.com/embargo/migrationAPPX.pdf>

Cover: <http://www.thelancet-press.com/embargo/migrationCOVER.pdf>

Research Article (Global patterns of mortality in international migrants), linked Comment and Appendix: <http://www.thelancet-press.com/embargo/migration1.pdf>

Research Article 2 (Health impacts of migration on left-behind children), linked Comment and Appendix: <http://www.thelancet-press.com/embargo/migration2.pdf>

**NOTE: THE ABOVE LINK IS FOR JOURNALISTS ONLY; IF YOU WISH TO PROVIDE A LINK FOR YOUR READERS, PLEASE USE THE FOLLOWING, WHICH WILL GO LIVE AT THE TIME THE EMBARGO LIFTS:**

COMMISSION:

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

<http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32114-7/fulltext>

RESEARCH ARTICLES:

Article: Global patterns of mortality in international migrants: a systematic review and meta-analysis (Aldridge R A et al) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32781-8/fulltext>

Linked Commentary: Do migrants have a mortality advantage? (Borhade A, Dey S) <https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)33052-6/fulltext>

Article: Health impacts of parental migration on left-behind children and adolescents: a systematic review and meta-analysis (Fellmeth G et al) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32558-3/fulltext>

Linked Commentary: Forgotten needs of children left behind by migration (Griffiths SM, Dong D, Yat-nork Chung R) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)33004-6/fulltext>

COMMENTS:

Opening up to migration and health (Richard Horton, Jocalyn Clark, The Lancet) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32935-0/fulltext>

Historic global agreement on migration (Louise Arbour, Special Representative of the UN Secretary-General for International Migration) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32753-3/fulltext>

Migration and health: human rights in the era of populism (Walid Amar, Director General of the Lebanese Ministry of Public Health) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32617-5/fulltext>

Advancing health in migration governance, and migration in health governance (Kolitha Wickramage, International Organisation for Migration, and Giuseppe Annunziata, Regional Office for Europe, World Health Organization) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32855-1/fulltext>

The unmet needs of refugees and internally displaced people (David Miliband, President and CEO of the International Rescue Committee, and Mesfin Teklu Tessema, Director of the Health Unit for the International Rescue Committee) <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32780-6/fulltext>