Health equity and displaced people: challenges, progress, and the path forward

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In 2024, more than 123 million people were forcibly displaced worldwide, driven largely by conflicts, persecutions, and human rights violations.[1] Displaced populations include refugees (people who flee their country due to conflict or persecution), internally displaced people (those forced to flee their homes but who remain within their country's borders), and undocumented migrants and asylum seekers (individuals who cross borders without formal legal status, including those awaiting a decision on their protection claim). Our focus is primarily on undocumented migrants and asylum seekers (collectively referred to as undocumented migrants herein), whose exclusion from legal protection often leaves them the most vulnerable to gaps in health-care access. For millions of such individuals, health outcomes are determined not solely by medical need but also by legal status in host countries, which governs access to health care as well whether they are afforded protection and dignity. Many individuals flee from places where health systems have already collapsed due to war or economic crisis, compounding their vulnerability when they arrive in new countries.[2,3]

In many contexts, laws and administrative barriers tie health-care access to residency permits, resulting in de facto health-care segregation. Restrictive eligibility requirements, temporary permit systems, and bureaucratic delays often prevent displaced people from receiving essential services.[3-5] Even when basic benefits exist, they might exclude preventive, reproductive, or chronic disease care, reinforcing cycles of inequity and instability.[4,6,7]

Undocumented migrants are disproportionately exposed to sexual abuse, harassment, and coercion in workplaces, shelters, and transit settings where there is little oversight or legal recourse.[8] In nations where health-care access is tied to legal status, the fear of deportation, detention, or arrest prevents many undocumented migrants from reporting sexual assault or seeking medical treatment.[8] Beyond reproductive and emergency care, undocumented migrants are frequently confined to informal or exploitative labour that increases their risk of injury, chronic pain, and mental distress, yet fear of detention prevents them from seeking treatment or compensation.[9]

Global estimates suggest that one in five people in conflict settings has a mental health condition, although emerging evidence indicates that the true prevalence might be considerably higher.[10] Displaced communities frequently experience cumulative psychological strain, as prolonged insecurity, isolation, and uncertainty compound trauma. Despite a clear need, access to mental health services remains scarce, and many undocumented migrants are placed in environments that intensify rather than alleviate distress.[3,11,12] In addition, political and media rhetoric that portrays migrants as burdens further deepens marginalisation and erodes social cohesion, making it more difficult and less likely for displaced people to seek and sustain care.[13,14]

Exclusionary approaches towards undocumented migrants are not inevitable. Restrictive and inclusive national policies shape the prevailing health inequities in distinct ways, with country examples illustrating how legal status determines health-care access, protection, and health outcomes (table).

Inclusive health-care policies that extend access regardless of legal status can improve both population health and societal resilience. When displaced people can obtain official identification, preventive care, and treatment for chronic conditions, they are better able to participate in education, employment, and community life. Evidence from international and multilateral agencies shows that such inclusion benefits entire nations.[19] It improves population health, reduces emergency-care costs, strengthens epidemic preparedness, fosters social cohesion and promotes social development, and enables migrants' economic participation through a healthier workforce, promoting economic development for the entire society. In Colombia, for example, extending health-care access and legal protection to Venezuelan migrants expanded vaccination and chronic disease management, with the World Bank estimating that every US$1 invested in integration yields a $2 return for Colombian society.[19] Such outcomes show that the inclusion of displaced populations in health systems supports not only individual wellbeing but also broader country-level goals of equity, stability, and sustainable development.

Although contexts and health systems vary widely across countries, advancing equity in a country requires coordinated action across health systems and society. Clinicians should provide non-judgemental, trauma-informed, and culturally competent care that remains separate from immigration enforcement. This care can be implemented through measures such as designating health-care facilities as enforcement-free spaces, avoiding the collection or sharing of immigration status unless medically necessary, and ensuring that patients are informed that care is available regardless of status. Established clinical frameworks for migrant and refugee health care emphasise confidentiality, continuity of care, interpreter support, and patient control over disclosure, which together foster safety and trust.[23] However, implementation of these frameworks of migrant care remains challenging due to limited resources, staff shortages, fear among clinicians and displaced individuals of legal repercussions, and the absence of clear institutional guidance in many settings. In under-resourced systems, clinicians might experience moral distress when ethical duties conflict with restrictive administrative rules, and language barriers and insufficient training on migration health— such as understanding culturally influenced care-seeking patterns and managing conditions linked to displacement and precarious living conditions—further impede equitable care delivery.[23] The 2025 Halifax Declaration, which was developed at the International Refugee and Migration Health Conference through a participatory process involving clinicians, researchers, and individuals with lived experience of displacement, calls on governments,

	Timeframe	Policy or context	Health and social impact for migrants
Restrictive			
Australia	Introduced 2013; ongoing	Indefinite detention for unauthorised arrivals and asylum seekers with offshore processing centres on Nauru and Papua New Guinea	Linked to severe mental health decline, self-harm, and preventable deaths in detention[12]
Bangladesh	Introduced 2017; ongoing	Government classifies Rohingya migrants as Forcibly Displaced Myanmar Nationals, with no legal refugee status and movement restricted to closed, overcrowded camps predominantly in Cox's Bazar (with overcrowding increasing spread of communicable diseases)	Limits access to comprehensive care; contributes to unsafe births and preventable maternal and infant mortality[6,15]
Egypt	Introduced 2024; ongoing	A 2024 decree ties health-care access to valid residency permits; a new asylum law (number 164) expands detention powers and allows revocation of refugee status on vague grounds	Excludes thousands of undocumented Sudanese and Palestinians from essential care; heightens the risk of detention[3,16]
Germany	Amended January, 2024; ongoing	The Asylum Seekers Benefits Act extended the waiting period for full health benefits from 18 months to 3 years and restricted coverage during the waiting period	Limits access to preventive, perinatal, and chronic disease care during the extended waiting period[4]
Japan	Amended 2010; revised 2024; ongoing	Extremely low asylum seeker acceptance rate and prolonged immigration detention for undocumented migrants	Deters care-seeking and leaves chronic and mental health conditions untreated[11]
South Africa	Intensified 2015; ongoing	Police profiling, law-enforcement operations such as Operation Fiela, and immigration raids targeting undocumented Zimbabwean and Mozambican migrants	Fear of arrest or deportation deters undocumented migrants from seeking clinic-based care, HIV and tuberculosis treatment, and post-violence care[17]
UK	Introduced 2012; ongoing	Anti-asylum seeker protests, and Hostile Environment (pre-2018) and Compliant Environment (2018 onwards) policies to restrict access to free National Health Service care for undocumented migrants and individuals not deemed ordinarily resident, with upfront charging of up to 150% of the cost of treatment	Deters undocumented migrants from accessing services and reinforces stigma and care avoidance[7,14]
USA	Codified 1996; ongoing	Excluded undocumented migrants from the Medicaid, Medicare, Children's Health Insurance Program, and Affordable Care Act plans except emergency-only coverage; political rhetoric portraying migrants as security threats	Exclusions, together with enforcement fears, drive avoidance of care and worsen chronic and mental health outcomes[5,13]
Inclusive			
Canada	March, 2020, to March, 2023	Provincially supported community health clinics and non-profit clinics in Ontario and Quebec serve uninsured and undocumented populations	Improves preventive care; reduces emergency room reliance[18]
Colombia	Introduced 2021; ongoing to 2031	10-year Temporary Protection Status (2021) granted to more than 2 million Venezuelan migrants	Expanded vaccination, antenatal, and chronic disease care; estimated two-to-one economic return for society[19]
EU	Introduced 2022; extended to 2027	Activation of the Temporary Protection Directive (2022) for displaced Ukrainians	Enabled rapid and barrier-free access to health care and social services[20]
France	Established 2000; ongoing	Continuation of the Aide Médicale d'État scheme despite parliamentary and governmental attempts to repeal it	Universal access to essential health-care for undocumented residents including more than 380 000 beneficiaries[21]
Thailand	Introduced 2004; expanded 2013; ongoing	Mobile and non-governmental organisation-run clinics along the Thailand–Myanmar border offering antenatal, maternal, and vaccination services to undocumented migrants	Improved maternal and child health outcomes, increased skilled birth attendance, and reduced care delays[22]

***Table:* Examples of restrictive and inclusive policies and contexts affecting health-care access for undocumented migrants**

professional bodies, and health institutions to protect health-care settings from border control, uphold non-discriminatory access to care, and ensure that clinicians are empowered to act in accordance with medical ethics and humanitarian principles rather than immigration policy.[24]

Medical and health institutions should advocate for and implement clear firewalls between patient data and immigration authorities, to build trust and reduce care avoidance. Although regulatory frameworks are often established by governments, medical institutions and professional associations can have a critical role in promoting confidentiality safeguards and resisting information-sharing practices that deter care-seeking. Establishing migrant-friendly service points with flexible hours, mobile outreach, culturally responsive care, and gender-concordant providers can help to remove practical barriers within existing policy constraints, and has been shown to improve health-care access for displaced and undocumented populations.[18,20,22] Fee-waiver or charity care programmes for chronic or urgent needs, and partnerships with non-governmental organisations and diaspora organisations, can further expand access while health institutions work collectively to advance national policies that protect patient confidentiality and equal access to care.

Policy makers should remove immigration checks from health-care settings, strengthen data protection, and guarantee access to essential services regardless of legal status. Expanding health-care access to include all residents of a country and ensuring that migrant representatives participate in policy design are essential steps towards sustainable reform. Such sustainable reform requires institutionalisation of these measures through stable funding, legal protections, and integration into national health strategies so that access does not depend on temporary programmes or political shifts. A human rights-based approach to health recognises that care is both a legal obligation and a social investment.

Societal efforts should also challenge narratives that portray migrants as burdens. Evidence-based media coverage, public education on migrants' contributions, and programmes that foster social cohesion through volunteerism, cultural exchange, and mentorship can build solidarity. The medical and public health community also has a vital role in countering misinformation and advocating for the right to health care as a shared societal good. By communicating evidence on the economic and epidemiological benefits of inclusive health care and engaging with policy makers and the media, health professionals can help reframe migration as a positive determinant of public health rather than a threat to it.

Health systems must protect lives, not borders. At a time of record-high displacement, with displacement almost doubling globally over the past decade,[1] health systems cannot be weaponised to police borders. The health of displaced populations must no longer hinge on nationality, race, or paperwork. Legal exclusion should be recognised as a determinant of health in its own right. Seeking safety is not a crime, and health care is the first and most urgent need that must be guaranteed.

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Parkinson's disease: emerging opportunities through global collaboration

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Precision medicine holds enormous promise in enhancing treatment efficacy and advancing therapeutic development, leading to more equitable care. However, to realise this promise in all individuals with Parkinson's disease, the disease needs to be understood in populations other than those traditionally studied. Pursuing this approach has many rewards. The identification of a *GBA1* risk factor for Parkinson's disease in west Africa in 2023, through a global collaboration, is a clear example.[1] *GBA1* is a common risk factor, present in more than 40% of patients with Parkinson's disease from Nigeria. Further work indicated that this genetic risk is mediated by a novel non-coding mechanism, resulting in lower glucocerebrosidase levels and activity.[2] These findings collectively add to current understanding of the general role of *GBA1* in Parkinson's disease risk. More importantly, these findings identify a large, underserved population who might potentially benefit from precision therapeutics.

This work provided evidence of the considerable impact of genetic research in underserved populations, explicitly enabled through initiatives such as the Global Parkinson's Genetics Program (GP2), an effort to accelerate our understanding of the genetic basis of Parkinson's disease and related disorders, through the analysis of genetic data from 250 000 individuals globally. It also highlighted three opportunities in neurodegenerative disease, which, if not capitalised on, will delay the development and testing of therapeutics and limit globally equitable care.

The first opportunity is phenotyping. Characterisation of Parkinson's disease as a clinical and neuropathological entity has predominantly, although not exclusively, been done in patients of northern European ancestry, giving a potentially skewed impression of Parkinson's disease. A small but growing body of research suggests that the clinical heterogeneity of Parkinson's disease is partly related to genetic ancestry.[3–6] Individuals with Parkinson's disease who are of different racial and ethnic backgrounds and from different regions of the world demonstrate variability in a range of motor and non-motor manifestations, disease progression, and complications related to therapy.[3,7] There are also cultural and sociocultural influences on the experience of disease, and variation in the range and impact of symptoms on patients.[3,4] Incorporating this diversity into the development of patient-reported outcomes, culturally and linguistically appropriate cognitive testing, and other outcomes is essential for capturing the full spectrum of disease, especially as it relates to measures used in