

and equitable ways, exploring how its use and deployment could have the potential to close the chasm of health inequalities for key populations.

In concert with the GENERAL MEASURES stipulated below, this Joint Statement calls for a renewal of EU commitments and coordination of efforts of all EU institutions, Member States, and relevant stakeholders, with existing strategies, plans, and directives/guidelines/legislation, *including but not limited to* the following:

1. The European AI Strategy
2. The Coordinated Plan on AI
3. The Artificial Intelligence Act
4. The Product Liability Directive
5. The AI Liability Directive
6. The Medical Devices Regulations
7. The In-Vitro Diagnostic Medical Devices Regulations
8. The European Health Data Space Regulation
9. The General Data Protection Regulation
10. The Data Governance Act

This Joint Statement emphasises the following concerns about health AI:

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undocumented people or people with insecure residence status⁸, persons experiencing mental health problems, persons with rare diseases and disabilities, members of the LGBTQI community, and racial and ethnic minorities such as Roma people, Travellers, and the Sami, and draw attention to intersecting systems of oppression, such as gender inequalities, anti-Roma racism, and other patterns of discrimination, which may ultimately feed into AI systems unless an appropriate governance/legislative framework is in place.

Despite the promise and opportunity AI holds in some contexts, such as assistive technologies for persons with rare diseases and disabilities for communication and enhancing access to information, it is not a neutral technology. On a societal level, AI is exacerbating structural inequalities and health inequalities due to existing historical, social, and cultural patterns of discrimination and systems of oppression, which most key populations have extensively experienced.⁹ The below provides a short overview of particularly marginalised groups which should inform the development of AI in healthcare:

- Persons with disabilities have long been subject to ableism narratives and with their lives not being perceived as equally valuable as persons without disabilities. The outdated medical model of disability viewed disabilities as problems that needed to be fixed; instead of reflecting on how barriers faced by persons with disabilities are in fact socially constructed. During the COVID-19 pandemic, for example, procedures for the rationing of access to healthcare discriminated against people with disabilities simply by virtue of a presumed triage that undervalued their disabilities. In the UK, this led to a horrifying statistic of 60% of mortalities¹⁰ during the pandemic being among persons with disabilities. Persons with disabilities have also been historically subject to patterns of coercion, segregation, institutionalisation, forced treatment or forced ~~de~~areÑin their so-W`YX`Ī VYgĭ

⁸ ~~ð~~ bXcW`a Yb`YX`dYcd`YÑcf` ð bXcW`a Yb`YX`a][fUbrg`NUFY`dYcd`Y`k` \cgY` fYg]X`YbW`]g`bch`fW`[b]gYX`Vm`h`Y`V`i` blf`m`h`Y`m`i`]j` Y`]b`" They are unable to obtain a residence permit or citizenship because of restrictive migration and residence policies. Many have had residence permissions linked to employment, study, family, or international protection, but those permits were either temporary or very precarious and their validity expired. There are also children who are born to undocumented parents and inherit this precarious residence status. Gianco, M. and Kanics, J. (2022) [Resilience and resistance in defiance of the criminalisation of solidarity across Europe](#)

Further, many persons with disabilities living under guardianship have no legal voice and personal autonomy to make decisions relating to their own lives and bodies.¹¹

- Older persons are most likely to face ageist stereotypes and infantilising or surveillant technologies which attempt to mimic social interactions as part of care for older persons.

violence¹⁶. Increasingly, racialised people and migrants are over-surveilled, targeted, detained and criminalised through EU and national policies, with technology (including AI) forming part of those infrastructures of control.¹⁷ It is essential that the use of AI in the health system is not used to replicate these patterns of human rights violations.

- Racial and ethnic minorities, including Roma people and Travellers, also experience lower and discriminatory access to care and higher mortality rates, and face longstanding institutional, interpersonal, and societal anti-Roma racism, discriminatory attitudes and views, which sometimes materialise and are reinforced through highly unethical and racist research, including genetic research practices.¹⁸ It is also critical to recognise t00000887 0 595.25

economic determinants and other forms of structural and systemic barriers are important contributors to the complexities of mental health.¹⁹

- Members of the LGBTI community: Gender and sexual minorities face unique health challenges not experienced by cisgender and heterosexual people and face a disproportionate burden of physical and mental health issues, as well as sexual violence.²⁰ For example, the provision of sexual health and care is different for transgender people and men who have sex with men (MSM) as they may be at a higher risk of HIV. Women who have sex with women are also marginalised in terms of response to their specific health needs, precisely due to the biased assumption that none is needed. In addition, these individuals experience unique access barriers due to stigmatisation and discrimination²¹. Also, the health needs of LGBTI older persons differ greatly from the older persons who are not part of the community. AI trained on health datasets of cisgender and heterosexual people could not be applicable for use on LGBTI patients.

The above examples are a mere partial illustration of the injustices faced by key population groups. Due to these patterns, many key populations face reduced access to healthcare and/or discrimination in provision of healthcare, which results in unrepresentative health and medical data in the long term. When unrepresentative datasets are being used to train algorithms in machine

diseases) and may inadvertently pose the risk of replicating and aggravating such issues.²² If we are not consciously and cautiously investigating the way in which these issues can be mirrored, the issues of systemic inequalities will continue to persist, and AI, the tool that can lead to important gains in many disease areas, may exacerbate those in the absence of an appropriate legal/governance framework. Techno-solutionist narratives which claim to have technical solutions for societal problems should be profoundly scepticised. If we truly want to develop AI to reduce health inequalities, this can only happen in a community-based and radically co-creational way. Otherwise, it will simply be another tool which may bring health benefits to some at the exclusion of others; particularly those who are, and have been, traditionally excluded and remain in the fringes of society, often referred to as the 'dead spaces' of society.²³

This Joint Statement calls for GENERAL MEASURES for health AI by EU institutions, Member States, and relevant stakeholders:

6. Ensuring robust protection of personal data and confidentiality to ensure that personal data obtained in the context of receiving care is not further shared or in particular, for secondary uses outside the provision of healthcare.
7. Setting up effective redress mechanisms allowing patients to contest the application of the AI system or challenge the decisions made by the AI systems.
8. Setting up a public EU-wide system to record the relevant usage of health AI systems and

consent. In case of purpose that is limited, such limitation criteria should be reasonably crafted,

attention to key populations, including biomedical, digital, eHealth and mHealth services, and the IoMT (Internet of Medical Things).

2. Creating awareness and implementing professional training

Innovations, and Health Action International } together with network partners
from the following institutions/organisations: -

Margareta Matache, Director of the Roma Program, FXB Centre for Health and Human Rights, Harvard University | Lecturer on Social and Behavioural Sciences, Harvard T.H. Chan School of Public Health

Raymond Gemen, Senior Policy Manager for Health Inequalities, European Public Health Alliance
Tackling Health Inequalities through Mainstreaming Anti-Racism and Anti-Discrimination Policy (DisQo)

Francesca Centola, Policy and Knowledge Officer, Mental Health Europe | Leader of the 2022
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Michele LeVoy, Director, Platform for International Cooperation on Undocumented Migrants (PICUM)

Louise Bonneau, Advocacy Officer, Access to Justice, Racial Equality and Health, Platform for International Cooperation on Undocumented Migrants (PICUM)

Laurence Meyer, Racial and Social Justice Lead, Digital Freedom Fund