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HEALTH DATA USE DURING THE PANDEMIC

Sharing health data for immigration control affects marginalised communities

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Stokel-Walker raises an important concern that relaxation of data sharing restrictions during the covid-19 pandemic might continue after the pandemic has ended.¹ There was mixed opinion about the sharing of some data between healthcare providers and authorities at the height of the crisis, such as to enable police to enforce self-isolation to reduce the spread of covid-19.² It is essential, however, that further sharing is lawful and not to the detriment of vulnerable groups.

Data sharing between NHS organisations and the Home Office has long been used for immigration control purposes. This has had an adverse effect on access to healthcare for marginalised groups, such as asylum seekers and undocumented migrants, who fear their data being shared with the Home Office for immigration enforcement.^{3 4} This is likely to extend to influencing covid-19 vaccine uptake among these populations.⁵ There are also wider public health implications if people from a population with high rates of other infectious diseases, such as tuberculosis, avoid accessing healthcare, leading to low rates of detection and treatment.⁶

Healthcare data sharing should be used only to enhance healthcare. Such data should not be shared for the purpose of immigration control, and appropriate reassurances should be given that this will not occur. The changes to data sharing during the pandemic provide an opportunity to rethink how data are shared and how this affects the health inequalities faced by vulnerable populations.

Competing interests: MP has personal experience of the UK asylum system. LZW, CK, and MP are members of the Royal College of Psychiatrists Working Group for the Health of Asylum Seekers and Refugees.

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