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The UK Health and Care Bill: failure to address fundamental issues of coverage and funding

The UK Government has outlined its legislative proposals for a new Health and Care Bill.¹ The objectives, heavily aligned with the National Health Service (NHS) England Long Term Plan, include strengthening integration, reducing bureaucracy, and improving accountability. Although the timing is questionable, to the extent that these proposals aim to promote integration and cooperation, they should be welcomed.

However, this legislation underpins another aim: to take back control of the NHS, with plans for the government to have enhanced powers of direction over a merged NHS England and NHS Improvement, and to transfer functions between health-related bodies, such as the Care Quality Commission, Health Education England, and the National Institute for Health and Care Excellence.¹ The rationale and policy evidence behind these proposed legislative changes are unclear. The last attempt by the current government to supposedly take back control, Brexit, has not inspired much confidence in the smooth running of policy. Ask the UK fishermen or just about anyone in Northern Ireland. Certainly, if NHS management is drawn into ministerial control, there is the risk that NHS objectives will conflict with other pressing government priorities, not least the various public finance issues that will continue past the lifetime of this government.

In taking back control, reflection on how the UK Government has handled the ongoing pandemic is necessary. The UK has one of the highest COVID-19-associated death rates in the world.² The early shortages in personal protective equipment delivery were scandalous. The track and trace system was not a world-beating system, as

claimed. Conversely, aspects of the NHS response, particularly those not fully directed by the government, deserve recognition. In a matter of a few weeks, critical care capacity was massively expanded, many thousands of staff reallocated, and services reorganised to reduce transmission of COVID-19. The NHS has also established world-leading clinical trials on vaccines and treatments. As of March 14, 2021, the NHS has delivered the first of two vaccine doses to more than 24 million people in the UK.

The main messages from these legislative proposals are improved integration and ministerial control. Note that most ministers for health will last less time than it takes to train a nurse or a doctor—hardly the sustainable outcome that would be wished for. Little is said on how the legislation will fund the delivery of any improvements. Surely further savings are not envisaged, given the frugal funding in the decade up until 2018. Our forthcoming London School of Economics and *Lancet* Commission on the future of the NHS,³ in line with other bodies, calls for substantial increases in funding for the NHS, social care, and public health in the region of 4% per annum, in real terms, for each. We also recommend that long overdue reforms of the social care funding model are urgently implemented to improve financial protection. The obvious means of doing this for the NHS would be an increase in progressive taxation. Of course, there is some saving grace in this; most of these legislative proposals only relate to England. Scotland, Wales, and Northern Ireland have presumably to sort themselves out.

We declare no competing interests.

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Missing again: US racial and ethnic data for COVID-19 vaccination

In the USA, Feb 2 is Groundhog Day, when the famous Punxsutawney, PA, groundhog's sighting or absence of sighting of its shadow predicts how long winter will last. The phrase also now evokes thoughts of an endless time loop, following a 1993 comic film, in which an egotistical cynical weather reporter who is assigned to film the groundhog gets stuck in a time glitch, endlessly repeating the day. He escapes only by learning the errors of his ways, redeemed by self-reflection leading to self-improvement and finally authentic love for another person.¹

On Feb 2, 2021, readers of the US Centers for Disease Control morbidity and mortality report² could be forgiven for thinking that we, likewise, had entered a repeating time loop. Among the 12 928 749 people who initiated vaccination against COVID-19 (ie, received at least one dose of vaccine) during the first month of the US vaccine roll-out (Dec 14, 2020, to Jan 14, 2021), data for race and ethnicity were missing for 48.13% (6 222 052) of people, despite the reporting form prominently indicating that data for race and ethnicity are required (appendix). By contrast, data for age were missing for only 0.04% (4633) of people and data for sex were missing for 3.02% (390 908) of people.² These data



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For the **NHS England Long Term Plan** see <https://www.england.nhs.uk/long-term-plan/>

For more on **vaccinations in the UK** see <https://coronavirus.data.gov.uk/details/vaccinations>



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are essential to ensure that the vaccine roll-out meets stated standards and maintains equity in vaccine access and vaccine confidence.

Similarly, in early April, 2020, US journalists, advocates, and scientists raised alarm at gross gaps in data for race and ethnicity for COVID-19 cases and deaths, impeding the ability to document health inequities and guide interventions.³ Although the proportion of records for COVID-19 deaths that are missing racial and ethnic data is now low (<1%), the proportion of records of cases that are missing these data has not decreased: despite reporting mandates, these data were missing for 43.00% (181 484 of 422 057) of COVID-19 cases that were reported between Aug 28 and Sept 16, 2020,⁴ and for 33.00% (4 083 477 of 12 374 172) of COVID-19 cases that were reported between Dec 2, 2020, and Feb 3, 2021.

Journalists, advocates, and scientists are again decrying the extensive missing data for race and ethnicity for vaccination records; meanwhile large numbers of affluent white people with good computer access to book appointments are attending vaccination sites that were set up to serve communities of colour that were hard hit by COVID-19.⁵

At a time of heightened awareness about racial injustice and white supremacy, it is astonishing that racial and ethnic data for vaccination are missing. The first month of vaccination occurred in the final month of the Trump administration. To get out of this pernicious time loop, self-reflection, learning from past errors, and a commitment to equity are essential. The new Biden–Harris administration should ensure that these required data are reported.

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The medical right to repair: the right to save lives

Throughout the COVID-19 pandemic, hospitals worldwide have reported inadequate supplies of crucial equipment¹ such as ventilators, haemodialysis machines, personal protective equipment, and decontamination equipment. Having functional crucial equipment is essential for hospitals to meet patient care needs, especially now, when there is a demand for nearly every ventilator to be called into near constant service in COVID-19 hotspots worldwide.

With high-use demands brought on by COVID-19, even for newer equipment, repair and maintenance issues arise from high use related to patient volume, acuity, and turnover. COVID-19 has forced hospitals to use ventilators that have been in storage for many years,² including some that were previously decommissioned.

COVID-19 emphasises the long-standing refusal by manufacturers to provide information for repairing

medical equipment.³ For years, manufacturers have curtailed the ability of hospitals to independently repair and maintain medical equipment by preventing access to the necessary knowledge, software, tools, and parts.³

A solution exists—one that exists in other sectors of our economy. The right to repair is the right of consumers to repair and modify their own consumer electronic devices, such as mobile phones and automobiles. The European Commission announced plans in March, 2020, for new rules for the right to repair that would cover mobile phones, tablets, and laptops by 2021.⁴ In the USA, Massachusetts state passed the country's first Motor Vehicle Owners' Right to Repair Act in 2012,⁵ requiring automobile manufacturers to provide the necessary information for anyone to repair their vehicles.

There is an opportunity now for the medical community to ensure that the medical field benefits from access rights to open data that are similar to the rights for consumer electronics and automobiles. In August, 2020, Senator Ron Wyden of Oregon introduced the Critical Medical Infrastructure Right-to-Repair Act of 2020,⁶ removing barriers to fixing medical equipment during the COVID-19 pandemic that were imposed by manufacturers. This bill requires that manufacturers provide, on fair and reasonable terms, access to information and tools that can be used to diagnose, maintain, or repair medical equipment. The law also allows owners, lessees, and services for medical equipment to repair or maintain crucial medical infrastructure in response to COVID-19.

During these extraordinary times, such legislation for the right to repair not only moves the medical field in a more affordable, efficient, and sustainable direction but also enables life-saving services to continue to be available at times of high stress.

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