BUILD BACK FAIRER: THE COVID-19 MARMOT REVIEW

The Pandemic, Socioeconomic and Health Inequalities in England

The Health Foundation

INSTITUTE of HEALTH EQUITY

CONTENTS

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CHAPTER 1
INTRODUCTION

Build Back Better has become the mantra. Important, but we need to Build Back Fairer. The levels of social, environmental and economic inequality in society are damaging health and well-being. As the UK emerges from the pandemic it would be a tragic mistake to attempt to re-establish the status quo that existed before the pandemic – a status quo marked in England, over the past decade, by stagnation of health improvement that was the second worst in Europe and widening health inequalities.

That stagnation, those social and regional health inequalities, and health deteriorating for the most deprived people, are markers of a society that is not functioning to meet the needs of its members. There is an urgent need to do things differently, to build a society based on the principles of social justice; to reduce inequalities of income and wealth; to build a well-being economy that puts achievement of health and well-being at the heart of government strategy, rather than narrow economic goals; to build a society that responds to the climate crisis at the same time as achieving greater health equity.

It was precisely those principles of fairness and the need to do things differently that animated the concrete recommendations we set out in *Health Equity in England: The Marmot Review 10 Years On*, published in February 2020, just before the pandemic hit with such devastating intensity. The COVID-19 crisis, the pandemic and associated social and economic response, has made such action even more important. The UK has fared badly. Not only does excess mortality associated with COVID-19 in England vie with that of Spain for the dubious distinction of the highest excess mortality in Europe, but the economic hit is among the most damaging in Europe. The mismanagement during the pandemic, and the unequal way the pandemic has struck, is of a piece with what happened in England in the decade from 2010.

The recommendations we make in this report are, in large measure, built upon those we made in our *10 Years On* report. We offer them, along with an over-riding commitment to equity, as a way To Build Back Fairer.

The pandemic and Health Equity in England: The Marmot Review 10 Years On

"We have lost a decade. And it shows" was the simple summary of *Health Equity in England: The Marmot Review 10 Years On*, published in February 2020 (1) (2). Improvements in health, as assessed by ill-health and life expectancy, had slowed markedly over the decade from 2010. Health inequalities were growing. And, of extreme concern, life expectancy for women and men living in the most deprived areas outside London had dropped. In a rich society such as the UK we are used to health improving steadily. When the rate of health improvement in the UK lags behind all other rich countries except Iceland and the USA, and life expectancy for some groups begins to deteriorate... simply, it should not be happening.

So strong is the link between social determinants and health that health is a good measure of how well we are doing as a society (3). In England, we have been doing badly. The growth in health inequalities means that inequalities in society generally have been growing too.

With due caution, we asked if the policies of the UK government that came into office in 2010 could have been responsible for this miserable picture of the nation's health. The caution was scientific because what happened in the decade from 2010 was not a controlled experiment. That said, it is clear that the policies and their consequences have been damaging, from the closure of children's centres and increases in child poverty, through reductions in per-pupil education spending, to an increase in precarious and poorly paid work and in zero-hours contracts, to a housing affordability crisis and a rise in homelessness, to people with insufficient money to lead a healthy life, to reductions in adult social care. Roll-back of the state – public expenditure reduced from 42 per cent of GDP to 35 per cent over the decade from 2010 – and the regressive nature of cuts in public expenditure and fiscal policies damaged health and made health inequalities worse. Particularly striking were the increased regional inequalities in health. The more deprived the area of residence the greater the health disadvantage of living in Northern Regions of England. Life expectancy improved in London, regardless of level of deprivation. In most regions north of London, life expectancy declined for women and men in the most deprived areas.

In 10 Years On we made recommendations in five key domains that could lay the basis of building a better, more just, society, characterised by improved health and a fairer distribution of health, narrower health inequalities. We took encouragement from the Prime Minister's stated ambition "to level up" – to bring the life chances of those living in more deprived regions, particularly in the North of England, up to the levels of more privileged people – and his declaration that austerity was over.

The COVID-19 pandemic then crashed upon us.

Albert Camus in The Plague wrote that the "pestilence is at once blight and revelation. It brings the hidden truth of a corrupt world to the surface". Echoing Camus, we argue that this pandemic exposes the underlying inequalities in society and amplifies them (4).

The aim of this report is three-fold:

- To examine inequalities in COVID-19 mortality. Focus will be on inequalities in mortality among member of Black, Asian and Minority Ethnic groups alongside continued attention to the social gradient in health.
- To show the effects that the pandemic, and the societal response, have had on social and economic inequalities and effects on mental and physical health, and their likely effects on health inequalities in the future.
- To make recommendations on what needs to be done.

Our recommendations are made on three timescales: the long, medium and short term.

Most important are our **recommendations for the longer term**. We must ask ourselves, as we emerge from the pandemic, what sort of society do we want to build? The message of our *10 Years On* report was that the status quo before the pandemic hit was not desirable. As judged by the health situation summarised above, society was failing its population in important ways. Building back fairer will require fundamental thinking about the nature of society in light of two major challenges facing the global community in general and England in particular: the climate crisis and inequality – both with profound implications for health equity. These twin challenges must be dealt with at the same time. The recommendations in this report, building on those made in *10 Years On*, give the building blocks for what a fairer, healthier society could seek to achieve. We also refer the reader to a companion report produced by an advisory group at the request of the Government's Committee on Climate Change: *Sustainable Health Equity: Achieving a Net Zero UK*, and published by the Institute of Health Equity (5).

Our second set of recommendations deal with **overcoming the medium term** deterioration in social and economic conditions caused by the pandemic and associated societal response: lockdown and decreased economic activity.

The third set of recommendations looks at **what we must do right now** given the inequalities exposed and amplified by the pandemic.

A short background on social determinants of health

In 2005, the World Health Organisation invited Michael Marmot to chair the Commission on Social Determinants of Health (CSDH). The CSDH reported in 2008, in *Closing the Gap in a Generation* (3). On the cover of that report we said: "Social injustice is killing on a grand scale". The CSDH emphasised the importance of what has come to be known as Universal Health Coverage but concluded that the real determinants of health lie outside the health care system in the conditions in which people are born, grow, live, work and age. Inequity in these conditions is driven by inequities in power, money and resources.

The CSDH was global in its reach. After its 2008 report, the UK government asked how its conclusions and recommendations could be adapted for one country, England. This strategic review of health inequalities in England was conducted by what became the UCL Institute of Health Equity. The Marmot Review was published in 2010 as *Fair Society, Healthy Lives* (6).

The Marmot Review contained six domains of recommendations:

- Give every child the best start in life.
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.

We focussed particularly on socioeconomic inequalities in health – the social gradient: the more deprived the area of residence, the shorter the life expectancy in that area. The social gradient was even steeper for disability-free life expectancy. That social gradient grew steeper still in the decade following 2010, as socioeconomic and regional inequalities widened.

In our 2010 report we coined the term proportionate universalism. We were impressed by the evidence that universalist policies have better prospects for reducing inequalities in health, particularly in light of the social gradient in health. The argument for focussed policies, on the other hand, is to work harder where need is greatest. Putting these two approaches together led to proportionate universalism: universalist policies with effort proportionate to need. The NHS provides a good example of proportionate universalism: a universal service, but the greater the need the greater the focus and use of resources. Departures from this principle cause real hardship. In our 2020 Report we documented that cuts in per person spending by local government followed the social gradient in deprivation, but the wrong way. The greater the need, more deprived the area, the steeper were the cuts – this was spending inversely proportional to need. The impact on local government's ability address social determinants of health will be profound.

In both the 2010 Marmot Review, *Fair Society, Healthy Lives*, and in our *10 Years On* review published this year, we reported on ethnic differences in health, and in the social determinants of health.

Analysis of ethnic differences in health was also a major feature of the Commission of the Pan American Health Organization (PAHO) on Equity and Health Inequalities in the Americas, a commission led by the UCL Institute of Health Equity. Throughout the Americas – from North America to Latin America and the Caribbean – Indigenous peoples have worse health than non-Indigenous; and people of African descent consistently suffer disadvantage in health and in the social determinants of health. Our report highlighted the effects of colonialism and structural racism and emphasised the overwhelming need to deal with such racism in combatting the social determinants of health inequalities.

As the present report makes clear, there are consistently higher mortality rates from COVID-19 among Black British people and those of South Asian descent. Much of this shockingly higher rate of COVID-19 can be attributed to where people live and to socioeconomic disadvantage. The implication is clear: dealing with this higher risk entails not just healthy practices, handwashing and social distancing, but also recognising and dealing with structural racism. We have used the language of 'the causes of the causes' to describe social determinants of health. One interpretation of structural racism is that it represents the 'causes of the causes of the causes'. It is structural racism that means minority ethnic groups suffer from disadvantage in each of the social determinants highlighted and summarised in our recommendations. To put it simply, race and class are not the same. But dealing with social inequalities will go some way to dealing with the social and health disadvantage suffered by ethnic minorities. There must also be recognition and abolition of systemic racism.

Both the statistics on COVID-19 mortality and the Black Lives Matter movement should ensure that issues of ethnic inequalities in health gain attention and action. We welcome the increased focus on ethnicity and equity, particularly by the NHS and Public Health.

Managing health, managing the pandemic

As described above, the UK went into the pandemic with a health situation that was far from ideal: widening health inequalities between socioeconomic groups and regions and a rate of improvement in life expectancy slower than in all other rich countries except Iceland and the USA. After the pandemic struck, social inequalities in mortality from COVID-19 were similar to the pre-existing social gradient in health; there were increased inequities in relation to ethnicity and occupation; and the UK vied with Spain for the highest excess mortality in Europe.

If, as we argue when looking at health in England in the decade after 2010, health is a measure of how well society is meeting the needs of its members, then the UK's poor management of the pandemic may similarly be a marker of a society that is not functioning in a socially cohesive and supportive fashion. There are potentially four ways that continuity between the pre-pandemic and pandemic situation could operate.

First, is **governance and political culture**. The priority of the government elected in 2010 was austerity and rolling back of the state; it failed to improve the earnings of employed people. There was little evidence of policy that would improve health and well-being for all. There was a resurfacing of language of the undeserving poor perhaps as justification for the regressive changes made to the tax and benefit system. A striking example of failure of governance and political culture was that Brexit dominated political discussion of the last years of the decade, with scant regard for its effect on health and well-being, or even economic fortunes. We note that the government's Office of Budget Responsibility now estimates that Brexit with a Free Trade Deal will take 4% of UK GDP long term; without a trade deal the figure will be 5.5%. We also note that the Brexit "debate" was characterised by a level of public dishonesty that, if not unique in British history, was certainly conducive of lack of trust.

Second, is **widening socioeconomic inequalities**. The global financial crisis of 2007/8 led to an initial pause in the growth of inequalities of income. Subsequently, inequalities of income and wealth continued to grow. These contributed to growing inequalities between regions. More than the distribution of income there are inequalities in circumstance of daily life through the life course that play an important part in generating health inequalities. Parenthetically, we note a report from the US that during the pandemic, from March to September 2020, the wealth of America's 643 billionaires increased 29%, $845billion. By contrast hourly wages of the bottom 82% of the population went down by 4%.

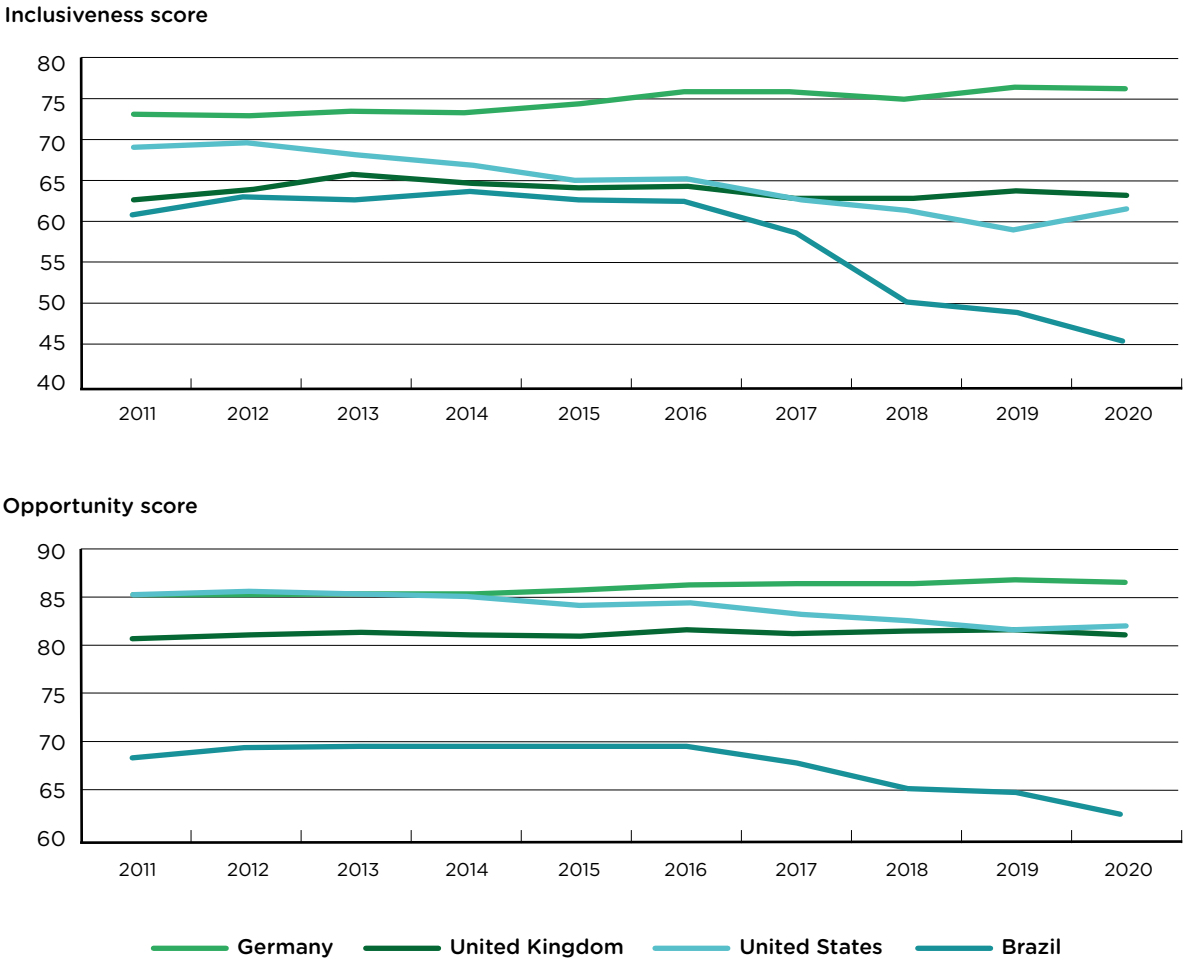
Following the Commission on Social Determinants of Health we describe these two sets of influences as inequities in power, money and resources. They were more inequitable at the end of the decade than they were before the global financial crisis.

Third, is **austerity**. Government policies succeeded in reducing public expenditure. Among the effects were regressive cuts in spending by local government, cuts to adult social care, failure of health care spending to rise in accord with historical patterns, cuts in public health funding. These were in addition to cuts in welfare to families with children, cuts in education spending per pupil, and closure of children's centres. England entered the pandemic with its public services in a depleted state and its tax and benefit system regeared to the disadvantage of lower income groups.

Fourth, **health had stopped improving**, and there was high prevalence of the health conditions that increase case fatality ratios of COVID-19.

Support for our speculation of failure of governance is provided by the Social Progress Index (7). We looked at two of the many dimensions of this index: inclusiveness and opportunity, over the decade to 2020, in four countries. Inclusiveness is measured as equality of political power by socioeconomic position, gender, ethnicity, and sexual orientation; as well as discrimination and violence against minorities. Opportunity, includes inclusiveness plus measures of personal rights, vulnerable employment, corruption, early marriage, access to advanced education. We contrasted Germany, which had controlled the pandemic well, with the UK and USA, which had controlled the pandemic badly, and Brazil as a country that was hit particularly badly. On both indices, Germany scores higher than the other countries, and maintains its high level. Brazil does worst, and the UK and USA lie in between (Figure 1.1.).

Figure 1.1. Trends in two measures of social progress: inclusiveness and opportunity



Source: 2020 Social Progress Index (7).

We would describe this as speculation rather than detailed analysis. That said, it is consistent with our formulation that a country's success in managing the pandemic is related to how well its society is functioning. In the case of COVID-19 there are readily understood specific influences that offer a partial explanation: ensuring supplies of personal protective equipment (PPE), and how closely advice is followed on social distancing and mask wearing. A major failure in the British and American cases has been the inability to set up a properly functioning 'test, trace and isolate' system. It is worth noting that Germany's leader, Angela Merkel, is a trained scientist and is widely considered to have communicated clearly and factually with the German population.

At a more fundamental level, the deep-rooted inequalities in society which manifest in overcrowded households and unsafe working conditions will have made it harder to manage the pandemic, as has the fact that the UK government's response to maintaining people's incomes, while welcome, was less generous than in many European countries.

Other countries besides Germany managed better, too. Perhaps New Zealand is an unfair comparator country – it has a small population and is geographically isolated. But while Britain was trying to decide how and whether to respond, New Zealand went hard and went early. Informal accounts suggest a high degree of social cohesion and mutual support in New Zealand. As was true in Britain in the first lockdown in the spring, people took action for the common good.

Other countries provide similarly good models. Japan, Taiwan, the Republic of Korea (South) and Hong Kong all set up rigorous test, trace and isolate systems and have experienced widespread adherence to social distancing and mask wearing.

These countries also illustrate the false dichotomy between choosing to manage the economy or the pandemic. In general, the greater the mortality from COVID-19, the worse the economic hit to the country. The Asian countries named above all had a relatively low drop in GDP following the pandemic's onset compared with the UK.

Building back fairer

Health Equity in England: The Marmot Review 10 Years On was published in February 2020, just before the pandemic really hit in Britain. Not only was it a review of what had happened over the previous decade: we also made recommendations for what a fairer, healthier society could look like, with specific recommendations in five of the original six Marmot domains.

For a brief moment it seemed that our report would be bypassed by events. Concerns with how to improve the kind of society that gives rise to stalling improvements in health and rising inequalities would be neglected given the immediate demands of the pandemic. That neglect was short-lived with recognition of the inequalities exposed and amplified by the pandemic, and the long term damage to social determinants of health.

There were other important lessons, relevant to building back fairer, to come out of the pandemic. Among them:

- The importance of government. A smaller state is not a priori a good thing. Without firm, evidence-based government action, it is impossible to control a pandemic and, we would argue, act on the social determinants of health to achieve greater health equity.
- The importance of local action, by local government and civil society, alongside action by the national government.
- Whatever it takes. Whereas the government elected in 2010, shortly after the global financial crisis, prioritised austerity, the government in 2020 said: whatever it takes. Austerity is neither necessary nor desirable in the face of great national need. The pandemic needs to be controlled and economic and social infrastructure need to be supported. Governments can spend, and they must, if we are to build back better and fairer.
- That said, the early signs from the Government's spending review in autumn 2020 present a mixed picture. There will be a permanent scarring effect on the economy – it will be 3% smaller, meaning it will take longer for the average family to recoup their losses. Amid welcome dedicated spending made necessary by the pandemic, there will be a reduction of £10 billion in 'normal public sector spending' next year (Resolution Foundation). There is a proposed freeze in public sector pay outside the NHS, and a failure to continue the boost to Universal Credit.
- Who keeps society functioning. During the pandemic there has been a high correlation between low pay and having to continue to work in frontline occupations. Nurses, care workers, drivers, food processors, supermarket workers, and others providing essential services, all put themselves at risk and kept society functioning. We need to recognise the value these people contribute to society as they enable us all to do

what we do. To take one example, one in ten workers in social care are on zero hours contracts and have neither adequate training nor opportunities for career progression. Sixty per cent of care workers in England earn less than the real living wage. We have previously laid out the case for better education and pay for people with responsibility for working with young children. Similarly, we should value the people who work with older people. Building back fairer has to value all these people who play such a vital role in society.

- Commitment to the common good. The better angels of our nature were in evidence during the first lockdown in England. People took action not only to protect themselves but to protect their communities. This flew in the face of the cult of selfishness that marked economic and social policy beginning in the 1980s. After the first lockdown, with inconsistent and changeable government information and advice, the demands of the common good became less clear. A socially cohesive society with concern for the common good is likely to be a healthier society. Government has both a clear enabling role and is a crucial source of accurate information and advice here.

- The wonders of clean air. With lockdown came dramatic reductions in car traffic; and with that came cleaner air, and a likely reduction in emission of greenhouse gases. Walking and cycling as modes of transport became both necessary and desirable. As the pandemic is brought under control and public transport again becomes safe, a future for our cities based on reduction in vehicle traffic and made safe for walking and cycling in addition to public transport is a future we can both imagine and realise.

- Patterns of work, taken for granted as necessary, have changed markedly. For some occupations being at the place of work is a necessity, for others less so. As society emerges from the pandemic there is the opportunity, and the need, to revisit patterns of work. In the companion report to this one, on sustainable health equity, we reviewed evidence that a four day week, for example, could reduce green house gas emissions without compromising productivity. It is time for a national debate on Universal Basic Income and Universal Basic Services.

Not so much a lesson from the pandemic, but a more general one: greenhouse gas emissions and inequality are linked. Higher income countries have greater greenhouse gas emissions per person than low and middle income countries; and within countries, it tends to be higher income groups that are responsible for a greater proportion of emissions. Responding to the climate crisis and dealing with the health consequences of inequality must go hand in hand.

In this report, in the light of the pandemic, we revisit the recommendations we made in our February 2020 report to offer a set of building blocks to build a better, socially just and healthy society. 'Build back fairer' entails tackling inequality and the climate crisis and will achieve sustainable health equity.

SECTION 1

INEQUALITIES IN THE RISK OF COVID-19 AND MORTALITY

CHAPTER 2

INEQUALITIES IN THE RISK OF COVID-19 AND MORTALITY

In February 2020 we provided an analysis of health inequalities in England in the report ***The Marmot Review 10 Years On***. The report evidenced widening health inequalities and worsening health outcomes in England between 2010 and 2020 (1). Both socioeconomic and regional inequalities in health increased over this period, likely associated with policies of austerity and their impacts on key social determinants of health. As we said in the original 2010 Marmot Review, such widescale health inequalities are 'unjust' and 'unnecessary' (6).

BOX 2.1. SUMMARY: INEQUALITIES IN HEALTH BETWEEN 2010-20. (FROM *10 YEARS ON REPORT*)

LIFE EXPECTANCY SINCE 2010

- Increases in life expectancy have slowed since 2010 with the slowdown greatest in more deprived areas of the country.
- The UK has seen low rates of life expectancy increases compared with most European and other high-income countries.
- Inequalities in life expectancy have increased since 2010, especially for women.
- Female life expectancy declined in the most deprived 10 percent of neighbourhoods between 2010-12 and 2016-18 and there were only negligible increases in male life expectancy in these areas.
- There are growing regional inequalities in life expectancy. Life expectancy is lower in the North and higher in the South. It is now lowest in the North East and highest in London.
- Within regions, life expectancy for men in the most deprived 10 percent of neighbourhoods decreased in the North East, Yorkshire and the Humber and the East of England.
- Life expectancy for women in the most deprived 10 percent of neighbourhoods decreased in every region except London, the West Midlands and the North West.
- For both men and women, the largest decreases were seen in in the most deprived 10 percent of neighbourhoods in the North East and the largest increases in the least deprived 10 percent of neighbourhoods in London.
- In every region men and women in the least deprived 10 percent of neighbourhoods have seen increases in life expectancy and differences between regions for these neighbourhoods are much smaller than for more deprived neighbourhoods.

HEALTH SINCE 2010

- There is a strong relationship between deprivation measured at the small area level and healthy life expectancy at birth. The poorer the area, the worse the health.
- There is a social gradient in the proportion of life spent in ill health, with those in poorer areas spending more of their shorter lives in ill health.
- Healthy life expectancy has declined for women since 2010 and the percent of life spent in ill health has increased for men and women.

MORTALITY RATES SINCE 2010

- There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45-49. It is likely that social and economic conditions have undermined health at these ages.
- For people in their 70s mortality rates are continuing to decrease, but not for those at older ages.
- The slowdown in mortality improvement cannot, for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, results from influences other than winter-associated mortality.
- There are clear socioeconomic gradients in preventable mortality. The poorest areas have the highest preventable mortality rates and the richest areas have the lowest.

COVID-19 has further revealed and amplified these inequalities in health, and there are clear socioeconomic and ethnic inequalities in risk mortality from the disease. It is clear that the existing health situation in February 2020 is highly relevant to what has happened during the COVID-19 pandemic. We therefore begin this chapter with a brief summary of the inequalities in life expectancy that existed before the pandemic and then assess the unequal risks of mortality and infection from COVID-19. These differing risks are related to socioeconomic factors and area deprivation, occupational exposures, living conditions, ethnicity, religion and previous health – itself closely related to socioeconomic status.

BOX 2.2. SUMMARY: COVID-19 AND INEQUALITIES IN MORTALITY

INTERNATIONAL COMPARISON

England has higher mortality from COVID-19 and higher excess deaths than other European countries. In addition to specific failures to control the pandemic it may relate to the policy decisions and socioeconomic conditions prior to the pandemic, that gave rise to England's relatively poor state of health, pre-pandemic.

HEALTH CONDITIONS

Some underlying health conditions significantly raise the risk of mortality from COVID-19. In England, prior to the pandemic, health was deteriorating, life expectancy stalling and health inequalities widening. Socioeconomic inequalities played a big part in these adverse health conditions in the decade before 2020.

DEPRIVATION AND INEQUALITY

COVID-19 mortality, the more deprived a local authority is, the higher the mortality rate during the COVID-19 crisis. Mortality from other causes follows a similar trajectory.

REGIONAL INEQUALITIES

While the pandemic is affecting Regions differently at various points during the pandemic, the close association between underlying health, deprivation, occupation and ethnicity and COVID-19 make living in more deprived areas in some Regions particularly hazardous. Given the widening health and social determinants inequalities between Regions in England prior to the pandemic, it is expected that mortality rates in deprived areas will be higher in Regions outside London – particularly the north west and north east and that has been the case since the end of the first wave.

LIVING CONDITIONS

Overcrowded living conditions and poor quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be in deprived areas and inhabited by people with lower incomes. Evidence from analysis in Ten Years on showed that housing conditions had deteriorated for many in the previous decade.

OCCUPATION

There are clear differences in risks of mortality related to occupation. Being in a key worker role, unable to work from home and being in close proximity to others put people at higher risk.

- Occupations at particularly high risk include those in the health and social care and leisure sectors, as well as those requiring elementary skills such as security guards and taxi drivers.
- While mortality risks are closely linked to occupation, area of residence has an important bearing on the extent of occupational risk. Managers living in deprived areas have above average risk for their occupation and workers in the elementary occupational group living in the least deprived areas have a lower risk of COVID-19 mortality

BAME

Mortality risks from COVID-19 are much higher among many BAME groups than White workers in England. These BAME groups are disproportionately represented in more deprived areas and high risk occupations; these risk factors are the result of longstanding inequalities and structural racism. This does not fully explain COVID-19 risk, there is also evidence that much of the BAME workforce in highly exposed occupations are not being sufficiently protected with PPE and safety measures.

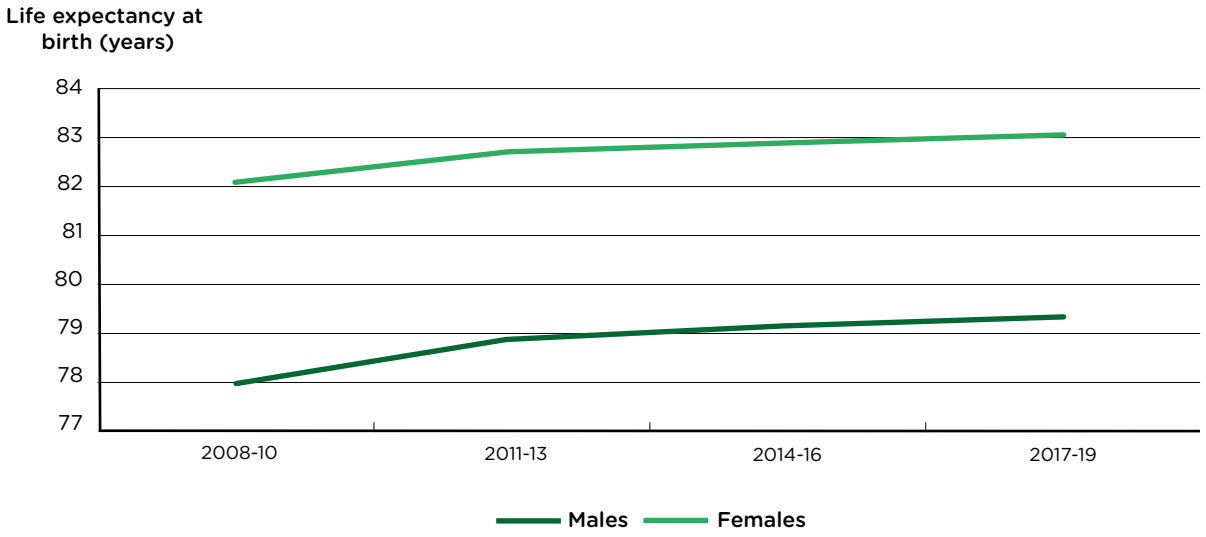
CUMULATIVE RISKS

Risks of mortality are cumulative – being male, older, and BAME with an underlying health condition, working in a higher risk occupation and living in deprived area in overcrowded housing led to much higher rates of mortality and reflect lifetime experience.

2.A THE CONTEXT: INEQUALITIES IN LIFE EXPECTANCY BEFORE THE PANDEMIC

As shown in our *10 Years On* report, there have been worrying deteriorations in health and widening health inequalities in England since 2010. In particular there has been a marked slowdown in the rate of increase in life expectancy with average annual increases of around six weeks for men and four weeks for women between 2011 and 2018 (1) (8). This equates to an increase of approximately 0.1 year each calendar year in that period. Figure 2.1 illustrates the change in trend since around 2011.

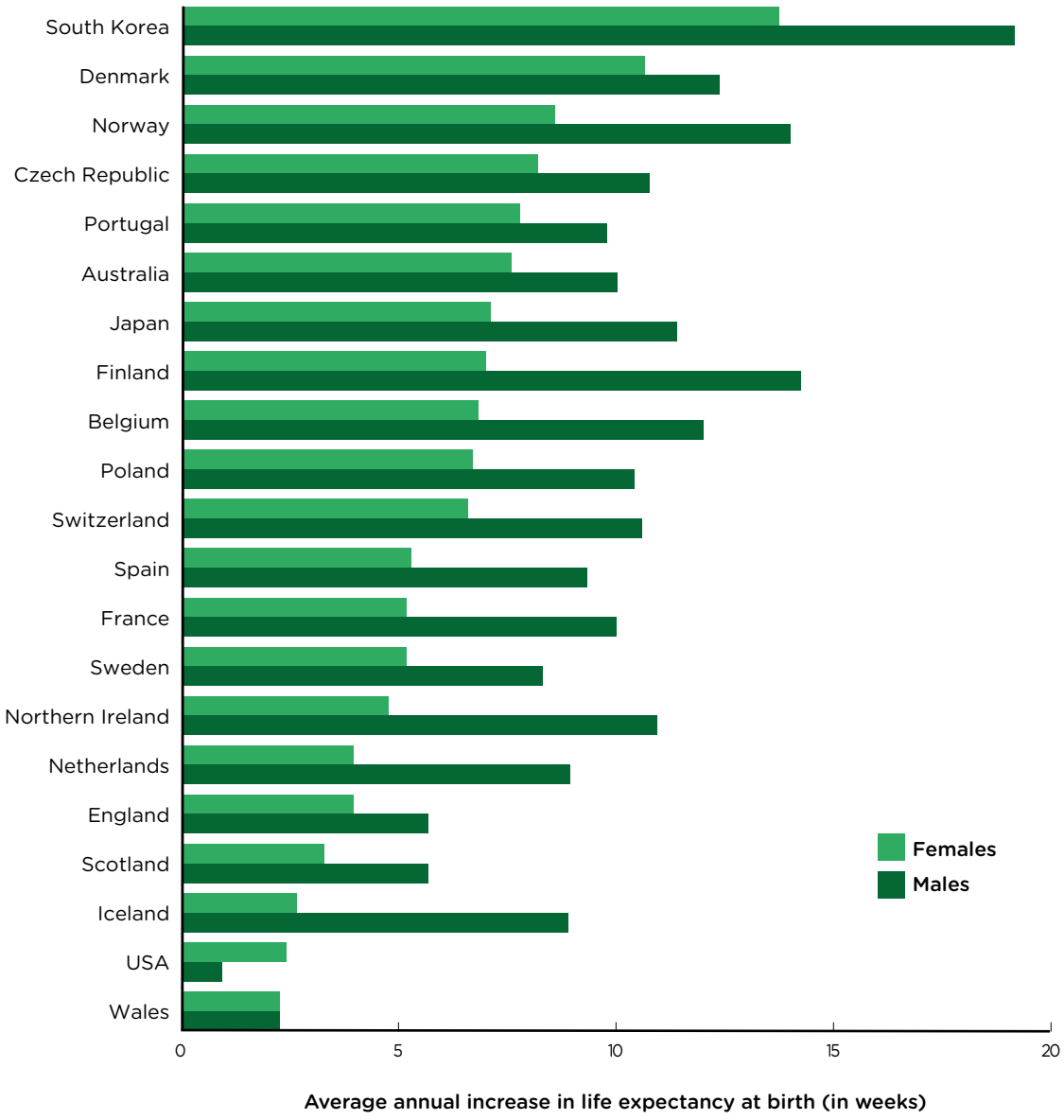
Figure 2.1. Life expectancy at birth for males and females, UK, between 2008-10 and 2017-19



Source: *ONS, 2020 (8).*

Figure 2.2 shows the average annual improvements in life expectancy for males and females in countries within the UK in the period between 2011 and 2018, and for 18 Organisation for Economic Co-operation and Development (OECD) countries with a similar level of economic development, for comparison. This shows that England, Wales and Scotland experienced some of the lowest average improvements during this period – only the USA, for both males and females, and Iceland, for females, had lower average improvements in this period.

Figure 2.2. Average annual life expectancy improvement in weeks in selected OECD countries including the UK, 2011 to 2018

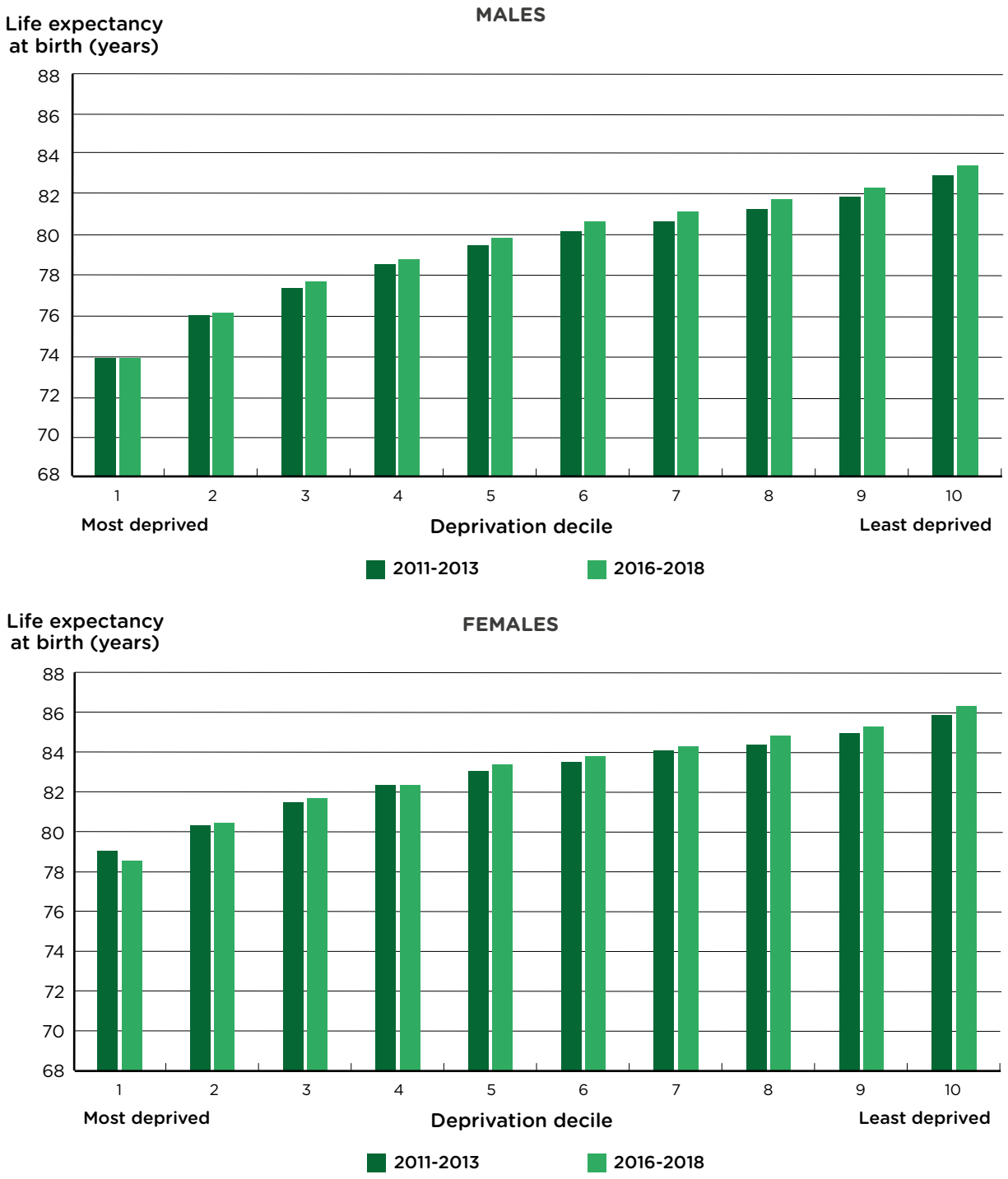


Note: *Countries were selected for which period life expectancy at birth data for 2018 were available in the Human Mortality Database at the time of the ONS publication.*

Source: *Based on ONS, 2019 (8).*

Life expectancy is closely related to the level of deprivation of areas – more deprivation leads to worse health and shorter life expectancy (Figure 2.3). In the 10 Years On report we showed that in England these inequalities widened between 2010 and 2018, the latest available years for data, and this is important to understanding and remedying inequalities in mortality from COVID-19. Pre-existing social conditions matter enormously to mortality rates from COVID-19 (9). As illustrated in Figure 2.3, prior to 2020, there were no improvements in life expectancy for men between 2011–13 and 2016–18 in the two most deprived area deciles, and there was even a reduction in life expectancy for women in the country's most deprived area decile. The largest increases in life expectancy between 2011–13 and 2016–18 nationally were seen in the five least deprived area deciles. For those living in London, however, life expectancy increased in all deciles for both men and women (see Section 2.E).

Figure 2.3. Life expectancy at birth by area deprivation deciles and sex, England, 2011–13 and 2016–18



Notes: *The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation for small areas in England. Decile 1 represents the most deprived areas and 10 represents the least deprived. For the period 2016–18, all estimates were calculated using IMD 2019; for the earlier period IMD 2015 was used.*

Source: *Based on ONS data, health state life expectancies by national deprivation deciles, England: 2011–13 and 2016–18 (2020) (10).*

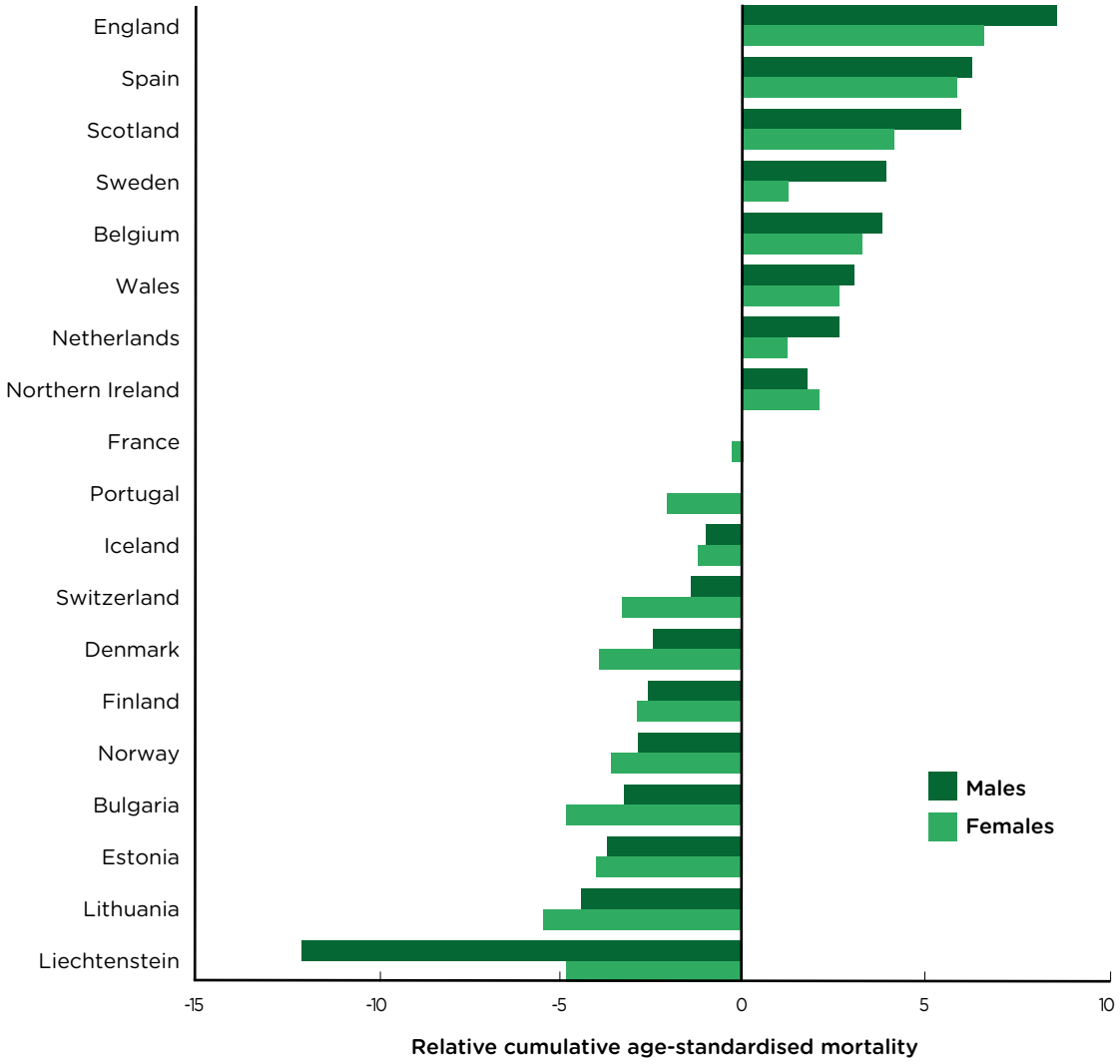
2.B MORTALITY FROM COVID-19 AND OTHER CAUSES DURING THE PANDEMIC

While the pandemic is still ongoing it is impossible to know what the full death toll will be. Methods of estimating mortality vary but all estimates will continue to rise for the foreseeable future. On 14 November 2020 the Public Health England (PHE) and NHS cumulative number of deaths involving COVID-19 in England stood at 45,592, recorded within 28 days of a positive test by date of death, while the Office for National Statistics (ONS) estimated 55,311 deaths in England and Wales up to 30 October, based on all deaths where COVID-19 was mentioned on the death certificate (11) (12).

The ONS and PHE have used different methods to estimate total excess deaths in England compared to the previous five years. By the week ending 30 October, PHE estimated that there were 56,313 excess deaths based on recent demographic trends (13) while the ONS estimated that, based on the five-year average (ignoring these trends), there were 60,332.

International comparisons of excess mortality rates between January and June 2020, compared with each country's average excess mortality over the previous five year are shown in Figure 2.4. England's poor position in relation to excess mortality in other countries is not unexpected. In the 10 Years On report we set out that England's life expectancy improvement between 2011-2018 was one of the lowest among other OECD countries, and the UK was the lowest apart from Iceland and the USA (Figure 2.4).

Figure 2.4 Relative cumulative age-standardised all cause mortality rates by sex, selected European countries, week ending 3 January to week ending 12 June 2020



Note: *Relative cumulative age-standardised mortality rates (rcASMRs) were developed by the Continuous Mortality Investigation (CMI) and described in working paper 111 (14). Rather than absolute values of death counts, rcASMRs sum all age-standardised mortality rates between two time points. In this figure, rcASMRs are calculated cumulatively from week 1, 2020 until week 24, 2020 and are relative to the 2015-2019 average cumulative age-standardised mortality rate for that time period in each country.*

Source: *ONS (2020) Comparisons of all-cause mortality between European countries and regions, January to June 2020 (14).*

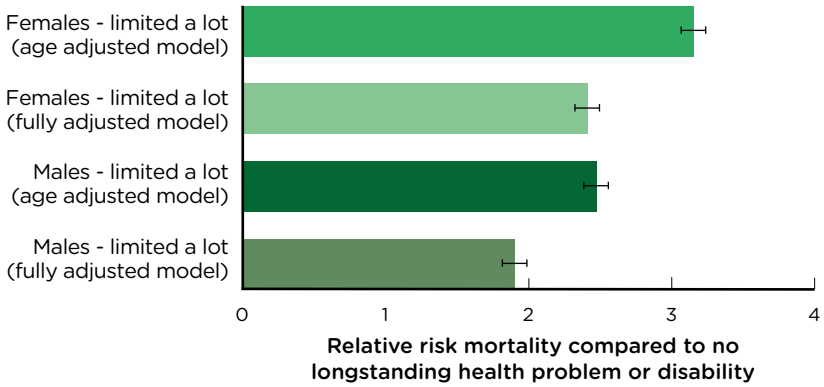
The COVID-19 mortality rate is much higher for older age groups, particularly those over 80, for men and for people with longstanding health conditions. Our 10 Years On report set out how health and disability are closely related to socioeconomic position and area (1). People living in more disadvantaged areas, with lower education and lower incomes and in areas outside the South of England and London, are more likely to be in poor health than those living in less disadvantaged areas in London and the South. Mortality rates for COVID-19 are far higher for people with disabilities. Poor health and disability are two of the explanations for differential rates of COVID-19, but are themselves closely related to socioeconomic factors.

The average number of pre-existing conditions for deaths involving COVID-19 between March and June 2020 was 2.1 for those aged 0 to 69 years and 2.3 for those aged 70 years and over. Particularly high risk pre-existing conditions include dementia and Alzheimer's disease, diabetes, hypertension, cardiovascular disease and other chronic diseases such as chronic obstructive pulmonary disease (COPD) and chronic kidney disease (15; 16). Some of these, such as dementia, largely reflect the ages at which COVID-19 deaths occur, while others, such as diabetes, have been identified as risk factors for adverse outcomes of COVID-19 viral infection. Obesity is also a risk factor for severity of symptoms and mortality from COVID-19 (17). ONS data show that the most

common pre-existing condition among those who have died from COVID-19 in England and Wales is dementia and Alzheimer's disease, a factor in 25.6 percent of all deaths involving COVID-19 during March-July, 2020. The second most common pre-existing condition is ischaemic heart disease, which was present in 9.9 percent of those who died with COVID-19 (18).

After adjusting for region, population density, socio-demographic, household characteristics and occupational exposure, the relative difference in mortality rates in England and Wales between those whose day-to-day activities were limited a lot because of a longstanding health problem or disability and those whose were not was 2.4 times higher for females and 1.9 times higher for males (from 2 March to 15 May 2020) for all those living in private households in 2011 (19). The graph shows 'fully adjusted' ratios which strip out any differences which might be related to age, region, population density, area deprivation, household composition, socio-economic position, highest qualification held, household tenure, multigenerational household flags and occupation indicators, and are intended to show the relevance only of health problems and disability to mortality from COVID-19; see Figure 2.5 (10).

Figure 2.5. Ratios of death involving COVID-19 comparing those who were limited a lot because of a longstanding health problem or disability to those with no such problems by sex, England and Wales, 2nd March to 15th May 2020



Notes:

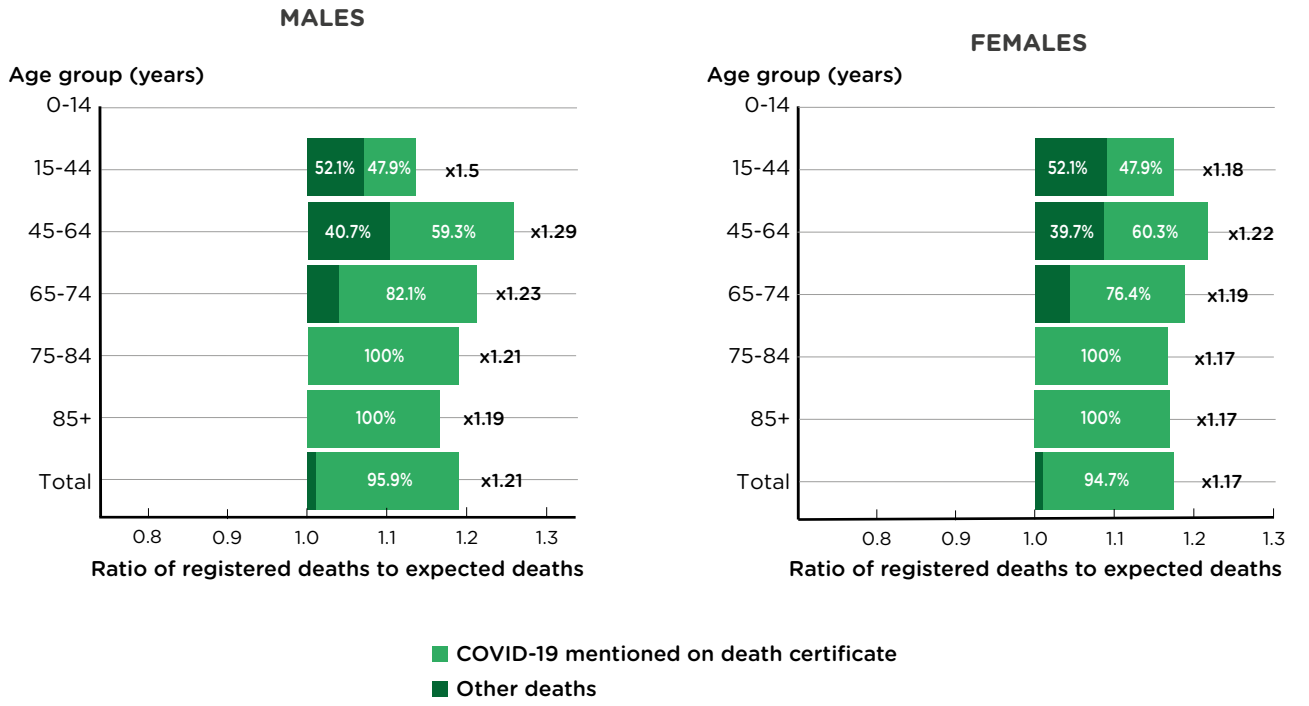
1. *Cox proportional hazards models adjusting for age and the square of age. Fully adjusted models also include region, population density, area deprivation, household composition, socio-economic position, highest qualification held, household tenure, multigenerational household flags and occupation indicators (including key workers and exposure to others) in 2011.*
2. *Office for National Statistics (ONS) figures based on death registrations up to 29 May 2020 that occurred between 2 March and 15 May 2020 that could be linked to the 2011 Census for the coronavirus (COVID-19) rate of death.*
3. *Deaths were defined using the International Classification of Diseases, 10th Revision (ICD -10). Deaths involving COVID-19 include those with an underlying cause, or any mention, of ICD-10 codes U07.1 (COVID-19, virus identified) or U07.2 (COVID-19, virus not identified).*
4. *Hazard ratios are compared to the reference category of no longstanding health problem or disability. "Whiskers" on each bar are 95 percent confidence intervals.*
5. *Health status was defined using the self-reported answers to the 2011 Census question: "Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months? - Include problems related to old age" (Yes, limited a lot; Yes, limited a little; and No).*

Source: *ONS, Coronavirus (COVID-19) related deaths by disability status, England and Wales, 2020 (19).*

While most excess deaths in older age groups had COVID-19 on the death certificates, the proportion with no mention of COVID-19 was higher in younger age groups. As shown in Figure 2.6, for males and females across all age groups the crude excess mortality rate (the ratio of registered to expected deaths) since the beginning of the pandemic was higher than expected for all age groups except for 0- to 14-year-olds but highest among 45- to 64-year-olds. For males the ratio of registered to expected deaths among 45- 64-year-olds was 1.29, which means there were 29 percent, or nearly a third, more deaths in that age group than usual for the time of year. Deaths with COVID-19 mentioned accounted for only 60 percent of these extra deaths.

The possible reasons for the large proportion of excess mortality involving deaths with no mention of COVID-19 at younger ages include some cases of COVID-19 going undiagnosed and thus not being counted (particularly when testing was not been carried out routinely), and excess deaths being caused by reduced access to health care for health conditions other than COVID-19 (e.g. suspension of some cancer treatments), and a reluctance to visit GPs and hospitals for serious conditions (e.g. suspected heart attacks) (20) (21). Further analysis is needed to understand which of these factors has predominated in producing these high levels of excess deaths (13). Their relationship with factors such as area deprivation is discussed in Section 2.D.

Figure 2.6. Ratio of registered deaths to expected deaths by age group and sex, England, 20 March to 30 October 2020



Source: *PHE analysis, 2020 (13).*

2.C INEQUALITIES AND LONG-COVID

There are increasing numbers of people suffering from long-term health impacts from both severe and mild infections with COVID-19, which has been termed 'long-COVID' i.e. more than four to six weeks longer than the common recovery time from severe COVID-19 disease (22). One study showed that patients with severe COVID-19 disease typically experience sequelae affecting their respiratory status, physical health and mental health for at least several weeks after hospital discharge (23; 24). Another study, from Italy, described that among patients who had recovered from COVID-19, 87.4 percent reported persistence of at least one symptom, particularly fatigue (25). Psychological distress and psychological morbidity due to viral illness are also long-term impacts of COVID-19 (24; 26; 25). One of the most insidious long-term effects is severe fatigue. Over the past nine months, an increasing number of people have reported crippling exhaustion and malaise after having the virus (27).

The effects of long-COVID are likely to be greater for people in more deprived neighbourhoods because they are more likely to have pre-existing existing health problems and, if they are able to work, are more likely to do so outside the home and in manual jobs. In some cases they have to continue working despite having long-COVID symptoms. Those who cannot work as a result of long-COVID are more likely to go into debt and those who were already unemployed may face additional challenges such as finding it harder to find employment because of poor health.

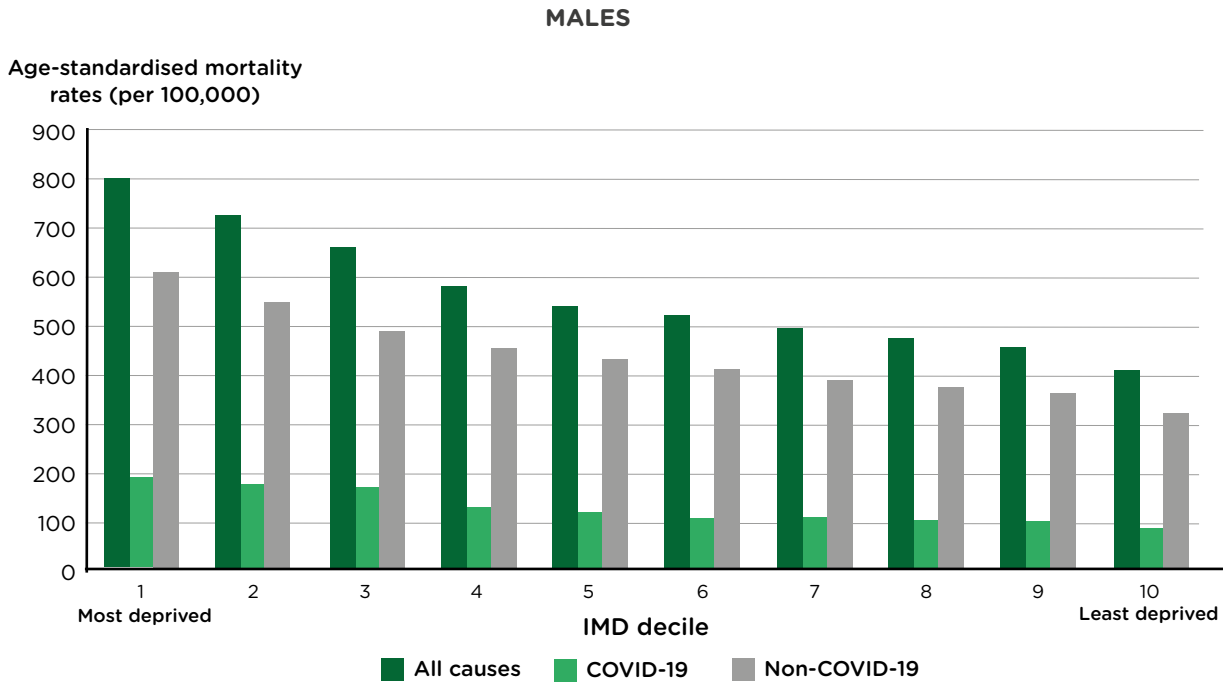
The Post-Hospitalisation COVID-19 Study (PHOSP-COVID) aims to follow 10,000 patients in the UK for a year to further understand the long-term impacts of the disease (27). More research is needed to understand inequalities associated with the likelihood of experiencing long-COVID, and also the likely inequality impacts – including inability to work and increasing poverty.

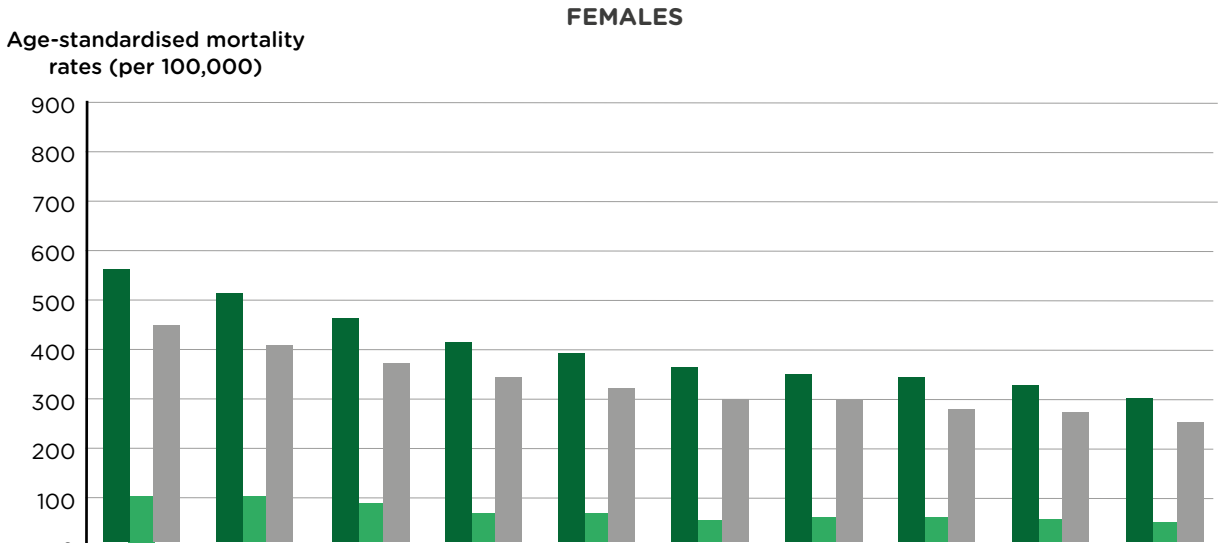
2.D AREA DEPRIVATION AND INEQUALITIES IN MORTALITY FROM COVID-19

Across England mortality rates from all causes are higher in more deprived areas, one of the clearest indicators of health inequalities. Deprivation-related inequalities in the mortality rate from COVID-19 follow a similar trajectory to inequalities in mortality from other causes, suggesting that the drivers of COVID-19 mortality are similar to the causes of inequalities in health more generally (26) (28) (29). In the 2010 and 2020 Marmot reports we set out evidence showing how health is closely related to level of deprivation in an area and to the key social determinants of health – conditions in the early years, education, employment and income, housing and (2) environmental factors. Similarly, inequalities in mortality from COVID-19 are related to levels of deprivation in an area, as well as gender, age and ethnicity.

According to analysis from the ONS, the mortality rate from COVID-19 in the most deprived areas was almost double that in the least deprived areas between March and July 2020, the latest period for which mortality data by deprivation are available. Figure 2.7 shows mortality rates by decile of deprivation, measured by the Index of Multiple Deprivation (IMD) – a measure of deprivation based on factors such as income, employment, health, education, crime, the living environment and access to housing within an area. The graph shows how COVID-19 mortality rates follow a similar inequality gradient to non-COVID mortality.

Figure 2.7. Age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000), by sex and deprivation deciles in England, for deaths occurring between March and July 2020.





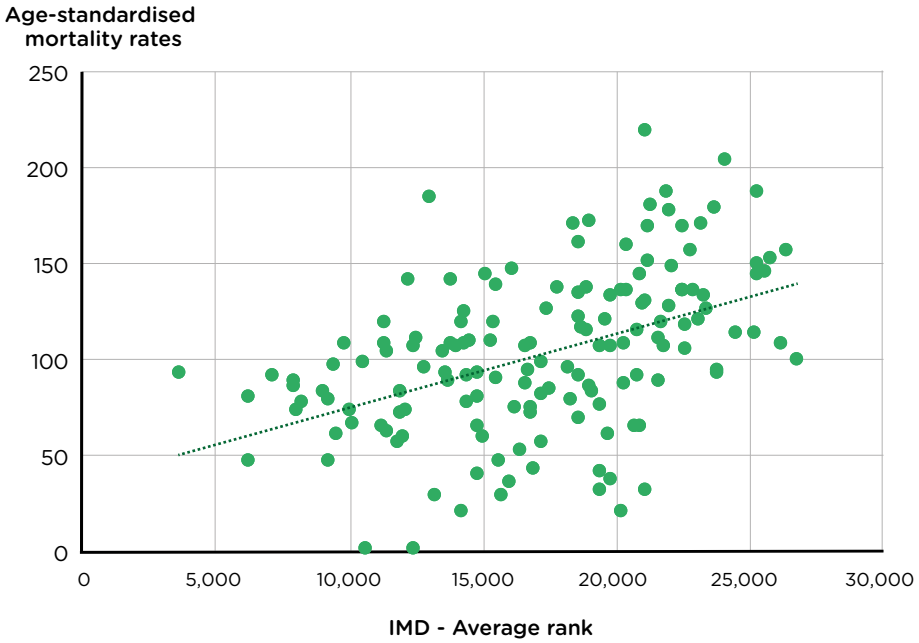
Note: *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus.*

Source: *ONS. Deaths involving COVID-19 by local area and socioeconomic deprivation, 2020 (30).*

Clearly, levels of deprivation and health within an area have an enormous impact on mortality rates from COVID-19 and deteriorating conditions in more deprived local areas in England in the years up to 2020 have meant that COVID-19 mortality has been higher than would have been the case if conditions in deprived areas had improved rather than worsened in the years leading up to the pandemic.

In relation to COVID-19 mortality, Figure 2.8 shows the close relation between the IMD rank of upper tier local authorities and age-standardised COVID-19 mortality rates in those areas. The more deprived the areas, the higher the mortality rates (31).

Figure 2.8. Age-standardised COVID-19 mortality rates (per 100,000) for March to July 2020 and IMD average rank, upper tier local authorities in England



Note: *Average rank: this measure summarises the average level of deprivation across an area, based on the population weighted ranks of all the neighbourhoods (lower super output areas – LSOAs) within it. All LSOAs in a local authority, whether highly deprived or not so deprived, contribute to this summary measure. Overall, highly deprived areas and less-deprived areas will tend to average out in the overall rank, so an area that is more uniformly deprived will tend to rank higher on this measure compared to other summary measures. A higher average rank means the average level of deprivation in an area is high and a lower rank means the level of deprivation is lower.*

Source: *ONS deaths by local authority, 2020 and Ministry of Housing, Communities & Local Government (MHCLG) English Indices of Deprivation 2019 (32) (33).*

2.E REGIONAL INEQUALITIES IN COVID-19 MORTALITY

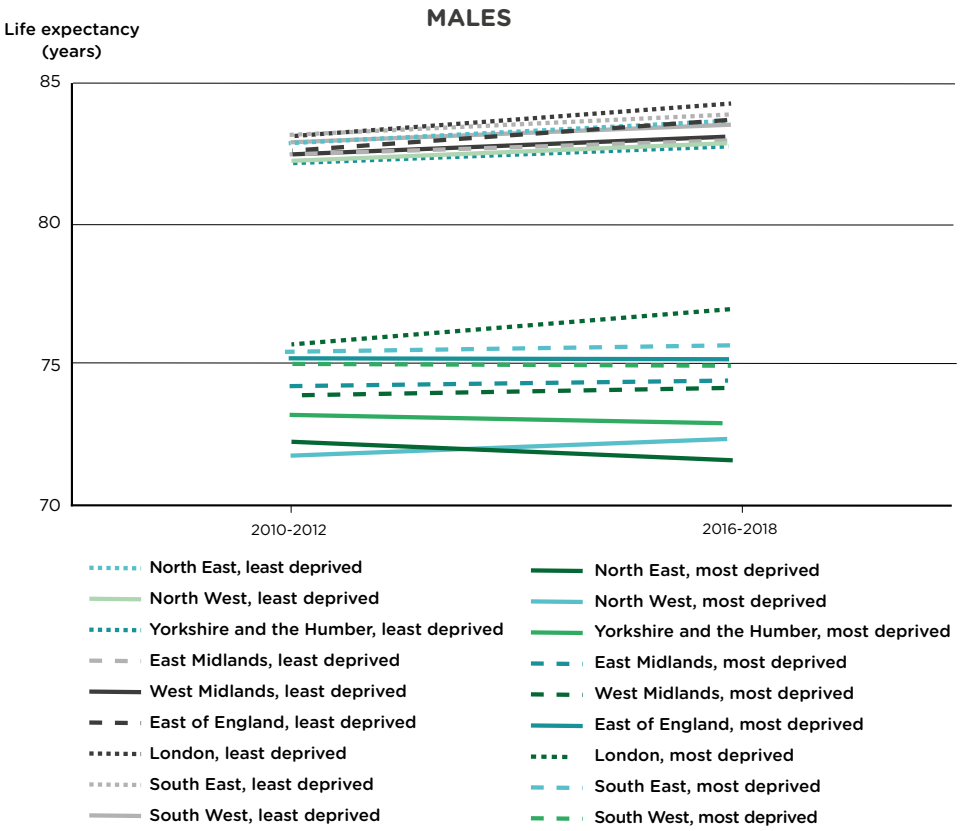
COVID-19 mortality may well further exacerbate and accelerate large and widening regional inequalities in health in England. This is both because of different regional mortality and infection from COVID-19 and because of the differential impacts of containment measures, which we discuss in subsequent chapters.

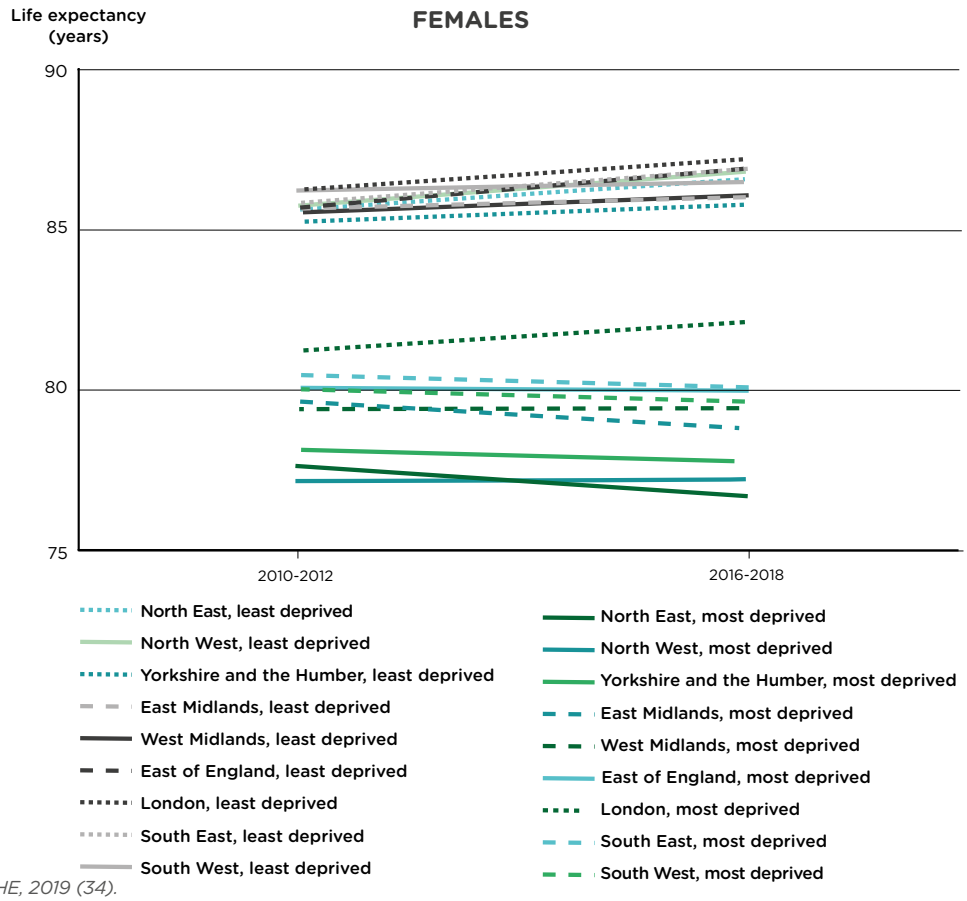
As there are wide differences in pre-existing health, levels of deprivation and the social determinants of health between different regions, all of which are closely related to levels of COVID-19 mortality, we expect that, in combination with differential rates of exposure, this is likely to result in wide regional inequalities in mortality in COVID-19.

In the 10 Years On report, we showed that inequalities in health between regions both were large and had increased between 2010 and 2020. This related to growing inequalities in the social determinants of health between regions, which were partly caused by widening inequalities between regions in wealth, income, employment and government funding. These inequalities now contribute to regional inequalities in mortality from COVID-19 (1).

The overall trend in life expectancy by area deprivation decile, shown in Figure 2.3, varied by region (Figure 2.9). Life expectancy for women in the most deprived area decile decreased in every region except London, the West Midlands and the North West between 2010–12 and 2016–18. For men in the most deprived area decile, life expectancy decreased only in the North East, Yorkshire and the Humber and the East of England. For both men and women, the largest decreases were seen in the most deprived area decile in the North East and the largest increases in both the least and most deprived area deciles occurred in London (1).

Figure 2.9. Life expectancy at birth by sex for the least and most deprived deciles in each region, England, 2010–12 and 2016–18





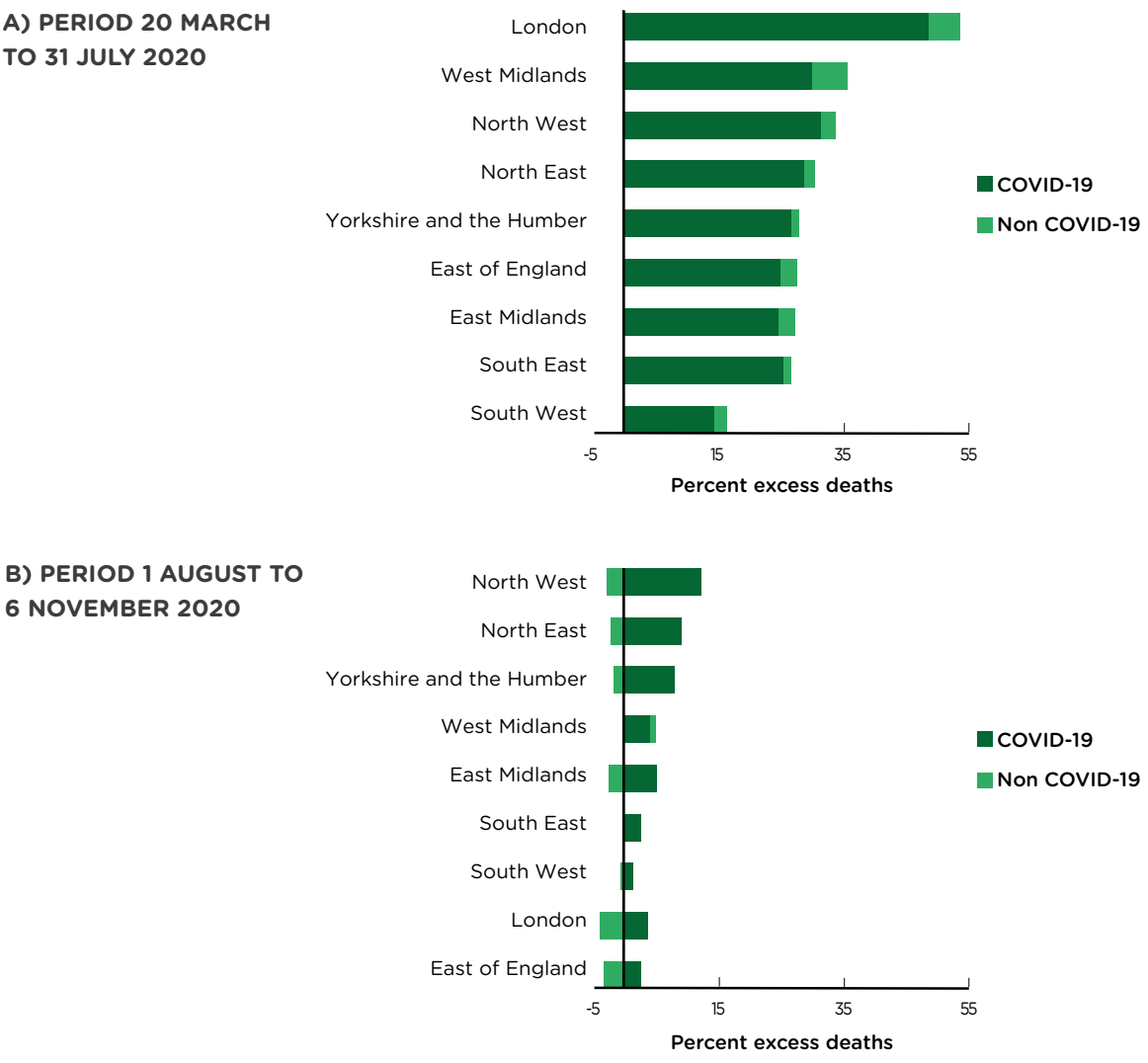
Source: *Based on PHE, 2019 (34).*

Between March and May 2020, London was the region with the highest COVID-19 mortality rate (28). As an indication of the importance of the pandemic in London, we note that in April age-standardised death rates where COVID-19 was mentioned on the death certificate exceeded those from non-COVID-19 causes. ONS data for October, however, showed that the North West and North East had the highest age-standardised COVID-19 mortality rates, while the South West had the lowest (35).

There are regional differences in rates of mortality from Covid-19, which relate to levels of poverty, occupational structure, ethnicity, age and housing conditions. In the first wave, London experienced highest mortality, and in the second wave Northern Regions and the Midlands experienced higher mortality in the period to 6 November. The South East and South West have had lower mortality during both waves so far, as shown in Figure 2.10.

As well as having the highest mortality rate where COVID-19 was mentioned on the death certificate early in the pandemic, London had the highest overall excess mortality rates between March and October. Across all regions in England, most of the excess deaths from 20 March to the end of October were due to COVID-19 (13). There is clear evidence relating COVID-19 mortality to occupation, being from a Black, Asian and minority ethnic (BAME) group, living conditions, deprivation, population density and prior health conditions – all factors that differ by region. With many of the social determinants of health widening between regions before the pandemic, this is likely contributing to widening regional inequalities in COVID-19 mortality and associated excess deaths. In the following sections of this chapter, we examine these inequalities in risk of infection and mortality.

Figure 2.10. Percent excess mortality compared to the trend in each region of England in the previous five years, by region and time period, 20 March to 6 November 2020



Source: *PHE Excess mortality in English regions - 20 March 2020 to 06 November 2020 (36).*

2.F INEQUALITIES IN LIVING CONDITIONS AND RISK OF COVID-19

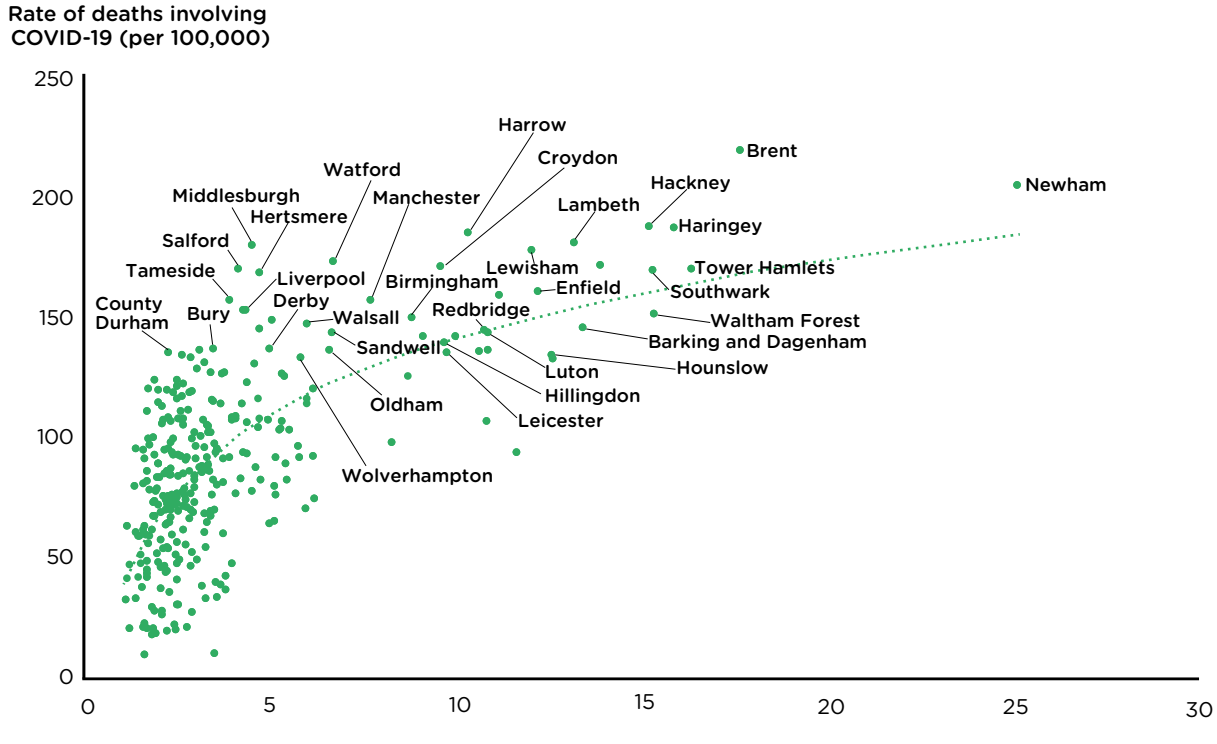
The association between area deprivation and mortality from COVID-19 relates partly to underlying health conditions, ethnicity and occupation. More deprived areas generally have more crowded housing and public spaces. The reduction in availability of affordable housing over the last 10 years means that more people are living in overcrowded, poor quality accommodation, and are now at heightened risk of COVID-19 infection and mortality, as well as other adverse health outcomes, as a result (1).

COVID-19 MORTALITY AND OVERCROWDED AND POOR QUALITY HOUSING

Higher COVID-19 mortality rates in areas with higher levels of deprivation are partly related to household overcrowding as shown in Figure 2.11. This includes multi-generational households, which increase the risk of transmission within households and between generations.

Overcrowding may also lead to an increase in severity of outcomes, because close proximity between people can lead to higher viral load. Overcrowded households are more likely to be located in more deprived areas, and there is more overcrowding among low-income households. In the last 20 years, overcrowding has increased in the rented sectors, and remains at the highest rate it has been in the social rented sector since this information was first collected in the 1990s (37).

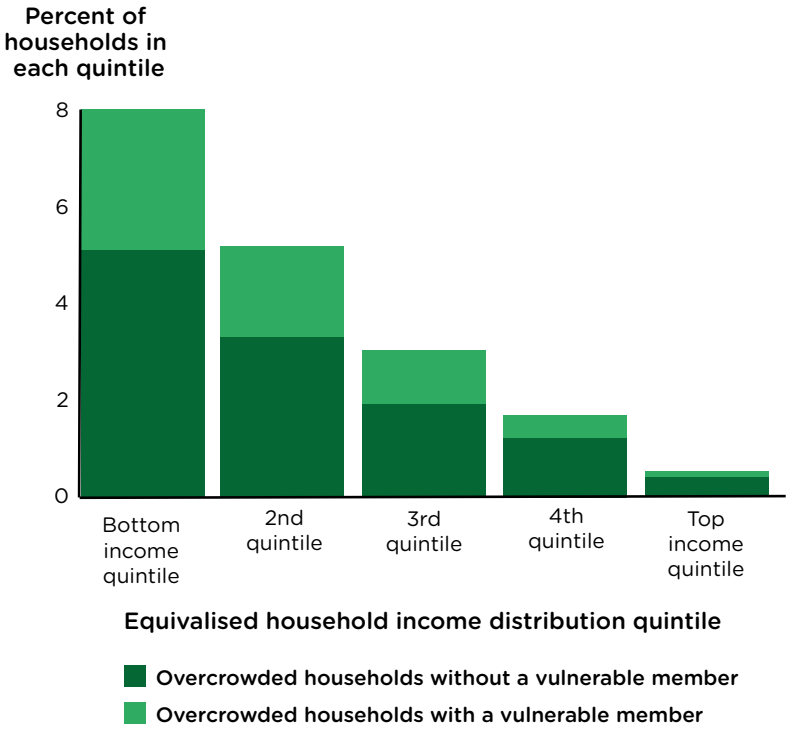
Figure 2.11. Age-standardised COVID-19 mortality rates and percent of overcrowded households, local authorities in England, deaths occurring between March and July 2020



Source: *ONS. COVID-19 age-standardised mortality rates by local authority and percent of overcrowding, 2020 (30) (38).*

Low-income, overcrowded households are also more likely to have a vulnerable person living in the house (Figure 2.12), and this combination contributes to a much higher risk of COVID-19-related mortality (39).

Figure 2.12. Prevalence of overcrowding by equivalised household income distribution quintile and presence of older adults or people with health conditions in the household, 2015/16–2017/18



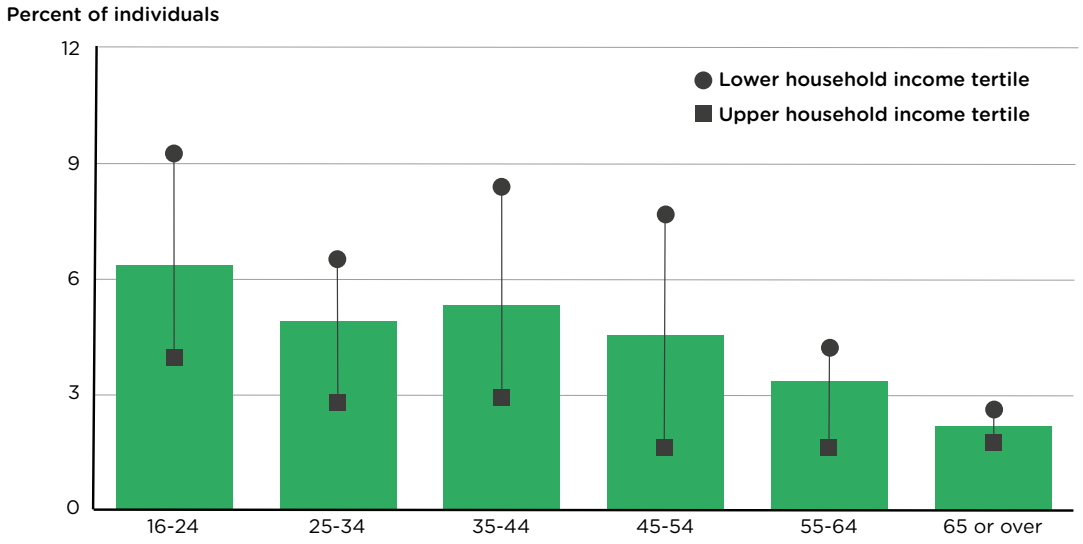
Source: *Health Foundation analysis of the English Housing Survey, MHCLG (36).*

Occupants of houses in multiple occupation (HMOs), defined as homes that are rented to five or more people not from the same family, with shared bathroom and kitchen facilities (26), are also at high risk of infection from COVID-19, as they are unable to fully control their home environment and live in close proximity to large groups of people (40). The increase in occupation of HMOs has been rapid in recent years, particularly among migrant workers, low-income and young workers, and HMOs house the most deprived populations in England. In a survey of 1,500 renters carried out by pressure group Generation Rent, nine in 10 renters sharing housing felt they could not stay safe in line with government guidance on COVID-19 (26).

As well as overcrowded housing raising the risk of infection, poor quality housing can increase the risk of having worse symptoms and of dying from COVID-19, especially for those with pre-existing health conditions (41). Living in damp conditions raises the risks of respiratory illnesses such as asthma and COPD which in turn raise the risk of having more serious COVID-19 symptoms (42). People shielding, self-isolating and locked down in poor quality housing have a higher risk of experiencing poor outcomes from COVID-19 as well as an increased risk of other poor health outcomes compared with people experiencing social distancing in good quality housing.

Figure 2.13 shows the proportion of each age group and income group living in a home with a serious damp problem, which is closely associated with income. Low-income 55- to 64-year-olds are more likely to contend with damp than 16- to 24-year-olds in the highest income tertile within their age group (44).

Figure 2.13. Proportion of individuals living in damp conditions, by age band and household income tertile in England, 2014–18



Source: *Judge L. Lockdown living: Housing quality across the generations, Resolution Foundation, 2020 (43).*

HOMELESS POPULATION MORTALITY RATES

There are higher rates of chronic disease and multiple morbidities among people who are homeless. Homeless people are three times more likely to report a chronic disease than those living in stable housing conditions (45). The high rate of chronic disease among the homeless population in England, combined with exposure to unfavourable living conditions such as overcrowded accommodation or 'living on the streets', means that homeless people are particularly vulnerable to higher rates of infection (46) (47). In December 2019, the charity Shelter reported that there were 280,000 people in England who were homeless and 220,000 who had been threatened with homelessness in the previous year (48).

At the beginning of the pandemic the Government rolled out a range of policies and initiatives aimed at people experiencing homelessness, particularly those who were rough sleeping and were severely vulnerable during the pandemic. On 26 March the Government instructed local authorities to provide accommodation for people sleeping rough (49).

A UCL study showed that during the first wave of COVID-19 the preventive measures imposed had avoided 21,092 infections in England among homeless people. However, the initial results of a survey conducted by the UCL Collaborative Centre for Inclusion Health, as reported on 4 May 2020, showed that the crude death rate of people living in London hostels housing homeless people during the crisis was 25 times higher than that of the general adult population (50). The survey also found that 38 percent of these hostels in London had suspected COVID-19 cases. In 41 percent of hostels with suspected cases of COVID-19, residents who were ill were sharing bathroom facilities with other residents (50). Furthermore, 35 percent of hostels that had been affected were still using communal dining areas (50).

People who stayed in their usual hostel accommodation during the COVID-19 outbreak described mixed experiences of how they have been supported to manage their wellbeing, including not receiving any support or assistance when they were severely ill with COVID-19 symptoms. Participants in Groundswell interviews which monitor the impact of COVID-19 on people experiencing homelessness told how there were very few preventive measures in place for hostel settings and said that staff did not have any personal protective equipment (PPE). Even though some measures separating those who were symptomatic from the rest of occupants were in place, residents said that the communal spaces and visitors made them feel unprotected from and at risk of catching COVID-19 (51).

2.G OCCUPATION AND COVID-19 MORTALITY

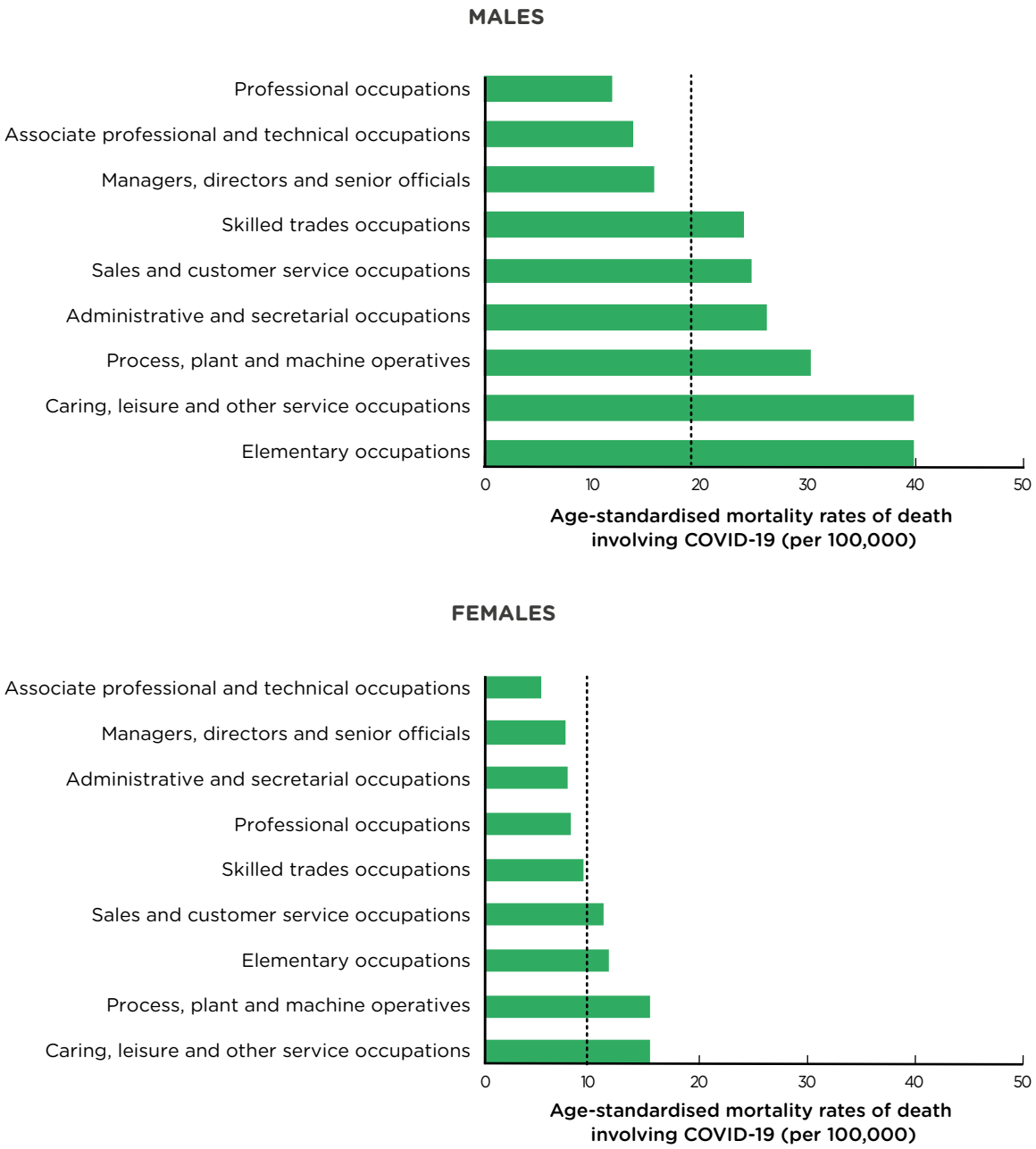
The inequalities in risk of COVID-19 mortality related to occupation are clear. Risk of exposure is a major component of this: people working in jobs that involve a great deal of public contact and contact between employees are at higher risk. Jobs that cannot be undertaken from home are higher risk – because of the inevitable contact between people at the place of work and also during travel to work. Health and care workers are particularly at risk as they are most likely to come into contact with people with infections and most have to travel to work.

These occupational risks are closely related to other socioeconomic risks; most people in professional occupations are able to work from home and avoid inter-person contact. Key worker jobs are disproportionately low-income and for many jobs with high levels of public contact there are high numbers of BAME workers. Consequently, these occupational risks reinforce socioeconomic and ethnic inequalities.

Mortality rates of major occupational groups are presented for men in Figure 2.14 for the period 9 March to 25 May 2020. There is a clear grading of COVID-19 mortality by occupation among men. Elementary workers had particularly high mortality rates (52). This group includes elementary construction and process plant occupations, postal workers, cleaners and domestic workers, security guards, elementary sales workers, hospital porters, waiters and bar staff. Care, leisure and other service occupations had similarly high mortality rates. Process, plant and machine operatives' occupations also had significantly higher than average rates. This group includes semi-skilled construction and process workers as well as taxi and cab drivers, chauffeurs and bus and coach drivers. On the other hand, men in professional occupations had the lowest mortality rate of 11.6 deaths per 100,000.

For women, those working in caring, leisure and other service occupations had the highest mortality rates from COVID-19 between 9 March and 25 May, also shown in Figure 2.14. These deaths were largely among care workers (25.9 deaths per 100,000 women).

Figure 2.14. Age-standardised mortality rates at ages 20 to 64, by sex, and major occupational group, deaths involving COVID-19 registered in England and Wales between 9 March and 25 May 2020



Notes:

1. *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus.*
2. *Elementary occupations are those that require the knowledge and experience necessary to perform mostly routine tasks, Most occupations in this group do not require formal educational qualifications but will usually have an associated short period of formal experience-related training.*
3. *The vertical line represents the average death rate at ages 20 to 64 in England and Wales for men and women, respectively, with an occupation*

Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (53).*

The ONS identified a number of characteristics of occupational groups that may have contributed to raised levels of COVID-19 mortality. These included proximity to others, exposure to disease, median hourly pay, and the percentages of the workforce that are female, aged 55 years and over and from a BAME background (54). Table 2.1 shows the numbers and rates for the 17 male occupations assessed as significantly at high risk by the ONS, ranked by age-standardised COVID-19 mortality rates. Security guards and related occupations and care workers had the highest rates and the majority of occupations considered high risk had double the age-standardised mortality rates than would be expected based on rates during the four previous years (53). Among women, only four occupations were identified as significantly high risk (nurses, national government administrative occupations, care workers and home carers and sales and retail assistants) due to the smaller overall numbers of deaths in women at working ages.

Table 2.1. Deaths involving COVID-19 and from all causes among male workers aged 20–64 years in 17 high-risk occupations England and Wales, registered between 9 March and 25 May 2020 (age-standardised rates per 100,000 population)

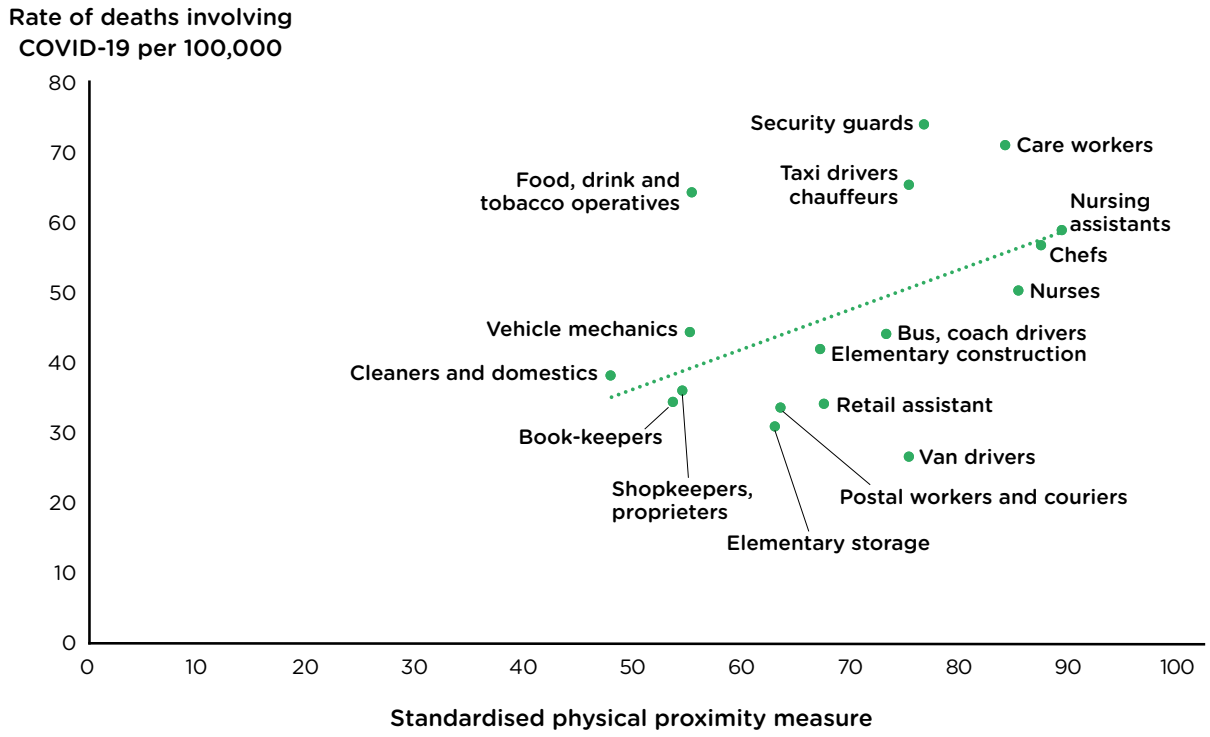
Occupation	Deaths involving COVID-19	All causes of death	Deaths expected based on rates in the same period in 2015–19
Security guards and related occupations	74.0	185.8	101.3
Care workers and home carers	71.1	192.3	135.6
Taxi and cab drivers and chauffeurs	65.3	134.3	73.2
Food, drink and tobacco process operatives	64.3	183.6	96.6
Nursing auxiliaries and assistants	58.9	128.5	62.3
Chefs	56.8	241.5	180.3
Nurses	50.4	111.5	80.3
Vehicle technicians, mechanics and electricians	44.3	181.7	126.4
Bus and coach drivers	44.2	128	64.9
Elementary construction occupations	42.1	333.7	306.4
Cleaners and domestics	38.3	133.9	77.4
Shopkeepers and proprietors: wholesale and retail	36.0	149.9	100.5
Book-keepers, payroll managers and wages clerks	34.5	87.6	71.7
Sales and retail assistants	34.2	142.5	78.1
Postal workers, mail sorters, messengers and couriers	33.6	113.6	88.1
Elementary storage occupations	30.9	138.0	92.0
Van drivers	26.7	104.9	73.4

Note: *Deaths involving COVID-19 include those with an underlying cause, or any mention, of COVID-19*
Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (53).*

OCCUPATIONAL RISK OF COVID-19 MORTALITY AND PROXIMITY TO OTHERS AT WORK

Applying the United States O*NET 'proximity to others' at work assessment to UK data, the ONS showed that among the 17 occupations in Table 2.1, nurses and nursing assistants, care workers, taxi drivers, security guards and chefs have experienced some of the highest rates of death involving COVID-19 – see Figure 2.15 (55).

Figure 2.15. Age-standardised male mortality rates (per 100,000) at ages 20 to 64 in 17 high risk occupations by proximity to others, based on deaths involving COVID-19 registered in England and Wales between 9 March and 25 May, 2020



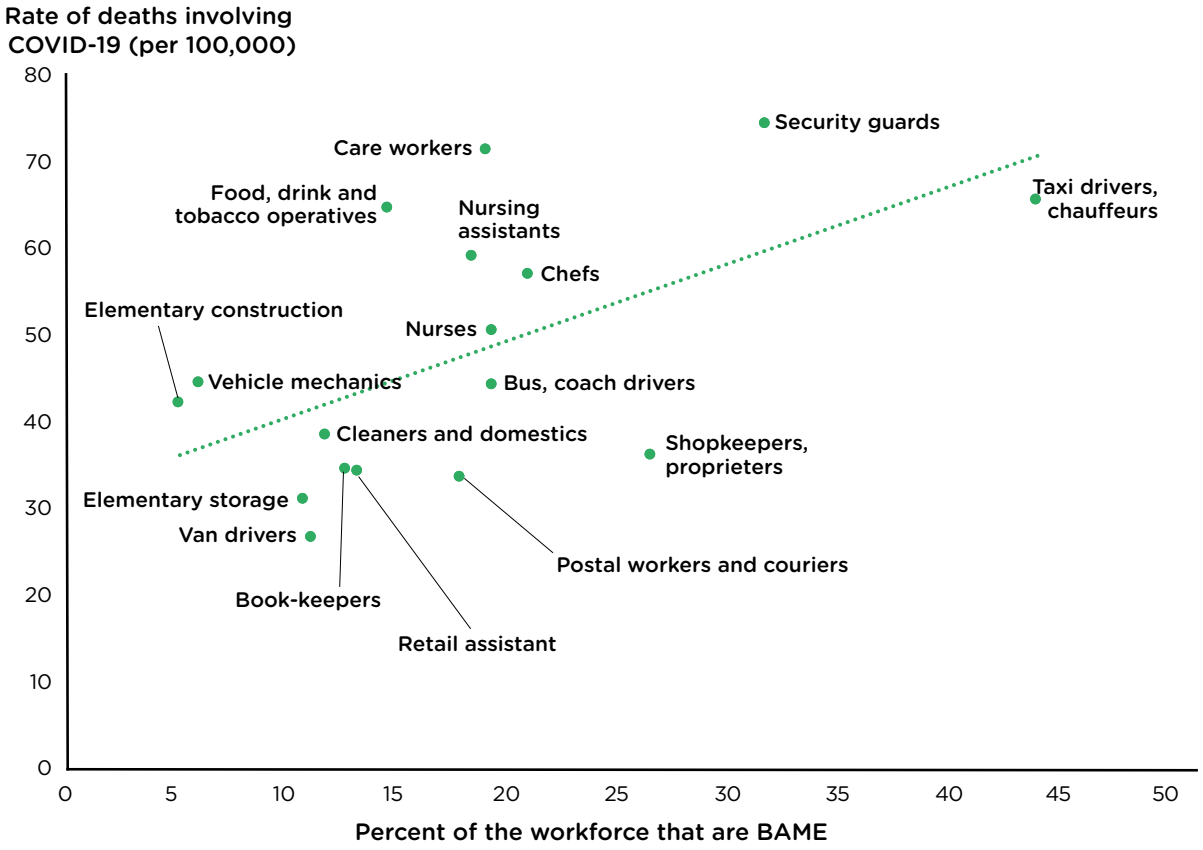
Note: *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus*

Source: *ONS, 2020 (55)*

BAME WORKFORCE

Figure 2.16 shows that some of the occupations with the highest age-standardised mortality rates of COVID-19 – taxi drivers, chauffeurs and security guards – feature a high proportion of BAME workers (55).

Figure 2.16. Age-standardised male mortality rates (per 100,000) at ages 20 to 64 in 17 occupations by percent that come from BAME groups, England and Wales, 9 March to 25 May 2020



Note: *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus*
Source: *ONS 2020 (55).*

Workers from BAME backgrounds have had more negative experiences related to discrimination and safety in the workplace during COVID-19 than White British workers. Those who identify as Black African, Bangladeshi and Pakistani have been less likely to have had adequate PPE than White British workers. Higher proportions of Pakistani (20 percent) and Indian (20 percent) key workers compared with White workers have reported that their safety complaints have been ignored (56). Differential treatment in the workplace has been highlighted as a key problem and described as a longstanding issue which existed prior to COVID-19. BAME workers have reported being concerned about raising issues because of past experiences and fear of the consequences of speaking up (57).

Concerns about the increased risk of exposure to COVID-19 among BAME staff in NHS and social care settings were raised in a survey carried out by the Royal College of Psychiatrists of their own members. For all respondents that gave a definitive answer to the question, 57 percent of BAME members felt their organisation was 'supportive' or 'very supportive' compared to 72 percent for those not from a BAME group. College members were also asked how confident they were in the COVID-19 risk assessment processes established within their organisation and in raising general concerns relating to COVID-19. Fifty-seven percent of BAME members felt 'confident' or 'very confident' (195 of 343) on these measures compared with 70 percent of those not from a BAME group (389 of 559) (58). Some participants in the survey reported that they had personally experienced or received reports from colleagues about racism, bullying or harassment at work during the epidemic. This meant that they were reluctant to speak up about issues (such as PPE shortages), which placed them at higher risk of catching the virus (58).

A report published by the Runnymede Trust in August 2020 showed that BAME frontline workers were being given substandard quality or inadequate PPE given the nature of their roles and the risk of exposure. Numerous examples were given of staff not able to access appropriate PPE to protect themselves adequately in line with national guidance and being afraid to speak up about this, and of requests for risk assessments or additional PPE by BAME workers being more likely to be refused, or less likely to be made because of fear of adverse treatment (56).

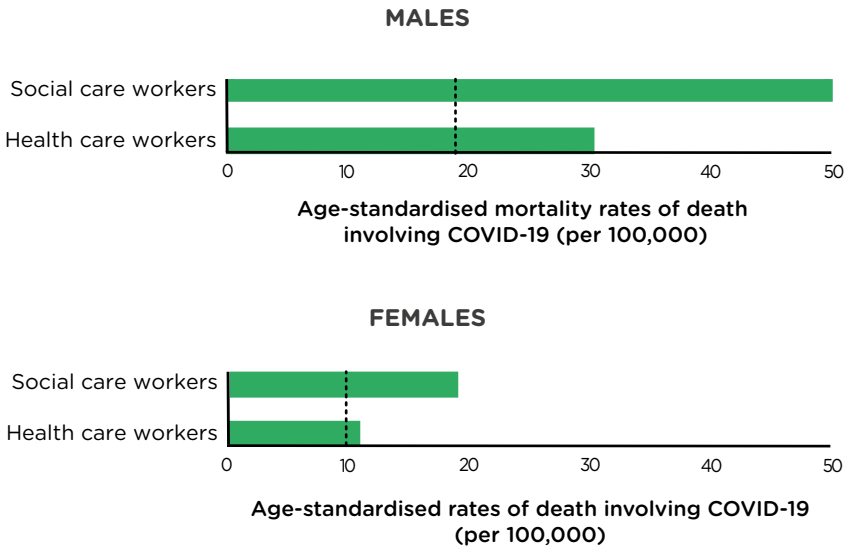
HEALTH AND SOCIAL CARE WORKFORCE

There has been a good deal of focus on mortality and infection rates from COVID-19 among health and care workers. At the start of the pandemic when there were shortages of PPE, health and care workers were found to be significantly exposed and this has resulted in higher rates of mortality among these workers compared with the average among all workers.

Figure 2.18 shows that health and social care workers had higher mortality from COVID-19 than the average for England and Wales between March and May 2020 and social care workers had the highest rate, at 50.1 deaths per 100,000 men (97 deaths) and 19.1 deaths per 100,000 women (171 deaths) (55).

Among health care workers – including occupations such as doctors, nurses and midwives, nurse assistants, paramedics and ambulance staff, and hospital porters – men had a statistically significant higher rate of death involving COVID-19 compared with the rate of deaths involving COVID-19 in the general working population, with 30.4 deaths per 100,000 men. Among women, the rate of death involving COVID-19 among health care workers was 11.0 deaths per 100,000 women, not significantly different to that observed in the general population, except for nursing staff. This is possibly the result of men having much higher death rates than women from COVID–19 therefore numbers are greater, leading to higher statistical certainty. Nurses had statistically significant higher rates of death involving COVID-19, with 50.4 deaths per 100,000 men and 15.3 deaths per 100,000 women. Nursing auxiliaries and assistants were also found to have elevated rates among men, at 58.9 deaths per 100,000 men – see Table 2.1.

Figure 2.17. Age-standardised mortality rates at ages 20 to 64 for social and health care workers by sex, deaths involving COVID-19 by sex registered in England and Wales between 9 March and 25 May 2020



Notes:

1. Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus

2. The vertical line represents the average death rate at ages 20 to 64 in England and Wales for men and women, respectively, with an occupation.

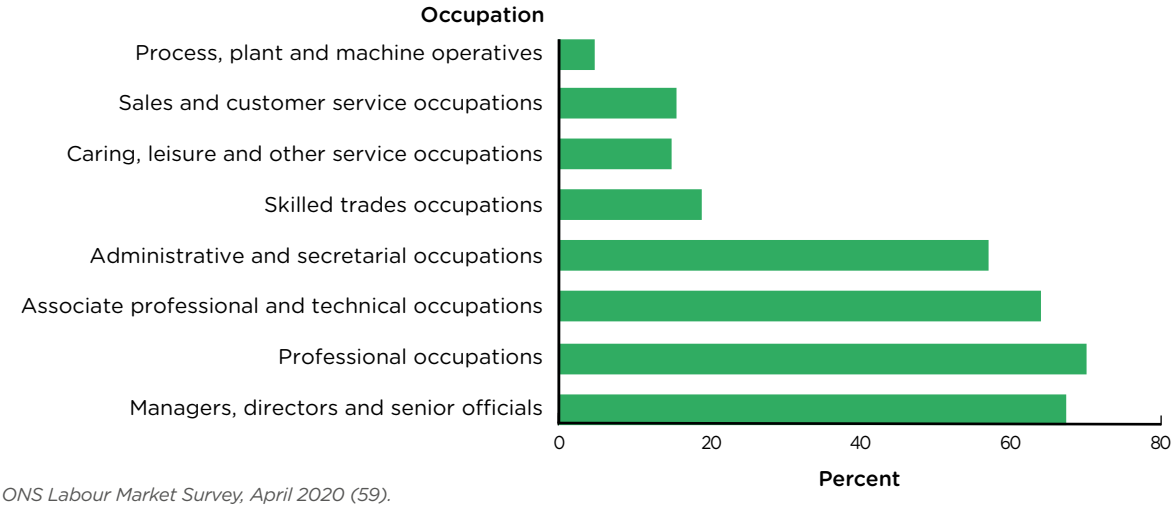
Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (55).*

INEQUALITIES AND HOME WORKING

In April 2020 nearly half (46.6 percent) of people in employment did some of their work from home, with the vast majority (86.0 percent) of these homeworkers stating that this was because of the COVID-19 pandemic. There are clear socioeconomic inequalities in who is able to work from home, and therefore in who can afford themselves greatest protection from COVID-19.

There was a higher proportion of individuals, 70 percent, in occupations requiring higher qualifications who reported to be working from home during the reference week in April 2020 compared with individuals in elementary and manual occupations: 19 percent of those in skilled trade occupations, 16 percent in sales and customer service occupations and 5 percent in process, plant and machine operatives reported to be working from home. This suggests that occupations with higher qualifications provide more homeworking opportunities (59); see Figure 2.18.

Figure 2.18. Home working by those in employment (aged 16 years and over) by occupation (not seasonally adjusted) in the UK in April 2020

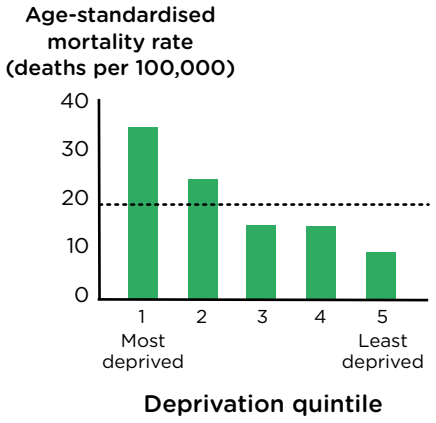


Source: *ONS Labour Market Survey, April 2020 (59).*

While occupation is an important risk for mortality from COVID-19, it intersects with other risks, such as living in a more deprived area, in poor quality or overcrowded housing, and having one or more underlying health conditions. Risks are cumulative and need to be considered together rather than separately. This point can be shown by looking at different mortality rates among workers in specific occupations according to where they live.

'Managers, directors and senior officials' is the occupational group with the lowest male COVID-19 mortality risk. However, this risk is graded according to the level of deprivation in the area of home residence (Figure 2.19). Between 9 March and 25 May, rates for those who lived in the 40 percent of the most deprived areas in England were actually higher than the England average.

Figure 2.19. Age-standardised mortality rates among managers, directors and senior officials by IMD quintiles, for deaths involving COVID-19 registered among men aged 20 to 64 years in England between 9 March and 25 May 2020



Notes:

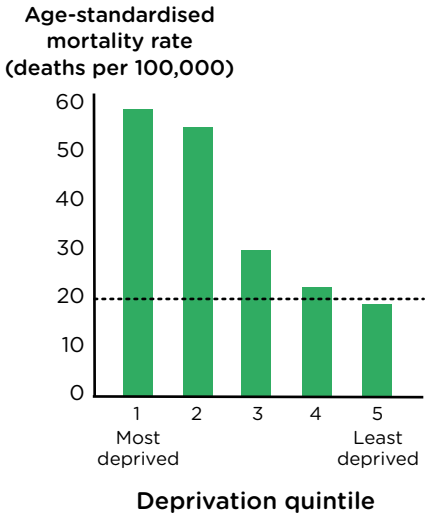
1. *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus.*
2. *The horizontal line represents the rate for all men aged 20–64 in England and Wales.*

Source: *ONS 2020 (55).*

For men in elementary occupations in England, the mortality rate for deaths involving COVID-19 was also graded by level of area deprivation with those in the 40 percent of least deprived areas having similar rates to the England average – see Figure 2.20. This suggests that deprivation levels where workers live contributed more than their occupation to their risk of dying of COVID-19.

Among women, 'caring, leisure and other service occupations' was the only major occupation group in England to have a statistically significantly elevated rate of death involving COVID-19, relative to that of all women of the same age. In this group, the excess was largely confined to the 40 percent of most deprived areas (Figure 2.21).

Figure 2.20. Age-standardised mortality rates among elementary workers by IMD quintiles, for deaths involving COVID-19 registered among men aged 20 to 64 years in England between 9 March and 25 May 2020

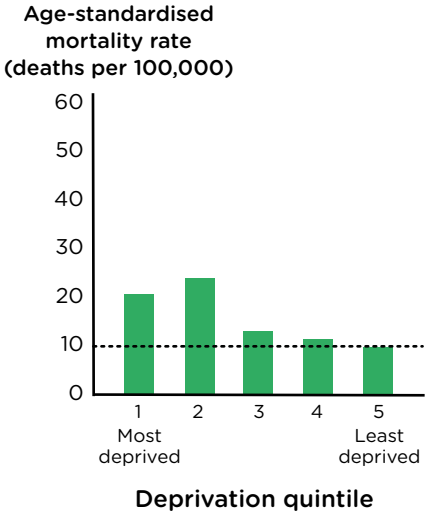


Notes:

1. *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus.*
2. *The horizontal line represents the rate for all men aged 20–64 in England and Wales.*

Source: *ONS, 2020 (55).*

Figure 2.21. Age-standardised mortality rates among caring, leisure and other service occupations by IMD quintiles, for deaths involving COVID-19 registered among women aged 20 to 64 years in England between 9 March and 25 May 2020



Notes:

1. *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus.*
2. *The horizontal line represents the rate for all women aged 20–64 in England and Wales.*

Source: *ONS, 2020 (55).*

These analyses by the ONS of differential COVID-19 mortality by occupational risk factors make clear that risks are profoundly unequal and much more needs to be done to protect key workers, those in occupations with high levels of inter-person contact, BAME workers who are not receiving adequate PPE and protection, and those who live in more deprived areas. Understanding the cumulative impacts of these risks means that actions can be taken for specific, particularly high-risk workers – based on occupation, but also area of residence and ethnicity.

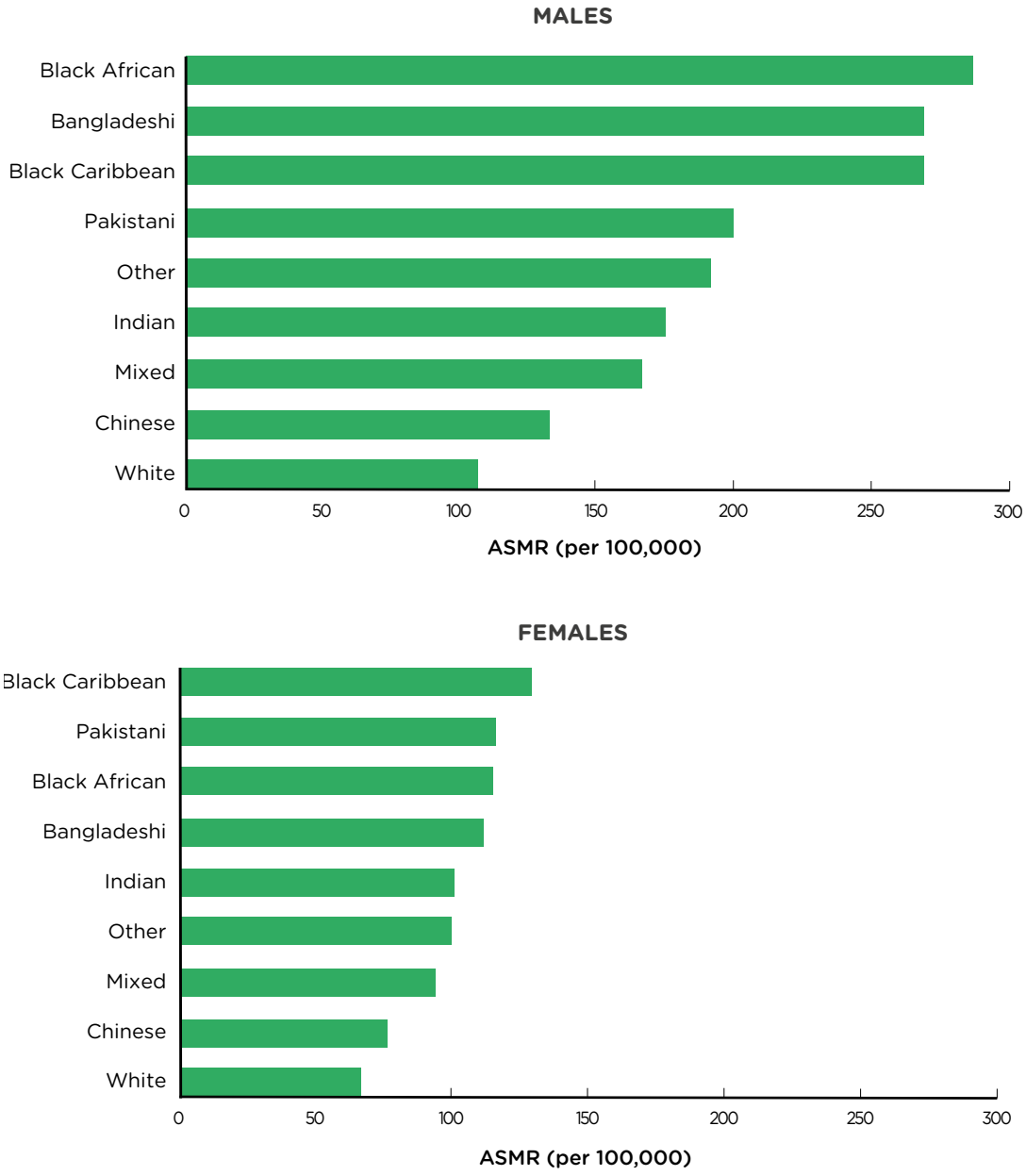
2.H INEQUALITIES IN COVID-19 MORTALITY BY ETHNICITY

There are clear inequalities in risks of mortality from COVID-19 across ethnic groups and several analyses from the ONS and PHE show much higher mortality for Black and Asian people. Prior to the pandemic, all-cause age-standardised mortality rates were lower in Asian and Black ethnic groups than in White groups – possibly because these groups include many healthy, young migrants (29).

Monitoring infection rates is important, but data are only as reliable as the testing system itself. Notwithstanding the limitations of the data, particularly during the height of the epidemic in April and May, studies show that individuals identifying as Asian or Asian British were 4.8 times more likely to test positive for COVID-19 on a swab test taken between 8 June and 2 August 2020 than people of White ethnicity (60). For the remaining ethnic groups, the limited number of positive cases reported make it difficult to draw conclusions. In this section we therefore focus on mortality data.

The ONS has reported that of deaths involving COVID-19 that occurred between 2 March and 28 July, the rates were highest among males and females of Black African ethnic background, 2.7 and 2.0 times respectively higher than for males and females of White ethnic background (61) – see Figure 2.22.

Figure 2.22. Age-standardised rates of death involving COVID-19 among males and females aged 9 years and over by ethnic group, England and Wales, for deaths occurring between 2 March and 28 July 2020



Notes:

1. Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus

2. Figure includes deaths occurring in the period 2 March and 28 July 2020 that were registered by 24 August 2020

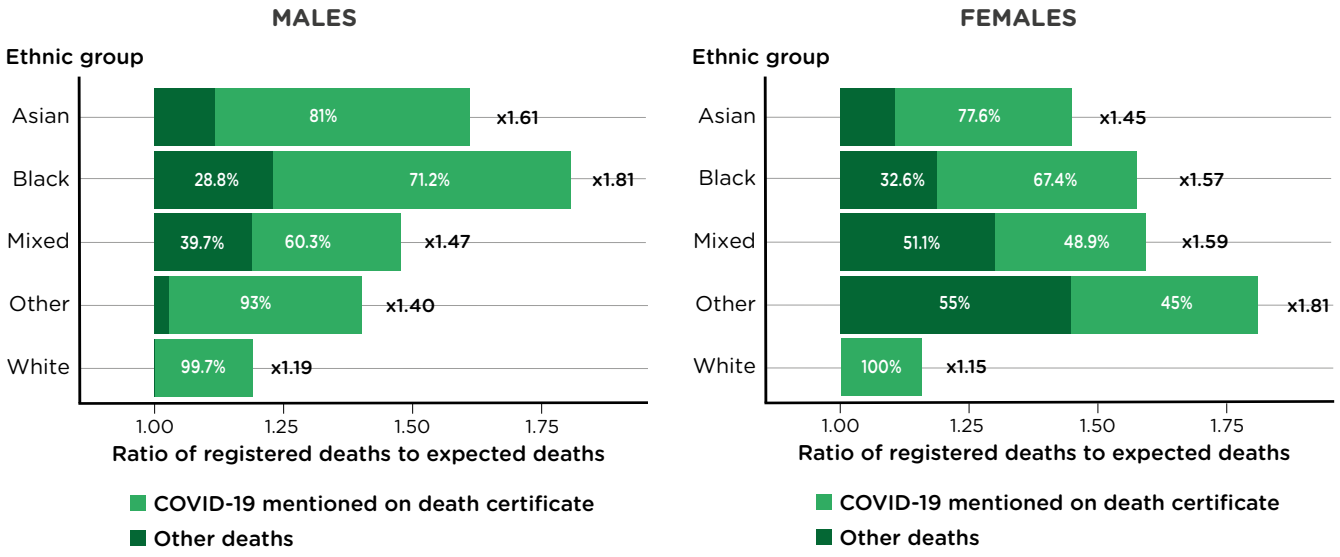
3. 'Other' includes: Asian other; Black other; Arab; Other ethnic group.

Source: *ONS, COVID-19 related deaths by ethnic group, England and Wales, 2020 (61).*

As well as deaths with COVID-19 mentioned on the certificate being higher among BAME groups, excess mortality excluding these deaths was also markedly higher for BAME groups. PHE has shown that the ratio of observed to expected deaths by ethnic group between 20 March and 30 October 2020 was highest for Black men with nearly twice the expected rate of deaths, followed by those who identify as Asian and those of mixed identity, while the rate was lowest for White men (Figure 2.23) (13). Nearly all, 98 percent, of excess mortality for White people was attributed on the death certificate to COVID-19, while other ethnic groups had a great deal of non-COVID-19 excess mortality. This largely reflects the younger age structure of BAME groups, as younger people are less likely to die from COVID-19 – see Figure 2.5 for comparison – but it may also indicate under-diagnosis or testing of COVID-19 in BAME groups.

For women, the ratios of excess deaths were slightly lower than for men, however it was those who identified as 'other' (Asian other; Black other; Arab; Other ethnic group) who experienced the highest excess mortality rates (nearly twice the rate of registered deaths in comparison to expected rates). Similarly to men, White women had the lowest excess death rates in comparison to other ethnic groups and that was mostly comprised of deaths with COVID-19 mentioned on the certificate.

Figure 2.23. Ratio of registered deaths to expected deaths by ethnic group and sex, 20 March to 30 October 2020, England

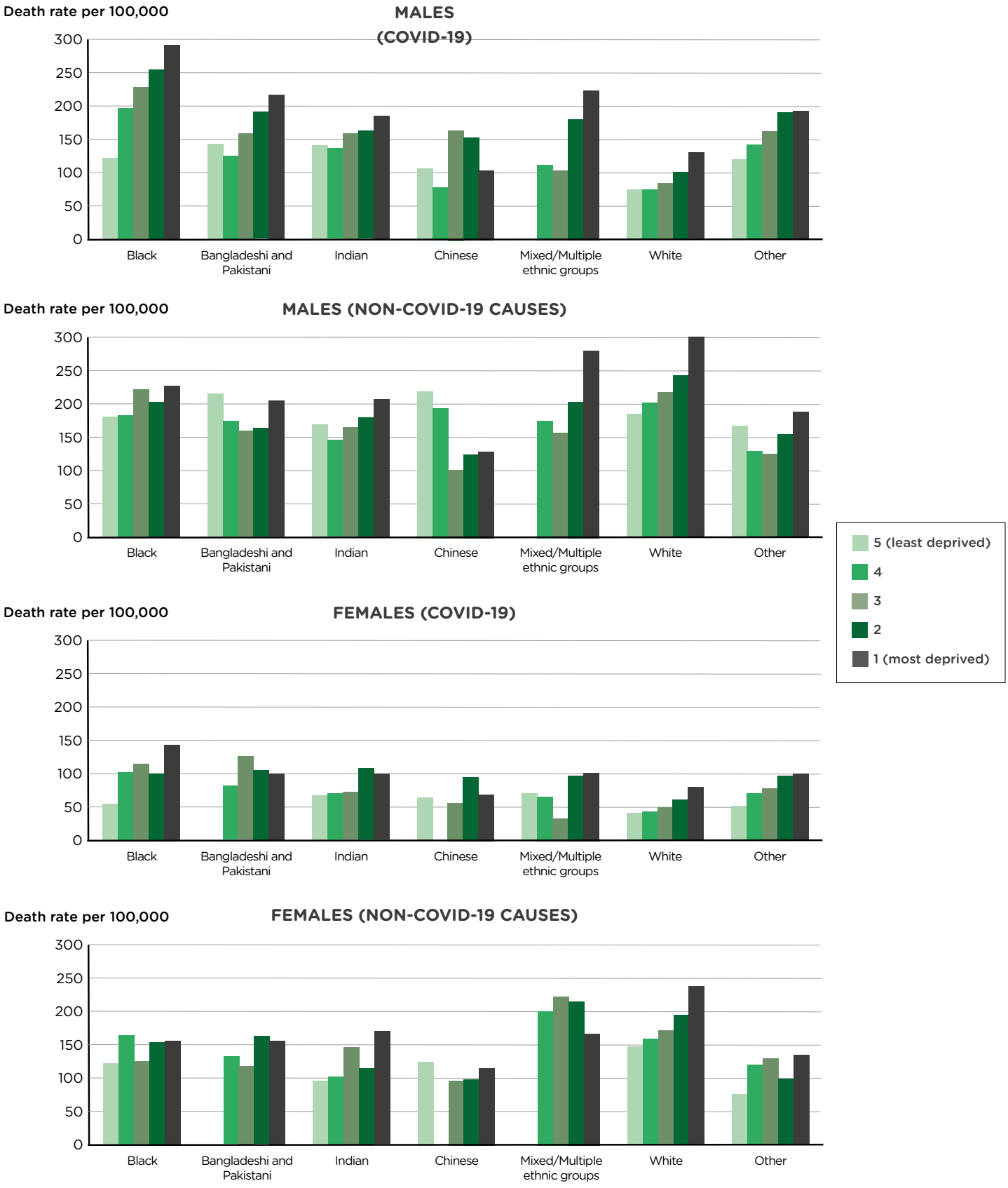


Note: *Other includes: Arab and other ethnic group categories in the classification.*

Source: *PHE analysis, 2020 (13).*

The risk of mortality from COVID-19 from March to May increased with level of area deprivation for most ethnic groups except Chinese – see Figure 2.24. The gradient was particularly steep for men of Black and mixed ethnicity, who experienced both particularly high mortality rates overall and very clear inequalities in rates related to deprivation. These steep deprivation gradients contrast with deaths from causes other than COVID-19, where the deprivation gradient was clear only for White groups. Therefore, COVID-19 mortality has introduced new, large ethnic inequalities in mortality for men and new deprivation-related inequalities for ethnic groups.

Figure 2.24. Age-standardised death rates from COVID-19 and other causes by ethnicity and deprivation quintiles, by sex, 2 March to 15 May 2020, England and Wales.



Notes:

1. Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus

2. "Other" includes: Asian other; Arab; Other ethnic group.

Source: *ONS, COVID-19 related deaths by ethnic group, England and Wales, 2020 (62).*

Several factors contribute to these patterns. People from BAME backgrounds are more likely to be key workers carrying out jobs that are in close proximity to other people, such as those working in health and social care and public transport, which contributes to higher rates of mortality (63) (55). BAME workers were more likely than White workers to be working outside their home during the lockdown period. As discussed in section 2.G, surveys show that they were less likely to be given PPE and more likely to be given tasks which exposed them to the coronavirus and studies show if they logged a safety complaint, they were more likely to be ignored than White British workers (56). These studies suggest that Black and minority ethnic groups have been more exposed to COVID-19 than their White peers, and less likely to have been protected despite having raised concerns about safety (56).

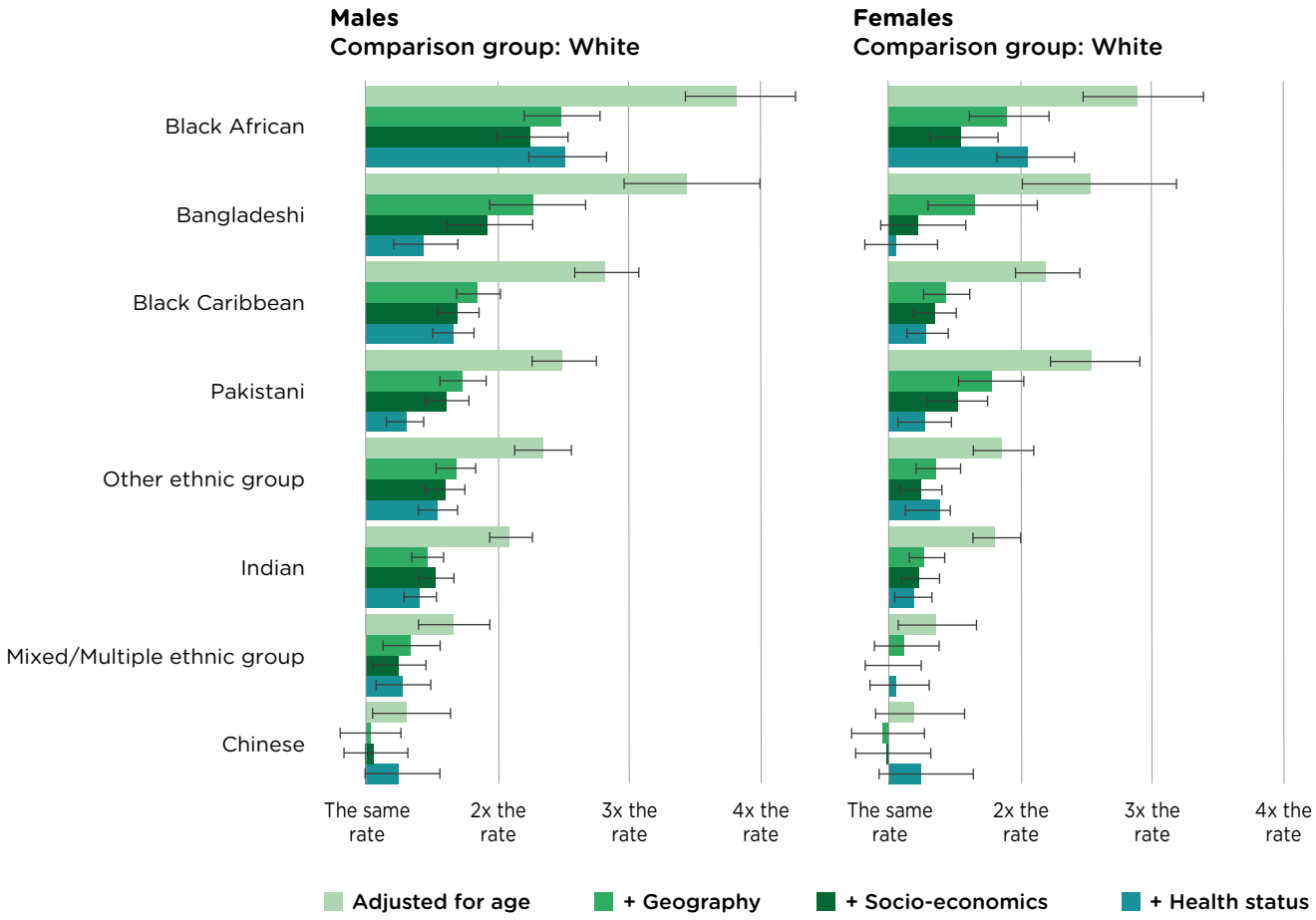
People from BAME backgrounds are more likely than White people to live in an overcrowded household with several generations or in a household of multiple occupation (26) (40) (43) (64) which, as set out previously, have been shown to increase the risk of COVID-19 infection and mortality (65). BAME groups are also more likely to live in deprived urban areas (66) (67) (68) (69), with higher rates of air pollution (70) (71), which increases the risk of COVID-19 infection and mortality. The cumulative occupational, living and environmental conditions and low-income risks experienced by many BAME groups are largely responsible for the disproportionately high mortality rates from COVID-19 among these groups.

In order to try to assess how much of the ethnic differences in mortality relate to age, health, geography, socioeconomic factors and occupation, the ONS produced a model which adjusted for these characteristics. The model relates to deaths occurring between 2 March and 28 July 2020 (61) – see Figure 2.24. Although specific pre-existing conditions place people at greater risk of COVID-19 mortality, this does not explain the remaining ethnic differences in mortality shown by the model. However, the prevalence of some conditions such as hypertension and diabetes will be under-recorded in hospital data as they are often managed in primary care settings and do not require hospital attendance. Therefore, it will be necessary to revisit this analysis once more complete data on disease prevalence become available (61).

The results from the ONS model confirm that statistically significant raised rates of death remain for males and females of Black African, Black Caribbean, Indian, Pakistani and Other ethnic groups after taking account of pre-existing health conditions, age, geography and socioeconomic factors. Compared with the rate for White males, the rate of deaths involving COVID-19 among Black African males was 2.3 times greater, for Bangladeshi males it was 1.9 times greater, for Black Caribbean males 1.7 times greater and for Pakistani males 1.6 times greater. However, females from Bangladeshi, Chinese and Mixed ethnic backgrounds were found not to be at significantly greater COVID-19 mortality risk than White females, following adjustments for other characteristics (see Figure 2.25).

The size of the relationship between COVID-19 mortality and ethnic group is different across age groups. The relative differences between ethnic groups are larger for those aged under 70 years.

Figure 2.25. Death rates at ages 9 and over involving COVID-19 by ethnic group and sex relative to the White population, taking account of demographic, socioeconomic and health-related factors, England, 2 March to 28 July 2020



Notes:

1. *Cox proportional hazards models adjusting for age, geography (local authority and population density), socioeconomic factors (area deprivation, household composition, socioeconomic position, highest qualification held, household tenure, multigenerational household flags and occupation indicators (including keyworkers and exposure to others), and health (self-reported health and disability status in March 2011, and hospital-based co-morbidities since April 2017).*
2. *Figures relate to persons enumerated in private households in the 2011 Census, for whom deaths that occurred between 2 March and 28 July could be linked to the 2011 Census.*
3. *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus*
4. *'Other' ethnic group encompasses Asian other, Black other, Arab, and other ethnic group categories.*
5. *Error bars not crossing the x-axis denote a statistically significant difference in relative rates of death.*

Source: *ONS, COVID-19 related deaths by ethnic group, England and Wales, 2020 (61).*

A recent study by IHE, commissioned by Transport for London (TfL), into the factors leading to high mortality rates among London bus drivers, shows the cumulative risks for BAME bus drivers deriving from their occupation, living conditions, and location of residence in more deprived areas. More details from this study are outlined in the box.

LONDON BUS DRIVER MORTALITY FROM COVID-19: AN INITIAL ASSESSMENT

The initial assessment of London bus driver mortality from COVID-19 showed that many of the TfL bus drivers who died, as well as working in a frontline occupation, had several other characteristics that put them at higher risk of death from COVID-19 in the period March to May 2020. These included living in more deprived areas of London (and in particular in boroughs with the highest COVID-19 rates), being from a BAME background and being aged 65 and older. Several had underlying health conditions which likely contributed to the severity of their COVID-19 infection.

Eight out of the nine Asian bus drivers who died had one or more underlying health conditions, and five out of the six White bus drivers had an existing condition. By contrast, out of the 11 Black bus drivers who died of COVID-19, only three had underlying conditions. This may indicate that the Black drivers were more likely to have died of COVID-19 independently of whether they had pre-existing health conditions. However, this needs to be interpreted with caution due to the possibility of under-reporting of previous health conditions in a small number of cases, as shown in Table 2.2.

Table 2.2. Numbers of bus drivers who died with COVID-19, by underlying health conditions and ethnicity, from March to May 2020

Underlying health conditions		
Ethnicity	**None**	**One or more**
Asian	1	8
Black	8	3
White	1	5
N/A	0	1

Source: *Goldblatt P, Morrison J. TfL initial assessment of London bus driver mortality from COVID-19, 2020 (72).*

There have been debates about the extent to which structural racism is at the root of higher levels of mortality from COVID-19 among BAME communities (73) (57). Long-standing evidence shows that structural racism is at the heart of worse living and working conditions for BAME communities, which leads to worse health – in turn this will lead to a higher risk of COVID-19 mortality (74). BAME groups face discrimination in different spheres of their lives, such as employment, working conditions and earnings, which leads to lower incomes, higher levels of stress and higher poverty rates than those experienced by White British populations, and high rates of some health conditions (1). BAME populations also face discrimination in access to decent housing, community services and other services and resources.

As previously discussed, there have also been reports of more BAME than White key workers in frontline positions being without effective PPE and differential treatment in the workplace is a pre-existing and longstanding issue. Staff in at-risk settings state that they want support and an environment for staff to express their concerns and have these met effectively (57).

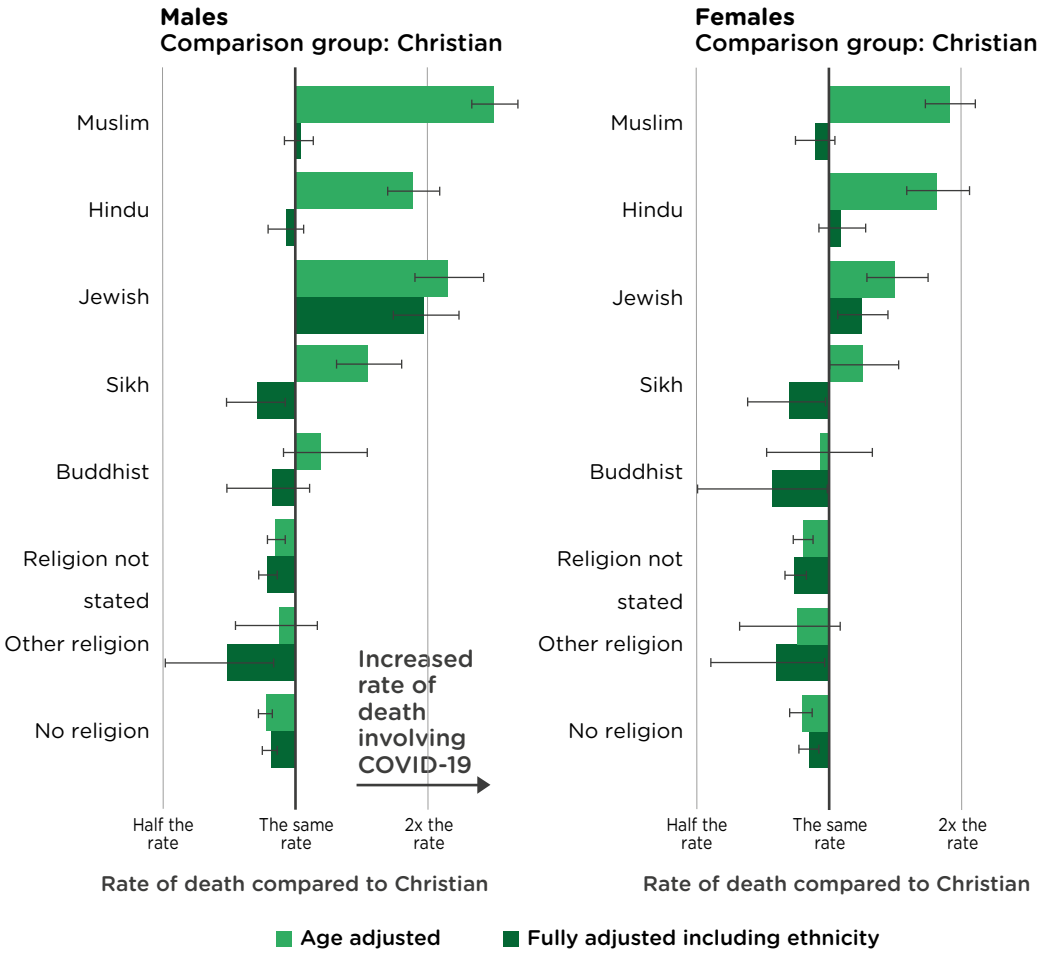
2.I INEQUALITIES IN COVID-19 MORTALITY BY RELIGIOUS GROUP

Clear inequalities related to religious group and COVID-19 infection and mortality have been observed (75). Much of this is simply a reflection of the religious identities of different ethnic groups and therefore reflects the factors affecting raised levels of mortality discussed in section 2.H. However, the analyses do point to possible additional contributory factors – see Figure 2.26. Some of this may be explained by relatively high levels of religious participation among some BAME and older communities (75). After taking age, socio-demographic factors and ethnicity into account, the analysis carried out by the ONS shows

that men and women who identify as having no religion are around 0.82 and 0.83 times less likely to die from COVID-19, respectively, than White Christians (75). Jewish males were twice as likely, and females 1.2 times more likely, to experience a death involving COVID-19 compared with White Christians. For Muslims there was no risk of mortality after adjusting for socio-demographic factors. This shows that a substantial part of the difference in rates of deaths involving COVID-19 between religious groups is explained by the different circumstances in which members of these groups are known to live; for example, living in areas with higher levels of socioeconomic deprivation and large BAME communities.

However, for the Jewish group, after taking age, ethnicity and socioeconomic factors into account, there are still higher rates of mortality than expected. The reasons for this are still to be identified (75) but possibly involve participation in religious gatherings. For example, research reported by the Guardian newspaper suggests that celebrations to mark the Jewish festival of Purim in March may have contributed to the spread of the virus among Jewish communities (76). Many Ultra-Orthodox Jewish communities, which have high rates of infection, have limited access to the internet and the media and may be less likely to adhere to physical distancing and self-isolation when presenting with symptoms. There have been several efforts from community leaders to ensure ultra-Orthodox communities adhere to national guidelines and safety measures and messaging has been emphasised during the Jewish holiday season, but high rates of infection still remained in October (76) (77).

Figure 2.26. Hazard ratios of death involving COVID-19 by religious group and sex, adjusting for age and for the fully adjusted model, England and Wales, 2 March to 15 May 2020



Notes:

1. *Cox proportional hazards models adjusting for non-liear effect of age. Fully adjusted models also include region, population density, area deprivation, household composition, socioeconomic status, Index of Multiple Deprivation (IMD) deciles, highest qualification held, household tenure, multigenerational household flags and occupation indicators (including key workers and exposure to others), as per the 2011 Census data.*
2. *ONS figures based on registrations of deaths involving COVID-19 up to 29 May 2020 that occurred between 2 March and 15 May 2020 that could be linked to data on religious affiliation recorded in the 2011 Census.*
3. *Deaths involving COVID-19 include those with an underlying cause, or any mention, of (COVID-19) virus*
4. *Error bars not crossing the x-axis at value 1.0 denote a statistically significant difference in relative rates of death.*

Source: *Office for National Statistics – Coronavirus (COVID-19) related mortality by religion, ethnicity and disability (75)*

2.J CONCLUSIONS

Analysis of risk factors for COVID-19 mortality clearly show that risks are much higher for those living in more deprived areas, in overcrowded housing, in key worker roles with close proximity to others, being from BAME groups, having underlying health conditions as well as being older and male. Living outside the south of England is also a higher risk. And the risks are cumulative.

BOX 2.3. IN SUMMARY:

PREVIOUS HEALTH CONDITIONS	Specific health conditions suggest a worse prognosis and higher rates of mortality. These higher risk health conditions are associated with living in more deprived areas and being in a lower income group and are therefore exacerbating existing health inequalities. Evidence presented in our *10 Years On* report showed that there had been a deterioration in health in England, specifically in more deprived areas in some regions; COVID-19 has exacerbated this situation.
DEPRIVATION OF AREA OF RESIDENCE	Living in more deprived areas is associated with a greater risk of mortality from COVID-19. The reasons for this are associated with the other risk factors we describe: worse living conditions and type of employment. It is clear that in some areas conditions have.
REGION	While the pandemic is affecting different regions differently over the course of the pandemic, the close association between underlying health, deprivation, occupation, ethnicity and COVID-19 makes living in more deprived areas in certain regions particularly hazardous. Given the widening health and social determinants inequalities between regions in England prior to the pandemic, described in our *10 Years On* report, it is to be expected that mortality rates will be higher in regions outside London and the South – particularly in the North West and North East – and that has indeed been the case since the end of the first wave of the disease.
LIVING CONDITIONS	Overcrowded living conditions and poor quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and inhabited by people with lower incomes. Evidence from the *10 Years On* report showed that housing conditions had deteriorated for many and that regional inequalities in health and the social determinants had widened in the 10 years to 2020.
EMPLOYMENT	Some occupations have a higher risk of mortality than others – these include occupations that do not facilitate working from home or social distancing. Close proximity to other people is a clear risk factor for mortality from COVID-19. All the occupations with above-average mortality rates are lower paid and lower status. The health and care workforce are particularly at risk, especially nursing and care staff.

ETHNICITY	BAME groups are experiencing higher rates of mortality from COVID-19. This is related to their disproportionate experience of high-risk living and working conditions. These are partly the result of longstanding impacts of discrimination and exclusion associated with systemic racism. There is also evidence that the BAME workforce in highly exposed occupations are not being sufficiently protected with PPE and safety measures.
RELIGIOUS GROUP	Most major religious groups have higher rates of mortality from COVID-19 than people who do not follow a religious faith. Some of this is explained by high numbers of BAME groups following a faith, and by attendance at religious gatherings.

In the *10 Years On* report we made clear that the government had not prioritised equity over the previous decade. We laid out evidence that inequalities in health and in key social determinants of health had widened, and that this was related to the policies of the decade from 2010 and the unequal cuts which had been made – affecting more deprived areas the most. The results of these inequalities can tragically now be seen again.

These recommendations are even more critical after the pandemic. Given all the evidence about inequalities in risks of mortality from Covid-19 it is essential that all efforts at rebuilding have greater equity at their heart – so that we can 'build back fairer' and ensure that unfair and unnecessary health inequalities are reduced. We make recommendations throughout the report for how to reduce the longer term health inequality impacts which will arise as a result of containment measures.

But given that the risk of infection and mortality are so unequal, efforts to reduce risk and mortality must be proportionate to that risk and be particularly focussed on the high-risk groups, areas and occupations.

The approach of proportionate universalism implies action to make whole communities safer with extra focus on higher risk areas, for example urban areas with overcrowded and multi-occupation housing. Without these kind of proportionate responses, high risk groups and places will continue to experience high rates of mortality.

As COVID-19 treatments and vaccinations roll out, it is essential to take into account the differential risks facing people. The Government has signalled its intention to prioritise health and care staff, care home residents and older people for early receipt of the vaccine, but social and economic risk factors for working age people could also be prioritised.

BOX 2.4. BUILD BACK FAIRER: REDUCING INEQUALITIES IN MORTALITY FROM COVID-19

- Consider proportionate allocation of measures to prevent COVID-19 including vaccinations and support to particularly high-risk occupations and areas
- Ensure that protection is available and enforced
- Provide adequate financial support for workers who cannot work because of COVID-19 risk and those who have to self-isolate

Subsequent chapters outline the profound and inequitable impacts on key social determinants of health as a result of the pandemic and of the ongoing containment measures. Worsening inequalities in education, income, employment, housing and environmental conditions and mental and physical health will affect health for years to come – and we risk seeing already significant inequalities in health widening even further. We suggest that these deteriorations in equity must be mitigated now and in the long term.

SECTION 2

THE IMPACT OF COVID-19 CONTAINMENT ON INEQUALITIES IN THE SOCIAL DETERMINANTS OF HEALTH

In the introduction to this Review we proposed a causal link between the UK's poor health picture coming into the pandemic and the UK's poor record of handling the pandemic. We linked both to governance and political culture and to inequities in power, money and resources. This proposed link is given plausibility by the marked inequalities in mortality from COVID-19, by level of deprivation, by Region, and by ethnic group that look similar to, or in some cases greater than, inequalities in health more generally – set out in the previous chapter.

It is not a mystery how these health inequalities come to be so marked. In our original 2010 Marmot Review, Fair Society Healthy Lives, reviewing the social determinants of health, we identified six causal areas where action to reduce health inequalities was justified and recommended: early life, education, employment and working conditions, having enough money to live a healthy life, healthy and sustainable communities in which to live and work, and healthy behaviours. In our 10 Years On Report we showed that, in the decade up to 2020, policies in each of these areas was likely to have caused damage.

Now we have the pandemic, lockdown and other restrictions. All of these are likely to have had further damaging effects on the domains that we have identified as the key social determinants of health inequalities, both now and in the future. The economic crisis hangs over all of this: the poor are likely to become poorer, and inequalities increase. People in better paid job who can work from home may see their income increase; those in lower paid jobs either have to go out to what may be front line occupations, or lose their jobs and much of their income. The effects are likely to be felt at every stage through the life course. Pre-schoolers who have had their early years settings closed, and are subject to the effects of a rise in child poverty, and going to bed hungry. School children, among whom lockdown increased the educational divide, with children from poorer families falling further behind and young peoples mental health deteriorating. Rising unemployment and those in precarious employment facing an uncertain future as the job furlough scheme comes to its predictable end; and the nature of work changing out of all recognition for good and ill. Crowded housing and lack of green space were a problem before the pandemic and have become more so during it. Calls to helplines reporting domestic violence have risen. Before the pandemic, there was national concern with loneliness, particularly of older people. This has got worse during the pandemic.

The chapters in this section examine all these effects on key social determinants of health inequalities. Our recommendations build on those we made in our 10 Years On report. We are bold enough to suggest that without acting on these, the future looks bleak and health inequalities will rise. More positively, we have laid out building blocks to Build Back Fairer.

CHAPTER 3

GIVING EVERY CHILD AND YOUNG PERSON THE BEST START IN LIFE: COVID-19 AND INEQUALITIES DURING THE EARLY YEARS AND EDUCATION

In *10 Years On* we showed that in a number of critical drivers of children's early years development, trends were going in the wrong direction – including an increase in child poverty since 2010. Children's Centres and early years services have been closed and the greatest impact of those closures has been in more deprived areas, where they were most needed all of which will harm health and widen health inequalities. However, we also pointed to positive outcomes in places that had a particular focus on improving equity in the early years, including London and Greater Manchester.

BOX 3.1. SUMMARY: INEQUALITIES IN EARLY YEARS AND IN EDUCATION (FROM *10 YEARS ON REPORT*)

- Since 2010, progress has been made in early years development, as measured by children's readiness for school. Clear socioeconomic inequalities persist, with a graded relationship between these measures and level of deprivation.
- For low-income children, levels of good development are higher in more deprived areas than in less deprived areas; providing encouragement that it is quite possible to break the link between deprivation and poor early child development.
- Funding for Sure Start and Children's Centres, and other children's services, has been cut significantly, particularly in more deprived areas.
- There are still low rates of pay and a low level of qualification required in the childcare workforce.
- Clear and persistent socioeconomic inequalities in educational attainment that were present in 2010 remain.
- Regionally, the North East, North West and East Midlands have the lowest levels of attainment at age 16 and London has the highest. The gap in achievement between poorer children and the average is less in London than in the rest of the country. This may result from higher levels of funding in London.
- Pupil numbers have risen while funding has decreased, by eight percent per pupil, with particularly steep declines in funding for sixth form (post-16) and further education
- Since 2010 the number of exclusions from school have significantly increased in both primary and secondary schools.

Inequalities in early childhood development were persisting and there had been widespread closure of Children's Centres and early years services, with greatest impact in more deprived areas, where they are most needed. Inequalities in attainment during education persisted, closely related to deprivation and socioeconomic position of households. We also pointed to positive outcomes in places which had a particular focus on improving equity in the early years, including London and Greater Manchester.

The persistent inequalities in attainment and severe cuts to school funding in England did not provide a sound footing to support early years development and educational attainment through lockdowns in an equitable way. And containment measures have led to widening inequalities in early years development and in educational attainment. Children with special needs and children with poor mental health are especially vulnerable.

Prior to lockdown, the UK ranked poorly in child well-being. UNICEF Report Card 15 ranks children in 38 rich (OECD) countries using three measures: mental well-being, physical health and academic and social skills. The UK ranks 27 out of 38 (78). The top five countries are Netherlands, Denmark, Norway, Switzerland and Finland. Quite apart from inequalities the UK was doing poorly. It is likely that lockdown will have damaged children's well-being. It will be instructive to learn whether the international rankings change during the COVID-19 crisis (78).

The closure of early year settings and schools between March and July have harmed the prospects for more deprived children the most. There have been delays in development for pre-school children, which will disproportionately hamper development for more disadvantaged young children. and there has been greater loss of learning time in more deprived areas which will lead to even wider inequalities in educational attainment. More deprived children tend to have less access to necessary technology and IT, less suitable home working environments and are more likely to experience crowded living conditions, stress and poverty at home which harm learning. The cumulative effects will be to worsen inequalities in educational attainment and lead to worse outcomes throughout life, unless mitigating actions are taken immediately. Pupils with SEND and excluded pupils require much greater support through containment measures, which schools and parents are largely inadequately resourced to undertake.

BOX 3.2. SUMMARY: COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN THE EARLY YEARS AND DURING EDUCATION

EARLY YEARS

- More disadvantaged children were disproportionately harmed by closures of early years settings and levels of development were lower than expected among poorer children
- Parents with lower incomes experienced greater stress when young children were at home, particularly those who continued working outside the home
- Many early years settings in more deprived areas are at risk of closure and of having to making staff redundant as a result of containment measures

EDUCATION

- More disadvantaged children were disproportionately harmed by closures in the following ways
  - Greater loss of learning time
  - Less access to online learning and educzational resources
  - Less access to private tutoring and additional educational materials
  - Inequalities in the exam grading systems
- Children with special educational needs and their families were particularly disadvantaged through school closures
- School funding continues to benefit schools in least disadvantaged areas the most – widening educational outcomes

As abundant evidence over many years has shown, early years settings are particularly beneficial for more disadvantaged children, helping to close inequalities in development levels at this early and critical stage. Closure of early years settings will have harmed the development of disadvantaged children the most.

Ofsted reported that almost all early years providers reported that the COVID-19 crisis had had a significant impact on children's learning and their personal, social and emotional development. However, providers reported that children who continued to attend their setting or who were well supported at home had made good progress in their learning (8). Parents who continued to work out of the home, and had less financial resources were unable to offer their young children the same levels of support as wealthier parents and those working from home. Stresses related to deteriorating family finances, poverty, larger family size and overcrowded households impacted on parents capacity to support their young children during lockdowns.

There is abundant evidence about how to reduce inequalities for young children, some of which was set out in the 10 Years On report (1). These lessons from experience should help inform future practice and support policies that make clear links between early years, education and health (79). And this should inform policy and practice at this critical moment in the context of COVID, when inequalities are rising very fast. Children with special needs and children with poor mental health are especially vulnerable.

3.A IMPACT OF COVID-19 CRISIS ON INEQUALITIES IN THE EARLY YEARS

The early years are integral in laying the foundation for a child's physical, social, intellectual and emotional development. Evidence shows that early childhood experiences are linked to later-life outcomes – including in educational attainment, income, employment and living conditions – all of which are themselves critical drivers of health (6) (1) (80). Socioeconomic inequalities in child development are already recognisable in the second year of life, have an impact by the time a child enters school and persist and deepen during their school years.

The most recent data available on child development during the early years are for 2018/19 and show wide inequalities in development. Then, children from disadvantaged backgrounds were 4.5 months behind their peers by the time they finished Reception at age 5. Data for 2019/20 were due to be published in October by the Department for Education but this has been postponed with no scheduled release date at present. It is not possible, therefore, to directly compare pre- and post-COVID-lockdown inequalities in child development. However, other evidence clearly indicates that early childhood development has been harmed by lockdown and given what we already know about inequalities in early childhood development it seems certain that the development of more deprived children will have been harmed the most.

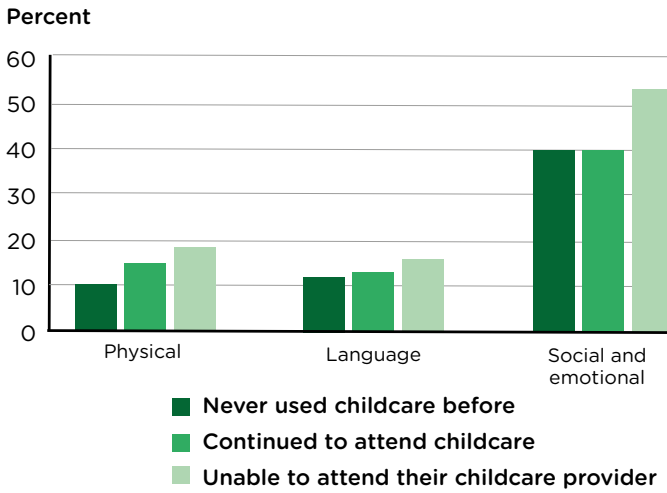
IMPACT OF CLOSURE OF EARLY YEARS SETTINGS ON INEQUALITIES IN EARLY YEARS DEVELOPMENT

Prior to March 2020, when the first lockdown measures came into effect in England, 68 percent of parents with children who were aged 2–4 years were accessing early education or childcare services such as preschools or nurseries (81). However, only seven percent of children who had previously attended formal early education and childcare providers continued to do so during the lockdown period (81). The additional time spent at home by the majority of children is likely to lead to an increase in the attainment gap between disadvantaged children and their better-off peers.

In the absence of early years services and settings, the first COVID-19 lockdown placed an enormous importance on the home learning environment (82). More disadvantaged children are less likely to have a suitable home learning environment, and the closures will therefore have further widened the widespread socioeconomic gaps in early years development.

The possible impact on children was assessed in a survey conducted by YouGov for the Sutton Trust (8– 15 June 2020) with 604 parents of 2- to 4-year-olds in the UK. Among measures of child development, the lockdown measures appear to have had the greatest impact on children's social and emotional development (Figure 3.1) (81). Parents reported more negative impacts on social and emotional development of children who had not attended compared with the children of critical workers or vulnerable children who continued to attend early years settings (81). Some early years providers also indicated impacts on physical development for children from deprived homes in particular (5).

Figure 3.1. Proportion of parents in the UK reporting negative impacts of lockdown on their child's development (ages 2–4) according to their childcare provider arrangements during the first lockdown (March to June 2020)



Source: *YouGov survey for the Sutton Trust, 8–15 June 2020 (81).*

Ofsted (the Office for Standards in Education, Children's Services and Skills) reported in an October 2020 briefing that almost all childcare providers said that the COVID-19 crisis had had a significant impact on children's learning and personal, social and emotional development. It was reported that when schools reopened after the lockdown some children returned less confident and more anxious. In some cases, children had also become less independent, for example returning to their setting using dummies or back in nappies having previously been toilet trained. However, providers reported that children who continued to attend their setting or who were well supported at home had made good progress in their learning (83).

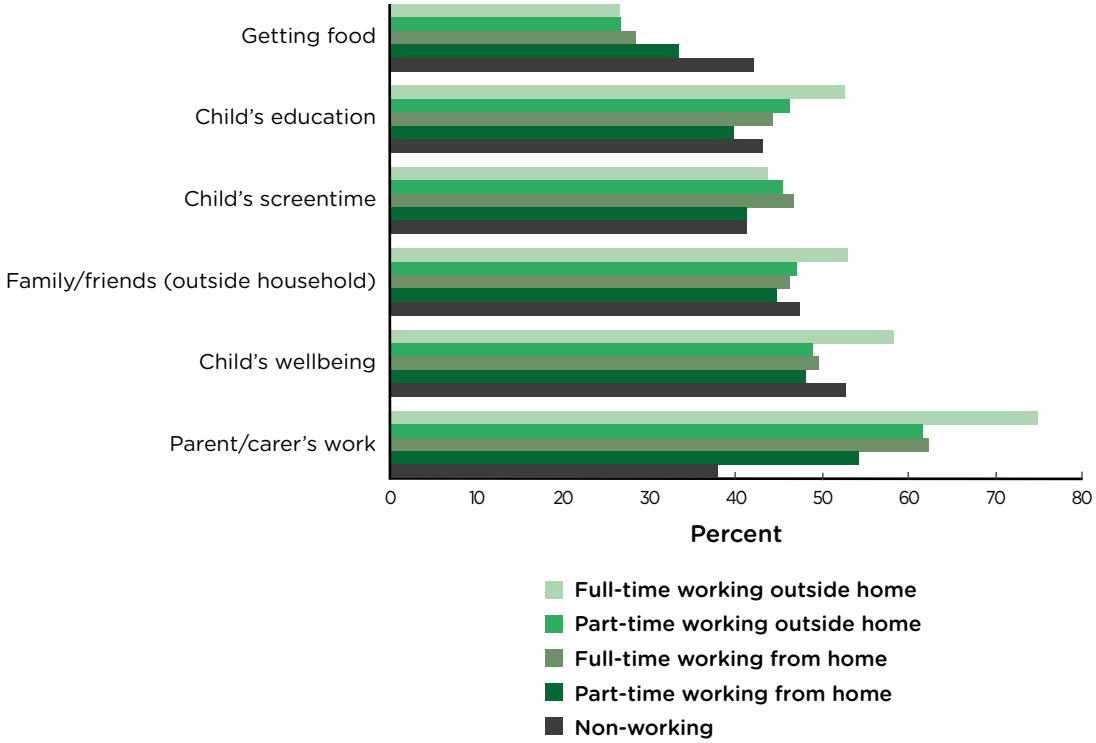
Children who begin school with low levels of development, as determined by the Early Years Foundation Stage Assessment, tend to be from a home environment that is unable to foster children's potential for development and ability to thrive. With the closure of early years settings, it is likely that prolonged periods at home reduced their prospects of catching up with their peers, and exposed some to increased risks of harm (84) (85). The Ofsted briefing on COVID-19 and the early years showed that many children have not returned to early years settings since they reopened after the lockdown.

INEQUALITIES IN SUPPORT FOR PARENTS DURING LOCKDOWN

Parenting is influenced by parents' own childhoods and their current lives, including their own mental wellbeing, their social and material circumstances and their networks of support (56) (57). Generally, parental stress is bad for children and bad for parents, and there are clear inequalities in who is most likely to be affected by stress. Stress particularly affects those who are more deprived and facing economic hardship and, in the present pandemic situation, those who cannot work from home – mainly key workers, and lower paid workers. Rising unemployment and reductions in income as a result of containment measures have affected more deprived families the most (see chapters 4, 5, 6 and 7 for more on this), and will lead to widening inequalities in children's development.

During the first lockdown a YouGov survey found that 65 percent of parents reported feeling stressed, worried and overwhelmed (81) and mothers were much more likely than fathers to report this (30 and 18 percent, respectively) (86). Results from the Oxford University CO-Space Survey showed that parents working full-time outside their home were the most stressed (Figure 3.2) (87) which related to work, their child's wellbeing and education, and concerns about family and friends outside their household (87).

Figure 3.2. Percent of parents/caregivers responding that they felt stressed by source of stress and work status during the first lockdown (in the week prior to completing the survey, between 30 March and 29 April 2020), UK



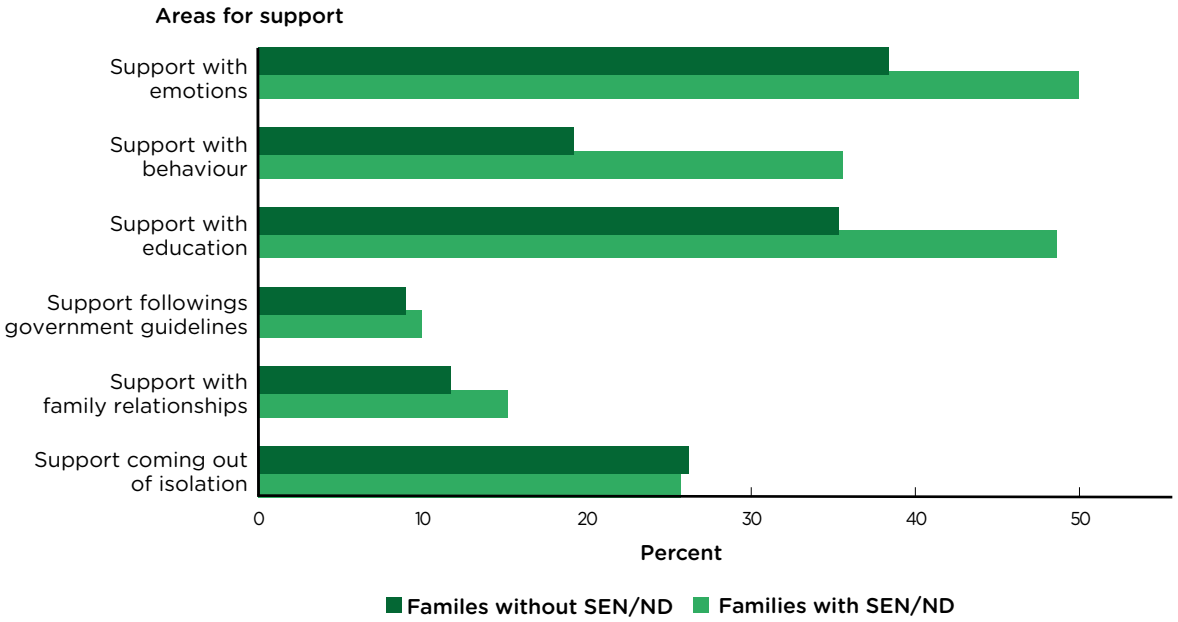
Note: *Based on a sample of 5,000 survey responses. The survey recruitment was of a self-selecting nature and therefore the sample is unlikely to be nationally representative. It should be noted that 92% of respondents were female, the majority were employed and had an overage income of >£30,000.*

Source: *Waite P. Co-Space Study (COVID-19: Supporting Parents, Adolescents and Children during Epidemics) 2020 (87).*

Many parents accessed some form of support to help with their children's development during the first lockdown (81). However, the level of support accessed varied by family income, with high-income parents being more likely than low-income parents to have received online support from their early learning providers – 31 percent compared with 23 percent (81). Forty-one percent of parents with a degree or higher level of education accessed online resources, compared with 30 percent of parents whose highest education was GCSE level or below. Lower-income parents were, however, more likely to have received resource packs from their local organisations (81).

Figure 3.3 shows that support for education and emotions were the two categories parents needed the most. Families with children with special educational needs or a neurodevelopmental disorder (SEN/ND) face the greatest demands on their time and required more support during lockdown than other families (88).

Figure 3.3. Different types of support requested by parents/carers with a child with SEN/ND and by those with a child without SEN/ND, UK, 10 April 2020 to 15 May 2020



Source: *Co-SPACE. COVID-19 worries, parent/carer stress and support needs, by child special educational needs and parent/carer work status, 2020 (88).*

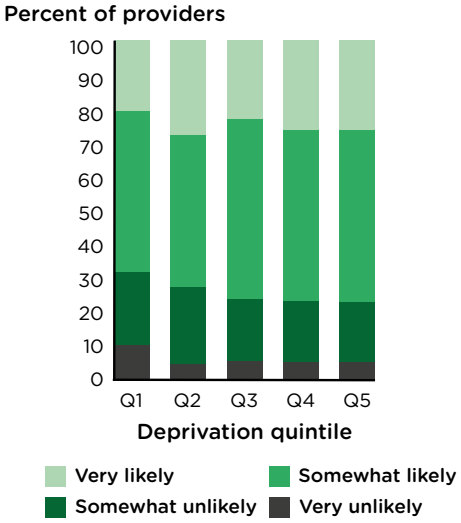
It is critical that ongoing and online support is provided even after lockdowns end, and that early years settings are properly resourced to achieve this. Additional resources and support should be offered to parent/carers of children with SEN/ND and to those living in more deprived areas who have had less access to support and face greater challenges in providing support at home. This additional support is essential in order to meet the different needs of families and parents in full-time work and to reduce the widening in inequalities in early child development that has occurred during the pandemic.

IMPACT OF CLOSURE ON EARLY YEARS PROVIDERS

The closure or limited opening of early learning and childcare settings as a result of the lockdown measures put in place in March has also had a significant impact on the finances of early year providers, particularly those in the most deprived areas. The level of government financial support to early years providers increased in April and eligibility for this support increased too (89) (90) (81). Early years providers in the most deprived areas were more likely to have accessed government support packages compared with those in the least deprived areas; business rates holiday, for example, were accessed by 35 percent of early years providers in the most deprived areas compared with 16 percent in the least deprived (82).

Despite the support measures introduced by the Government, a quarter of early childhood settings reported during lockdown that it was unlikely that they would be operating at the same point the following year (81). Early years settings in the most deprived areas were the most concerned about their futures – 10 percent more providers in the most deprived decile reported to be very unlikely or somewhat unlikely to be operating next year, in comparison with providers in other deciles (Figure 3.4). As we pointed outs in 10 Years On, closure of early years settings is damaging to the development of young children, and closures in more deprived areas are particularly harmful and will lead to even greater inequality (1).

Figure 3.4. Perceived likelihood by early year providers that they will be operating in Spring 2021, by local authority level of deprivation, England, April to May 2020

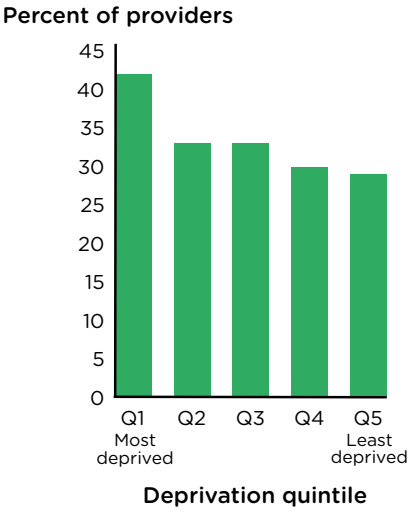


Note: *Level of deprivation measures have been divided into deprivation deciles, where Q1 refers to the most deprived and Q5 the least deprived.*

Source: *The Sutton Trust COVID-19 and Social Mobility Impact Brief #4: Early Years (81).*

The lockdown measures and uncertainty about the sustainability of early years settings have implications for the childcare workforce. In the original Marmot Review of 2010, we noted that there were low rates of pay and a low level of qualifications required in the childcare workforce and that both should be improved. However, as reported in this year's 10 Years On, both pay and levels of qualification remain low. Meanwhile, the pandemic has heightened the vulnerability of settings to closure and staff to redundancy and these are related to levels of deprivation in an area. Following changes to the rules on government support that early years providers received in April 2020, workers in childcare settings with higher deprivation levels were more likely to be made redundant than those in less deprived areas (Figure 3.5).

Figure 3.5. Perceived likelihood by early year providers that they will need to make redundancies, by local authority level of deprivation, April to May 2020, England



Note: *Level of deprivation measures have been divided into deprivation quintiles, where Q1 refers to the most deprived and Q5 the least deprived.*

Source: *The Sutton Trust COVID-19 and Social Mobility Impact Brief #4: Early Years (81).*

In the light of current child poverty levels (see Chapters 4 and 5), and increases in unemployment after the first lockdown, equitable access to early years and childcare provision is an increasingly urgent issue and a particular concern for immediate and longer term equity. While public funding for childcare was protected during the first lockdown, most providers combine public and private income and the loss of private income has meant they are vulnerable (91). Over the lockdown period, only 35 percent of 3-year-olds and 14 percent of 2-year-olds took up their funded early education in state nursery classes or nursery schools (92), and thus there was a significant shortfall in income.

An increase in the funding rates paid for free entitlement hours would reduce the trade-off between offering lower-paid parents/carers publicly funded hours and higher-paid parents/carers privately funded hours and help ensure that all eligible children, especially those in the most deprived areas, continue to have access to public early education (93).

3.B IMPACT OF COVID-19 CONTAINMENT ON EDUCATIONAL INEQUALITIES

In this section we assess the impact of COVID-19 containment measures on inequalities in educational outcomes, in parents' coping capacity and ability to support home schooling, and in access to online platforms and technologies. We assess how families are coping with the impact of the pandemic on family finances and, during the first lockdown, with having to home school, especially for families with few resources. There is an additional focus on students with special needs and the risk of children with temporary and fixed exclusions not re-engaging in the educational system. We also look at the equity impacts of cancelling public exams.

LOSS OF SCHOOLING AND INEQUALITIES IN EDUCATIONAL ATTAINMENT

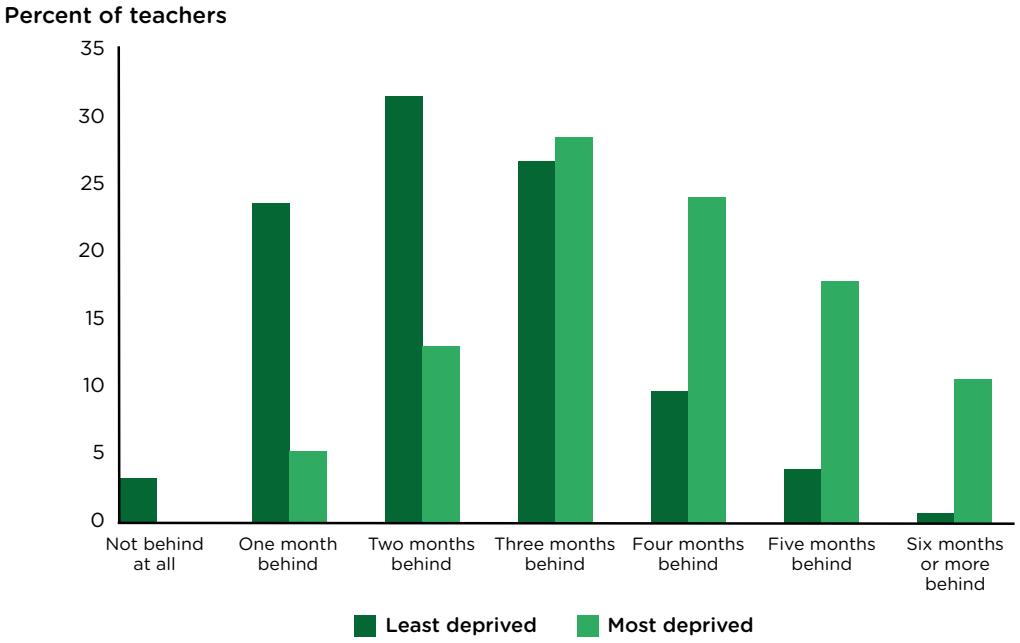
Schooling is an essential component of a child's development, an instrument for social mobility and reducing poverty and is highly protective of health. However, there are well-established inequalities in attainment related to family economic circumstances, living conditions, gender and ethnicity, quality of schools, access to other services and resources for education and other factors beyond the ability of individual students. Research from the Education Policy Institute found that prior to the pandemic, students from more disadvantaged backgrounds had, on average, levels of attainment 18 months behind their more affluent peers and that the gap was not closing (94). These differences translate into inequalities affecting health across the life course (95). COVID-19 containment measures have further harmed the education of more deprived children and without immediate and long-term action this will translate into even deeper lifelong inequalities, including in health (96) (97).

Underlying the importance of school for closing educational inequalities, research shows that children from more disadvantaged backgrounds fall further behind during breaks from school, for example during school holidays, in comparison to children from more affluent families (98). Systematic reviews of the effects of school closures as a result of other disease outbreaks suggest that loss of education harms child welfare, particularly among the most vulnerable and disadvantaged students, and causes nutritional problems, especially in children for whom free school meals are an important source of nutrition (99). School closures and students' social isolation have increased mental health problems among students and have exposed children to greater levels of violence at home. Shutdowns and school closures also contribute to increasing stress in parents and children, which threatens child growth and development (100). As an example of impact, school closures during the 2014–16 Ebola epidemic increased dropout rates and violence against children, and increased socioeconomic and gender disparities across a wide range of outcomes (101).

Overall, up to eight million children were affected by school closures in the UK as a result of the first COVID-19 lockdown (102) (103) and there have been high rates of absenteeism in schools since schools reopened. Also whole classes and year groups are still being routinely sent home following diagnoses – which is different to voluntary absenteeism. This will have affected children from more deprived backgrounds the most, as these children already had the highest rates of persistent absence from schools and will lose most learning. Also more deprived areas have higher infection rates, so social isolation will affect these communities most (104).

Figure 3.6 shows that in September 2020 teachers in more deprived areas were significantly more likely to report that their students were further behind compared to where they would normally expect them to be at that time of year.

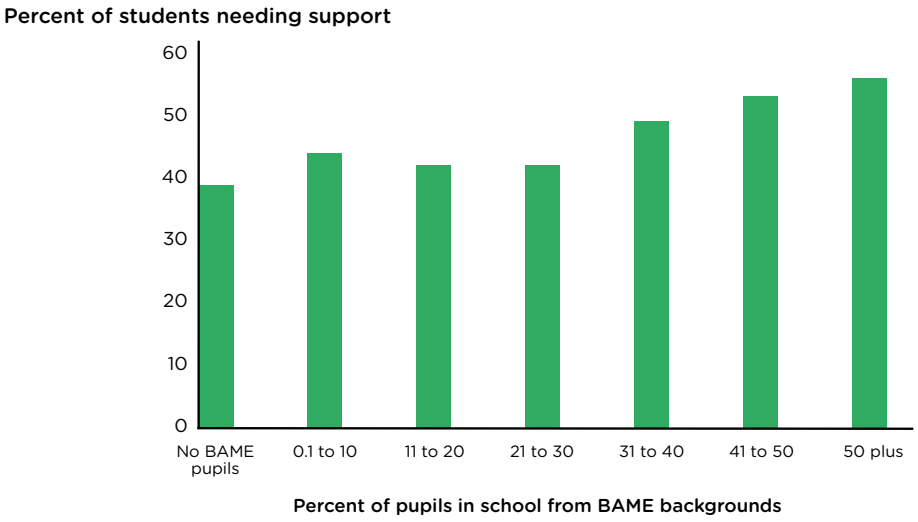
Figure 3.6 Proportion of teachers reporting loss of learning in the least and most deprived schools, England, September 2020



Source: *The National Foundation for Educational Research. The challenges facing schools and pupils in September 2020 (105).*

The proportion of students estimated to be in need of intensive catch-up support was higher in schools with higher proportions of students from BAME backgrounds, as shown in Figure 3.7, which reflects that a higher proportion of BAME students live in deprived areas.

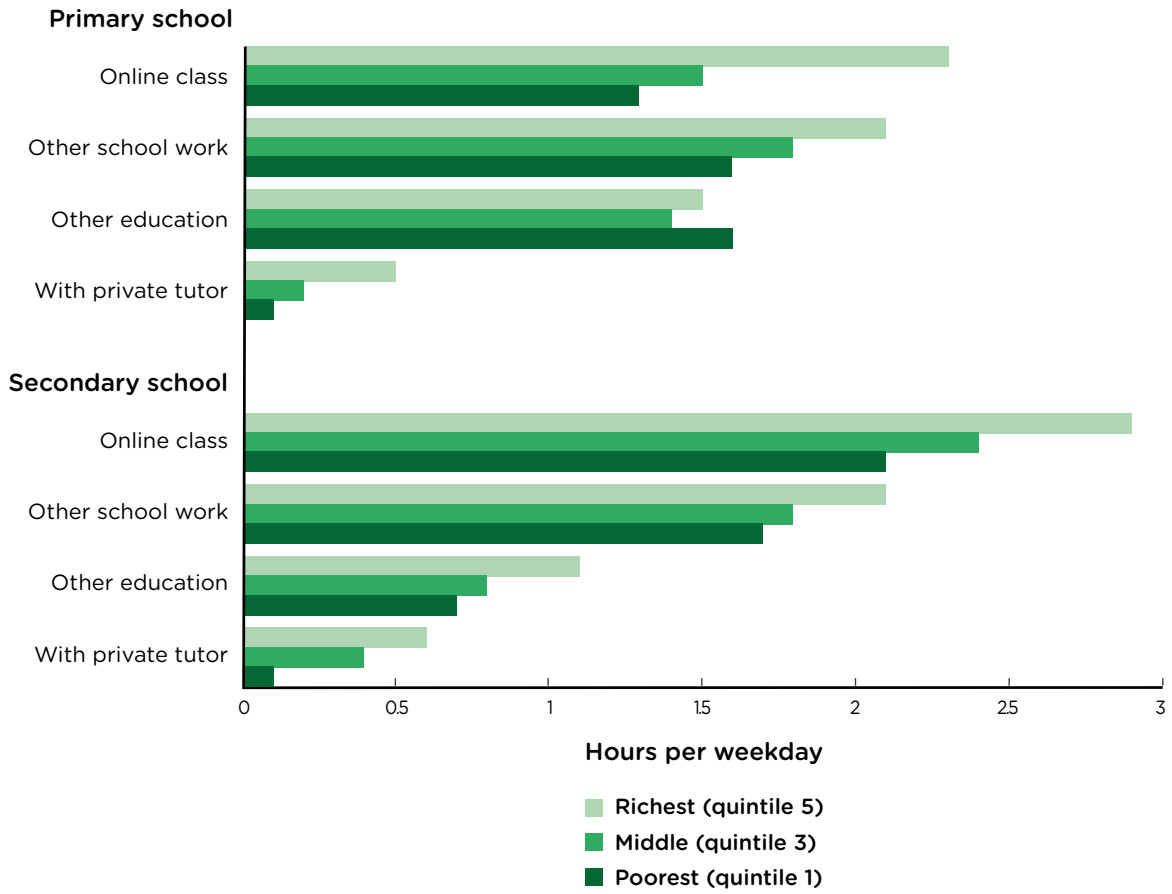
Figure 3.7. The proportion of students in need of intensive catch-up support by the proportion of students in the school from BAME backgrounds, England, September 2020



Source: *The National Foundation for Educational Research. The challenges facing schools and pupils in September 2020 (105).*

These socioeconomic inequalities in levels of setbacks in learning during the pandemic are partly related to differential uptake of and access to education and resources. The Institute for Fiscal Studies (IFS) reports that during the lockdown in May, children in the highest income quintile (Q5) spent more time in nearly all educational activities, and there was a clear gradient in daily learning time by income. The difference between the richest (Q5) and poorest (Q1) quintiles exceeded nearly one hour per day (Figure 3.8).

Figure 3.8. Children's daily learning time during lockdown by income, UK, April – May 2020

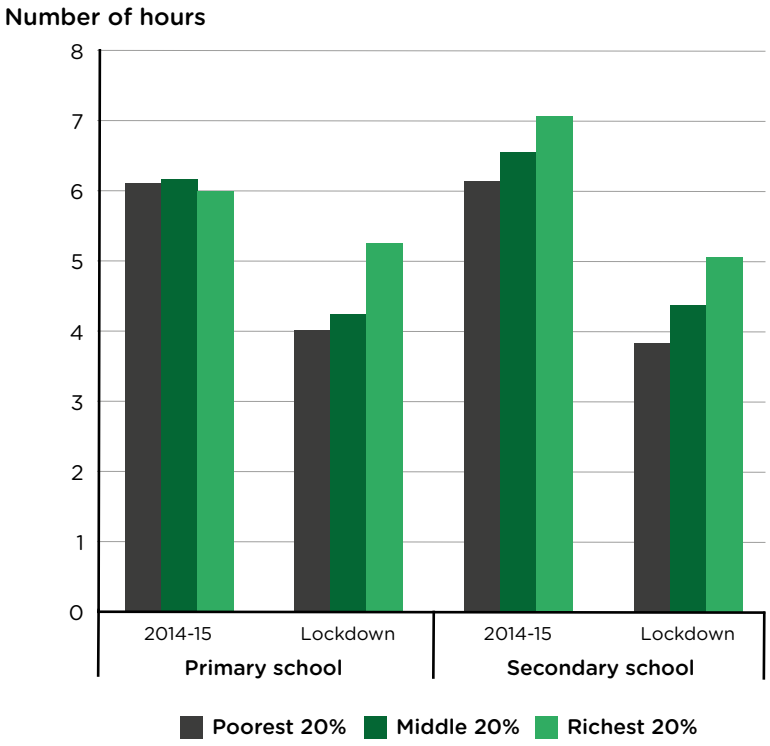


Source: *The IFS Deaton Review. COVID-19 and Inequalities, 2020 (106).*

The amount of time children spent on school-work during COVID-19 lockdowns varied due both to what schools have offered and to parents' ability to support remote schooling. Recent work from the UK (82) (107), Ireland and the Netherlands (108) outlines some of the factors behind growing educational inequality related to COVID-19 lockdowns. For example, higher-income parents have been much more likely than those with lower incomes to report that their child's school has provided online classes and access to online videoconferencing with teachers. Children from high-income families in England spent 30 percent more time on home learning than those from poorer families (107).

For primary school children, the school closures in the UK created new inequalities in learning time. Before the pandemic, there were relatively small differences in time spent on educational activities across different socioeconomic groups. During the lockdown, learning time fell for children from homes at all income levels, although unequally (107). Learning time fell the least for students in the highest-income homes, while for middle- and lower-income students the decrease in learning time was larger, creating an income gradient in learning time. For secondary school students, inequalities in learning time were present before the closures and increased further while they were in operation (109). For these students, the closures have slightly widened existing, persistent inequalities in learning time (Figure 3.9).

Figure 3.9. Number of hours spent learning during 2014/15 and lockdown in 2020, by family earnings, UK

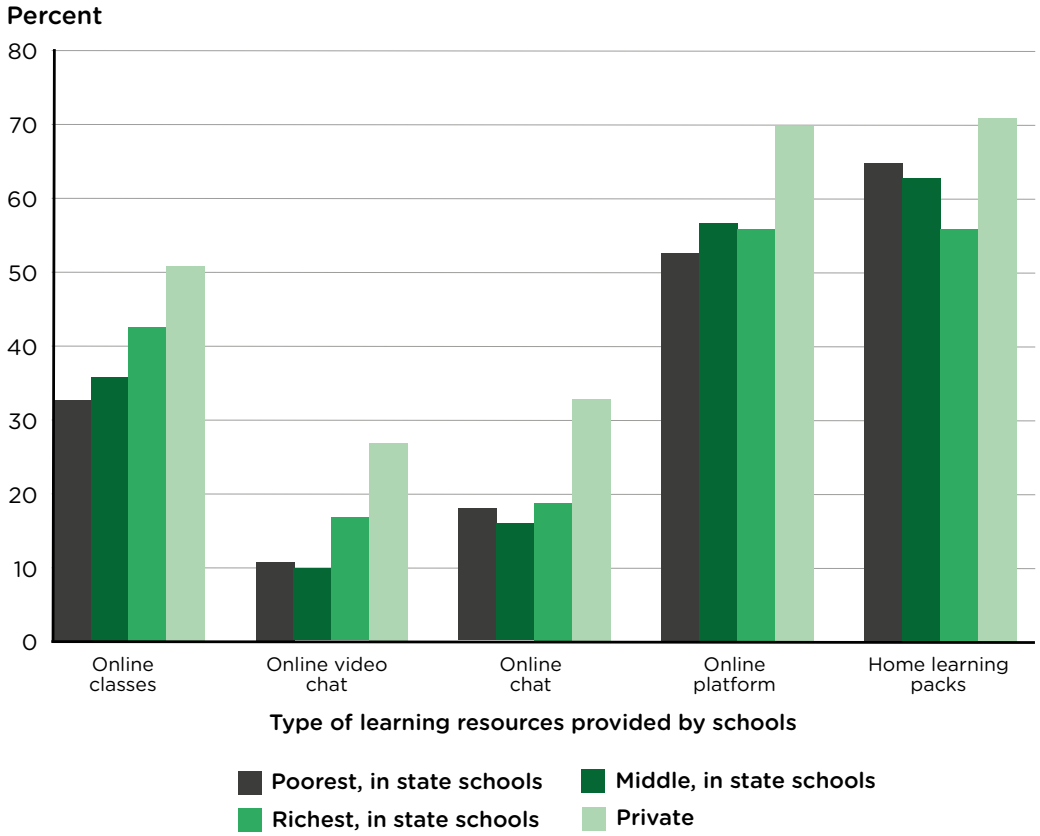


Note: *Poorest, middle and richest groups are based on equivalised family earnings (based on pre-pandemic earnings for lockdown data).*

Source: *IFS calculations using data from the 2014–15 UK Time Use Survey and the IFS–IoE survey of time use during COVID (109).*

A survey conducted by the Institute for Fiscal Studies and the Institute of Education between 29 April and 12 May 2020 showed that private primary school students had greater access than state primary school students to resources for home learning provided by their schools, as shown in Figure 3.10 (110). Even among state schools there were clear inequalities in provision related to levels of deprivation – those in the wealthiest quintile had more access to online platforms for learning compared with those in the poorest quintile.

Figure 3.10. Access to different home learning resources provided by primary schools in England during school closures in 2020, as reported by parents, by deprivation quintile



Notes:

1. *Based on responses from a sample of 4,157 parents in England with children aged 4-15 years. The respondents were weighted to ensure that the statistics were representative of parents and children across England.*
2. *Earnings data were categorised into five quintiles based on equivalised total household annual pre-tax earnings, where the first quintile refers to the 'poorest' housholds and the fifth quintile to the 'richest' households. For this graph, the 'poorest', 'middle' and 'richest' categories correspond to the first (£0 to £2,500), third (£8,335 to £16,000) and fifth (£26,001 and higher) quintiles.*

Source: *Institute for Fiscal Studies, 2020 (110).*

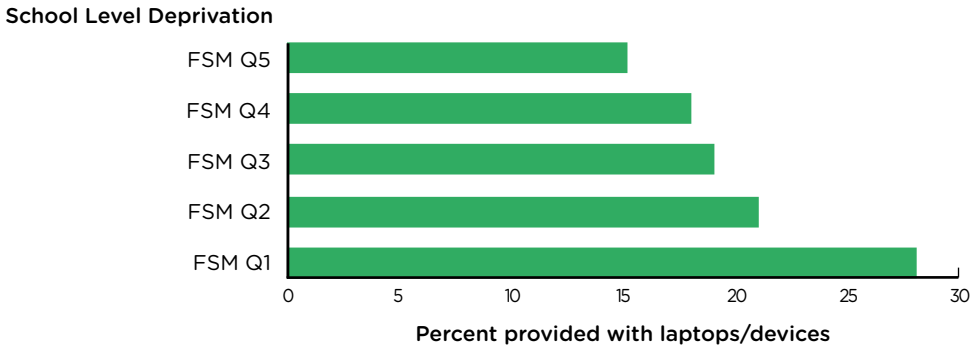
FACTORS AFFECTING INEQUALITIES IN HOME LEARNING

Education provision during school closures has been varied and there are clear inequalities linked to the socioeconomic status of families in the amount of tuition received and online access to learning (111) (112). The importance of the home learning environment is evident in analysis of the impact of long school holidays on attainment; research shows attainment of children from low-income families falls 18 times faster than their more affluent peers after the summer holidays (113).

Research by the IFS shows that approximately one million children and their families do not have adequate access to a device or Internet connectivity at home, and more children from poorer households use a phone rather than a computer to access educational resources (107). Data from the Teacher Tapp survey (114) show that a higher proportion of children from low-income families in the more deprived schools did not have access to the Internet or to electronic devices required for home learning; 700,000 disadvantaged students had no access to the Internet during the school closure period. For both primary and secondary school students there were marked inequalities by type of school too: more than 33 percent of students in state schools were left without access to home learning IT resources compared with just three percent of private school students, during the first lockdown (110).

As shown in Figure 3.11, just over half as many students in the most deprived quintiles were provided with a laptop for home learning during the lockdown as those from the least deprived quintile where need is highest, showing a gradient in access to the necessary IT for learning during lockdown (82) (115).

Figure 3.11. Provision of laptops and devices to students in schools by proportion of pupils eligible for free school meals (FSM), as reported by teachers in England, April 2020



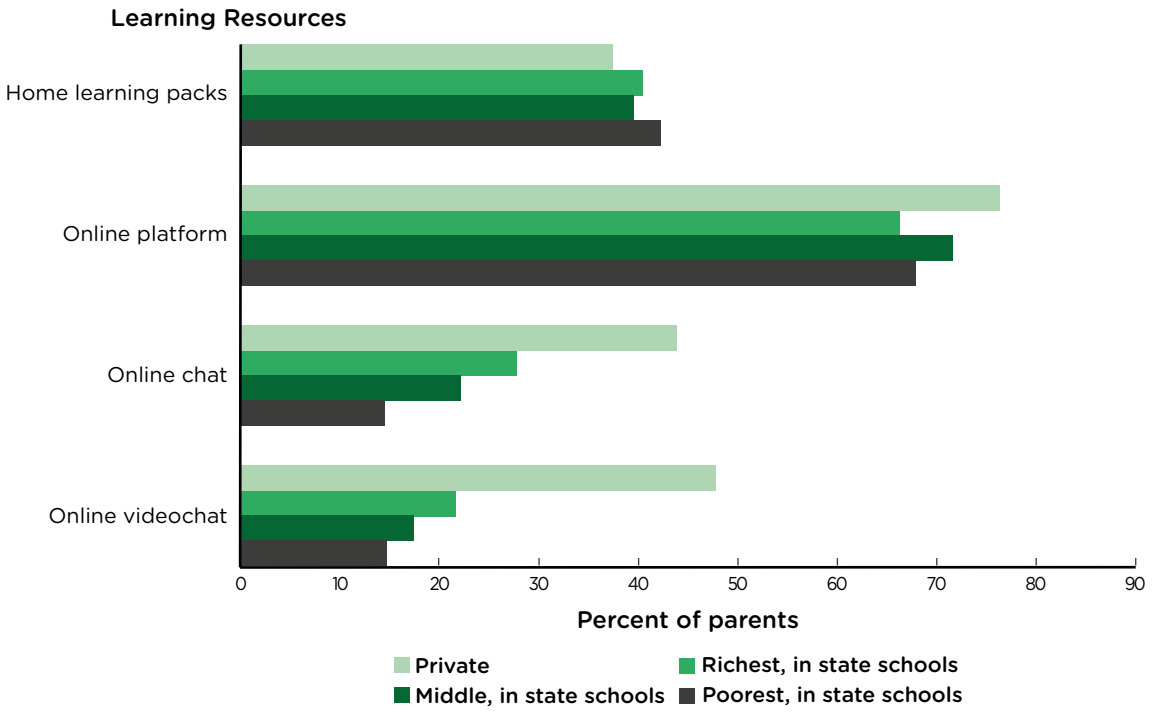
Note: *Deprivation quintiles are based on the 'eligibility for free school meals' (FSM) socioeconomic indicator where, FSM1 refers to the quintile of schools with fewest FSM eligible pupils and FSM5 those with the most pupils eligible.*

Source: *Sutton Trust/Teacher Tapp survey of teachers in England, 4 April 2020 (115).*

A digital access scheme was rolled out by the Government to provide laptops, tablets and 4G wireless routers to homes with children between May and July 2020 (116) but it was limited and insufficient, providing only 200,000 devices and 50,000 routers. Eligibility criteria included households with social workers, young care leavers and disadvantaged Year 10s, but only 37 percent of those eligible received a device (117). According to the Children's Commissioner for England, children from Years 7, 8 and 9 were potentially left without access to a device during the first lockdown – and 1.34 million children currently in these years are eligible for free school meals. In October 2020, the Department for Education announced a reduction in numbers of laptops from the digital access scheme for disadvantaged students by approximately 80 percent. This announcement was made two days after the Government used its COVID-19 emergency powers to impose a new legal duty on schools to provide a remote education to any student unable to attend lessons because of the pandemic (118). The failure of the digital access scheme to provide remote access to all children will lead to further widening of inequalities in attainment.

As shown in Figure 3.12, during the first lockdown there were significant inequalities in school provision for home learning according to whether schools are public or private and by income level. Students at private schools and high-income students were more likely to be provided with online teaching and video chats with teachers than low-income students attending state schools. However, lower-income students in state schools were as likely as private school students to be provided with printed home learning packs, possibly to due to some schools' efforts to address the income gradient in Internet and computer access.

Figure 3.12. Percent of parents reporting their child's school provided different home learning resources during the first lockdown, by school type and income level, secondary schools in England, as reported by parents/carers, 29 April to 12 May 2020

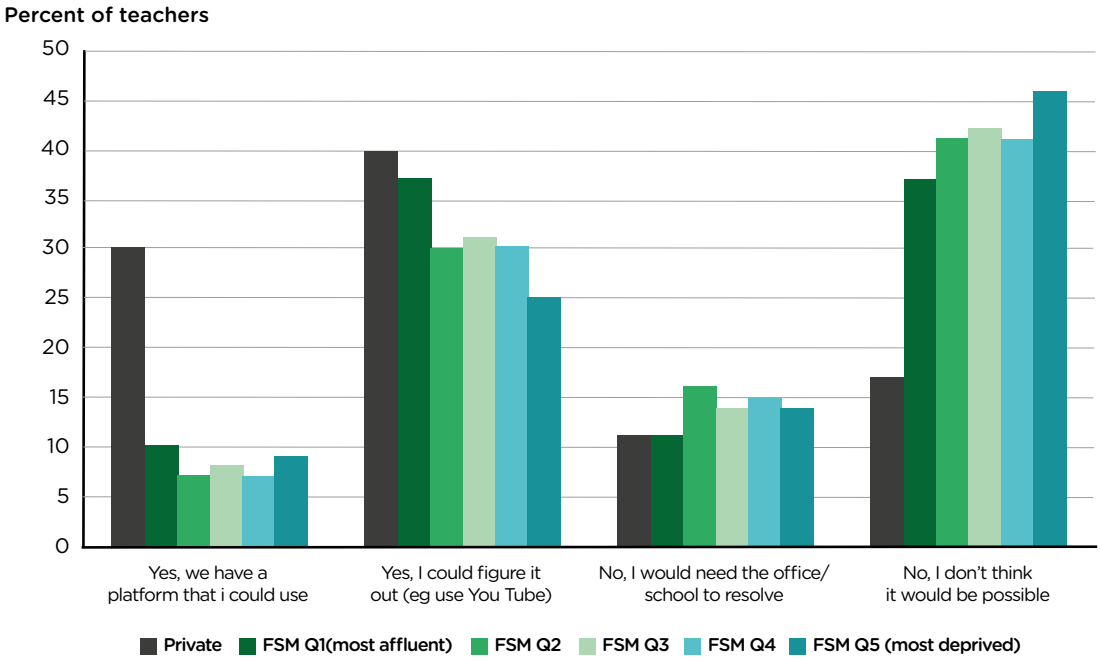


Note: *"Poorest", "middle", and "richest" refer to children in the first, third and fifth quintiles of the pre-pandemic equivalised family earnings distribution respectively. Quintiles are defined on the entire sample (not just those in state schools), and children in private schools are subsequently categorised separately here.*

Source: *IFS. Learning during the lockdown: real-time data on children's experiences during home learning, 2020 (107).*

During the first lockdown, children in some schools (particularly independent schools) had a full timetable of online lessons, with registers taken (117). A Teacher Tapp survey found private schools were more likely to be streaming lessons (66 percent of private secondary versus six percent of state secondary schools) and private school teachers were twice as likely as state school teachers to make telephone calls to families. Just 16 percent of state secondary teachers reported speaking to a parent on the day of the survey, and just 11 percent said they had spoken to a student (119). Before schools closed, the Teacher Tapp survey looked at schools' readiness to cater for distance learning and suggested that there was disproportionate preparedness of schools for adapting to this online learning, according to whether the school was a private or state school and relative to the level of deprivation of the school (114). Figure 3.13 shows how prepared teachers felt to provide online lessons: teachers in more deprived areas felt less able to do so.

Figure 3.13. Teachers' anticipated ability before school closures to broadcast a lesson online to their class, by proportion of pupils eligible for free school meals



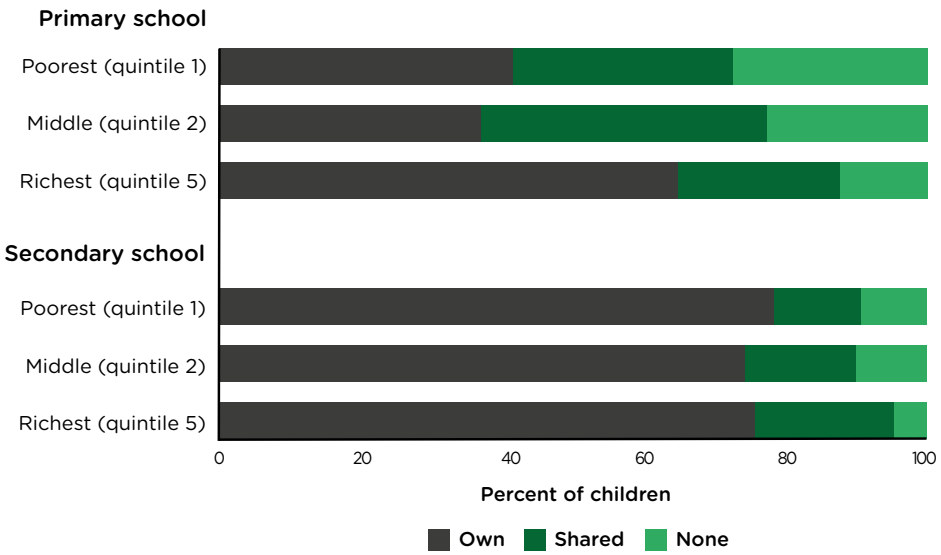
Note: *Deprivation quintiles are based on the 'eligibility for free school meals' (FSM) socioeconomic indicator where, FSM1 refers to the quintile of schools with fewest FSM eligible pupils and FSM5 those with the most pupils eligible*

Source: *Teacher Tapp, Monitoring COVID-19 Readiness in Schools (114).*

There were also differences in levels of satisfaction between parents from different socioeconomic backgrounds. For children in high income families learning from home, 66 percent of their parents reported being satisfied with the level of support provided by their school, compared with 56 percent of parents in working class families (117).

Essential components of home learning include quiet space to work, access to the Internet and technological devices, school resources for conducting remote learning, a parent's ability to support home learning and access to additional learning support (120), but these are not available to all children, particularly those from more deprived backgrounds. Research by the IFS found that 58 percent of primary school students in the poorest families do not have access to their own dedicated study space (Figure 3.14) (107).

Figure 3.14. Gaps in access to a dedicated study space, by household income, UK, April – May



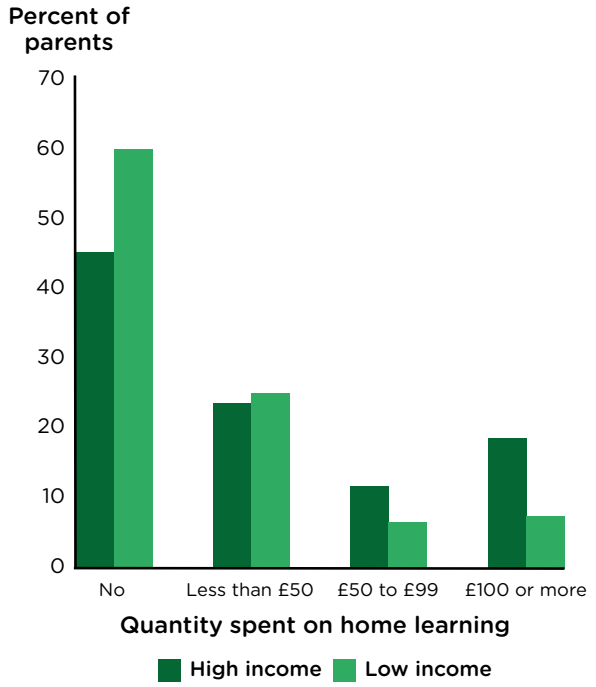
Note: *Parents were asked to tick all places that apply when asked 'Does [child] have a desk or dedicated space for studying at home?'*

Source: *Authors' calculations using IFS–IoE survey of families' time use (107).*

INEQUALITIES IN FINANCIAL RESOURCES FOR EDUCATION

Financial resources available at home play a significant role in a child's learning (121) and the impact of this is accentuated during school closures. Around half of children in the UK had money spent by their parents on their learning in the first week of school closures during the first lockdown, including on extra books or resources, subscriptions to websites or apps, or on electronic devices. However, not all families could afford such expenditure, particularly at a time of increasing financial pressures for many. Figure 3.15 shows inequalities in learning expenditure by social class (82).

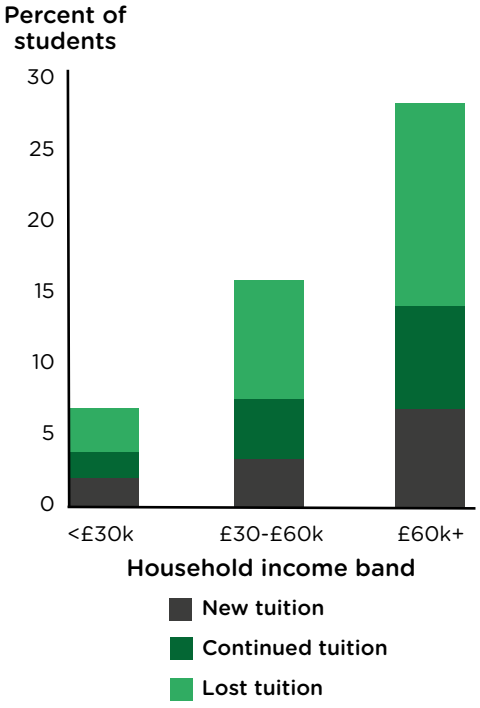
Figure 3.15. Percent of parents spending on home learning by quantity in the UK during the first week of school closures, by low or high income, April 2020,



Source: *Public First/Sutton Trust survey of UK parents, 1-3 April 2020 (30).*

Research from the Sutton Trust has shown that private tuition is an important way in which better-off parents support their children outside of school. Only eight percent of children received private tuition while schools were closed, following the banning of face-to-face tutoring; however, the distribution was unequal among households (115). In households earning above £100,000, a quarter of children received some form of tuition during the lockdown. Figure 3.16 shows the status of tuition across income categories during the school closures. Children in households earning more than £60,000 were twice as likely as those earning under £30,000 to be receiving tuition at the time (early April), but the gap had narrowed slightly due to the immediate decline in private tuition after the closure of schools (115).

Figure 3.16. Rates of new, continued and lost tuition, by household income band in the UK, April 2020



Source: *Public First/Sutton Trust survey of UK parents, 1-3 April 2020 (115).*

Additional support is required to address learning loss or setback, especially among the most disadvantaged students, including more resources to provide small-group tuition (122). Widening access to private and online tuition during and after school closures could help to reduce the impact on the attainment gap and reduce the significant risks of both the short-term and long-term effects on the most disadvantaged children who may not currently have a suitable home learning environment (123). Now that schools have reopened, the need for after-hours and holiday provision is even more pressing – especially for vulnerable children whose parents have struggled to afford and organise things for them to do during this period (124) (113). Holiday activity provision can go some way towards addressing these inequalities. According to the Education Endowment Foundation, students who attend summer schools make around two additional months' progress (which reaches to almost three for disadvantaged students), putting them in a far better position for the next academic year (125) (117).

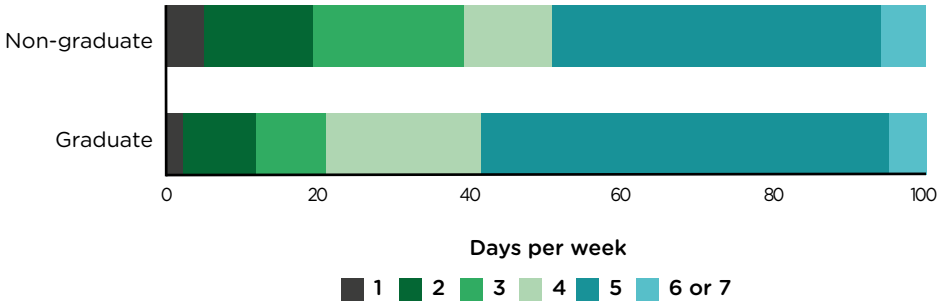
In an attempt to address inequalities in provision and tuition, the £350 million National Tutoring Programme (NTP) started delivering tutoring on 2 November 2020 to up to 2 million disadvantaged students who have been disproportionately affected by COVID-19 (126). Schools are able to decide whether to use tuition sessions in addition to their students' normal school day, or during their timetabled day and provide support for disadvantaged students and those most in need who have fallen behind in their learning (127). However, given the scale of need and the depth of inequality, it is unlikely that this relatively small scheme will reduce inequalities in attainment.

INEQUALITIES IN PARENTS' AND CARER'S CAPACITIES TO HOME SCHOOL

Most parents found supporting home learning over the lockdown difficult. Almost 60 percent of the parents of primary school children, and almost half of the parents of secondary school children, reported challenges in supporting their children's learning at home and there are inequalities in capacity to do this. A survey of more than 4,000 parents in England by the IFS (128) found that children from better-off households were spending 30 percent more time each day on educational activities than children from the poorest fifth of households.

Factors that impact on a parent's ability to support home learning include: the time and resources that they have available to dedicate to their child's learning at home, and their educational status (129). Results from the Kantar Public Voice Survey (2020) indicate that there were differences in the support for home learning while schools were closed according to factors such as parental education level, employment status and gender (130). The survey showed clear differences in the days per week spent on home schooling according to a parent's education level (Figure 3.17) (130). Eighty percent of parents who were graduates reported homeschooling their children for at least four days per week, compared with 60 percent of parents who were non-graduates (130). Graduate parents were more likely to be working from home during lockdown and thus more able to homeschool their children.

Figure 3.17. Number of days per week spent on home schooling during the first lockdown by parental education attainment level, end of April to the beginning of June 2020, England



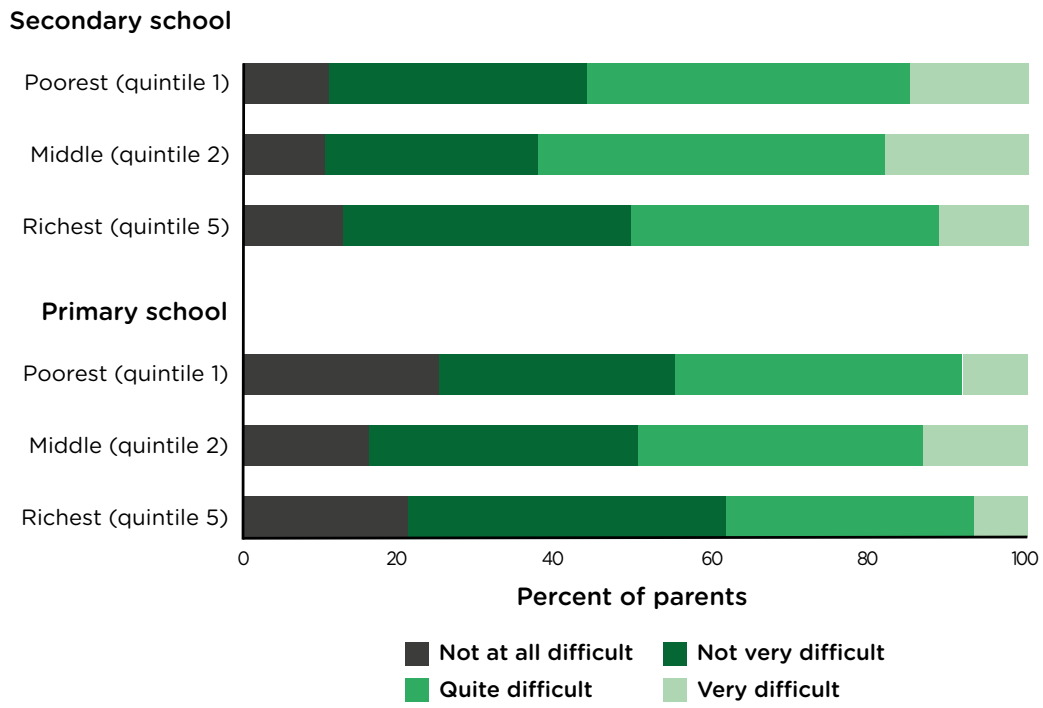
Note: *Based on a sample of 364 households with one or more children of school age.*

Source: *Kantar Public Voice Survey, 2020 (130)*

The ONS Opinions and Lifestyle Survey (2020) found that 64 percent of parents with a degree or equivalent felt confident in their ability to home school their child/children, compared with 29 percent of parents whose highest level of education was a GCSE or equivalent (48).

The IFS Learning During Lockdown survey (2020) indicates that there were differences in the level of difficulty experienced by parents of secondary school students in supporting home learning according to family equivalised household income (107). Sixty-two percent of parents in the richest families reported either finding it not difficult at all or not very difficult to support their child's home learning, compared with 56 percent of those from the poorest families (107), as shown in Figure 3.18 (131).

Figure 3.18. Level of difficulty reported by parents in supporting their child's home learning, by type of school and parental income level, UK, April – May 2020



Note: *Parents were asked 'How do you find supporting [your child] with home learning while schools are closed?'*

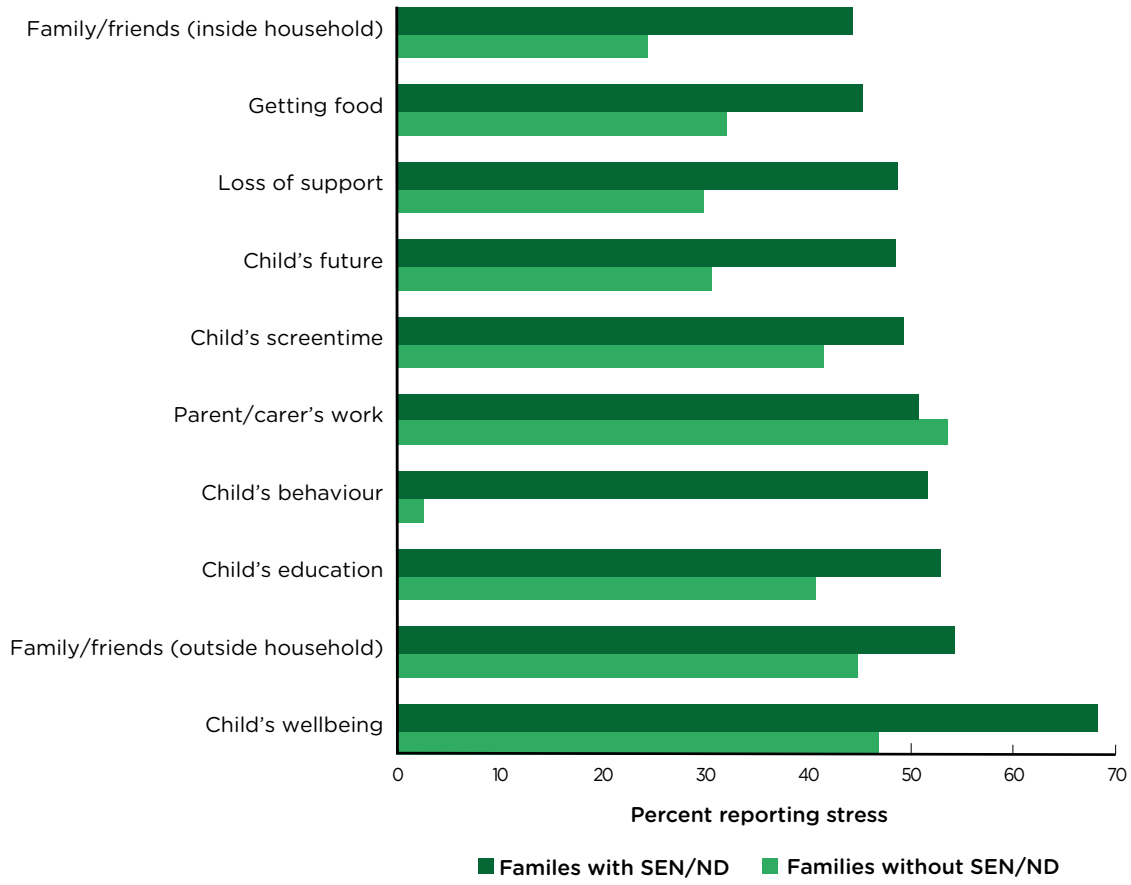
Source: *Authors' calculations using IFS–IoE survey of families' time use (107).*

3.C THE IMPACT OF COVID-19 CONTAINMENT ON STUDENTS WITH SPECIAL EDUCATIONAL NEEDS AND DISABILITY (SEND)

Students with special educational needs and disability (SEND) are, on average, more than three years behind their peers by the end of secondary education. The levels of support and quality of education for SEND students during school closures over the first lockdown varied and the situation has been described as a school lottery (134). The lack of differentiation and personalisation of instruction available to many young people with SEND, including language difficulties, in their online lessons and home education has acted as a barrier to learning during school closures. Even in cases where schools had initially provided high quality work and digital or printed materials, many parents and carers of children with SEND reported feeling that it would not be possible for them to maintain the level of learning and specialist teaching their child required (135).

The CO-Space Survey carried out between 30 March and 29 April 2020 showed that parents of children with special educational needs or a neurodevelopmental disorder (SEN/ND) were more stressed than parents with children without such a need or disorder about each of the sources of stress the survey covered (Figure 3.19), with the exception of stress about work. The wellbeing of their child was the stressor that the highest proportion of parents with children with SEN/ND reported experiencing (68 percent) (87).

Figure 3.19. Main sources of stress for parents/carers with and without a child with SEND/ND during the first lockdown in England (in the week prior to completing the survey), 30 March to 29 April 2020



Note: *Based on a sample of 5,000 survey responses. The survey recruitment was of a self-selecting nature and therefore the sample is unlikely to be nationally representative. It should be noted that 92% of respondents were female, the majority were employed and had an overage income of >£30,000. Within this sample, 871 parent/carers reported that their child had special educational needs or a neurodevelopmental disorder (SEN/ND).*

Source: *Co-Space Study (COVID-19: Supporting Parents, Adolescents and Children during Epidemics) 2020 (87).*

In terms of child support for mental health, emotional or behavioural difficulties, 80 percent of respondents whose children had been receiving such support prior to the pandemic were no longer receiving this during lockdown (87). Children with SEND who had been previously excluded from school may have had no access to any support or services while schools were closed (134).

3.D SCHOOL EXCLUSIONS AND SCHOOL CLOSURES

In the 10 Years On report we assessed that the needs of many vulnerable children were not being identified or met – and this was before schools closing due to COVID-19. The reasons for this included the deep cuts to children's services, the poor quality of services in many areas, the closure of some schools and the high thresholds in place for accessing specialist services (1) (136). The consequences of COVID-19 mean that the needs of children who were already vulnerable are now even less likely to be met and there are also children who have become newly vulnerable because of the pandemic's impacts, putting further strain on children's services. While schools were closed, there was no identification, monitoring or support for students, particularly those who are on the edge of being deemed as 'vulnerable'.

Rates in school exclusions increased for children both eligible and ineligible for free school meals (i.e. across household income bands) over the decade from 2010 (1). However, 2018/19 data show that the permanent exclusion rate for FSM-eligible students was 0.3 percent, compared with 0.06 percent for those not eligible, and the fixed period exclusion rate was also higher for FSM students at 13.7 percent, compared with 3.8 percent for those not eligible (137). According to a report from the Institute for Public Policy Research (IPPR), excluded children were twice as likely to be in the care of the state, four times more likely to be growing up in poverty and 10 times more likely to have poor mental health in 2017 compared with non-excluded children (138).

Exclusion rates vary too by ethnic group. The Timpson Review of 2019 set out that Bangladeshi, Chinese and Indian children are around half as likely to be excluded as White British children. Children from other ethnic groups are more likely to experience exclusion than White British children, in particular Black Caribbean, Gypsy, Roma and Traveller children and students of a mixed background (139). Those living in more deprived areas are also more likely to be excluded, and young people with SEND are over five times more likely to be excluded permanently than young people without (140) (141) (142).

Children who experienced any form of exclusion before the first lockdown school closures will most likely have experienced a double exclusion, as a result of being excluded from access to schooling and from receiving support from social care. Research in the Department for Education's report School exclusion risks after COVID-19 shows that students who were excluded directly before lockdown – or very close to lockdown would not have an Education Health and Care Plan or be known to children's social care. This means that they would not have had access to any interim provision in their local Pupil Referral Unit during the lockdown and would not have been placed at a new school (135).

Approximately 10,000 Year 11 students who were excluded from mainstream schools in England and moved to alternative provision were due to leave that provision in September 2020 as a result of becoming further disengaged under lockdown (143). The Centre for Social Justice and education charity 'The Difference' commissioned a survey in the week commencing Monday 15 June to explore the post-16 support in place for students in alternative provision. The survey's findings showed that a quarter of their students would be immediately not in education, employment or training (NEET) in September because of the disruption caused by the COVID-19 crisis. Furthermore, an estimated 35 per cent were vulnerable to criminal or sexual exploitation and an estimated 29 per cent had serious mental health conditions (144).

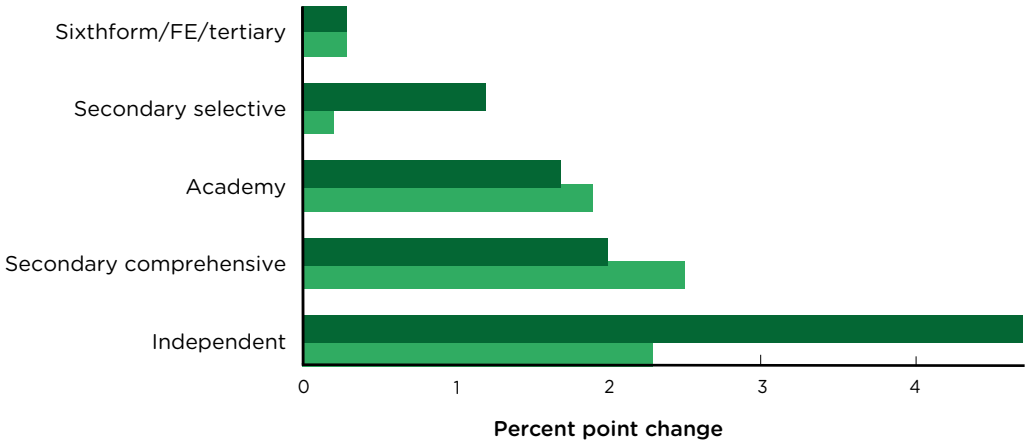
3.E CANCELLATIONS OF PUBLIC EXAMS

As a result of the lockdown restrictions and school closures, school exams were cancelled for the academic year ending in July 2020 and changes to how grades were decided were made. Concerns about the fairness and the impact of the new grading system on students' results were heightened following the release of the results in August 2020 when the assessment methodology led to 40 percent of A-level results being downgraded from teachers' assessed grades (145).

This created widespread anxiety and distress, eventually leading the Government to retract those grades and replace them with grades decided by teachers (146). Teachers' predicted grades (used for university applications) have been shown in the past to disadvantage Black and minority ethnic, low-income and other marginalised students (147). These are students who are already under-represented in top universities, which tend to favour students from White, high-income backgrounds, especially those from private schools (147).

Figure 3.20 shows that independent schools and their students benefited most from the teacher assessed moderated A-level results in summer 2020, by comparing them with the previous year's results gained through sitting exams.

Figure 3.20. Percentage point change in allocation of A-level results at grade A and above and grade C and above, by type of school in England, between 2019 and 2020



Source: *Financial Times analysis of Ofqual data, 2020 (148)*

The Government announced in October 2020 that it would be deferring the 2021 GCSE, AS and A-level exams in England by three weeks. Wales had already announced that it was cancelling its GCSE, AS and A-level exams and England may yet follow a similar route. The Welsh government will work with schools and colleges to put in place teacher-managed assessments (149). In Scotland there will be no National 5 exams in 2021 and the Scottish government has not ruled out cancelling Higher exams; a final decision will be reached in mid-February 2021 (150).

According to Education International, these new assessment arrangements for students in 2021 will increase inequality and pressure on students and teachers in the UK (151). Students taking GCSE and A-levels next summer have missed five months of in-school teaching – a loss which impacts most severely on disadvantaged students, 700,000 of whom had no access to the Internet over that time, as we have described. In addition, many students have had to self-isolate since schools reopened in September or have been sent home due to a positive COVID result within their class or year group. As explained by Education International, arrangements need to be made to adapt exams to the disruptions to school learning experienced by students, especially the most disadvantaged ones (151).

One suggestion has been made for GCSE and A-level exams to be altered to include a greater choice of topics from the existing subject specifications. This would provide students with a greater chance of finding questions they can answer – or, to be examined on what they have been taught, not on what they have not been taught, according to the unions.

To avoid a repetition of the chaos experienced with this year's exam results it is important to implement a range of transparent contingency measures to address the wide range of possible scenarios due to COVID-19 that could impact on exams and the fair assessment of students' abilities. Reducing unfair inequalities in grading must be prioritised (151).

3.F EDUCATION FUNDING

Although the Government has recognised the need to support at-risk families and vulnerable children's mental health and announced an additional £12m in April 2020 for vulnerable children, the Early Intervention Foundation (EIF) views this as a relatively small intervention. The programme, which was aimed at families at risk of domestic abuse, provided community volunteers to work with families and continued support for teenagers at risk of exploitation, but it targeted only a few areas of the country and the EIF concluded it will not have sustained impact on outcomes for vulnerable children (152).

Data from the Department for Education on the impact COVID-19 is having on local authority finances show that between March and August 2020 children's services in England incurred an additional £164 million of spending (153). The Government provided £3.7 billion of funding for local authorities to support services for children and families, between 19 March and 2 July (154). On the 12th of October the Government announced that it would provide an additional £1 billion to local authorities as a result of the high COVID-19 alert levels (155). However, the Children's Commissioner stated that only eight percent of the first £3.7 billion was spent on children's services (156).

There was an increase in school funding targeted at more deprived schools over the decade from 2000. However, Table 3.1 shows that since 2009–10, spending per student has fallen by the largest amount among the most deprived primary and secondary schools (157) (158) (159). This will have harmed educational outcomes for schools with more deprived students, widening inequalities in education even before the pandemic hit.

Table 3.1. Spending per student, by student quintile of eligibility for free school meals (2020–21 prices)

A) PRIMARY SCHOOLS

	Q1 (least deprived)	Q2	Q3	Q4	Q5 (most deprived)
2000-01	**£2,886**	**£2,870**	**£2,962**	**£3,144**	**£3,546**
Change	£1,602	£1,670	£1,835	£2,101	£2,464
Real-terms growth	56%	58%	62%	67%	69%
2009-10	**£4,488**	**£4,540**	**£4,797**	**£5,244**	**£6,011**
Change	£291	£343	£326	£216	**-£84**
Real-terms growth	6%	8%	7%	4%	-1%
2018-19	**£4,779**	**£4,883**	**£5,123**	**£5,460**	**£5,927**

A) SECONDARY SCHOOLS

	Q1 (least deprived)	Q2	Q3	Q4	Q5 (most deprived)
2000-01	**£3,787**	**£3,774**	**£3,846**	**£4,012**	**£4,581**
Change	£2,266	£2,264	£2,442	£2,739	£3,333
Real-terms growth	60%	60%	64%	68%	73%
2009-10	**£6,053**	**£6,038**	**£6,288**	**£6,751**	**£7,914**
Change	**-£500**	**-£408**	**-£376**	**-£466**	**-£988**
Real-terms growth	-8%	-7%	-6%	-7%	-12%
2018-19	**£5,553**	**£5,630**	**£5,912**	**£6,284**	**£6,926**

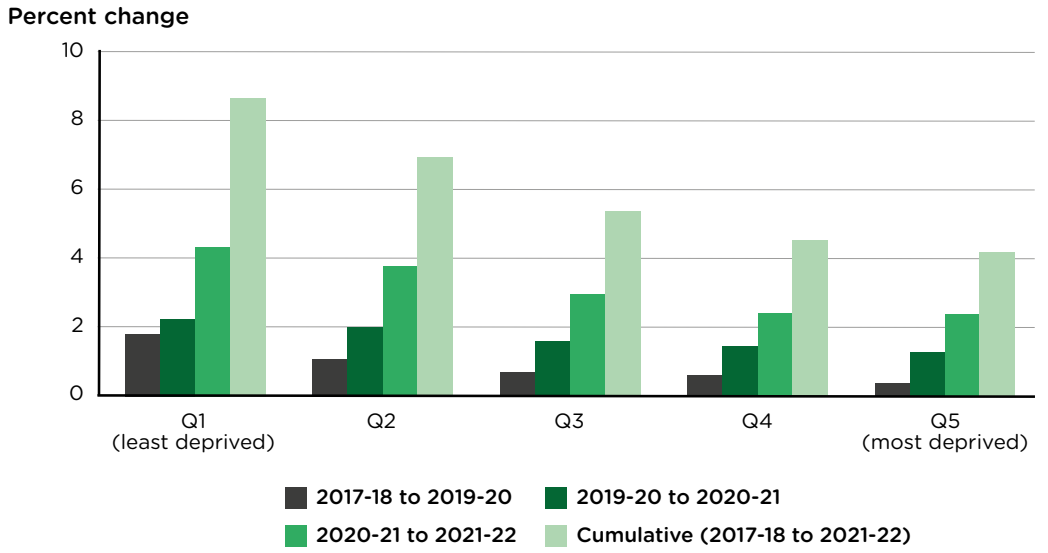
Source: *IFS. Education spending in England: schools. Report chapter, 2020 (157).*

Post-16 education has been particularly hard-hit by funding reductions, with spending per student in school sixth forms reported to have fallen by 23 percent in real terms between 2009–10 and 2018–19. Funding for further education (FE) has declined the most: in 1990–91, spending per student in FE was 50 percent higher than spending per student in secondary schools, but by 2018 it was about eight percent lower.

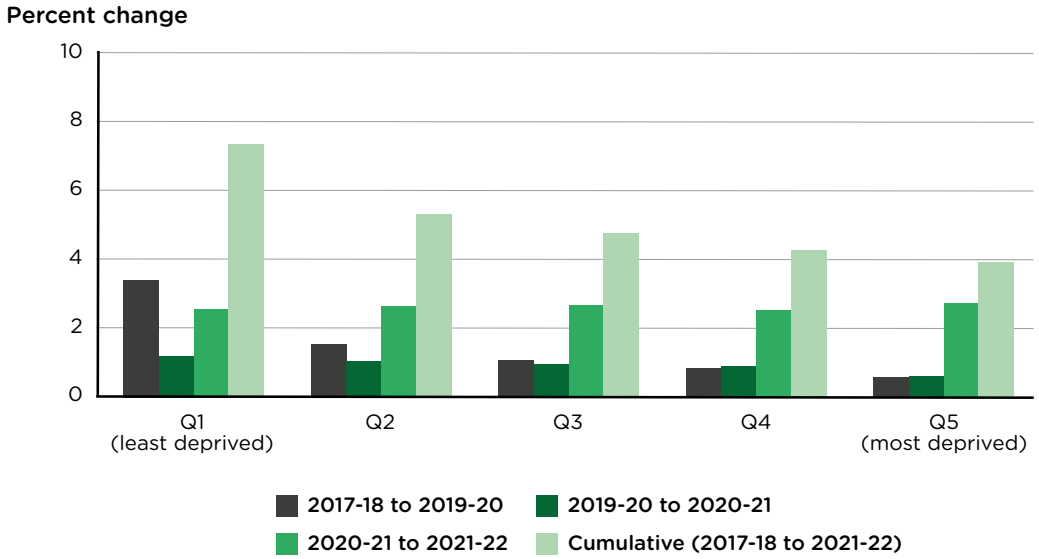
Figure 3.21 shows the real-terms changes in national funding formula (NFF) allocations by school deprivation quintile (based on the percent of students eligible for free school meals) for each year. The first bar for each quintile compares the NFF's allocations for 2019–20 with the baseline for 2017–18, while the next two compare 2020–21 and 2021–22 with the previous year. The final bar shows the cumulative change from 2017–18 to 2021–22. More deprived schools are due to receive lower real-terms increases in funding per student for each year of the NFF up to 2021–22. NFF funding per student will increase by 4 percentage points less in real terms among the most deprived primary schools when compared with the least deprived ones.

Figure 3.21. Real-terms changes in national funding formula (NFF) allocations by quintile of student eligibility for free school meals, England

A) PRIMARY SCHOOLS



A) SECONDARY SCHOOLS



Source: *IFS. Education spending in England: schools. Report chapter, 2020 (157).*

An analysis by the National Education Union published in 2019 found that funding for special needs provision in England had been reduced by £1.2 billion since 2015 because of shortfalls in funding increases from central government; this reduction will worsen inequalities in attainment (132).

3.G CONCLUSIONS

This chapter has documented that closure of early years facilities and schools between March and July 2020 impacted more deprived children the most. It will have caused delays in the development of children in the early years phase, which will hold back progress for more disadvantaged young children the most. And there has been greater loss of learning time in more deprived areas, which will lead to even wider inequalities in educational attainment. More deprived children tend to have less access to necessary technology and IT, less suitable home working environments and are more likely to experience stress and poverty at home – which harms learning. Differences in the provision of lessons and support will have added to these inequalities; more deprived children were less likely to receive good quality online teaching during the closures. Students with SEND and excluded students have also been adversely impacted and require much greater support, which schools and parents are largely inadequately resourced to undertake.

The cumulative effects will be to worsen inequalities in educational attainment and lead to worse outcomes throughout life, unless mitigating actions are taken immediately.

These recommendations remain critical to 'building back more equitably' but there is now an imperative for greater speed and intensity too, in response to the additional inequitable impacts of the COVID-19 containment measures on the early years and during education. It is also essential that programmes for support and development in the early years and for families are universally available but targeted at more deprived areas.

In the 10 Years On report we set out proposals to reduce widescale development and attainment inequalities during the early years and throughout education. These proposals are even more urgent following the widening inequalities for young children and school age children during the pandemic. pandemic. Child poverty has increased since 2010 and containment measures are leading to increases in child poverty, discussed in the subsequent section. Poverty harms early years development and education.

Shortfalls in funding for early years settings and schools mean that the intensity and resources required to reduce widening inequalities is not available. The 2.2% increase in funding for schools announced in November 2020 is insufficient to meet the task and does not compensate for cuts to funding in the pre-pandemic decade which harmed more disadvantaged areas the most and inequalities will continue to widen. It is essential we learn the lessons from the pandemic and from the previous ten years and invest proportionately more in early child development and education in more deprived areas in order to build back fairer and for the long term. In the shorter term, investments in laptops and online infrastructure in more disadvantaged areas will help reverse some of the inequitable impacts arising from the pandemic.

BOX 3.3. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EARLY YEARS

LONG TERM

Reduce inequalities in early years development as a priority for government

MEDIUM TERM

- Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
- Improve availability and quality of early years services, including Children's Centres, in all regions of England.
- Increase pay and qualification requirements for the childcare workforce.

SHORT TERM

- Early years settings in more deprived areas are allocated additional Government support to prevent their closure and staff redundancies.
- Improve access to availability of parenting support programmes
- Increase funding rates for free child childcare places to support providers

BOX 3.4. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EDUCATION

LONG TERM

- Put equity at the heart of national decisions about education policy and funding.
- Increase attainment to match the best in Europe by reducing inequalities.

MEDIUM TERM

Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

SHORT TERM

- Inequalities in access to laptops, are addressed and the programme designed to enable provision of laptops to more deprived pupils is expanded and adequately resourced.
- Significantly greater focus on achieving equity in assessments for exam grading.
- Catch up tuition is fully rolled out for children in more deprived areas urgently
- Additional support is provided for families and pupils with SEND
- Excluded pupils are urgently given additional support and enrolled in Pupil Referral Units

CHAPTER 4

CHILDREN AND YOUNG PEOPLE: INEQUALITIES AND COVID-19 CONTAINMENT

Despite children and young people having a much lower risk of the adverse physical health impacts of the COVID-19 virus, the containment measures and the resulting social and economic impacts are having significant negative impacts on young people's mental health and long term prospects for young people. Impacts include reductions in family income, increases in child poverty, food poverty and hunger, employment and training prospects as well as educational attainment, set out in the previous section. In each of these areas there are widening inequalities, which will, blight the lives of many more disadvantaged young people and in turn translate into widening health inequalities in the longer term.

In the *10 Years On* report, we assessed how the previous decade had been particularly scarring for many children and young people and particularly those from more disadvantaged households and areas.

BOX 4.1. SUMMARY: (FROM *10 YEARS ON REPORT*)

- Rates of child poverty increased since 2010, with over four million children affected and are highest for children living in workless families - in excess of 70 percent.
- More deprived areas have lost more funding for children and youth services than less deprived areas, even as need has increased.
- Violent youth crime has increased greatly over the period.

BOX 4.2. SUMMARY: COVID-19 CONTAINMENT AND INEQUALITIES IN CHILDREN AND YOUNG PEOPLE

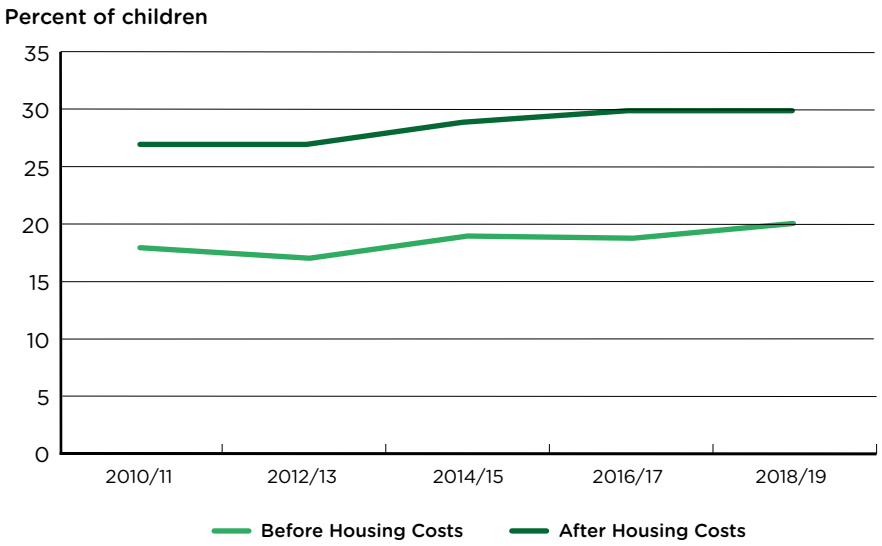
- Child poverty is set to increase further.
- Food poverty among children and young people has increased significantly.
- The mental health of young people, already hugely concerning pre-pandemic, has deteriorated further and there is widespread lack of access to appropriate services.
- Exposure to abuse at home has risen through the pandemic, from already high levels pre-pandemic.
- Numbers of young people unemployed are rising more rapidly than among other age groups and availability of apprenticeships and training schemes have declined.

4.A IMPACT OF THE COVID-19 CRISIS ON CHILD POVERTY

Child poverty is a critical determinant of early child development and has a negative impact on other outcomes throughout life, including educational attainment, employment and income and health (6). Child poverty rates, the result of low wages and benefits, are likely to rise significantly as a result of the pandemic, from an already high level. As described in Health Equity in England: The Marmot Review 10 Years On, rates of child poverty increased over the decade from 2010 (1). Impacts from COVID-19 will worsen these trends and increase levels of child poverty. Meanwhile benefits are insufficient to keep many children out of poverty, particularly in larger families (160).

In 2018/19, 30 percent of children were living in poverty after accounting for housing costs, and 20 percent before housing costs (see Figure 4.1 for trends since 2010); both rates have increased since 2010 (161).

Figure 4.1. Percent of children living in poverty – in households with less than 60 percent of contemporary median household income, before and after housing costs, UK, 2010/11–2018/19



Source: *Based on Department for Work and Pensions, Households below average income: 1994/95 to 2018/1, 2020 (161).*

Publication by the Department for Work and Pensions (DWP) of 2019/20 data in March 2021 will allow analysis of poverty rates during the COVID-19 pandemic and comparison with previous years (28); here we report on surveys and data from other sources, which describe increasing financial strain and food poverty as a result of the pandemic. It is highly likely that child poverty has increased, from an already high level in 2018/19, as families face rising unemployment, and furlough schemes that cover only 80 percent of wages (162).

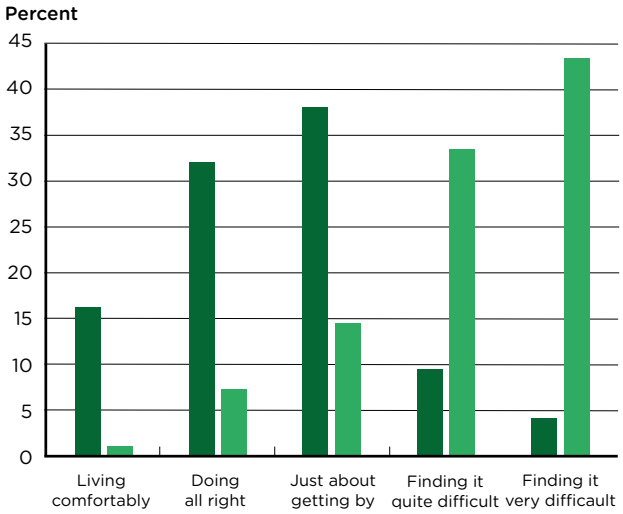
During the first lockdown, parents were nearly twice as likely to be furloughed (14 percent) as those without children (7 percent). There is increasing hardship among self-employed people and single mothers (see Chapters 5 and 6). Many families have simultaneously faced significant additional costs due to school closures and self-isolation while experiencing loss of income (163). And, as we discussed in Chapter 3, the closure of schools placed an additional strain on families who rely on the financial and social support that schools provide (121),

including school meals, and many parents found it hard to cover the costs of food, home schooling and leisure.

Parents expressed feelings of guilt and shame linked to inadequate access to food during the lockdown and the loss of emotional and interrelated financial support from extended family has also had a negative impact on wellbeing and increased levels of anxiety. Through qualitative research by the Sutton Trust, parents reported feeling unsupported or alone. Some parents had accessed relief programmes to defer payments or bills, but parents stated that having to make these payments in addition to the higher costs of lockdown was an overwhelming prospect (121). Preliminary research using the Child Poverty Action Group's 'Early Warning System' described how lockdown made parents' and carers' usual budgetary practices impossible – for example, visiting multiple supermarkets to find the best prices or buying unbranded goods. The constant strain affected some families' mental health. Parents described depression, low mood, paranoia, anxiety, insomnia, apathy, and a loss of routine and control. Some also felt humiliated by having to ask for help with basic survival needs (164). Parental stress and anxiety usually affects children mental health and well being, with potential for long term impacts on health, education and during working lives (121).

Eight in 10 respondents to on an online survey of 285 low-income families by the Child Poverty Action Group reported a significant deterioration in their living standards due to a combination of falling income and rising expenditure. As shown in Figure 4.2, in July to August 2020 low-income families were doing substantially worse than they were before the COVID-19 crisis and the financial situation of families who responded to the survey had worsened since an earlier survey carried out in May to June.

Figure 4.2. Low – income families' responses to how they were coping financially, July–August 2020, England

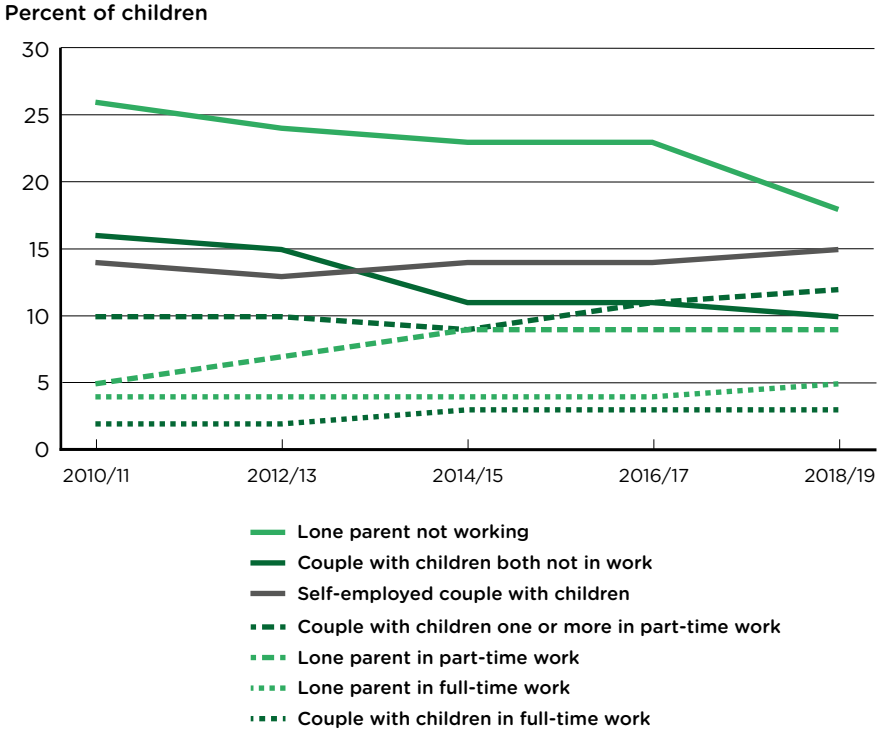


Source: *Child Poverty Action Group. Poverty in the pandemic, 2020 (164).*

The financial impacts of COVID-19 on families have been particularly hard because of the perilous financial circumstances for high, and increasing, numbers of families in the preceding years (see Figure 4.1 above). It is clear that having parents in work is not a guaranteed route out of poverty for children in England (165); the 10 Years On report showed that although government responses aimed at reducing child poverty have been to encourage parents to work, and to provide free or reduced-cost childcare places to support this strategy, it is ineffective for many families (1).

Figure 4.3 shows trends for poverty in households between 2010/11 and 2018/19, which is the latest data available from the DWP but of course do not reflect the impact of the COVID-19 crisis. Child poverty was highest for children living in lone-parent, workless families in 2018/19, but working families also had high and increasing rates of child poverty. Even prior to the pandemic child poverty rates were increasing for lone-parent families in full-time work, couples in part-time work and self-employed parents (161) (166).

Figure 4.3. Percentof children living in poverty – in households with less than 60 per cent of 2010/11 median household income held constant in real terms, by family type of employment, after housing costs, UK, 2010/11–2018/19



Notes: *Data provided in DWP tables use grossing factors based on 2011 Census data, so caution should be exercised when making comparisons with reports prior to 2012/13.*

Source: *Based on Department for Work and Pensions (166).*

Some minority ethnic groups have particularly high rates of child poverty (66). In 2017/18, 45 percent of children from a Black, Asian or minority ethnic (BAME) background lived in a family in poverty after housing costs, compared with 20 per cent of children in White British families in the UK (70). These children experience cumulative impacts of the intersections between poverty and exclusion and discrimination, which harms health and life chances even from the earliest age (14). COVID-19 has increased poverty for BAME families still further. A poll carried out on 7–9 April 2020 by BMG for the Independent newspaper estimates that approximately 46 percent of respondents from a BAME background reported their household income had reduced as a result of COVID-19, compared with around 28 percent of White British respondents (167). A survey carried out by the Fawcett Society showed that 23.7 percent of BAME mothers reported that they were struggling to feed their children, compared with 19 percent of White mothers (168).

Existing profound regional inequalities in child poverty have also likely increased as a result of the impacts of the pandemic. In 2018/19, London had the highest rates of child poverty (39 percent) followed by the North East (35 percent), and the North West (32 percent) (161). The South [outside London] had the lowest rate (25 percent). The regions with higher rates of pre-existing child poverty are most affected by COVID-19 mortality and the social impact of containment measures such as loss of employment and decline in income for many families, and it is highly likely that regional inequalities in child poverty will rise substantially over coming years with the long-term impacts of the COVID-19 crisis as a factor.

During and after lockdowns in the UK, additional benefit schemes have been introduced to try to mitigate the loss of income due to the containment measures. However, as set out here, for many families these measures have not been sufficient to keep them out of poverty and there are concerns that when these schemes end, there will a large rise in child poverty.

In April 2020 the DWP put in place a three-month suspension of benefit-related debt recovery, including housing benefit overpayments and social fund loans. This helped provide some temporary relief for families who were facing financial hardship (121). However, the reintroduction of debt recovery on 6 July has further threatened family finances (87).

Hurdles to accessing Universal Credit payments – including the five-week wait and the two-child limit – will also be particularly punishing for families facing economic crisis at this time (discussed in more detail in Chapter 5) (169) (170). Clearly, stronger measures need

to be in place to support families who have lost income due to unemployment, furloughing, additional costs and other reasons; without this, many more children will be living in poverty, with consequent lifelong impacts on health, education, employment prospects, income and living conditions.

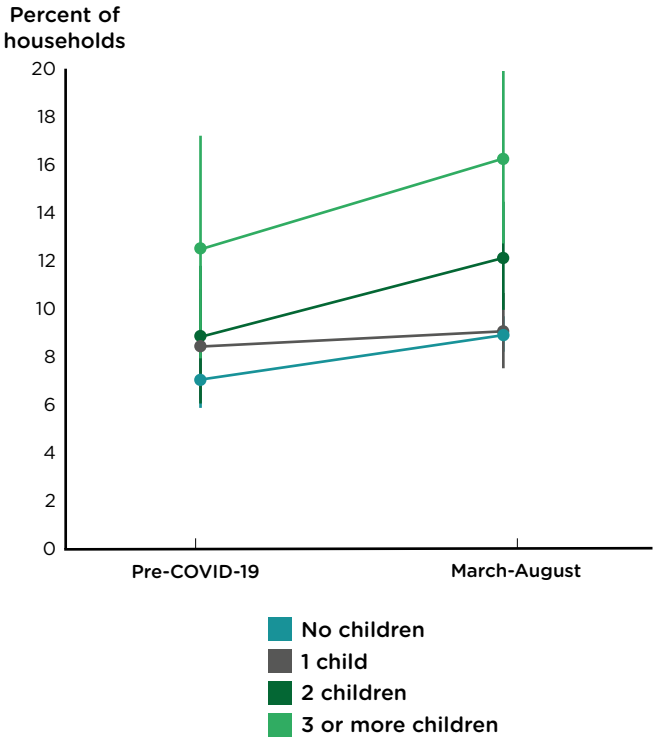
THE IMPACT OF COVID-19 ON ACCESS TO FOOD FOR FAMILIES WITH CHILDREN

Food poverty, which was already high before the pandemic hit, has increased significantly, a result of reduced income, reduced access to free school meals during school closures, and self-isolation measures (171). In January 2020, 1.4 million students – about one in six – were eligible for means-tested free school meals (FSM). This had risen to 1.9 million children in primary and secondary school by the end of April (172). Currently, for children to be eligible for FSM families receiving Universal Credit must have after-tax earnings of £7,400 or less; those on working tax credits must earn £16,190 or less (172).

A Teacher Tapp survey carried out between 1 and 3 April 2020 asked teachers their views on which additional interventions they would support to stop vulnerable students from falling behind in their schoolwork (115). The intervention most favoured by teachers was providing additional food boxes to vulnerable families, with around 60 percent of teachers in both primaries and secondaries choosing this form of support. This reflects the level of basic needs that many children face in the crisis (115).

England's high level of child poverty and food poverty and resulting need for food charity even before the pandemic has contributed to high levels of both during the pandemic. School closures led to greater strain on family finances as 1.3 million children who normally receive school meals no longer did. The food voucher scheme mitigated the impacts, but did not eliminate it and there have been increases in hunger and food poverty among young people. The Food Foundation report that food poverty rose from 12-16% among families, as shown in Figure 4.4.

Figure 4.4 Food insecurity in households by number of children, before lockdown and March- August

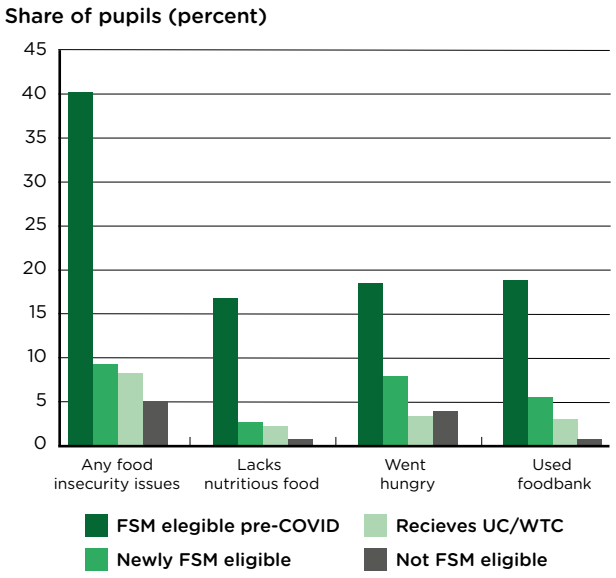


Notes: *Analysis by Loopstra R comparing 12 month food insecurity data for 2016 to 2018 to 6 month food insecurity data from YouPoll collected at the end of August, 2020. Analyses are adjusted for age, gender, ethnicity, marital status, region, and employment status.*

Source: *The Food Foundation (173).*

Figure 4.5 shows the share of children living in families that had some form of food insecurity during the pandemic by type of food insecurity and by whether eligible for FSM or Universal Credit or those on working tax credit. It shows that 40 percent of children who were eligible for FSM before COVID-19 experienced some form of food insecurity during the first lockdown. Food insecurity is discussed in more detail in Chapter 6. The rate of children in families receiving Universal Credit or those on working tax credit who experienced any form of food insecurity was nearly as high as those in families that were newly eligible for FSM, suggesting that extending eligibility for free school meals to all families receiving means-tested benefits would help reduce the percent of children who experience food insecurity.

Figure 4.5. Share of children in families experiencing food insecurity, end April 2020, England



Notes: *'Any food insecurity issue' captures students whose parents report any of the three other food insecurity indicators. Food insecurity questions are asked about the family as a whole, not necessarily the child. 'Newly FSM eligible' refers to families that became eligible in April 2020.*

Source: *IFS analysis of understanding Society COVID module, wave 1 (172).*

During the lockdown around 80 percent of children who were eligible for free school meals before the pandemic received food vouchers from their school, meaning 20 percent of children who were eligible and likely to be experiencing food insecurity did not receive vouchers. The results of a survey by the Food Foundation in May 2020 showed that 370,000 children eligible for free school meals did not receive any provision (174). A survey in April 2020 of 635 eligible children in the UK found that only 51 percent had accessed their meal entitlement during the lockdown measures and school closures (171). The Government's decision not to provide food vouchers for some of England's poorest families over the summer was overturned as a result of a campaign led by the footballer Marcus Rashford and subsequently a £120m 'COVID summer food fund' was established for 1.3 million students in England (175).

The Government again decided not to extend the free school meals programme for the October half-term holiday and 1.4 million disadvantaged children in England were not given food vouchers over that holiday. Public pressure and another campaign by Marcus Rashford led to local authorities, local charities and businesses helping (176) (177). As a result, the Government has reinstated food vouchers for the Christmas holidays.

England's high levels of child poverty and food poverty and resulting need for food charity even before the pandemic, with millions of families with children relying on food banks and latterly increasingly on ad hoc campaigns mounted by individuals and organisations, has contributed to the very high levels during the pandemic.

THE IMPACT OF COVID-19 ON CHILD HOMELESSNESS AND DEVELOPMENT

Family homelessness was increasing even before the COVID-19 crisis, and temporary homelessness already presented an important challenge to children's ability to keep up at school (178) (179). Often, children in these circumstances live in conditions that are unhealthy, noisy, overcrowded, a long distance from school and lacking spaces to work at home (178). The number of families with children in temporary accommodation rose from 37,940 in 2010 to 62,700 in 2020 (178). The Children's Commissioner's Office report Bleak Houses in 2019 suggested that there were approximately 375,000 children living at financial risk of homelessness (169).

The Government provided housing for 5,400 rough sleepers when the crisis began but since then there has been no equivalent action to get children out of temporary accommodation such as Bed and Breakfasts and into long-term homes (117). The number of households in temporary accommodation has risen greatly – by nearly 10,000 – since COVID-19 containment measures were introduced, from 88,310 on 31 December 2019 to 98,300 on 30 June 2020 (178). This is a substantially larger quarterly growth in the number of homeless households than seen previously. Greater levels of poverty, reduced income and high housing costs are driving these increases – all made worse by the pandemic (178).

4.B IMPACT OF THE COVID-19 CRISIS ON YOUNG PEOPLE'S MENTAL HEALTH WELLBEING

Containment measures have had profound effects on mental health among young people and children. There have been additional challenges for young people who were already struggling with their mental health and for others the containment measures have created new mental health issues, because of traumatic experiences, social isolation, loss of education, a loss of routine and a breakdown in formal and informal support (180). Access to services and support and protection from schools has decreased, leaving children more at risk of violence, sexual exploitation and neglect (103). Many children have experienced higher levels of abuse compared with pre-COVID-19 levels, inflicted by family members and others, as described in section 4C.

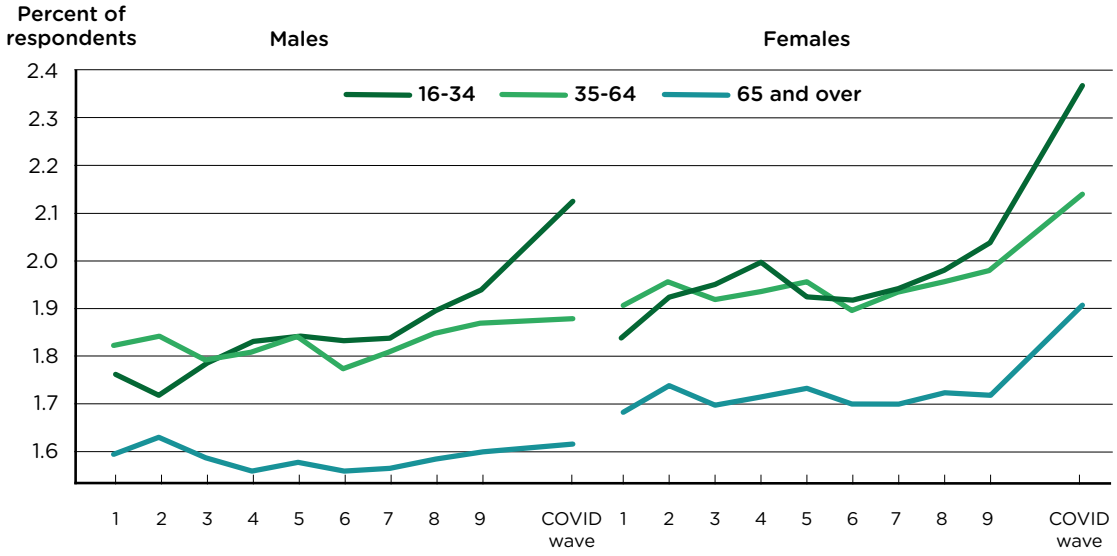
Feedback from the UK Youth Movement predicts that the impact on young people will include the following, ranked by order of importance (based on number of responses) (134):

1. Increased mental health or wellbeing concerns
2. Increased loneliness and isolation
3. Lack of safe space – including not being able to access their youth club/service and lack of safe spaces at home
4. Challenging family relationships
5. Lack of trusted relationships or someone to turn to
6. Increased social media or online pressure
7. Higher risk of engaging with gangs, substance misuse, carrying weapons or other harmful practices
8. Higher risk of sexual exploitation or grooming

Results from a survey carried out during the first lockdown published in the British Journal of Psychiatry found that the proportion of respondents reporting that on at least one day in the previous week they had wanted to end their life increased from 8.2 percent to 9.2 percent and then to 9.8 percent, over the three waves of the study. These rates were highest in young adults aged 18–29, rising from 12.5 percent to 14.4 percent throughout the three waves. Respondents from lower socioeconomic backgrounds were more likely to experience suicidal thoughts than those in higher socioeconomic groups, as well as respondents with pre-existing mental health conditions when compared with those without (181).

Figure 4.6 shows that unhappiness and depression had been increasing slightly before the pandemic but then increased dramatically, especially for women and all young people. Children and young people living in deprivation experience higher levels of mental distress. For some groups rates are much higher including LGBTQ+.

Figure 4.6. Percent unhappy or depressed, UK household longitudinal survey waves 1-9 (January 2009 to May 2019) and April 2020 by gender and age group

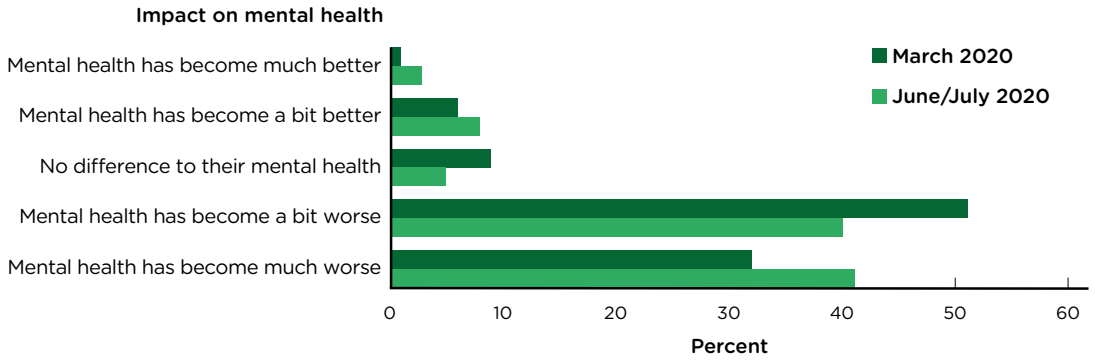


Note: *The waves ran as follows: wave 1 January 2009-March 2011, wave 2 January 2010-March 2012, wave 3 January 2011-July 2013, wave 4 January 2012-June 2013, wave 5 January 2013-June 2015, wave 6 January 2014-May 2016, wave 7 January 2015-May 2017, wave 8 January 2016-May 2018, wave 9 January 2017-May 2019. Higher values reflect poorer mental health.*

Source: *UKHLS waves 1-9 and April Covid-19 survey (182).*

Minds in March and again in June and July 2020 revealed that 81 percent of respondents agreed that their mental health had become worse as a result of the COVID-19 crisis (183). Of these, 41 percent said that it had made their mental health much worse (183), shown in Figure 4.7.

Figure 4.7. Mental health impacts of the COVID-19 crisis on young people (aged 13–25 years) in the UK with a history of mental health problems, March 2020 and June/July 2020

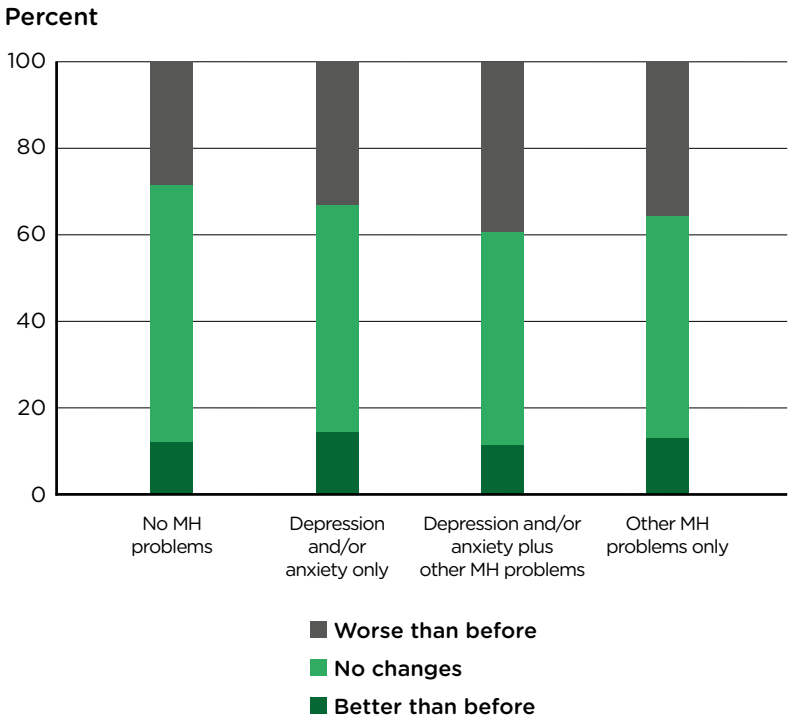


Notes: *The first survey was conducted between 20 and 25 March 2020 and included a sample of 2,111 young people. The second survey was conducted between 5 June and 6 July 2020 and included a sample of 2,036 young people.*

Source: *Based on results from survey conducted by Young Minds, 2020 (183).*

A study conducted by UCL, Imperial College London and the University of Essex during April and May 2020 found that around 50 percent of 16- to 24-year-olds who were previously without mental health issues had reported high levels of depressive symptoms during the lockdown period (184). Additionally, 53 percent reported that they were experiencing more stress and 39 percent of respondents with previous mental health issues reported that the quality of their relationships had worsened as a result of the pandemic (184), shown in Figure 4.8.

Figure 4.8. Changes to quality of relationships reported, by presence and type of previous self-reported mental health condition, in a sample of 16- to 24-year-olds in the UK, during the lockdown period

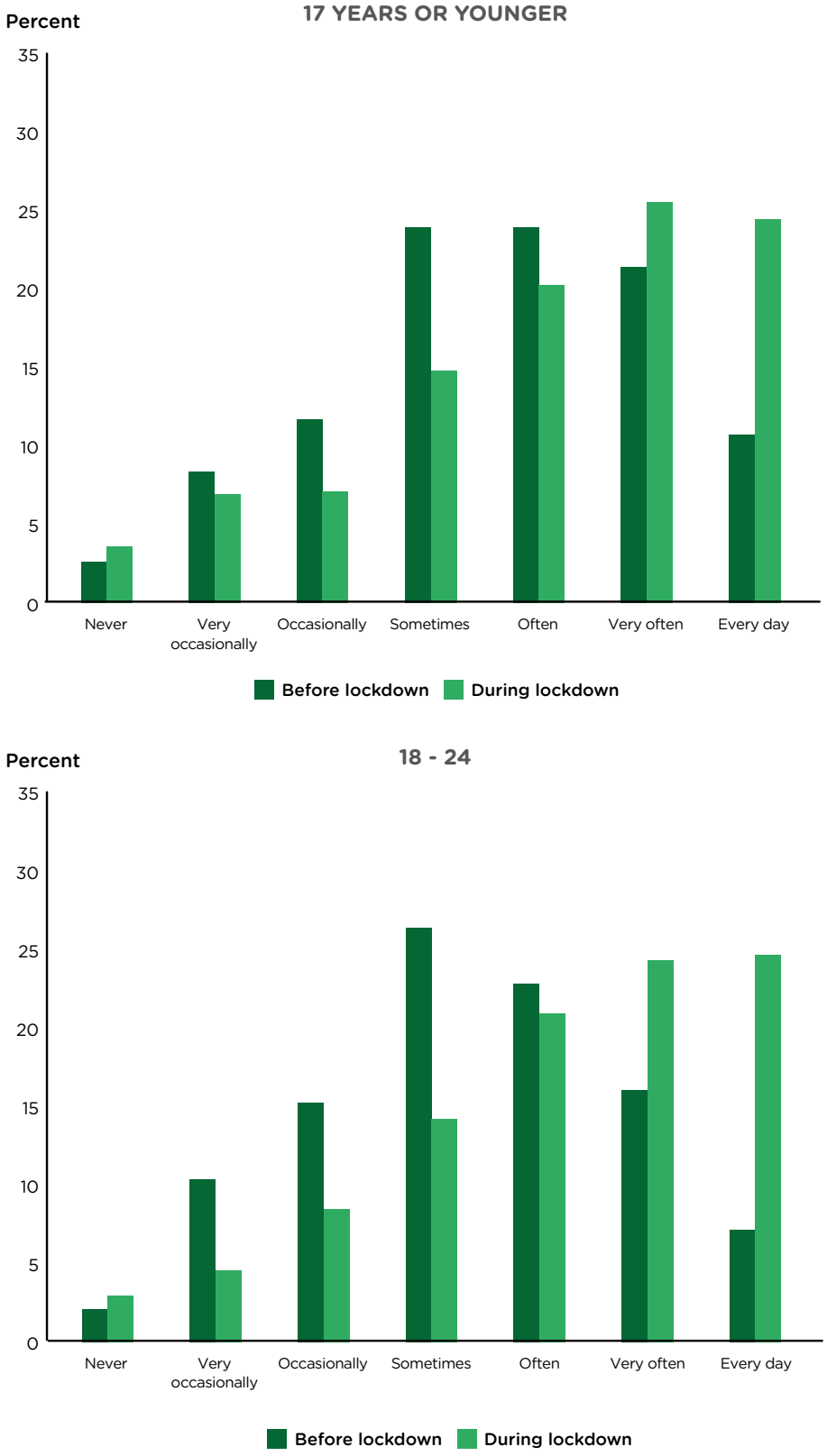


Source: *You-COPE, Mental health consequences experienced by young people aged 16-24 during first months of the COVID-19 lockdown (185).*

Children and young people from disadvantaged backgrounds have been identified to be at higher risk of developing mental health illnesses as a result of the pandemic. School closures, food poverty, poor access to technology and risks of homelessness have been cited as potential contributing factors to the increased risk of mental health decline and susceptibility to mental health conditions such as post-traumatic stress among this group (186).

Mental health problems were higher among LGBTQ+ people than others even before the pandemic but increased markedly during the first lockdown. 23 percent of LGBTQ+ 18- to 24-year-olds reported experiencing regular depression, i.e. 'very often' or 'every day', prior to the pandemic, rising to 49 percent during the pandemic (187). Furthermore, 31 percent of respondents who were under 18 reported experiencing regular depression, rising to 49 percent during the lockdown (187) – Figure 4.9.

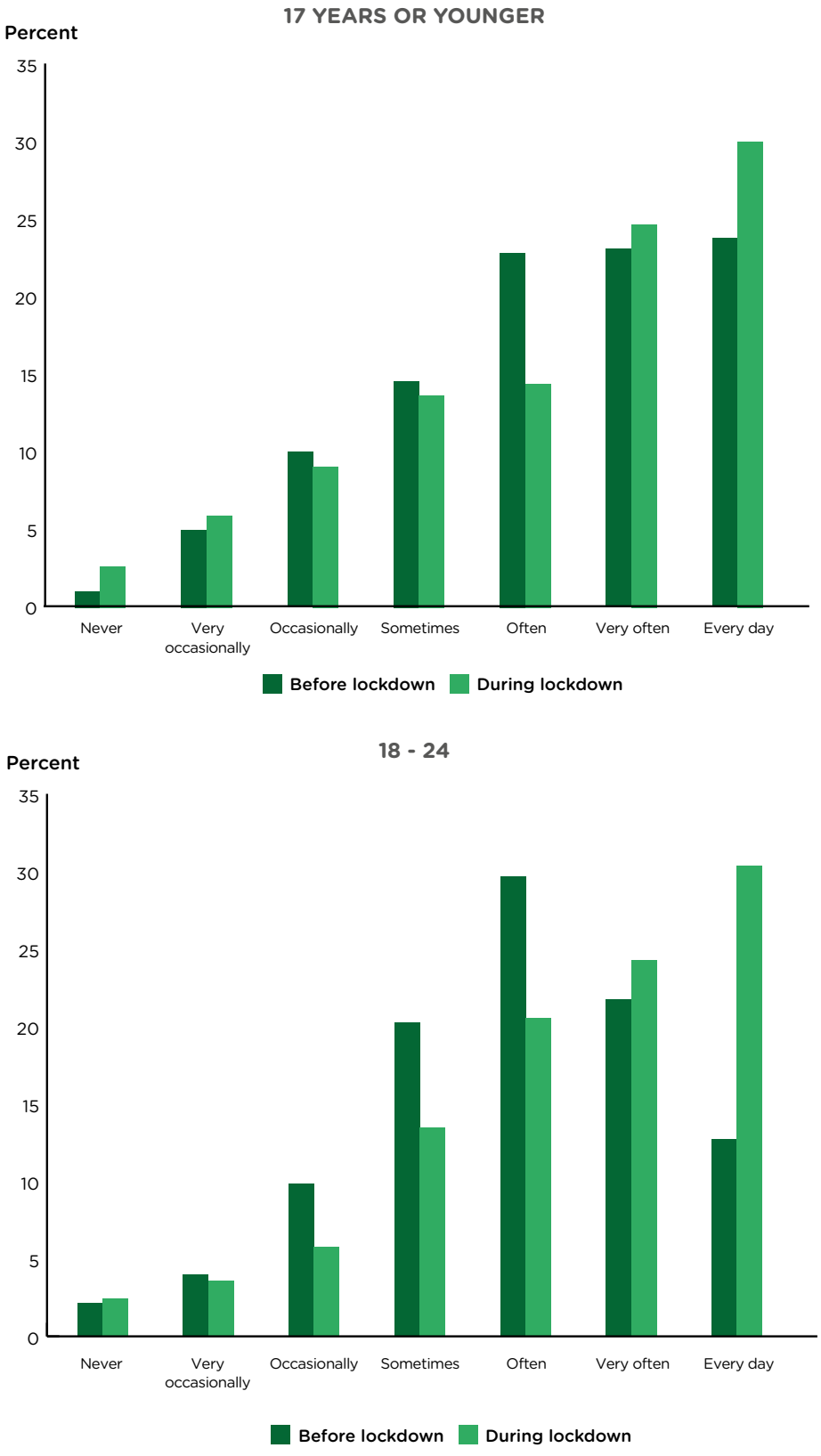
Figure 4.9. Experiences of depression among LGBTQ+ young people aged 18–24 years and <17 years, reported between 14 and 29 May 2020, in the UK, before and during the first lockdown



Source: *Based on data from the OutLife survey (14–29 May 2020) (187).*

In terms of anxiety, young LGBTQ+ people had considerably higher levels of anxiety overall during the lockdown when compared with older LGBTQ+ people (187). Under-18s had the highest levels of regularly occurring (i.e. 'very often' or 'everyday') anxiety both before and during the lockdown, at 47 and 54 percent respectively – Figure 4.10 (187).

Figure 4.10. Experiences of anxiety among LGBTQ+ young people aged 18–24 years and <17 years, reported between 14 and 29 May 2020, in the UK, before and during the first lockdown



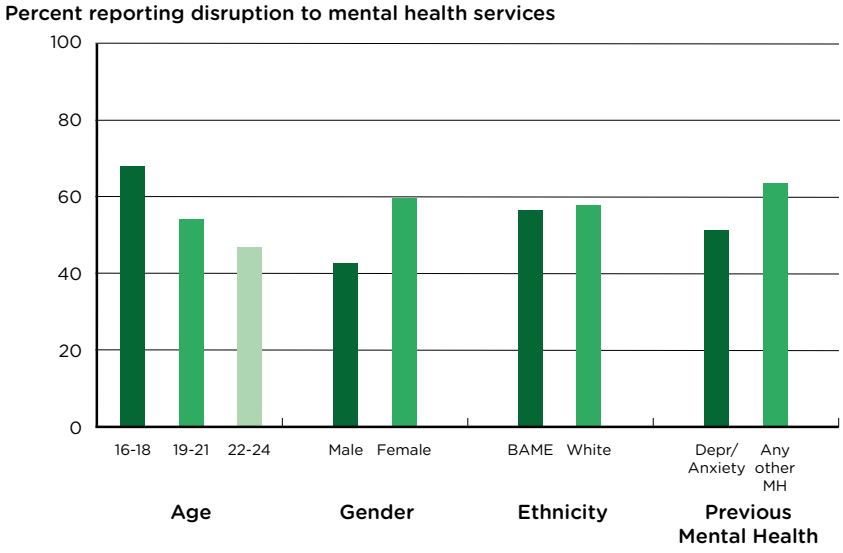
Source: *Based on data from the OutLife survey (14–29 May 2020) (187).*

In relation to inequalities in mental health problems among different ethnic groups, survey data collected from XenZone, which is one of the largest providers of digital mental health support, showed that the mental health of children and young people of BAME ethnicity has been disproportionately affected by the pandemic compared with their peers of White ethnicity (188). The proportion of children aged under 18 of BAME ethnicity seeking support for anxiety or stress from the service rose by 11.4 percent from March to May 2020, while it increased by 3 percent among children of the same age of White ethnicity (188). Additionally, suicidal thoughts increased by 26.6 percent on the same period last year for children and young people from BAME groups and by 18.1 percent for children and young people of White ethnicity (188). In terms of depression, the data revealed a 9.2 percent increase for BAME children and young people, and a 16.2 percent decrease among children and young people of White ethnicity (188).

Gaps in provision of mental health services for young people were a serious concern prior to the pandemic, but have become even more acute subsequently. The Young Minds March 2020 survey, of the respondents who had accessed mental health support in the past three months, 74 percent indicated that they were still able to access some form of mental health support, while 26 percent said that they were unable to access such support (189). Of the respondents to the survey in June/July 2020 who had been accessing support in the three months before the start of the pandemic, 31 percent indicated that they were no longer able to access such support despite still needing it (183).

Waiting times for Child and Adolescent Mental Health Services (CAMHS) increased after the start of the pandemic, becoming longer than they were before March (134). Figure 4.11 illustrates interruptions to mental health services reported by young people in May 2020.

Figure 4.11. Percent of 16- to 24-year-olds in the UK with pre-existing mental health problems reporting interruption to their mental health services as a result of the pandemic, by age, gender, ethnicity and their previous mental health problem, May 2020



Source: *Based on data from the You-COPE survey (11–31 May 2020) (190).*

As well as reductions in the availability of CAMHS services, support from schools has also been reduced, even after they reopened. A survey by Young Minds undertaken between 15 and 30 September 2020, shortly after schools reopened for the Autumn term, showed that of those students with previous mental health conditions, 69 percent described their mental health as poor after being back at school, rising from 58 percent before returning to school (180). By the time they completed the survey, only 27 percent had had a one-to-one conversation with a teacher or another member of staff in which they were asked about their wellbeing. Almost a quarter of respondents (23 percent) said that there was less mental health support in their school than before the pandemic, while only nine percent agreed that there was more mental health support (180).

The deteriorating mental health of young people and the reductions in available mental health services are among the clearest immediate health impacts of the containment measures. Unfortunately, the situation prior to the pandemic has exacerbated the mental health impacts and the lack of support. It is essential that youth mental health services receive greater funding and recruitment of staff, and schools also need additional training, such as in mental health first aid and a wide range of other support services.

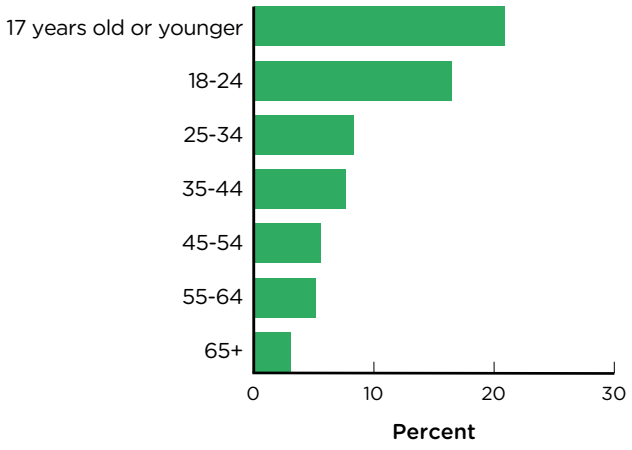
4.C VIOLENCE AND ABUSE AT HOME DURING LOCKDOWN

Before the pandemic, the number of children exposed to violence in England was exceptionally high; it is estimated that one child in five was exposed to domestic abuse (191). During the first lockdown it was estimated that there were around 160,000 children living in households in England where domestic abuse was occurring, and the occurrence of abuse increased by an estimated 25 percent during this period (192). Experiencing adverse childhood experiences (ACEs), which include being exposed to abuse or neglect, elevates the risk that children and young people will experience damage to health, or to other social outcomes, across the life course. In many cases multiple ACEs are experienced simultaneously. Those who experience multiple ACEs such as domestic violence and parental substance abuse, among others, have an increased risk of disease, including heart disease, cancer, lung disease, liver disease, stroke, hypertension, diabetes, asthma, arthritis and mental health problems and mental illness during adulthood (1).

Kooth, a service commissioned by the NHS to provide support to young people, found that between the 3rd of March and 12th of April 2020 there was a 51 percent increase in the number of young people who were experiencing abuse at home compared with the same period in 2019 (193). Further Kooth data released on 15 May 2020 showed that there was a 69 percent increase in issues relating to child abuse, sexual exploitation and neglect in England compared with a year earlier (194).

Experiences of abuse and violence during the lockdown could also be another contributing factor to increases in poor mental health among LGBTQ+ young people, as found from the results of the Outlife survey. A higher proportion of younger LGBTQ+ people reported experiencing violence or abuse during the lockdown compared with older LGBTQ+ people, as shown in Figure 4.12: 21 percent of LGBTQ+ people who were under 18 years of age and 17 percent of 18- to 24-year-olds reported experiencing violence or abuse during lockdown (187).

Figure 4.12. Percent of LGBTQ+ people who experienced violence or abuse during the first lockdown in the UK, by age group



Source: *Based on data from the OutLife survey (14–29 May 2020) (187).*

The increased incidence and risk of harm during COVID-19 lockdowns is blighting the lives and prospects of many children. Schools and a range of other support services have a key role in identifying and supporting the young victims of abuse. However, support services are insufficiently available, not even reaching the pre-pandemic level, which was already too low. Additional support is clearly needed urgently.

4.D COVID-19 CONTAINMENT, UNEMPLOYMENT AND YOUNG PEOPLE NOT IN EMPLOYMENT, EDUCATION OR TRAINING

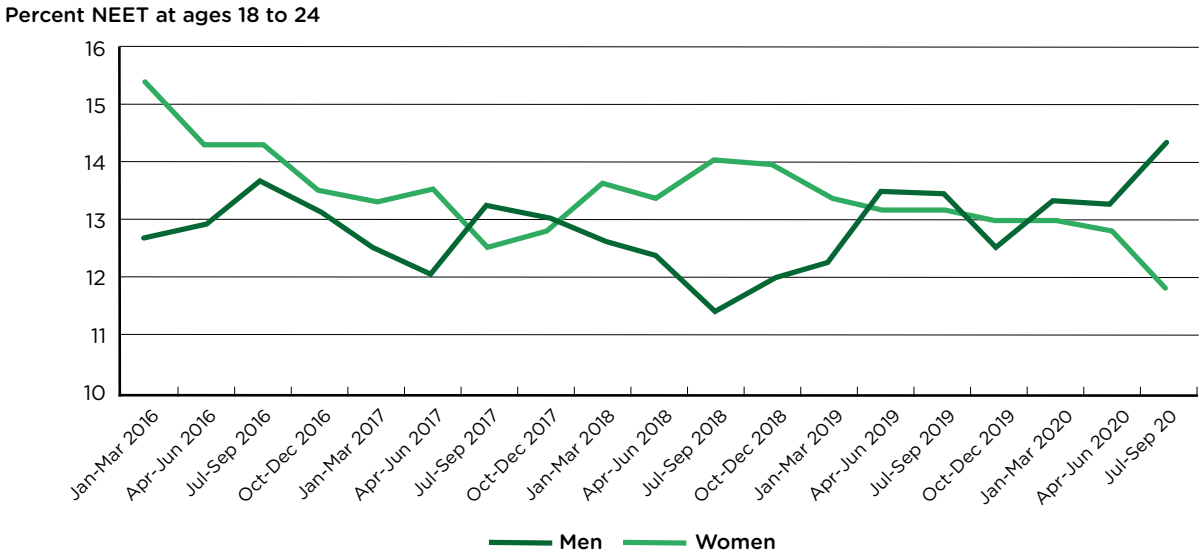
Young aged 16 – 24 the age group experiencing the greatest impacts from COVID-19 containment measures on their employment prospects and the availability of apprenticeships and other training programmes (117), which will result in worse health and wellbeing in the longer term. Youth unemployment is considered in more detail in the next chapter, but it is important to note here that there have been large increases in youth unemployment, as this age group has been among the most affected by the COVID-19 crisis, and that youth unemployment has particularly severe impacts on young people's outcomes for the rest of life.

NEET YOUNG PEOPLE

'NEET' is used to describe young people who are not in employment, education or training. Evidence shows that time spent NEET can have a significant detrimental effect on long-term outcomes and physical and mental health. Being NEET increases the likelihood of long-term unemployment, low quality and low wage work later in life, and social exclusion, which are all also associated with poorer health outcomes (195) (196). Those who are NEET for longer than six months are of particular concern (195) (197). The Annual Population Survey of the UK estimated that in 2017 around 38 percent of the age 16–24 population who were NEET had a health problem, compared with 21 percent of this age group in general. Twenty-two percent of the 16–24 NEET population reported depression, learning problems, mental problems or nervous disorders as their main health problem, compared with just 8 percent of the overall 16–24 population, a statistically significant difference (195).

The latest ONS data on rates of young people who are NEET are for July - September 2020, and show that the percent of men aged 18-24 who were NEET increased by nearly two percentage points since pre-pandemic levels (October - December 2019), while the percent of NEET women of the same age group decreased by one percentage point during that same period, this shown in Figure 4.13.

Figure 4.13. Percent of men and women aged 18-24 who were NEET, UK, July – September 2010 to July – September 2020



Source: *ONS. Young people not in education, employment or training (NEET) (198).*

A brief published by the House of Commons shows that the most significant educational risk factors for being NEET are low educational attainment at GCSE and having special educational needs. Difficult family circumstances such as being in care or experiencing a breakdown in a relationship with parents were also identified as key risk factors for being NEET (196) (195). Identified structural risk factors included difficult labour market conditions, and a lack of vocational training and apprenticeship opportunities (196). As labour market conditions decline as a result of containment measures, the structural factors will become more adverse for young people, increasing unemployment, while the availability of training schemes declines.

It is essential that employment and training for young people are prioritised to deal with the impacts of the pandemic. In the next chapter, we discuss schemes such as the Government Kick Start programme which provides funding to create new job placements for 16 to 24 year olds on Universal Credit who are at risk of long term unemployment.

APPRENTICESHIPS

Apprenticeships have an important role in providing opportunities and employment for more deprived young people, supporting equity and are thus important in reducing inequalities. They are likely to be hugely impacted by the crisis. Sutton Trust research shows that in 2018–19, 43 percent of all apprentices came from the two most deprived quintiles. Younger apprentices from lower socioeconomic backgrounds are more likely to have been placed in sectors that have been vulnerable in the crisis, for example the hospitality sector (199). The Sutton Trust research suggests that by May 2020 fewer than 40 per cent of apprenticeships were continuing as normal. More than one-third of apprentices had been furloughed and one in 12 made redundant. A quarter of employers reported that a learning provider had closed. Perhaps most worryingly, a third said that they were likely to hire fewer new apprentices than usual this year, or none at all (122). There is an incentive payment to employers who hire an apprentice between 1 August 2020 and 31 January 2021 (200).

The Supplier Relief scheme, should be refocused on providing opportunities for young people and those who would benefit most from upskilling, and not on becoming a vehicle for subsidising training for senior employees. Additionally, employer 'top-ups', where employers are required to pay a certain percent of training costs for certain types of apprentice – for example, those who are older, are already well-paid, or already have an equivalent qualification – could help both to relieve pressure on funds, and to incentivise apprenticeship provision in areas where it could have greater benefit.

The most immediate concern is the difficult financial situation many apprentices are likely to be facing during the crisis. A large proportion of apprentices have reported facing financial difficulties even before the pandemic (201). While apprentices could be furloughed, for many their wages were already so low that they are unable to cope on less. The minimum wage for apprentices is lower than that of other employees at £4.15 per hour compared with £6.45 for 18- to 20-year-olds, rising to £8.72 for those aged 25 and over in regular employment (202). Since the pandemic started, apprentices from poorer backgrounds may have been less likely to receive financial support from their families, especially if their families are under increased financial strain. With a combination of redundancies, furloughing and breaks in learning, many apprentices may be forced to leave their apprenticeships altogether.

4.D IMPACT OF THE COVID-19 CRISIS ON YOUTH ORGANISATIONS

Youth services are vital in providing children and adolescents with support, especially for those most at risk of falling behind (134). These services are particularly effective in reducing inequalities in opportunities and for reducing anti-social behaviour, school exclusions and youth crime. By building up relationships of trust and support with young people, working in their communities, helping them make their own decisions about their lives, and developing their confidence and resilience, youth workers play invaluable roles in supporting young people (203). However, councils cut real-terms spending on youth services by 40 percent on average between 2016 and 2019 (119), which has been deemed partly responsible for increases in gangs and violence (204), and created a crisis situation even before the pandemic.

Some local authorities reduced their spending on services such as youth clubs and youth workers by as much as 91 percent over that period (2016 – 2019) Many organisations have large-scale income-generating activities to support their work, such as trading, training and events and fundraising activities. However, the very large reduction of footfall on the high street and containment measures during the pandemic will lead to a large decrease in income from charity shops and reduce the number of events to raise funds for centres and organisations (205).

In a survey of youth service providers carried out from 20 to 27 March 2020, 72 percent of respondents said their organisation needed access to emergency funds to continue to support young people during and after the pandemic. Eighty-one percent said that unreliable or no access to IT infrastructure could pose a barrier to young people engaging in youth services digitally. Sixty-nine percent indicated that unreliable or no access to a private space could also be a challenge to engaging in digital services and one-third said they did not have the infrastructure to provide youth services digitally (205).

Once restrictions are lifted, it is vital that funding to youth organisations is restored to pre-2010 levels. Building back fairer requires far greater investment and resourcing in services for young people, especially in more disadvantaged areas.

4.E CONCLUSIONS

Rates of child poverty have increased since 2010 and are likely to rise significantly as a result of the pandemic. In our *10 Years On* report our recommendations for children and young people included that efforts be made to reduce levels of child poverty to 10 percent – level with the lowest rates in Europe; investment be made in preventive services to reduce exclusions and support schools to stop off-rolling students; and that the number of post-school apprenticeships and support to in-work training throughout the life course be increased. Clearly, stronger measures need to be put in place to support families who have lost income due to the impacts of COVID-19. Without this many more children will be living in poverty, with consequent lifelong impacts on health, education, employment prospects, income and living conditions.

England's high levels of child poverty and food poverty, and resulting need for food charity even before the pandemic, have contributed to the very high levels of both during the pandemic. Benefits and wages must be increased to provide a minimum income for healthy living, particularly for larger families. Increasing levels of child benefit for low-income families and lifting the two-child cap on other benefits would help prevent the rising numbers of families and children falling into poverty and hunger. It is also crucial to extend free school meals to all children whose families are in receipt of Universal Credit, regardless of their income, and meals should be provided through all school holidays.

In order to address child poverty and associated food poverty among children, benefits and wages must be increased to provide a minimum income for healthy living, particularly for larger families. Increasing levels of child benefit for low-income families and removing the two-child cap on other benefits would help prevent the rising numbers of families and children falling into poverty and hunger.

While the Government and local authorities made significant and important interventions to reduce rough sleeping during the pandemic, the already-increasing number of children in temporary accommodation continues to rise. Greater levels of poverty, reduced income and high housing costs have been driving these increases – all made worse by the pandemic (178).

COVID-19 containment measures have had profound effects on mental health among young people and children. These are some of the clearest and most immediate health impacts of the containment measures and have been exacerbated by a situation of inadequate support before the pandemic. It is essential that youth mental health services receive greater funding and recruitment of staff, and schools also need additional training in this area.

The lockdowns have placed young people living in abusive households, temporary accommodation or with poor mental health at much greater risk of harm and reports of abuse have increased. Schools and a range of other support services have a key role in identifying and supporting the young victims of abuse. However, extra resources and support are needed urgently.

Young people have borne the brunt of the impacts of COVID-19 containment measures in terms of rising unemployment and reduced prospects. We anticipate further increases in youth unemployment when the furlough scheme ends, which could have significant lifelong repercussions, including on health. Protecting apprenticeships and prioritising youth employment is important, taking into account the financial impact the crisis is having on entry-level roles. The Government also needs to support firms to keep providing apprenticeships and more investment in education and training for young people who have finished their compulsory schooling, particularly for the most disadvantaged young people, is required to develop skills for the difficult labour market conditions (122).

We recommend that the minimum wage for apprenticeships is raised and further incentives given to employers to offer such schemes. Additional training schemes should be made available for school leavers and unemployed young people, and protecting training providers is important.

Once restrictions are lifted, it is vital that funding to youth organisations is restored to pre-2010 levels. Youth services are particularly effective in reducing inequalities in opportunities and for reducing anti-social behaviour, school exclusions and youth crime. Building back fairer requires far greater investment and resourcing in services for young people, especially in more disadvantaged areas.

Many young people are facing particularly bleak prospects as a result of the pandemic and associated containment measures and while all young people have been affected, the impacts are greatest among most disadvantaged young people. Reversing these impacts and reducing inequalities is a critical challenge – short term interventions to reduce family poverty and food poverty and improve access to mental health service must be prioritised. Longer term, investments in employment and training for young people and more support for good mental health are critical.

BOX 4.3. RECOMMENDATIONS TO BUILD BACK FAIRER FOR CHILDREN AND YOUNG PEOPLE

LONG TERM

- Reverse declines in the mental health of children and young people and improve levels of well-being, from the present low rankings internationally, as a national aspiration.
- Ensure that all young people are engaged in education, employment or training up to the age of 21.

MEDIUM TERM

- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Improve prevention and treatment of mental health problems among young people.

SHORT TERM

- Reduce child poverty:
  - Remove the 'two-child' and benefit cap
  - Increase child benefit for lower income families to reduce child and food poverty
  - Extend free school meal provision for all children in households in receipt of Universal Credit.
- Urgently address children and young peoples mental health with a much strengthened focus in schools and teachers trained in mental first aid.
- Increase resources for preventing identifying and supporting children experiencing abuse.
- Develop and fund additional training schemes for school leavers and unemployed young people.
- Further support young people training and education and employment schemes to reduce NEET and urgently address gaps in access to apprenticeships.
- Raise minimum wage for apprentices and further incentivise employers to offer such schemes.
- Prioritise funding for youth services.

CHAPTER 5

CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL: COVID-19 CONTAINMENT AND INEQUALITIES

One of the most immediate and inequitable impacts of the COVID-19 containment measures has been in relation to employment and income. Both employment and income are closely related to health outcomes and the impacts of containment measures on employment and income will have profoundly negative impacts on health and levels of health inequality in England unless effective mitigating action is taken.

In Chapter 2 we assessed inequalities in risk of exposure to infection and mortality from COVID-19 in relation to type of employment. As well as inequalities in the risk of mortality related to occupation, measures to contain COVID-19 have had significant implications for long- and short-term health and health inequalities. Containment measures have significantly impacted economic output, hitting some sectors particularly hard, and led to decreases in wages, greater job insecurity and higher rates and risks of unemployment, all of which have damaging health impacts (206).

The Office for National Statistics (ONS) reported that the UK's Gross Domestic Product (GDP) decreased by one-fifth in April 2020, just after the first lockdown measures had come into effect (207). Estimates of declines in GDP over the short to medium term for the UK vary, but all show large drops. Forecasts from the Office for Budget Responsibility estimate the economy will contract by 11.3 percent this year, the biggest decline in three centuries (208).

In countries which had good control of infection and relatively low rates of mortality the economic damage has been less severe than countries, such as England, where the mortality rates and economic damage have been high. There has been much discussion of the trade-offs between protecting health and protecting the economy but less remarked on is that economic impacts are also health impacts. The current economic crisis is also another health crisis, even without COVID-19, and some groups are at particular risk of experiencing these health impacts from economic declines.

The labour market situation before the pandemic is highly relevant to the impacts through the pandemic and beyond. As we showed in the 10 Years On Report since 2010 there have been increases in employment in low-paid, unskilled, self-employed, short-term and zero-hours contract jobs. Rates of pay have not increased and, notably, more people in poverty are now in work than out of work. The impacts of COVID-19 containment have fallen on these workers especially and made the long-term health and health inequality impacts particularly severe in England.

BOX 5.1. SUMMARY OF INEQUALITIES IN WORKING LIVES (FROM *10 YEARS ON REPORT*)

- While employment rates have increased since 2010, there has been an increase in poor quality work, including part-time, insecure employment.
- The number of people on zero-hours contracts has increased significantly since 2010.
- The incidence of stress caused by work has increased since 2010.
- Real pay is still below 2010 levels and there has been an increase in the proportion of people in poverty living in a working household.
- Automation is leading to job losses, particularly for low-paid, part-time workers and this will particularly affect the North of England.

As set out in the previous section young people are experiencing the greatest loss of employment but damaging impacts have also been experienced by low paid workers, BAME groups, older workers disabled workers, women, part time workers and the self-employed. Some sectors have been particularly affected including hospitality, non-food retail, leisure, aviation, transport and tourism (209). As England's economic woes deepen through 2020 and into 2021, it is important that those most at risk are supported most and this will protect health as well as livelihoods.

BOX 5.2. SUMMARY: BUILD BACK FAIRER: EMPLOYMENT AND GOOD WORK

- Countries that controlled the pandemic better than England have had a less adverse impact on employment and wages.
- Rising unemployment and low wages will lead to worse health and increasing health inequalities.
- Rising regional inequalities in employment in England relate to pre-pandemic labour market conditions.
- Overall, unemployment has risen slowly so far, protected by the Coronavirus Job Retention Scheme (furlough), but will rise considerably once the scheme ends, in March 2021.
- Low-income groups and part-time workers are most likely to have been furloughed and furloughed staff have experienced 20 percent wage cuts from their already low wages.
- Older Pakistani and Bangladeshi people were more likely to be working in shutdown sectors, compared with other groups.
- There were over 2 million jobs where employees were paid below the legal minimum in April 2020, more than four times the 409,000 jobs a year earlier.

This chapter provides an overview of the impacts of COVID-19 and its containment measures on inequalities in employment and earnings. It includes the effects on BAME groups and disabled people, for whom the impacts have been particularly severe. While containment measures are necessary to reduce infection and mortality, it is essential that the health equity impacts of containment measures and support measures are taken into account. There is not a simple question of protecting either health or the economy: employment and income drive health outcomes and deteriorations will lead to widening health inequalities. More generally, good control of the pandemic would lessen the need for the kinds of economic measures that will damage both the economy and health.

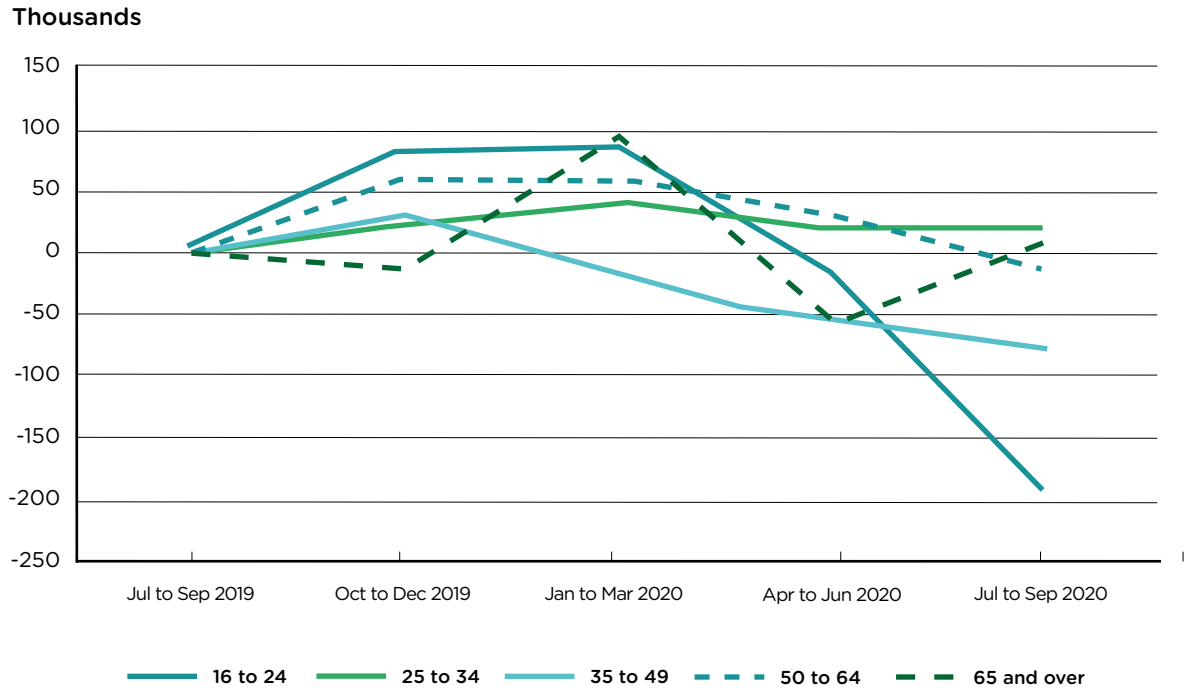
5.A IMPACT OF COVID-19 ON INEQUALITIES IN EMPLOYMENT

The 2010 Marmot Review concluded that being in good employment is usually protective of health, while unemployment, particularly long-term unemployment, contributes significantly to poor health (6) (210). Employment is most people's main source of income and should be a way out of poverty (211), and good quality work is rewarding and gives people purpose. The period covered by employment usually encompasses the longest segment of people's lives: approximately 40 to 50 years. It also often covers the years when people are raising families, and as such is a particularly important period for the transmission of inequities to the next generation (211).

Prior to the pandemic, in December to February 2020, the employment rate in the UK was 76.6 percent. The impact of COVID-19 containment measures reduced the employment rate, which fell between February and October 2020, at which point it stood at 75.6 percent (212). This decrease in employment was the largest annually since January to March 2010 (213). Temporary support measures, such as the furlough scheme, have protected much employment but the expectation is that employment will fall significantly once the furlough schemes end in March 2021 (214). Unemployment is expected to reach 7.5 percent next spring, with 2.6 million people out of work (215) (216).

Many low-paying occupations employing high numbers of young people are in sectors that have been the most affected by containment measures: for example, hospitality and non-food retail. In 2019, 22 percent of people aged between 22 and 25 working in their first full-time job after leaving education were employed in these sectors (217). The steep decline in employment for 16- to 24-year-olds and the steady decline for 35- to 49-year-olds, are particularly concerning, shown in Figure 5.1 (213).

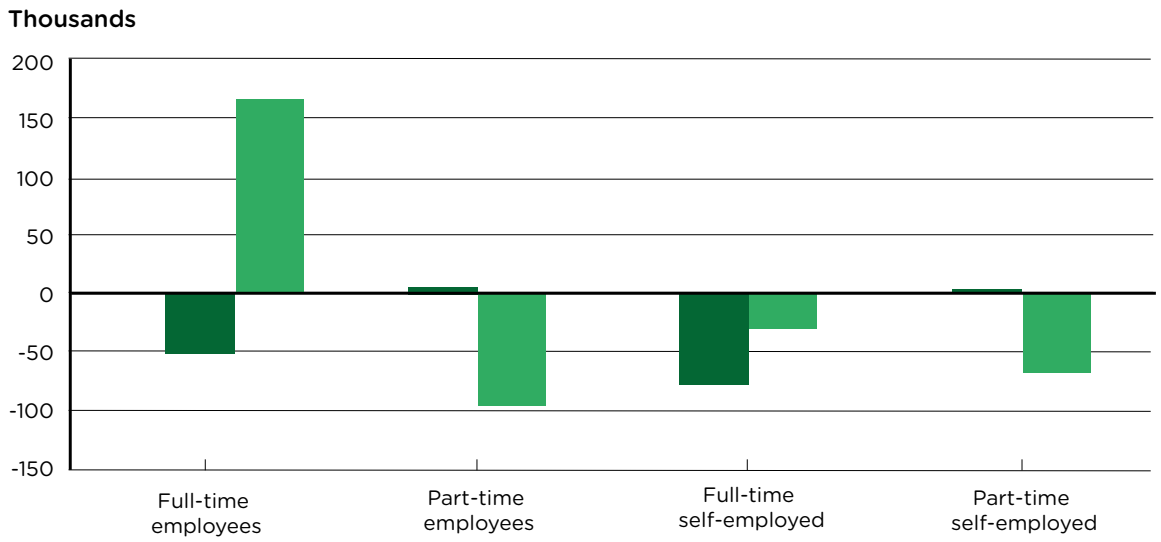
Figure 5.1. Numbers in employment in the UK by age (16 years and over), seasonally adjusted, cumulative growth from July to September 2019, for each period up to July to September 2020



Source: *Based on ONS. Employment in the UK: November 2020 (213).*

The decline in employment from the second to the third quarter of 2020 was notable for men working full-time, whether employees or self-employed; and for women, the decline was in part-time work, shown in Figure 5.2.

Figure 5.2. Quarterly changes in the UK for total in employment, full-time and part-time employees, full-time and part-time self-employed by sex (aged 16 years and over), seasonally adjusted, between April to June 2020 and July to September 2020

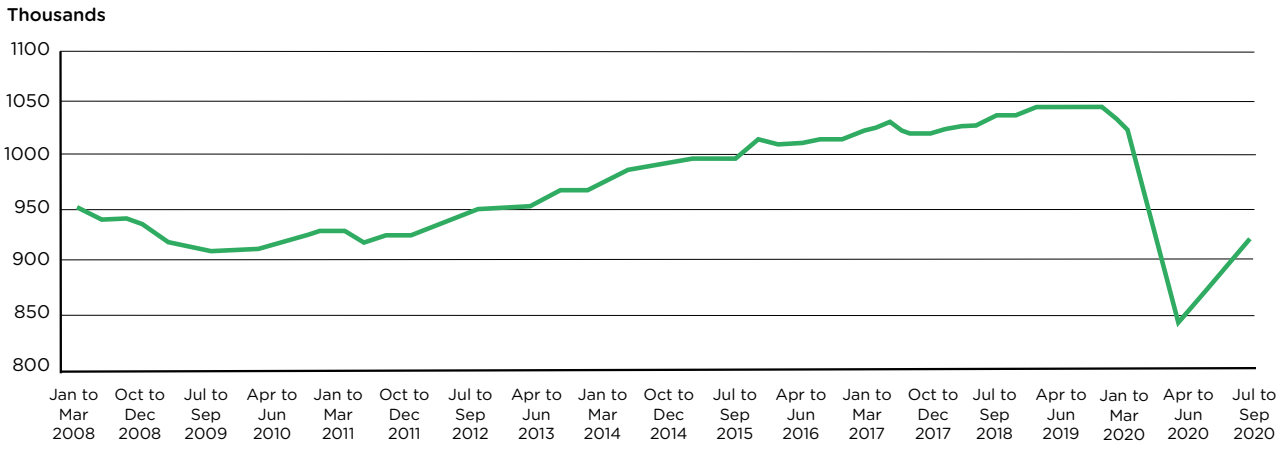


Source: *Based on ONS. Employment in the UK: November 2020 (213).*

The Annual Population Survey 2019 showed that there was a higher proportion of self-employment among those of Pakistani (25 percent) and Bangladeshi (19 percent) ethnicities, when compared to that of all other ethnicities and to the average proportion of self-employment among the general population (15.3 percent) (218). This suggests that these ethnic groups could be particularly vulnerable to the adverse employment impacts of COVID-19 containment measures (219).

Number of hours worked is a good indicator of underemployment – being employed for less than desired. Figure 5.3 shows that the large decrease in hours worked during 2020 was more pronounced than the decrease that occurred in 2008 as a result of the financial crisis. There was a small increase between May to July and July to September, but these latest data published by the ONS do not yet reflect the impact of the second COVID-19 lockdown on weekly hours worked, which will see another decrease.

Figure 5.3. Total actual weekly hours worked in the UK (people aged 16 years and over), seasonally adjusted, between January to March 2008 and July to September 2020



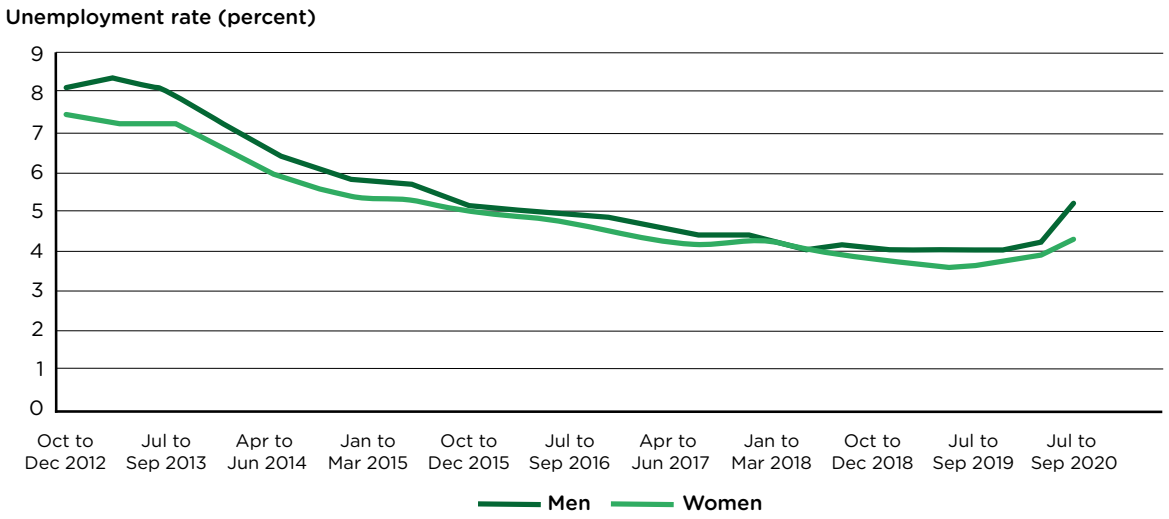
Source: *Based on ONS. Employment in the UK: November 2020 (213).*

5.B IMPACT OF COVID-19 CONTAINMENT ON UNEMPLOYMENT

The relationship between unemployment and poor health has been well documented. The available evidence shows that unemployment is harmful to health and wellbeing, even when accounting for other factors (6). One mechanism is that unemployment, especially if long term, causes or exacerbates poverty and hence ill health. Unemployment also causes stress by disrupting important psychosocial factors and elements of wellbeing, such as personal identity and status, self-esteem, and how people structure their time (11). Unemployment can also cause a loss of social support networks when social relationships at work are lost. Longitudinal studies have shown that higher levels of depression are a direct result of unemployment (220) (221).

The unemployment rate for July to September 2020 increased, as shown in Figure 5.4. Although unemployment rates are still lower than those seen after the 2008 financial crisis, this is mostly the result of the Coronavirus Job Retention Scheme (CJRS), also known as the furlough scheme. When the scheme is discontinued on the 31 March 2021, unemployment rates are likely to experience a larger increase, possibly reaching 2010 levels. The IFS expects unemployment rates of 8.5 percent (2.8 million) in the first half of 2021, while OBR expects a 7.5 percent unemployment rate (215).

Figure 5.4. Unemployment rates in the UK (aged 16 years and over), seasonally adjusted, between January to March 2010 and July to September 2020



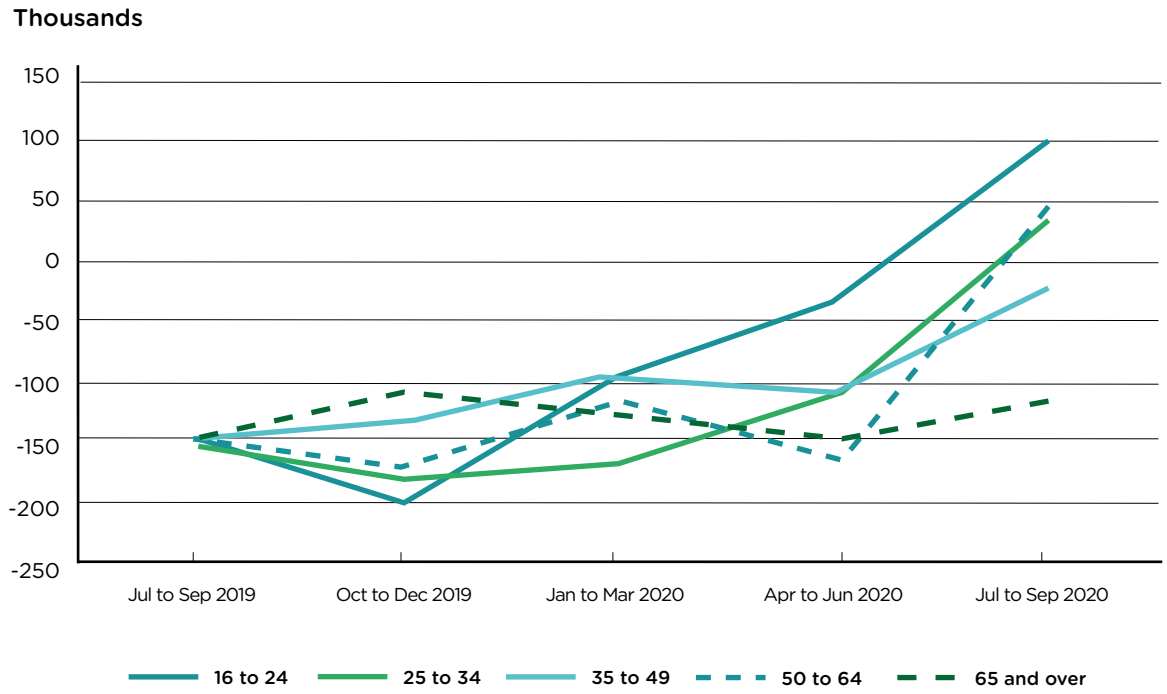
Source: *Based on ONS. Employment in the UK: November 2020 (213).*

Experiencing unemployment as a young person can lead to poor mental health and can also harm career development and earnings potential, and in the longer term lead to worse physical as well as mental health (222).

The Resolution Foundation found that one-third of 18- to 24-year-old employees (excluding students) have lost jobs or been furloughed, compared to one in six adults, since the pre-COVID-19 period. Thirty-five percent of non-full-time-student employees aged 18 to 24 were earning less during April to May 2020 than they were prior to the outbreak, while the same was true for 23 percent of 25- to 49-year-olds (223).

Figure 5.5 shows that unemployment increased on the year, and on the quarter, for all age groups, but to the greatest extent among the 16 to 24 age group. There were 100,000 more unemployed 16- to 24-year-olds in July to September 2020 than there were a year earlier. The 25 to 34 and 50 to 64 age groups have also experienced a sharp increase in unemployment since April to June 2020 (213).

Figure 5.5. UK unemployment by age (aged 16 years and over), seasonally adjusted, cumulative growth from July to September 2019, for each period up to July to September 2020

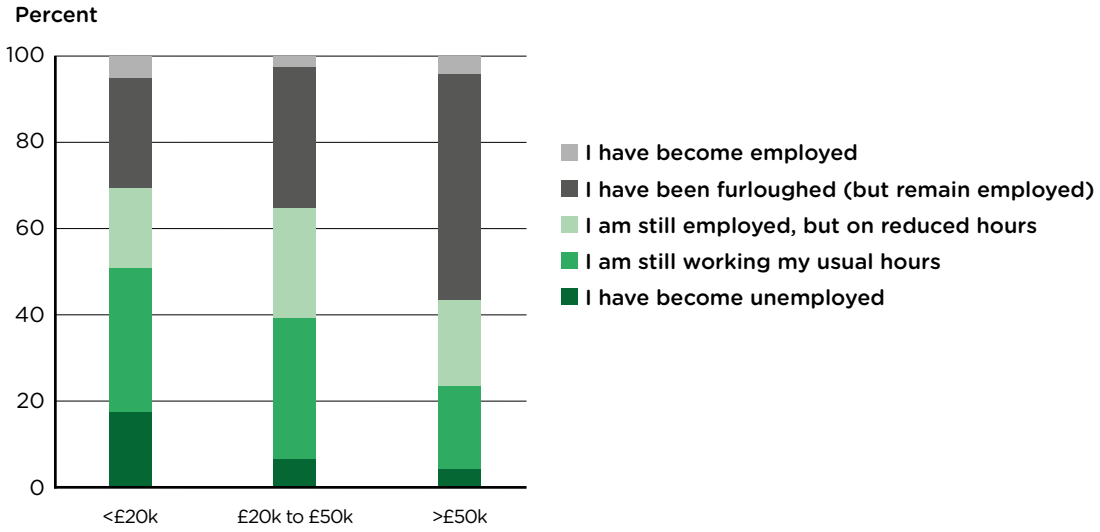


Source: *Based on ONS. Employment in the UK: November 2020 (213).*

The annual increase in unemployment is driven by those unemployed for up to six months, the number of which in July -September 2020 was up 224,000 on the year to 1.04 million. This is the largest annual increase for the short-term unemployed since June to August 2009. The number unemployed for over 12 months has also increased, by 30,000 on the year, the first annual increase for the long-term unemployed since June to August 2013 (213). There are clear associations between long periods of unemployment and physical and mental ill health, while rates of mortality increase as unemployment periods lengthen (224) (225).

A survey by PwC on the impact of COVID-19 on employment carried out in April 2020 found that 70 percent of those who were earning more than £50,000 per year had continued to work their normal hours in comparison to 40 percent of those who were earning less than £20,000 per year (Figure 5.6). Those earning less than £20,000 were also more likely to have become unemployed (nearly 20 percent) than those in the other pay ranges, and more likely to have been furloughed (30 percent) (226).

Figure 5.6. Impact of COVID-19 on employment status in the UK, by income group, April 2020



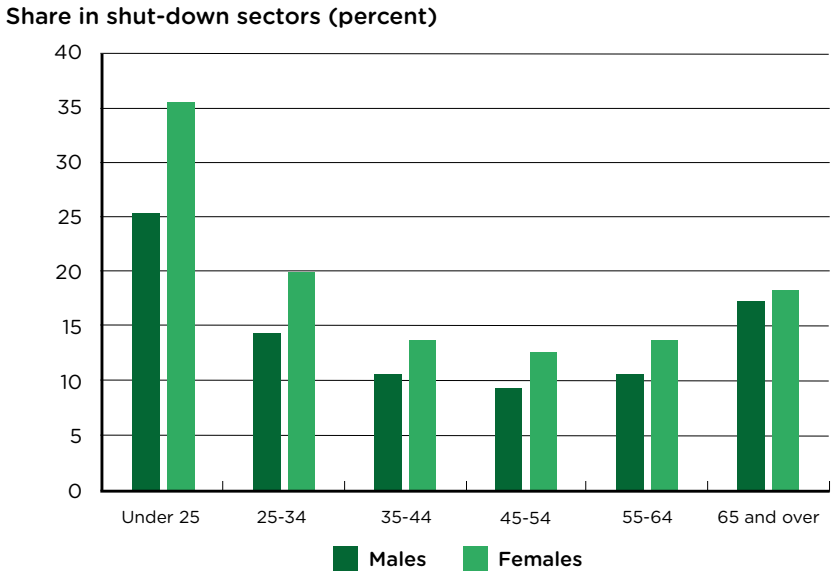
Source: *PwC. COVID-19 UK Economic update, 2020 (226).*

The lockdown in response to the COVID-19 pandemic has effectively shut down a number of sectors. Restaurants, shops and leisure facilities were ordered to close, air travel largely halted, and public transport use and provision were greatly reduced. According to the IFS, employees aged under 25 were about two-and-a-half times as likely as other employees to work in sectors shut down during April to June (227). Those under 25 are more exposed to jobs that cannot be worked from home. These differences across age groups are larger for those who only have GCSE qualifications or less (228).

ONS employment data, published in November 2020, show unemployment by industry: the highest level of unemployment in July to September 2020 was for those previously employed in wholesale, retail and repair of motor vehicles (213).

Fifty-seven percent of those working in shutdown sectors are women, compared with a workforce average of 48 percent (229). Because women disproportionately work in retail and hospitality, COVID-19 had a larger effect on their employment than on men. There have been large inequalities by age too. Employees aged under 25 were approximately two-and-a-half times as likely to work in a sector that closed during lockdown as other employees, as shown in Figure 5.7 (230).

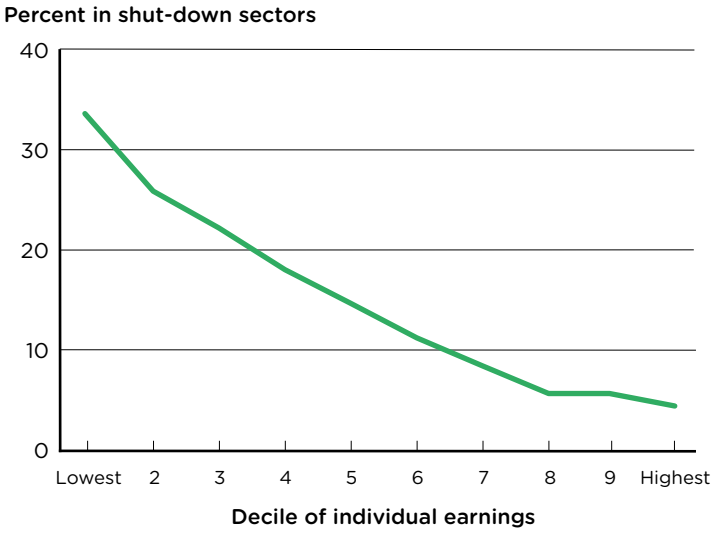
Figure 5.7. Share of workers in shutdown sectors, by age and gender, January – March to October – December 2019, UK



Source: *IFS, Sector shutdowns during the coronavirus crisis: which workers are most exposed? 2020 (230).*

As well as young people and women being disproportionately affected by shutting down sectors, low income groups are also most affected. Figure 5.8 shows that employees in the lowest decile for earnings were seven times as likely to be working in a shutdown sector as those in the highest decile (230).

Figure 5.8. Percent of workers in shutdown sectors, by earnings decile, January – March to October – December 2019, UK



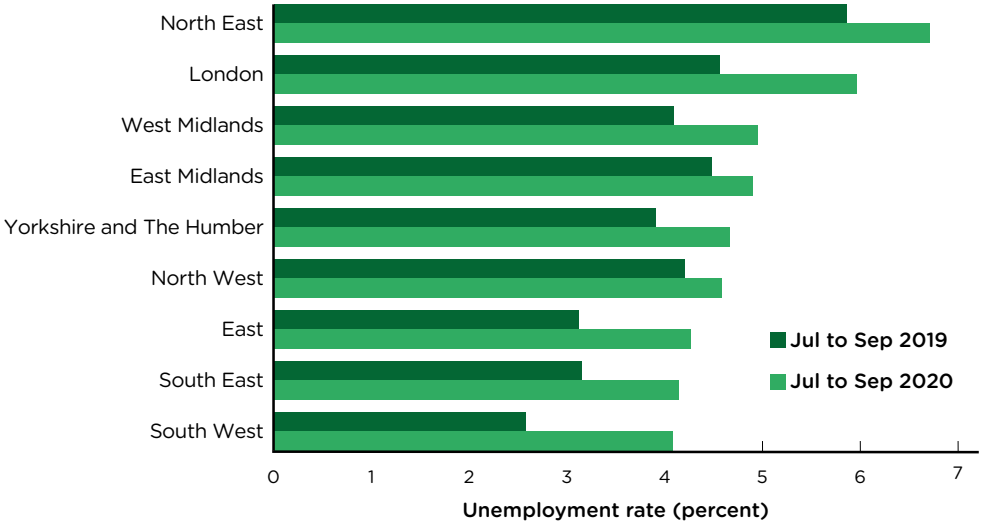
Source: *IFS, Sector shutdowns during the coronavirus crisis: which workers are most exposed? 2020 (230).*

Key workers are more than three times as likely as those working from home to be in the bottom 10 per cent of earners (231). Fifteen percent of workers in shutdown sectors have some form of disability (as defined by the Equality Act 2010) (232) (233).

Widening regional differences in unemployment will inevitably lead to widening and long-term regional inequalities in health. The unemployment rate increased for all English regions compared with same period last year. The South West saw the largest increase in unemployment rate (213), which could be explained by

the region's tourism-reliant economy. The significant increases in unemployment also seen in London and the South East could also be a result of their reliance on the accommodation, food service and tourism sectors. Despite these increases in unemployment in the South and London, they started from a relatively low unemployment position. The highest unemployment rate estimate is for the North East at 6.7 percent, and this Region had the highest rate before the pandemic as shown in Figure 5.9. Rates for counties, local and unitary authorities are provided in Figure 5.10, showing local differences too.

Figure 5.9. Unemployment rate estimates for the economically active population (aged 16 years and over), by England region, seasonally adjusted, between July to September 2019 and July to September 2020

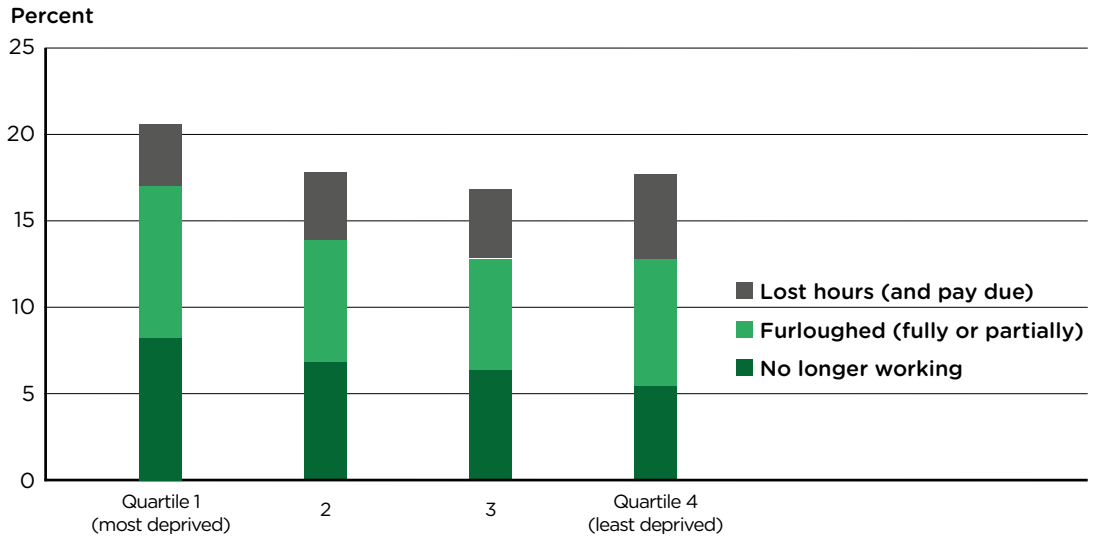


Source: *Based on ONS. Employment in the UK: November 2020 (213).*

There have been longer lasting impacts on local areas where higher unemployment may be more difficult to reverse due to continuing high levels of restrictions in areas with less dynamic labour markets, discussed further in chapter 7. Some of these are localised: for example, many coastal areas are dependent on tourism and have relatively limited alternative activities (234).

Populations living in the most deprived areas have been the hardest hit by the COVID-19 crisis. A survey carried out by the Resolution Foundation and YouGov during 17–22 September showed that one in five workers in the most deprived places was not working in September (Figure 5.10) (235).

Figure 5.10. Change in employment status among those employed before the COVID-19 crisis, by level of deprivation



Source: *Resolution Foundation analysis of YouGov, Adults Age 18 to 65 and The Coronavirus (COVID-19) - September wave, 2020 (235).*

5.C FURLOUGHED WORKERS AND GOVERNMENT-FUNDED COVID-19-RELATED JOB SCHEMES

In order to protect the labour market and support households by sustaining businesses and employment through containment, the Government has put in place a set of economic measures corresponding to 15 percent of GDP in discretionary spending since the start of the pandemic, as of November 19, 2020 (236). The 2020/21 budget deficit is expected to be larger than at any time since World War II and could exceed £375 billion in 2020/21, approximately 19 percent of GDP, according to the IFS (237).

The measures are described below.

Coronavirus Job Retention Scheme (CJRS)

The Coronavirus Job Retention Scheme (CJRS), known informally as the furlough scheme, was launched on 20 April 2020. Subsidised by the Government, it allows workers who are furloughed to be kept on by their employer, and to be paid 80 percent of their February earnings, up to a cap of £2,500 per month, until 31 March 2021 (234). There are currently more than 9 million people whose jobs have been furloughed (238).

The impact of COVID-19 on the labour market has been sector-specific, as shown by variation in the fall in job vacancies across different industries (239). The arts, entertainment and recreation sector and the accommodation and food service activities sector had the highest proportions of furloughed workers, at 64 and 45 percent respectively.

In the UK, from July 2020 onwards, the Coronavirus Job Retention Scheme allowed partial furloughing, where furloughed workers doing some work for their employer have their non-working hours subsidised. The Resolution Foundation found that in September partial furloughing comprised a similar proportion to fully furloughed employees. Workers furloughed in lockdown were around twice as likely as other workers to no longer employed by September (235).

Self-Employment Income Support Scheme (SEISS)

The SEISS was announced on 26 March 2020 and allows the self-employed recipient to claim a taxable grant worth 80 percent of average monthly trading profits, paid out in a single instalment covering three months'-worth of profits, and capped at £7,500 in total. The first SEISS grant closed for claims on 13 July 2020 (240) followed by the second SEISS grant, worth 70 per cent of average monthly trading profits, capped at £6,570 in total (240). The window for the second grant closed on 19 October 2020, but the Government has announced an extension to the scheme to include two further taxable SEISS grants. The third grant is available for the period 1 November 2020 to 31 January 2021 and will cover 80 percent of average trading profits to a maximum grant of £7,500 (241). The fourth grant will cover the period 1 February 2021 to 30 April 2021; the level is yet to be set (242).

There has been high uptake of this scheme. By 30 September 2.3 million (67 percent) of the potentially eligible population had claimed a second SEISS grant with the value of these claims totalling £5.7 billion (240).

According to the Resolution Foundation the impact of COVID-19 containment support for self-employed has been poorly targeted, however. Their survey results show that three-fifths of those whose earnings fell to zero received no support (235). In September, more than half of self-employed workers were receiving less than their pre-crisis level of pay, including one-in-six who are not working at all.

Other work support schemes during COVID-19

In order to encourage youth employment during the pandemic, the Kickstart scheme provides funding to employers to create job placements for 16 to 24 year olds on Universal Credit. It provides 100 percent of the National Minimum Wage for 25 hours per week for a total of six months (243). The scheme is due to run until December 2021 with the possibility of an extension (244). A similar scheme, the Future Jobs Fund, was introduced in 2009 in the UK and saw a net benefit for participants and employers (245).

Business rate relief

Support has also been given to businesses, with business rates being waived by the Government for the whole of 2020–21 for most businesses in the retail, hospitality and leisure sectors (234).

Council tax relief

In addition to the CJRS, the Government announced a COVID-19 hardship fund in the Budget released on 11 March 2020 in response to the pandemic. As part of this grant, £500 million was allocated to local authorities in England in order to allow them to provide council tax relief to those who were economically vulnerable within their local areas (246).

Self isolation payments

Those in the UK on lower incomes who cannot work from home and have lost income as a result and are required by law to self-isolate from 28 September will be supported by a payment of £500. These payments have been made from the 12 October onwards.

Table 5.1 shows that OECD countries in Europe have taken a generous approach in terms of their labour market policy responses, and evidence shows that job retention schemes have been effective in preserving existing jobs in the short term for the most part.

Table 5.1. Labour policy responses to the COVID-19 crisis in European OECD countries

EU OECD countries	Income support to sick workers and their families	Income support to quarantined workers who cannot work from home	Income support to persons losing their jobs or self-employment income	Changes to dismissal regulation	Helping economically insecure workers stay in their homes
Austria	✓	✓	✓		✓
Belgium	✓	✓	✓		✓
Czech Republic	✓	✓	✓		✓
Denmark	✓	✓	✓		
Estonia	✓	✓	✓		
Finland	✓	✓	✓	✓	
France	✓	✓	✓	✓	✓
Germany	✓	✓	✓		✓
Greece			✓	✓	✓
Hungary		✓	✓		✓
Iceland	✓	✓	✓		
Ireland	✓	✓	✓		✓
Italy	✓	✓	✓	✓	✓
Latvia	✓	✓	✓		
Lithuania	✓	✓	✓	✓	✓
Luxembourg		✓	✓		✓
Netherlands		✓	✓		✓
Norway	✓	✓	✓		
Poland	✓	✓	✓		✓
Portugal	✓	✓	✓		✓
Slovak Republic		✓	✓	✓	✓
Slovenia	✓	✓	✓		
Spain	✓	✓	✓	✓	✓
Sweden	✓	✓	✓		
Switzerland	✓	✓	✓		
United Kingdom	✓	✓	✓		✓
Percent of 26 OECD countries	81	96	100	27	65

Source: *OECD, Policy responses to the Covid-19 crisis (247).*

As shown in Table 5.2, in the UK the Government subsidises wages for hours that an employee is no longer working. This is also the case in Denmark, France, Germany and Sweden, where long-standing 'short hours' policies top up employees' wages if their employer is forced to cut their hours. In Australia, Canada, Ireland and the US, governments offer a wage subsidy for all employees, provided the business in question has experienced a large decline in turnover due to COVID-19 (248).

Table 5.2. COVID-19 wage subsidy schemes by country (selected countries in the OECD), as at June 2020

UK	Furloughed employee jobs received 80 percent of normal pay from the scheme, to a maximum £2,500 a month. Employers were able to top up emplyees' pay, but they were not required to.
Australia	Uniform AU$1,500 per fortnight (£410 pw) per employee.
Canada	Up to 75 percent of previous wage (gross); if hours are cute, sceme pays the lower of 100% of new wage and 75 percent of previous wage.
Denmark	Government pays 75 percent (gross) for workers paid monthly, 90 percent (gross) if paid hourly. Emplyers are required to top up to 100 percent of previous salary.
France	70 percent (gross) or €8 (£7) per hour (whichever is higher).
Germany	Starts at 60 percent (gross), increases to 80 percent over time. Extra 7 percent for workers with children.
Ireland	85 percent (net) for lowest earners, 70 percent for others.
Sweden	76 percent (gross) of wages for hours cut. Hours can only be cut by up to 60 percent. Employer must top up wages beyond this to around 90 percent previous wage.
United States of Amercia	50 percent (ERC); UI replacement rate varies by state.

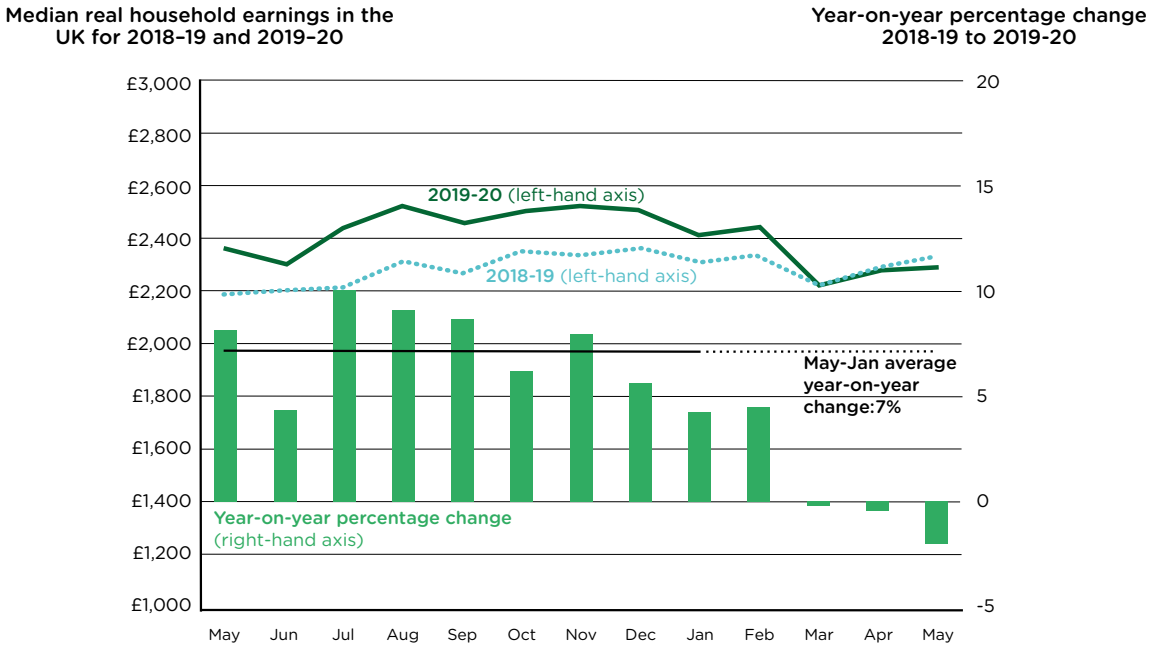
Source: *Institute for Government. Coronavirus: how have different countries supported workers through the crisis? (248).*

5.D IMPACT OF COVID-19 CONTAINMENT ON EARNINGS

The hit to earnings and financial security has been among the most immediate impacts of COVID-19 containment measures, particularly for those on low wages. We showed in the *10 Years On* report of February 2020 that there were already many people employed in a job and receiving benefits who live on an income that is below the minimum for healthy living and many live in poverty. Even before containment measures, real pay at the start of 2020 was below 2010 levels and in the decade from 2010 there was an increase in the proportion of people in poverty living in a working household (1). ONS data show that average weekly earnings at 2015 prices were £502 in September 2019, only £5 higher than in 2008 (249).

Figure 5.11 shows declines in household earnings in March, April and May 2020 (250).

Figure 5.11. Median real household earnings in the UK for 2018–19 and 2019–20 and the year-on-year percentage change in these earnings

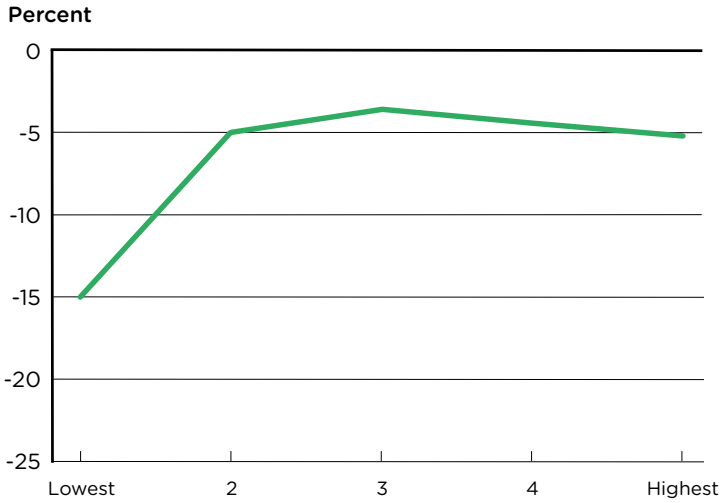


Note: *Government furlough payments from the Coronavirus Job Retention Scheme were included as earnings in this analysis.*

Source: *Based on analysis by Bourquin et al. (2020) of data from Money Dashboard data (12 June 2020) (250).*

Declines in household earnings appear to have been particularly severe for those families who were in lower income quintiles prior to the pandemic, as shown in Figure 5.12. There was a 15 percent decrease in median household income earnings for those in the lowest income quintile, compared with a 4–5 percent decrease for all other household income quintiles; quintile 3 was least affected (250).

Figure 5.12. Change in median real household earnings in the UK between January and May 2020, by pre-COVID-19 income quintile



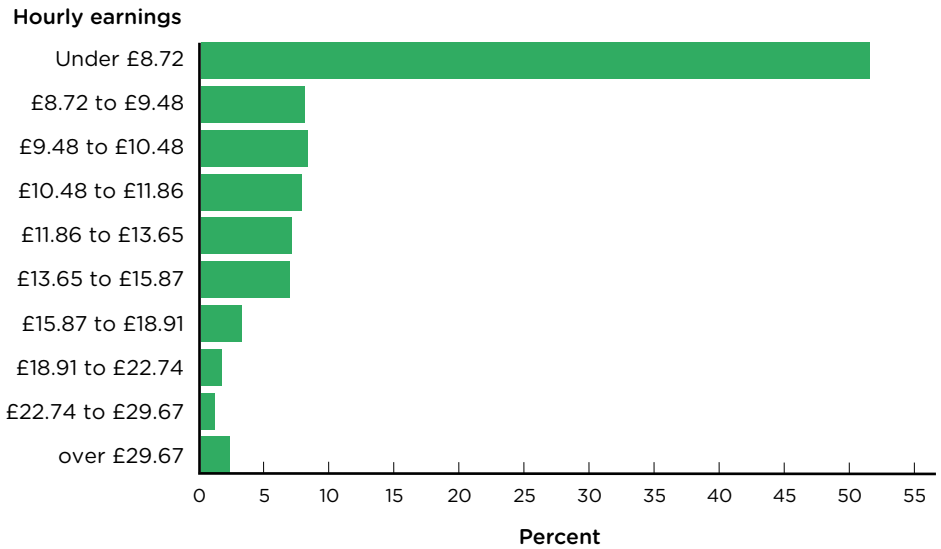
Notes: *The household income quintiles are based on the Households Below Average Income (HBAI) measure. Government furlough payments from the Coronavirus Job Retention Scheme were included as earnings in this analysis.*

Source: *Based on analysis by Bourquin et al. (2020) of data from Money Dashboard data (12 June 2020) (250).*

In June 2020, around 18 percent of non-furloughed workers were receiving lower pay than usual, rising to 71 percent for furloughed workers; more than half (55 percent) of furloughed workers said their financial security had worsened since the onset of the pandemic, compared with 28 percent of non-furloughed workers (251).

Despite minimum wage policies and the introduction of the National Living Wage, in April 2020 there were 2,043,000 jobs where employees aged 16 or over were paid below the legal minimum, more than four times the number of jobs a year earlier (409,000) (252). More than half of employees earning less than £8.72 an hour (that is, in the bottom decile of hourly pay) in April 2020 were furloughed and receiving reduced pay, as shown in Figure 5.13 (253). This compares with less than 10 percent in other hourly pay deciles, meaning that people in the lowest-paying jobs were over five times more likely than other employees to be furloughed with reduced pay (253).

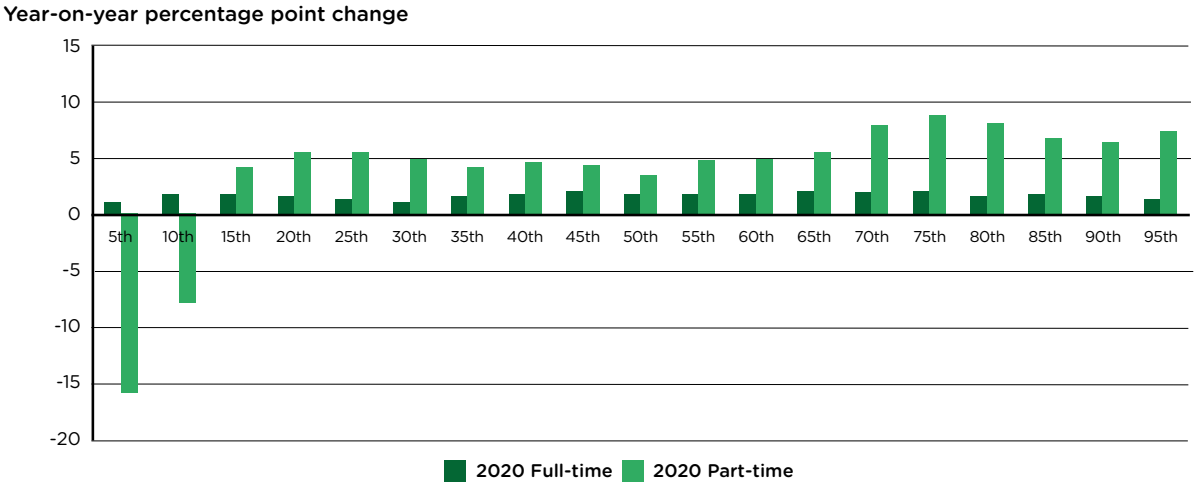
Figure 5.13. Percent of employees in the Annual Survey of Hours and Earnings who were furloughed with reduced pay, by hourly pay (excluding overtime) bands 2020, UK, all employees



Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (253).*

The lowest paid part-time jobs have seen a noticeable decrease in pay rates since the start of the pandemic, figure 5.14. However, the highest paying part-time jobs, from the 70th percentile upwards, have seen larger hourly pay growth than in 2019.

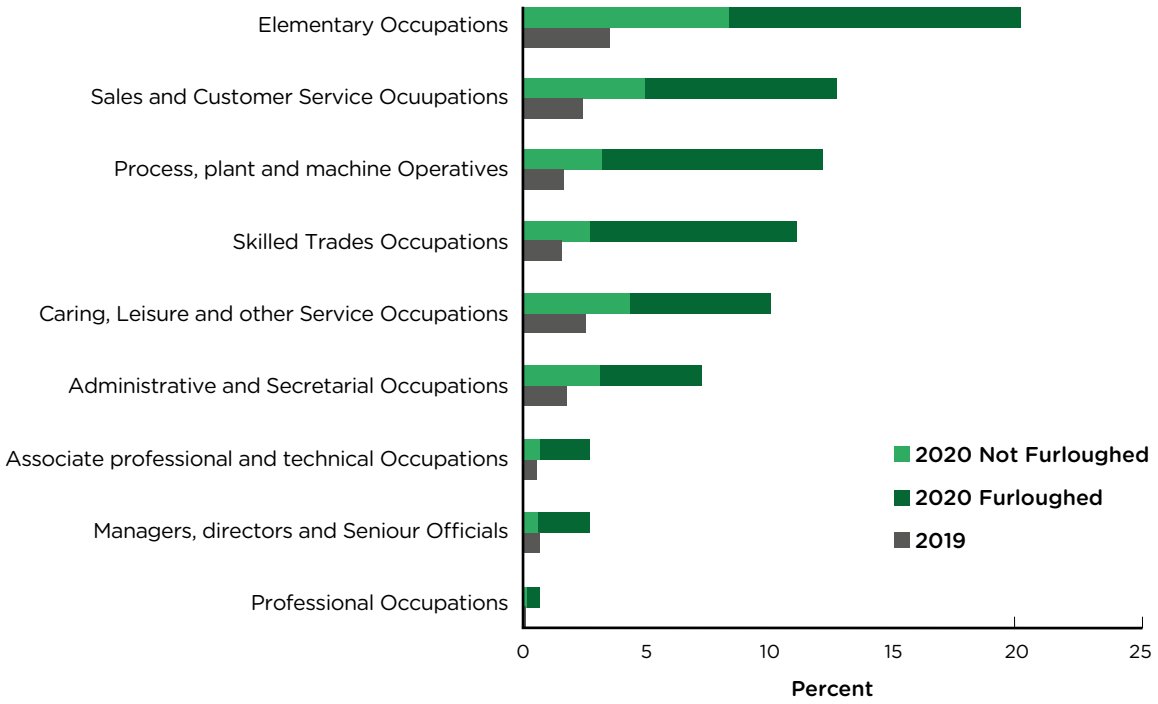
Figure 5.14. Year-on-year percentage point changes to the distribution of full-time and part-time hourly earnings (excluding overtime) for every 5th percentile, UK, 2019 and 2020



Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (253).*

Figure 5.15 shows a large increase in the percent of jobs below the minimum wage between 2019 and 2020 for most occupation types. The greatest proportion of these were in elementary occupations, followed by sales and customer service occupations (253).

Figure 5.15. Percent of jobs below the national minimum wage/living wage by type of occupation, 2019–20, UK



Note: *All jobs below national minimum wage; includes all furloughed employees.*

Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (253).*

Figure 5.16 shows that there are large inequalities in the percentage of jobs below the national minimum wage (NMW) by region, with the North East doubling the rate in London in 2020 for example, and that these inequalities have increased when compared with rates of jobs earning below the NMW in 2010.

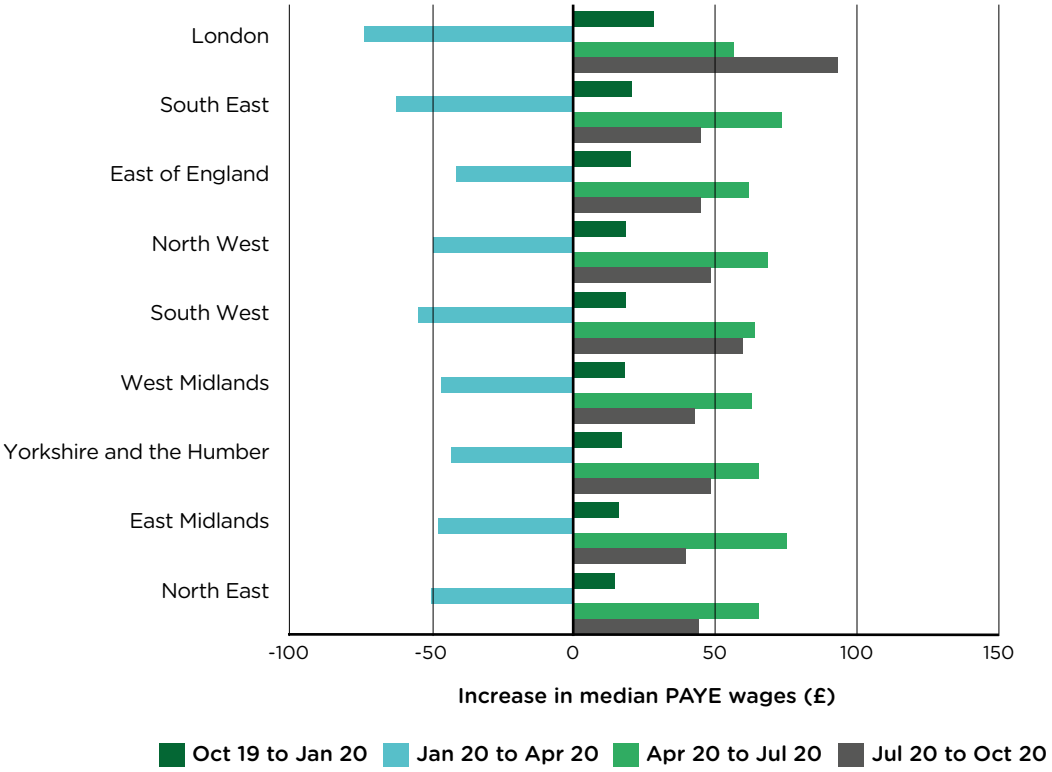
Figure 5.16. Percent of jobs paid below the national minimum wage/living wage by region in England, 2010 and 2020

Note: *Includes all furloughed employees.*

Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (253).*

Despite low levels of wage in the North East in particular, it had the lowest increase in wages at the end of last year while London had the highest level of increase (Figure 5.17).

Figure 5.17. Three-monthly Increases in seasonally adjusted median PAYE wages by region, England, October 2019-January 2020 to July 2020-October 2020

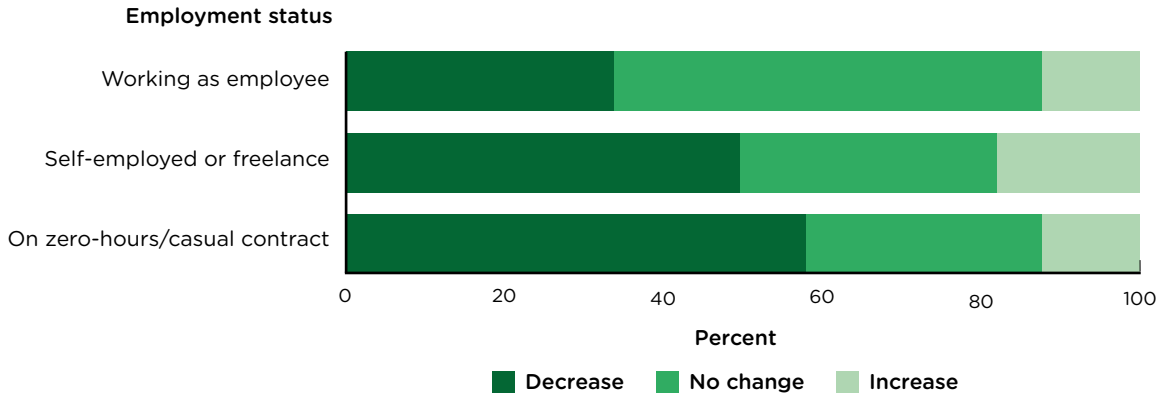


Source: *ONS. Earnings and employment from Pay As You Earn Real Time Information, seasonally adjusted, 2020 (254)*

It is important to note that the income of the poorest have been protected by increases to benefits. In chapter 6 we show how the income of the second lowest income decile have not been so protected. In relation to Regional changes in wages and income as a result of containment measures, there have been similarly protective effects in the poorest regions. This will be undermined when the coronavirus related relief schemes and benefit increases ends and we anticipate widening regional inequalities in income and wealth.

A study by national charity Turn2us, which was conducted with a nationally representative sample of 2,056 working adults aged 18 to 65 years between 22 and 27 April 2020, found that individuals who are in 'atypical' forms of employment, which includes those who are self-employed and on zero-hours or casual contracts, were more likely to have experienced a drop in income when compared with those considered to be in more 'typical' forms of employment (Figure 5.18). For example, 58 percent of respondents on zero-hours or casual contracts reported experiencing a drop in their income from the outbreak of the pandemic, compared with 34 percent of those who were working as an employee (255).

Figure 5.18. Percent of working adults (aged 18 to 65 years) in the UK who experienced a change in their income between February and March 2020, by employment type



Source: *Turn2us survey, 22–27 April 2020 (255).*

The Women's Budget group found that women are more likely to be low earners than men. They constitute 69 percent of low earners (256) and as they are more likely than men to work on zero hours contracts and part time work are particularly vulnerable to job insecurity and decreasing employment due to COVID-19 containment measures. Prior to the introduction of lockdown measures in March 2020, workers on casual contracts were receiving on average around £605 less per month that that of employees (255). The difference has widened to £730 per month since the outbreak of the pandemic.

Care workers have been at high risk of COVID-19 mortality and infection through the pandemic and, as key workers, have had to carry on working throughout the pandemic, mostly on very low wages, with poor working conditions and highly precarious employment. The decision not to increase their pay must be reversed, in recognition of their vital role in society and to encourage recruitment to the sectors which is seriously understaffed, discussed in box 5.1.

BOX 5.3. CARE WORKERS

In the UK there are more than 900,000 people working in frontline care roles as their main job and 83 percent of this workforce are women. There is disproportionate representation of people from BAME backgrounds among care workers: 18 percent of carers come from these groups compared with 12 percent for all occupations. One in seven care workers is a single parent, compared with four percent for all occupations (257).

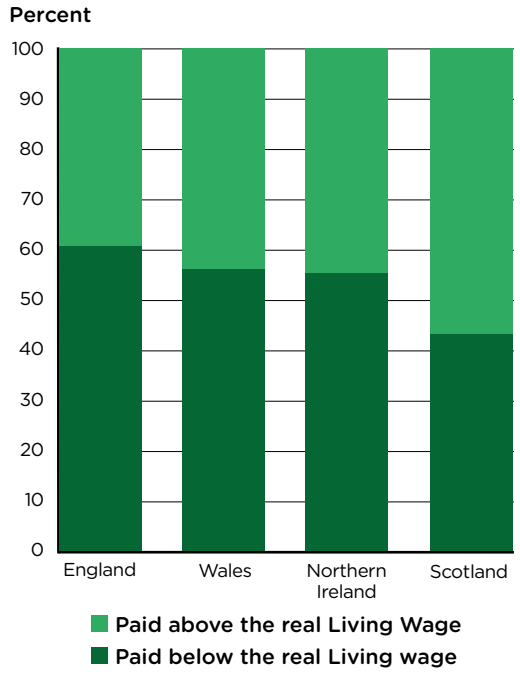
The Labour Force Survey suggests that one in 10 frontline social care staff is on a zero-hour contract, much higher than the one in 40 in the economy as a whole. Frontline care staff are also about three times more likely than other workers to be employed through agencies, for which turnover rates are very high (258). Seven out of 10 earn less than £10 an hour, according to a TUC analysis (259). At least 60 percent of frontline care workers in England are earning below the 'real' living wage, which is calculated based on public consultation

about necessities and analysis of the cost of living. It differs from the statutory national living wage which is currently £8.72 per hour for people aged 25 and over. There are growing calls for reform of the social care sector to create parity with NHS pay (258).

The proportion of care workers earning below the real living wage is higher in the regions in the North of England, where care homes have been the most affected by COVID-19. In the North East and the North West, with 82 and 78 percent of care staff respectively earn less than the England-wide real living wage of £9.50 per hour (259).

Within the UK, England is doing worse than the other nations in terms of care workers' pay and has the highest rates of carers paid below the living wage, as Figure 5.19 shows. Care workers are better paid in Scotland than elsewhere in the UK. In 2016 the Scottish Government announced a commitment to ensure all social care staff are paid the living wage (a commitment followed up by a COVID-19-related funding boost). However, 43 percent of care workers in Scotland are still being paid below the living wage, showing the need to improve the wages of care workers across the whole of the UK.

Figure 5.19. Percent of frontline care workers paid below the real living wage by UK nation, 2017–19

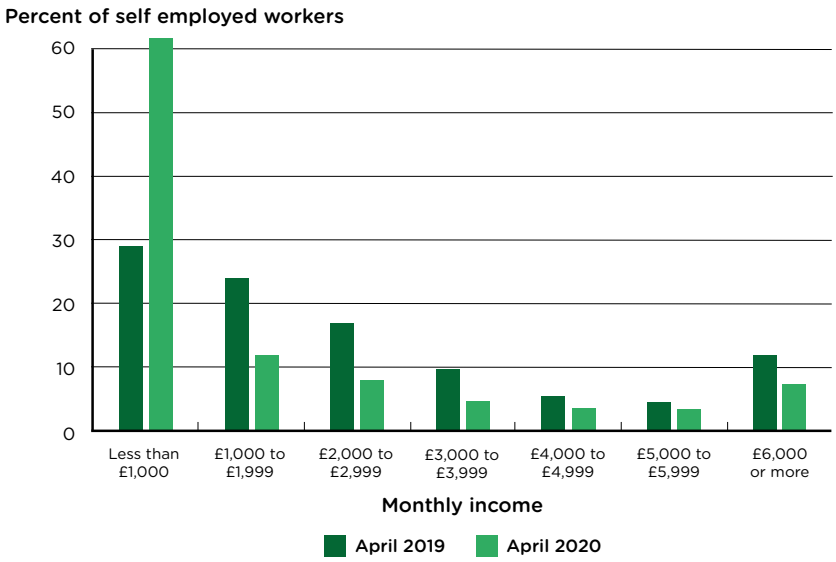


Note: *Real living wage rates are applied from announcement in November of relevant year.*

Source: *Resolution Foundation analysis of ONS, Labour Force Survey (257).*

In terms of earnings, in April 2020 there was over twice the proportion of self-employed workers earning less than £1,000 per month as in April 2019, at just over 60 percent (Figure 5.20) (260). Forty-six percent of survey respondents reported that they were finding it difficult to cover their basic expenses including rent and essentials, so this loss of income evidently has impacted significantly on the financial situation of a large proportion of self-employed people (261).

Figure 5.20. Percent of self-employed workers in the UK, by monthly income, April 2019 and April 2020



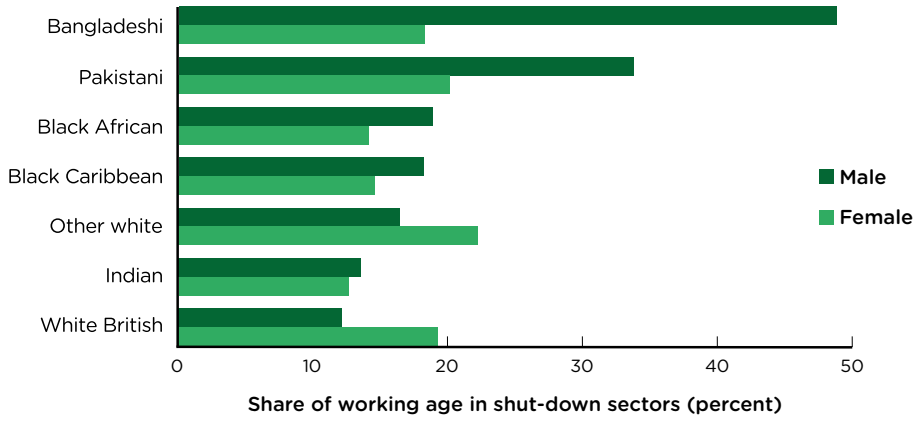
Source: *LSE-CEP Survey of UK Self-Employment, May 2020, as reported by Blundell et al. (2020) (260).*

5.E IMPACT OF COVID-19 CONTAINMENT ON WORKERS FROM BAME BACKGROUNDS

People from BAME groups are often employed in sectors that increase the risk of infection and mortality from COVID-19, as discussed in Chapter 2. Additionally, many BAME people are particularly vulnerable to the labour market changes that have resulted from the containment measures. People in BAME groups – including 39 percent of workers of Pakistani descent, 36 percent of Bangladeshi descent and 34 percent of Indian descent – are more likely to work in insecure and casual forms of employment, and as containment measures are particularly impacting insecure forms of work, there are likely to be disproportionate impacts on the security of work and income of these groups (255). In contrast, 17 percent of workers who identify as White British work in such forms of employment (255).

While differences in family structures imply that the effects of the crisis would vary across groups even if members of each ethnic group were equally likely to work in shutdown sectors, the chances of working in a directly affected industry are not evenly distributed. Figure 5.21 shows substantial differences in the share of each ethnic group working in shutdown sectors. White women were more likely to work in one of these sectors than White men. Across minority ethnic groups, men were more likely to work in shutdown sectors than women, especially among Bangladeshi and Pakistani groups, due to their high participation in the restaurant sector, and in taxi driving (262).

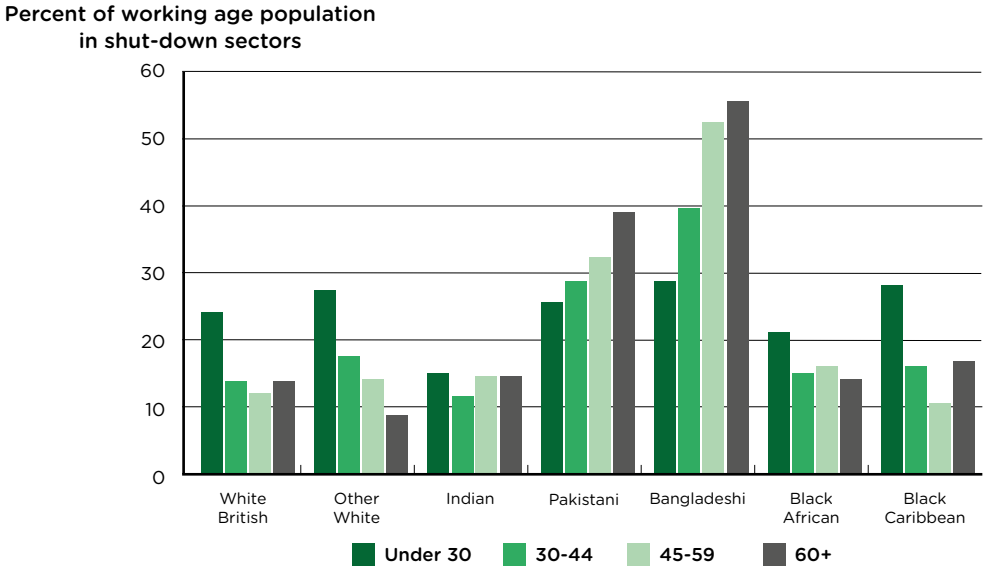
Figure 5.21. Percent of working-age population in each ethnic group working in shutdown sectors in England and Wales, by sex, January - March 2016 to October - December 2019



Note: *Shares represent the percent of the working-age population (aged 16–64) (excluding students) of each group in shutdown sectors.*
Source: *Platt L, Warwick R. COVID-19 and Ethnic Inequalities in England and Wales, 2020 (263).*

In White, Black African and Black Caribbean groups younger workers were more likely to work in shutdown sectors. By contrast, among Pakistani and Bangladeshi groups it was older people who were more likely to be working in these sectors, as shown in Figure 5.22.

Figure 5.22. Percent of working-age population in each ethnic group, by age in shutdown sectors in England and Wales, January - March 2016 to October - December 2019

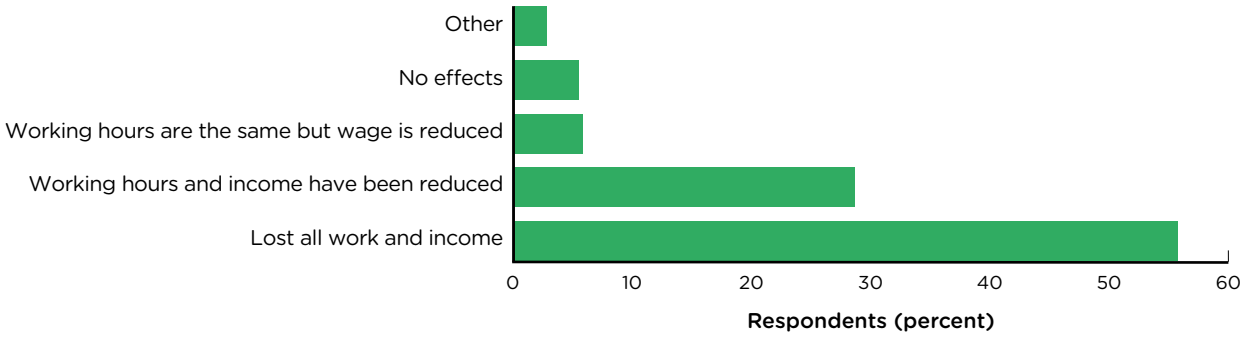


Note: *Shares represent the percentage of the working-age population (aged 16–64) (excluding students) of each group in shutdown sectors.*

Source: *Platt L, Warwick R. COVID-19 and Ethnic Inequalities in England and Wales, 2020 (263).*

A study by the Kanlungan Filipino Consortium and RAPAR was carried out with a sample of Filipino migrants in the UK between May 2020 and June 2020, to investigate the impacts of the COVID-19 pandemic on these migrants (264). As sown in Figure 5.23, 89 percent of respondents worked in domestic or care work (264). Among the respondents, there were consistent reports of difficulty in finding employment with fair wages and working conditions, with the average wage of the respondents being £6.01 per hour (264). This is lower than both the UK minimum and London-weighted minimum wage, which are £8.72 and £10.75 per hour respectively (264).

Figure 5.23. Impacts of COVID-19 on the employment and income of Filipino migrant workers in the UK, May to June 2020



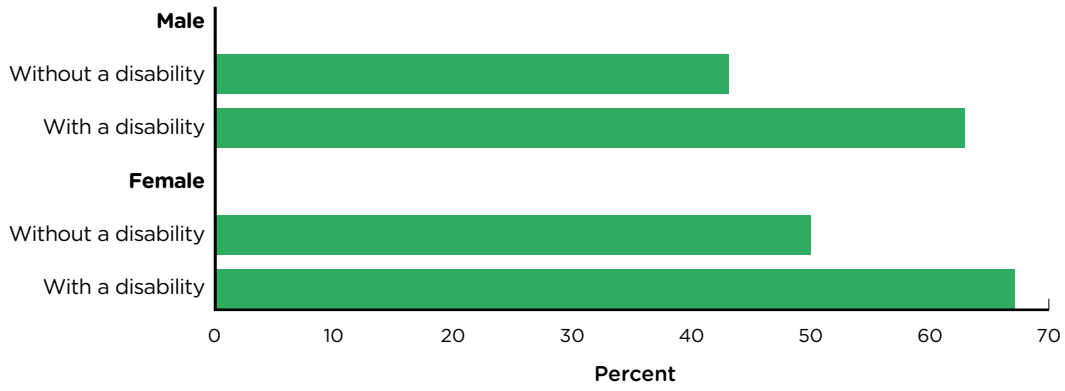
Source: *Data from study by Kanlungam Filipino Consortium and RAPAR (2020) (264).*

5.F IMPACT OF COVID-19 CONTAINMENT ON WORKERS WITH DISABILITIES

Before the COVID-19 outbreak, disabled people in the UK had an employment rate which was 28.6 percent lower than that of people without disabilities (1) (265). The COVID-19 pandemic and containment measures have created further challenges for those workers with a disability, especially if they are 'clinically vulnerable' and were advised to shield. In a submission to the Work and Pensions Committee for the DWP's response to the Coronavirus Outbreak Inquiry, the group Disabled People Against Cuts noted that disabled workers have reported difficulties getting access to workplace adjustments and equipment to enable them to work from home (266). These problems place disabled workers at a considerable disadvantage compared with people without disabilities (267).

The results of a survey carried out by Turn2us also suggest that workers in the UK with a disability have been more impacted by the COVID-19 pandemic than workers without a disability (268). Overall, two-thirds of people with a disability who responded to the survey have had their work impacted by the pandemic in the UK. As a result, working aged disabled people are much more likely to need to claim Universal Credit to cover the cost of living – one in five compared with one in 10 among people without disabilities (268), outlined in Figure 5.24.

Figure 5.24. Percent of workers who have had their employment affected by COVID-19 in the UK, by disability status and gender, June 2020



Source: *Turn2us Survey (268).*

5.G CONCLUSIONS

The COVID-19 containment measures are having a damaging impact on the labour market in England and the UK as they are worldwide and this damage will lead to poor health and increasing health inequality. While containment measures were applied nationally during March to May and in November, the effects have been unequal. The most damaging impacts have been for young people, low-paid workers, BAME groups, disabled workers, women, part-time workers and the self-employed. Women and minorities occupy critical but often marginalised or poorly valued roles. Some sectors have been particularly affected, including hospitality, non-food retail, leisure, aviation, transport and tourism.

The Coronavirus Job Retention Scheme (CJRS) should continue to be extended as long as the effects of the current (November 2020) and previous COVID-19 lockdowns are having an impact on workers, especially low-income and disadvantaged people working in jobs with low levels of security and protection. COVID-19 has had a disproportionate impact on the youngest and oldest workers. These employees are more likely than middle-aged workers to have lost work or to have been furloughed due to the crisis and have experienced the biggest loss in earnings.

High rates of people from Bangladeshi and Pakistani backgrounds work in shutdown sectors and/or are self-employed, and this is combined with a high prevalence of single-earner households, which reduces the potential for income buffers within the household. Key worker employment in other minority groups reduces their risk of income losses, while leaving them at a heightened risk of exposure to the virus itself. Both scenarios, though, are in part a consequence of the way the current labour market draws on both immigrant and ethnic minority workers to fulfil roles in care, transport and delivery sectors and in the more marginal hospitality and self-employed sectors.

BOX 5.4. BUILD BACK FAIRER: RECOMMENDATIONS FOR CREATING FAIR EMPLOYMENT AND GOOD WORK FOR ALL

LONG TERM

- Establish a national goal so that everyone in full time work receives a wage that prevents poverty and enables them to live a healthy life.
- The social safety net must be sufficient such that people not in full time work receive a minimum income for healthy living
- Engage in a national discussion on the balance of the work-life balance including consideration of a four day week.

MEDIUM TERM

- Reduce the high levels of poor-quality work and precarious employment.
- Invest in good quality active labour market policies
- Increase the national living wage to meet the standard of minimum income for healthy living

SHORT TERM

- Provide subsidies or tax relief for firms that recall previously dismissed workers
- Coronavirus Job Retention Scheme to be extended to cover 100% of wages for low income workers
- Enforcement of minimum wages so that the large number of workers who are currently exploited earn their entitlement

CHAPTER 6

ENSURE A HEALTHY STANDARD OF LIVING: COVID 19 CONTAINMENT AND INEQUALITIES

An adequate income is essential for achieving the living standards and control of one's life that are needed for good health and wellbeing (269). Conversely, inadequate income is closely associated with poor health, as it will not be enough to provide the household resources needed to provide healthy living conditions; furthermore, living in poverty is stressful, impacting mental health and making it much more difficult to initiate and maintain healthy behaviours (270). As we summarised in our report *Health Equity in England: The Marmot Review 10 Years On*, "insufficient income is associated with poor long-term physical and mental health and low life expectancy" (1). Household income, unlike household earnings (described in Chapter 5), includes benefits such as Universal Credit and any income from savings and investments, as well as wages.

The impacts of COVID-19 containment measures have increased poverty and debt and the precarious financial situation of large segments of the population. By the end of July 2020, around one in three people reported that they were unable to save for the year ahead (272). Food poverty (see also Chapter 4) has been one of the most visible and immediate effects and reliance on food charities has increased from already high levels (273).

The past decade was marked by stagnant wages, declining benefits and in-work and child poverty increased and there were rapid increases in food poverty. The introduction of the Living Wage was insufficient to prevent increases in rates of in-work poverty and the tax and benefit system, was modified and resulted in widening incomes and wealth inequalities. Incomes for the wealthier people and regions, increased markedly – buoyed by rising house prices and share values, and the relatively low levels of income and other taxes for higher earners.

BOX 6.1. SUMMARY OF INEQUALITIES IN STANDARDS OF LIVING AND INCOME (FROM *10 YEARS ON REPORT*)

- Wage growth has been low since 2010 and wage inequality persists.
- Rates of in-work poverty have increased.
- Incomes have risen slowly and inequalities in income persist.
- Wealth inequalities have increased.
- Regional inequalities in wealth have increased: London and the South of England have increased their share of national wealth compared with the North.
- The number of households with children that do not reach the minimum income standard has increased.
- Food insecurity has increased significantly.
- Social mobility in England has declined.
- Tax and benefit reforms have widened income and wealth inequalities.

This pre-pandemic context relates closely to the effects from COVID-19 containment measures. The groups of people and places which were struggling before the pandemic are the same people and places which are now facing the greatest risk of poverty, and entrenchment of persistent poverty. The job losses, and falls in earnings have negatively affected household incomes. By the end of July, around one in three people reported that they were unable to save for the year ahead (272). Food poverty has been one of the most visible and immediate effects and reliance on food charity has increased from already high levels (273).

BOX 6.2. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN STANDARDS OF LIVING AND INCOME

- Young people and BAME groups have been most affected by decreases in income.
- Poverty is increasing for children, young people and adults of working age.
- Increases to benefit payments have protected the lowest income quintile (the poorest) from the effect of decreases in wages, but have not benefitted the second quintile to the same extent.
- The two-child limit and the benefit cap are harming families and pushing people into greater poverty.

Whilst the COVID-19 containment measures have had significant economic impacts generally, the level of impact varied between households, related to prior socioeconomic position, region, occupation, age, ethnicity and disability (272). This differential impact has led to further widening of income inequalities and increases in the numbers of people in poverty and debt. There are already increases in poor mental health and there will be a range of longer-term health impacts as a result which will widen existing health inequalities in England.

6.A IMPACT OF COVID-19 CONTAINMENT ON INCOME

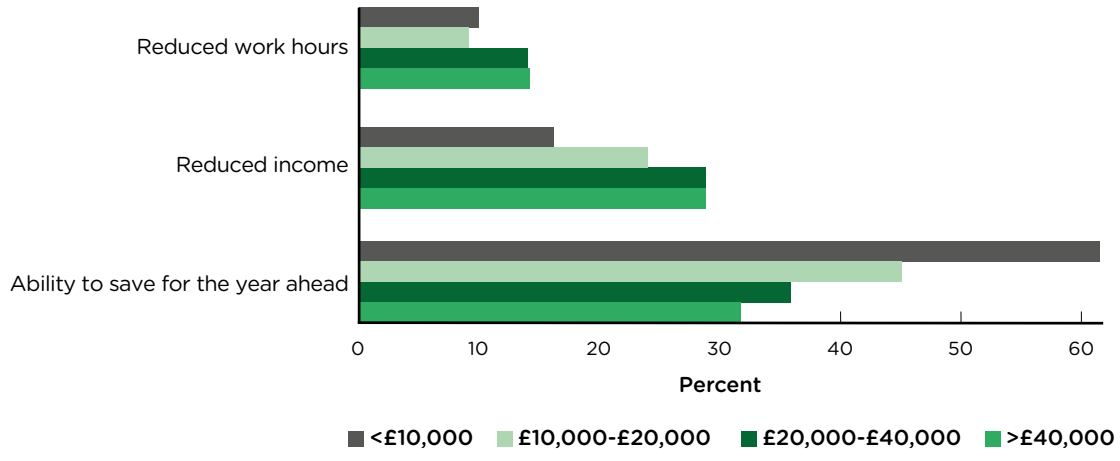
Household income fell in the UK in April 2020, following the outbreak of the pandemic. In Chapter 5 we reported on declines in wages as a result of rising unemployment and furlough, which is part of this picture for low income groups, benefits constitute some, or all of their income. Changes to the benefit system, which we describe further below did reduce the negative impact of the containment measures on the lowest-income groups, but if, as planned, the increases are removed in March 2021, those on the lowest incomes will lose the greatest proportionate reduction in their income. People on a low income but who are not reliant solely on benefits experienced large declines in their income.

The Standard Life Financial Tracker estimated that 3.1 million households (11 per cent of all UK households) were already in serious financial difficulty by April 2020 as a result of falling income and financial problems, many of which predated the pandemic (274). The Office for National Statistics (ONS) Opinions and Lifestyle Survey (COVID-module) was carried out early on in the pandemic (from 3 April to 10 May 2020) and even at that stage nearly one-fifth – 17 percent – of respondents reported reduced income and 7 percent reported using savings to cover living costs (275).

INCOME INEQUALITIES AND SOCIOECONOMIC POSITION

The declines in income since March have been unequal, and lower-income groups have lost a greater proportion of their income from earnings than better-off groups. The ONS Opinions and Lifestyle Survey illustrates how the economic wellbeing of lower-income individuals (those with an income of less than £20,000 per year) has been particularly affected by the pandemic, shown in Figure 6.1 (272). Reduced income clearly has affected individuals' ability to save, also shown in Figure 6.1.

Figure 6.1. Economic wellbeing of individuals by income, between 3 April and 10 May 2020, Great Britain

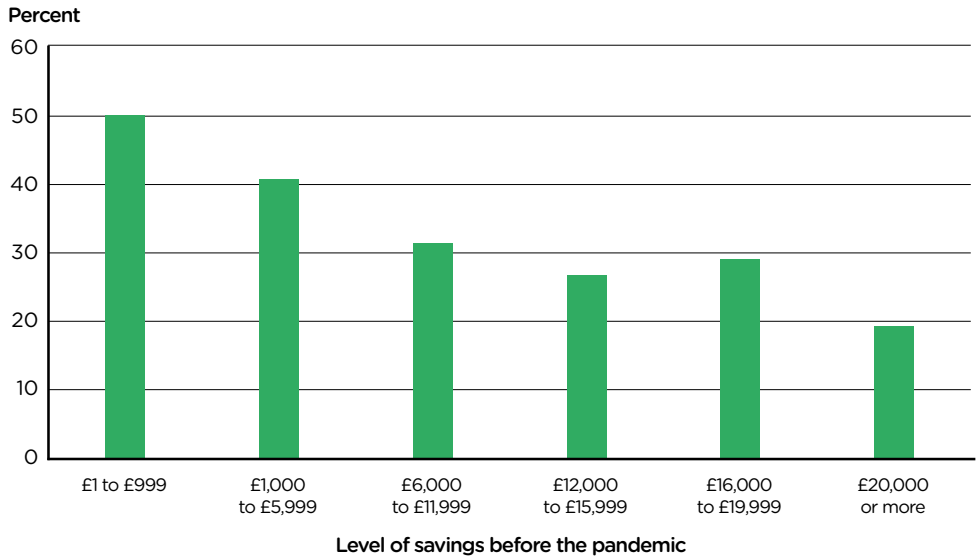


Note: *Income groups based on individual income in £/year.*

Source: *Opinions and Lifestyle Survey (Covid-19 module), 20 March to 07 June 2020 (272).*

One-third of families in the top income quintile saved more than usual in the first two months of the pandemic, whereas lower-income families were more likely to have taken on additional debt, as Figure 6.2 shows. People with lower levels of family savings were more likely to use their savings to cover everyday expenses during the early pandemic (276). This will increase levels of poverty among lower-income families in the immediate and longer term, as savings are eroded, and will further increase wealth inequalities.

Figure 6.2. Percent of respondents who used their savings for everyday spending during the COVID-19 pandemic, by level of savings before the pandemic



Notes: *Base = all UK adults aged 18–65 with any savings in February (n=3,703). Those with no savings, or who did not respond to savings in February question are excluded. Sample size for the subgroups are as follows: £1 to £999, 596; £1,000 to £5,999, 934; £6,000 to £11,999, 500; £12,000 to £15,999, 222; £16,000 to £19,999, 144; £20,000 and more, 1,307. These figures have been analysed independently by the Resolution Foundation.*

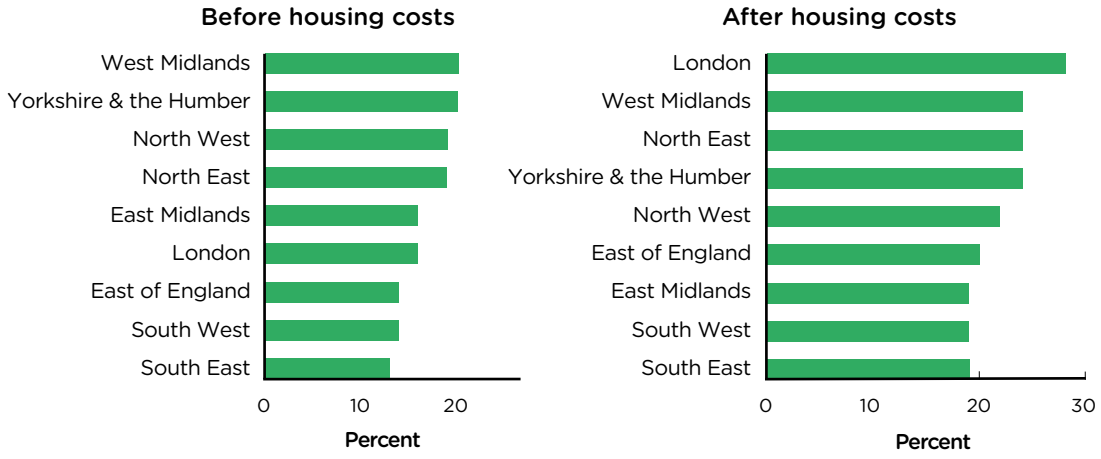
Source: *Resolution Foundation analysis of YouGov, UK Adults Age 18 to 65 and The Coronavirus (COVID-19) – September wave (276)*

REGIONAL INEQUALITIES IN INCOME

In the 10 Years On report we assessed wide and increasing regional inequalities in income and wealth, wealth includes income and assets such as property, stocks and pensions. Between 2006 and 2018, and particularly from 2010 onwards, households in London and the South East rapidly increased their wealth (271). Average household wealth in South East England was 2.6 times the wealth of households in North East England by 2017/18. These regional inequalities have significant long-term impacts on inequalities in health between regions and these will be accelerated by the differing regional employment impacts and differing containment measures in response to COVID-19 enacted in different regions.

The latest data on poverty published by DWP are for 2016/17 to 2018/19 and therefore only reflect poverty levels from before COVID-19 containment. These show that rates of people in relative low income before housing costs (BHC) were highest in the West Midlands and Yorkshire and Humber and were lowest in the South East of England. After taking housing into account, London was the region with the highest levels of poverty owing to the high cost of housing (277), Figure 6.3.

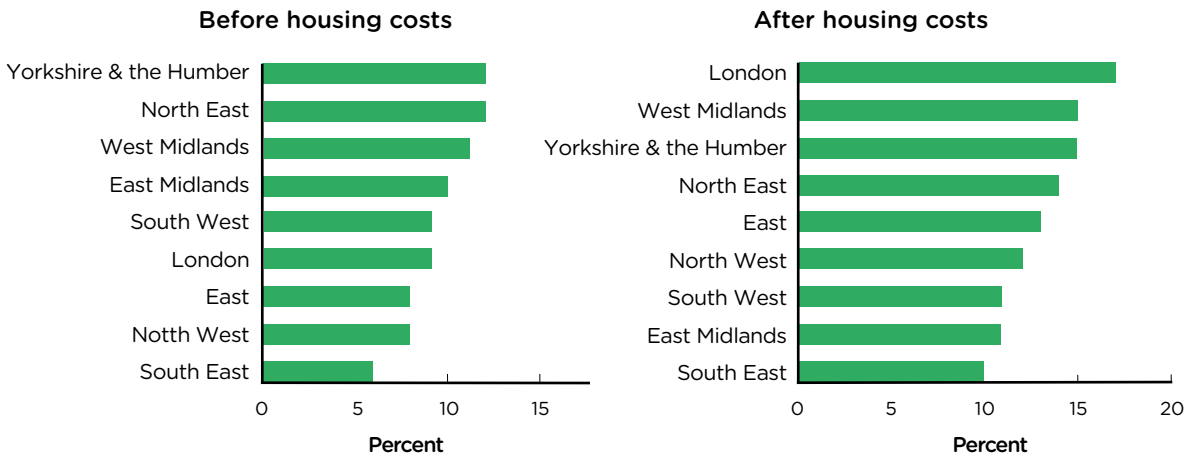
Figure 6.3. Percent of people in relative low income by region/country, 2016/17 to 2018/19



Source: *DWP, Households Below Average Income, 2018/19 (277).*

London is also the area with the highest levels of persistent poverty, after housing costs, and the south east the lowest, Figure 6.4 (277).

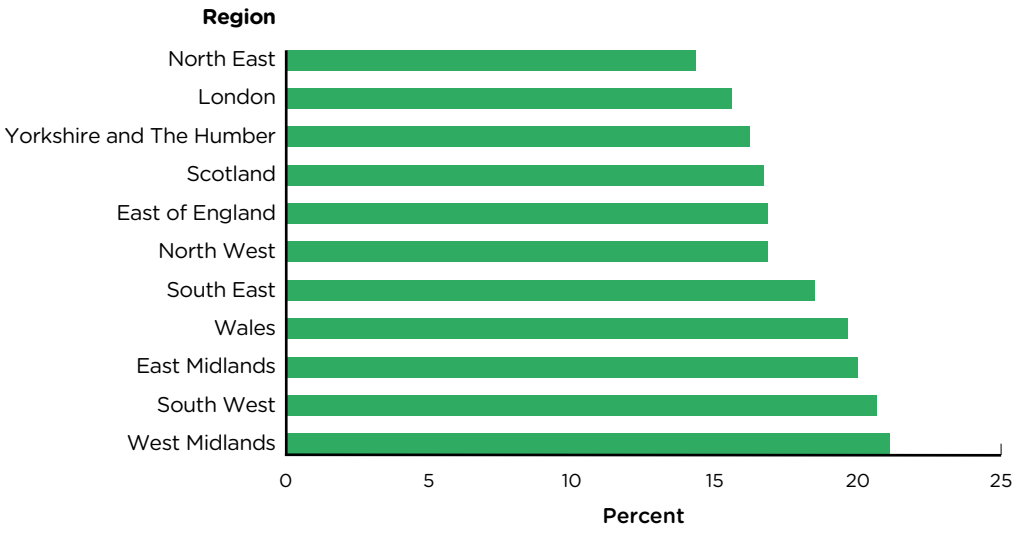
Figure 6.4. Percent of people (all ages) in persistent low income by region/country, 2014/15 to 2017/18



Source: *DWP, Households Below Average Income, 2018/19 (277).*

In the first stage of the pandemic, the highest proportion of people reporting reduced household income was in the West Midlands (21 percent) and the lowest proportion was in the North East of England (14 percent) (Figure 6.5) (275). The North East was relatively protected from income loss, because it already had relatively high numbers of Universal Credit and other benefit recipients who were unaffected by furlough and were relatively well protected due to the government support schemes. However, as support schemes end we expect to see larger declines of income in the North East, London and Yorkshire and Humber.

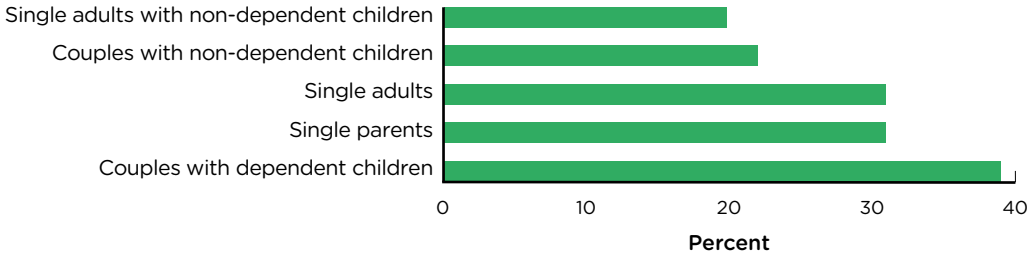
Figure 6.5. Percentage of people reporting reduced household income in the English regions, Scotland and Wales, 3 April to 3 May 2020



Source: *ONS Opinions and Lifestyle Survey (COVID-19 module), 3 April to 3 May 2020 (278).*

A survey by the Step Change debt charity on Coronavirus and personal debt found that by late May particular groups were more adversely affected financially than others by the COVID-19 crisis and containment measures. Those who were aged 18 to 24 were almost twice as likely to have been affected financially as those who were 65 years or older, in chapter 4, we outlined high rates of youth unemployment as a result of the crisis (279). Thirty percent of women reported that their finances had been adversely affected by the COVID-19 crisis, compared with 26 percent of men (279). Families with children have been most affected in Great Britain according to data from this poll, Figure 6.6 (279).

Figure 6.6. Percent reporting their finances had been affected as a result of COVID-19 containment, by family household arrangement, Great Britain, May 2020



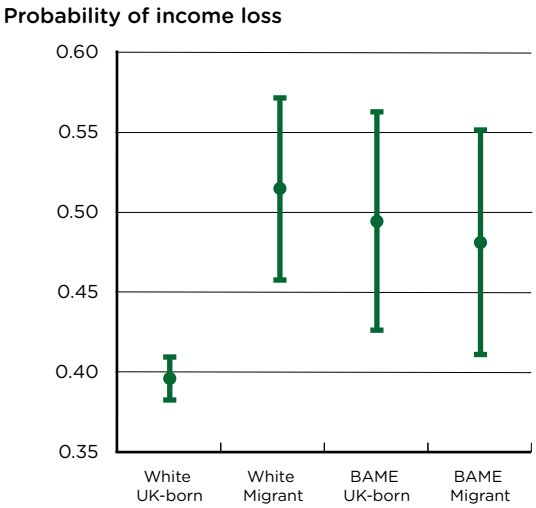
Note: *Finances that had been is defined as being furloughed, a fall in income, a reduction in hours worked, unemployment or redundancy*
Source: *Based on Data from Step Change poll (279).*

IMPACTS ON THE INCOME OF PEOPLE FROM BAME GROUPS

The most recent ONS data on household income by ethnicity, which are from before the pandemic, show that for the three year period between 2015/2016 and 2017/2018, over half of the Pakistani, Bangladeshi, Asian and Black ethnic groups fell into the two lowest-income groups, both before and after housing costs (280). Analysis of data from the pandemic period shows that as low-income groups have lost the greatest share of earnings, and as BAME groups are overrepresented in the low-income groups, it can be assumed they will have experienced disproportionately the largest decrease in earnings. Additionally, given the employment sectors and types of employment that are being most affected by the pandemic, it is likely that BAME groups will again be disproportionately negatively impacted by the economic effects of COVID-19 containment measures as they are over-represented in these sectors (see also Chapter 5).

An analysis conducted by Hu et al. of survey data on COVID-19 from Understanding Society (a UK household longitudinal survey) shows that BAME and migrant groups have been more likely to experience income loss as a result of the pandemic (281) compared with those who are White and born in the UK, as shown in Figure 6.7. The probability of income loss was 1.3 times higher for White migrants and 1.2 times higher for both BAME British nationals and migrants, when compared with White British nationals (281).

Figure 6.7. Predicted probability of income loss due to COVID-19 by ethnicity and migrant status in the UK, during the first lockdown



Source: *Based on the study findings by Hu et al which was based on data from the Understanding Society COVID-19 Survey, 2020 (281).*

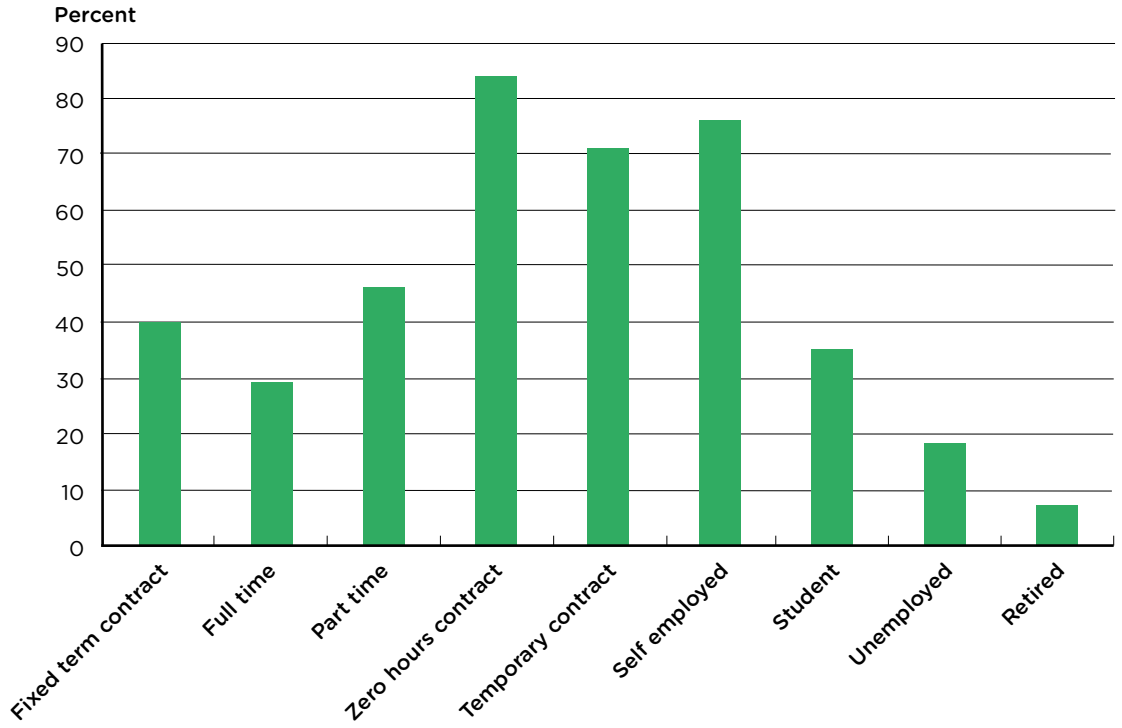
In 2017, the PEW Research Centre estimated that there were between 800,000 and 1.2 million undocumented immigrants in the UK (282). Such workers do not have any access to financial support by the UK government, due to their illegal immigration status.

INCOME LOSS DUE TO FURLOUGH

The lowest-paying jobs, which are often staffed by young people, were more than five times more likely than workers from non shut down sectors to be furloughed with reduced pay (274). These patterns mean that younger workers and those in low-paid and/or insecure work have experienced the greatest losses of income (see Chapter 5).

As shown in Figure 6.8, 84 percent of those working a zero-hours contract, experienced a loss of earnings by late May compared with 40 percent of those with a fixed-term contract (279) Self-employed and zero-hours workers include many households that had been living on low incomes before the effects of COVID-19 containment on inequalities in work and earnings (274).

Figure 6.8. Percent reporting their finances had been affected as a result of COVID-19 containment, by employment category, Great Britain, May 2020



Note: *Finances that had been is defined as being furloughed, a fall in income, a reduction in hours worked, unemployment or redundancy*

Source: *Based on Data from Step Change poll (279).*

6.B COVID-19 CONTAINMENT AND INCOME PROTECTION FROM BENEFITS

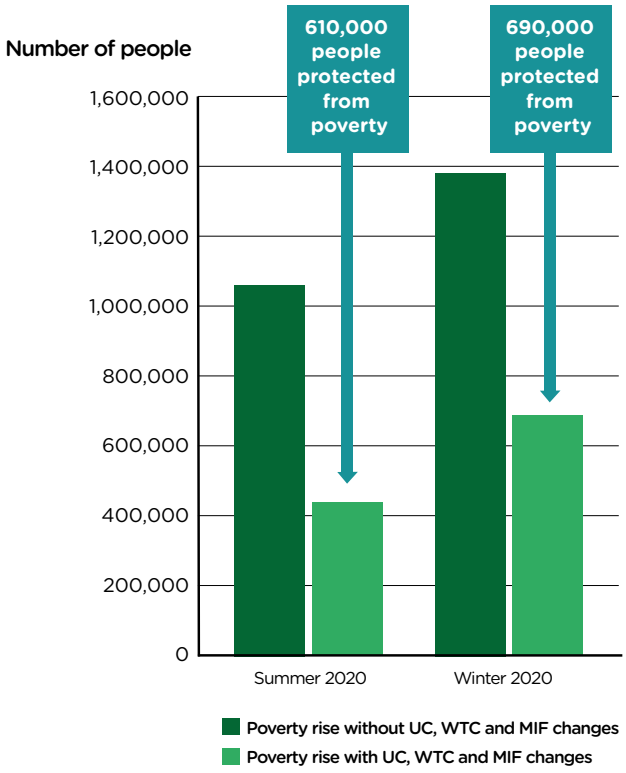
While the pandemic and associated periods of ill health and containment measures have had a significant impact on household incomes, Government support schemes have protected many from falling into poverty. Looking at total incomes rather than just earnings, it is clear that the changes so far have been much more evenly spread than changes in earnings. This is, in the short term, a real achievement. It highlights how important benefits will continue to be while the current crisis persists.

Despite these recent improvements, since 2010 changes to the benefit system, principally the introduction of Universal Credit (UC), the two-child limit – the restriction of the child element in UC and tax credits to the first two children – the benefit cap and changes to tax credits, have significantly and negatively affected low- and middle-income households and children and widened income inequalities. These changes have caused increasing hardship (283) (211). The disproportionate impacts on more deprived families and regions of cuts to local government and reduced support for babies, children and families over the past 10 years were well documented in the 10 Years On report (211).

As well as the furlough scheme, a temporary, £1,040 a year increase to the Employment and Support Allowance – which supports those who are unable to work due to a disability or health condition – was introduced for one year from April 2020. Additionally, local housing allowance rates were increased to the 30th percentile of local rents from April 2020 (284).

To mitigate some of the economic and financial impacts of COVID-19 containment, the Government introduced financial support and benefits for families including a temporary increase of £20 a week to Universal Credit and the suspension the Minimum Income Floor (that applies to self-employed people claiming Universal Credit). The Legatum Institute estimate that these policies have protected some 690,000 people from poverty in winter 2020, as shown in Figure 6.9 (285).

Figure 6.9 Number of people in poverty in summer and winter 2020, compared to pre-COVID-19, with and without increased generosity in Universal Credit and Working Tax Credit and the suspension of the Minimum Income Floor in Universal Credit

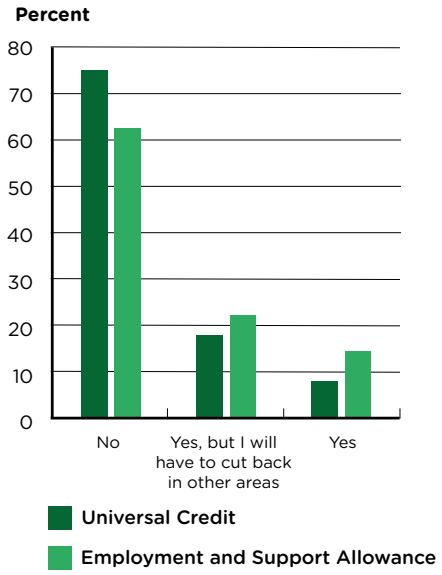


Notes: *Summer 2020 scenario is the Legatum Institute 5.8 percent unemployment rate scenario. Winter 2020 is the Legatum Institute 7.5 percent unemployment rate scenario*

Source: *Legatum Institute, Family Resources Survey and HBAI dataset (1998/99 – 2018/19), IPPR tax and benefit model (285).*

A survey conducted by the House of Commons Work and Pensions Select Committee between 8 and 15 April 2020 found that 44 percent of respondents were claiming UC because of the COVID-19 outbreak (286). However, 75 percent of survey respondents did not think that the UC money would be enough to cover their basic living costs and 63 percent of those claiming Employment and Support Allowance thought the same; see Figure 6.10 (286).

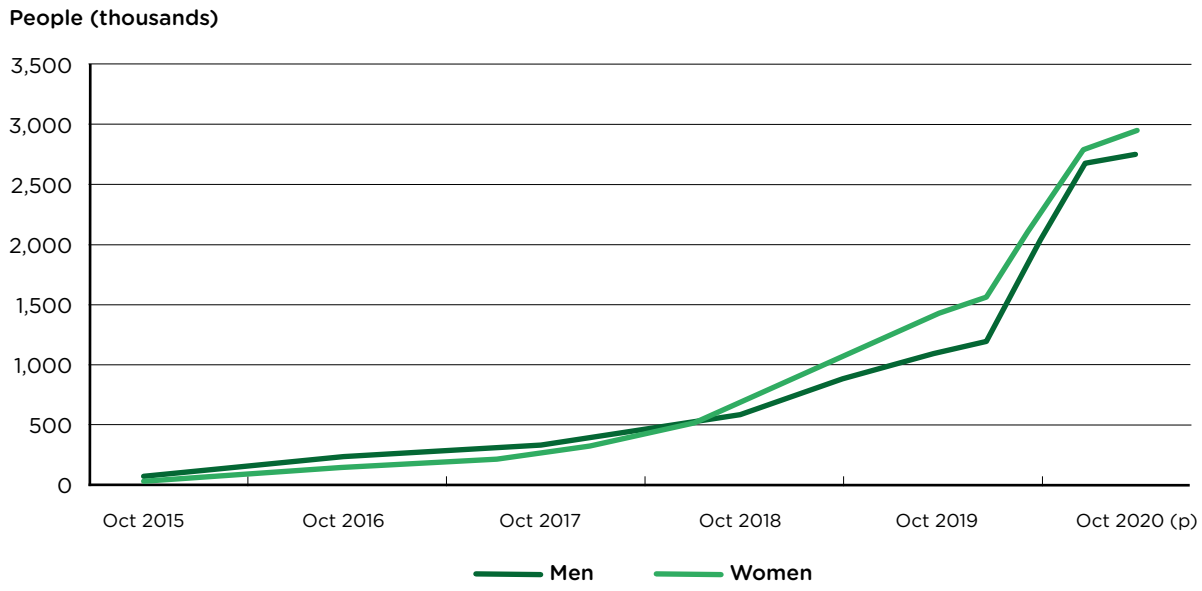
Figure 6.10. Percent of people responding to whether Universal Credit (UC) and the Employment and Support Allowance (ESA) are enough to cover basic living costs among recipients, as reported between 8 and 15 April 2020



Source: *Based on data from House of Commons Work and Pensions Committee survey (286).*

UC claims increased as a result of COVID-19 containment were nine times higher than the usual number made per week in the first two weeks of the lockdown that began in March (287), Figure 6.11. 5.7 million people were receiving UC at 8 October 2020 – of these, 3.6 million were starting claims (284).

Figure 6.11. Number of people receiving Universal Credit between October 2015 and October 2020, by sex, UK



Note: *'(p) October 2020' is a provisional figure.*

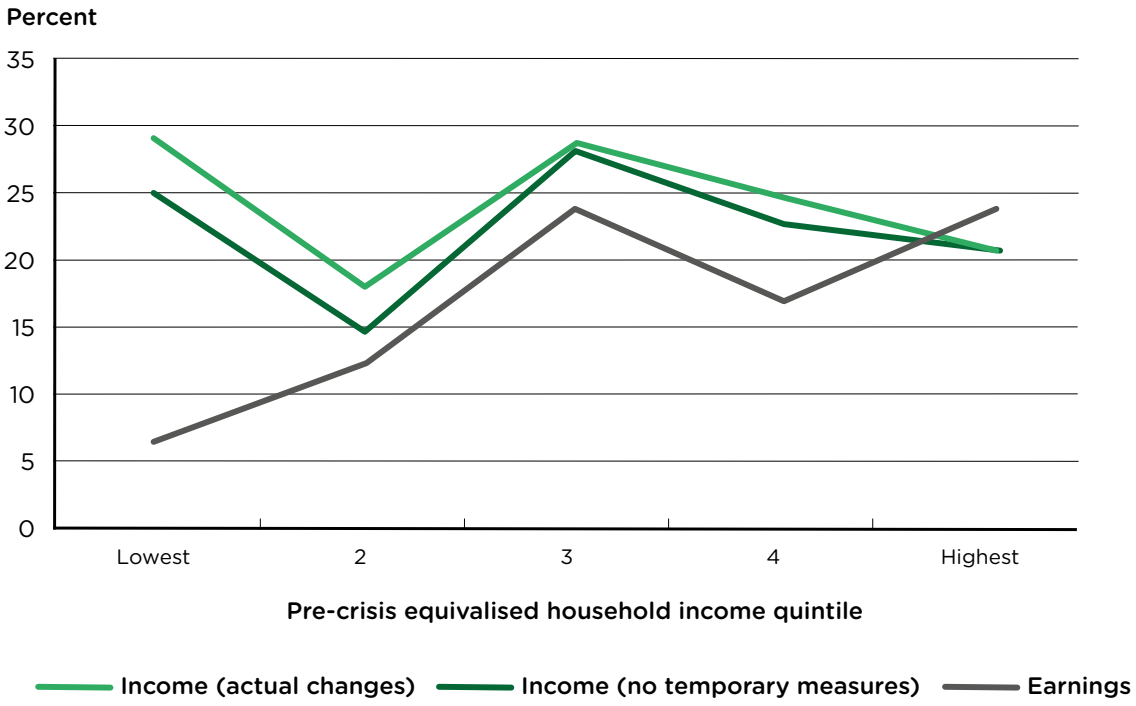
Source: *Department for Work and Pensions Universal Credit Statistics (284).*

There have been regional differences in the growth of the number of people receiving UC during the pandemic. The greatest growth was in London (119 percent), the South East (109 percent) and the East of England (102 percent) between 12 March and 8 October 2020, more than doubling the number of people receiving UC in those regions. The North East has seen the smallest growth (62 percent) followed by the North West (284), because there were already relatively high numbers of claimants in these regions.

New claimants to UC since the beginning of COVID-19 containment include an above-average proportion of households where the main or secondary earner was either self-employed (16 per cent) or worked in the gig economy (11 per cent) during February, their temporary and insecure job stats made them particularly vulnerable to closure of job sectors due to containment and their exposure will continjue to be high during the economic downturn.

Analysis conducted by Bourquin et al. of the UK Household Longitudinal Study data waves 7–9, up until April 2020 (250), shows how much the lowest-income quintile had been protected from earnings losses due to the changes in UC, housing benefits and working tax credits brought in by the Government in March 2020. The lowest-income quintile had the highest decreases in earnings over the period from March to April, a reduction of nearly 20 percent, but had their income protected through benefits so that loss of income was reduced to 4 percent. The benefit changes have not helped the second-lowest-income quintile so much and they experienced the greatest decline in income, down more than 12 percent, with the benefit increases from March only affording them a three percent improvement (250). This highlights the importance of using the benefit system to support the income of at least the bottom three income quintiles. A more progressive and proportionate benefit system, without cliff edges in entitlements, would prevent many more people experiencing a collapse in household income associated with the reductions in earnings from the pandemic (see Figure 6.12).

Figure 6.12. Change in median net equivalised household income and earnings between January/February 2020 and April 2020 in the UK, by equivalised household income and earnings



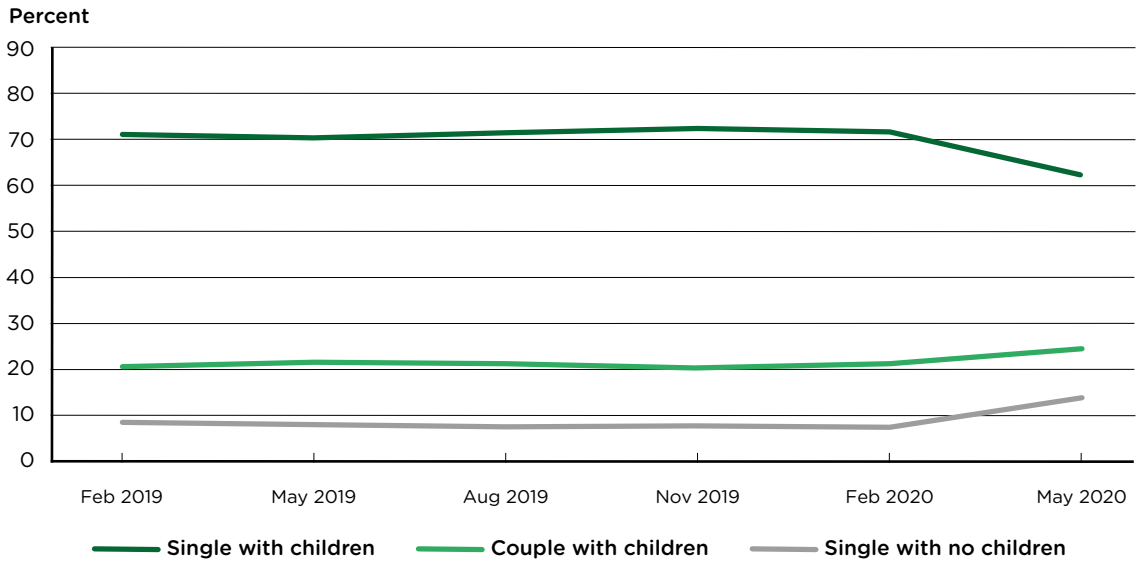
Note: *The 'no temporary measures' refers to the income changes that would have been without the temporary expansion of certain benefits, including Universal Credit, in March 2020.*

Source: *Understanding Society COVID-19 Study 2020 and Understanding Society (UKHLS) waves 7-9, as reported on in a report by Bourquin et al. (2020) (250).*

While Government support schemes have played an important role in protecting incomes and businesses across the UK during the pandemic (288), there are important and significant limitations. These include those experienced by people in the second-lowest income quintile who were less protected by the benefit changes, described earlier and for low income workers, who are in receipt of CJRS and receiving 80 percent of their pre-pandemic incomes –which is simply insufficient to cover costs for low income workers. A further limitation is that the benefit cap (described below) keeps levels of benefit too low to cover many reasonable household costs and meet minimum income standards for an increasing number of families.

In August 2020, the Department for Work and Pensions (DWP) published statistics on the number of households affected by the benefit cap in May 2020 (289). The benefit cap limits the financial support available to households who are not working or not considered to be working sufficient hours, to £20,000 a year outside of London or £23,000 a year in London. The number of households that had their benefits capped increased by 93 percent between February and May 2020 to 154,000 households (289). This is the biggest increase in the number of capped households since April 2013 and has been driven by an unprecedented increase in the number of new UC households (290) (291). Sixty-two per cent or 96,000 households that had their benefits capped in May 2020 were single-parent families (Figure 6.13) (291). Capping benefits during the pandemic is leading to much higher levels of poverty, including food poverty and inability to pay rent.

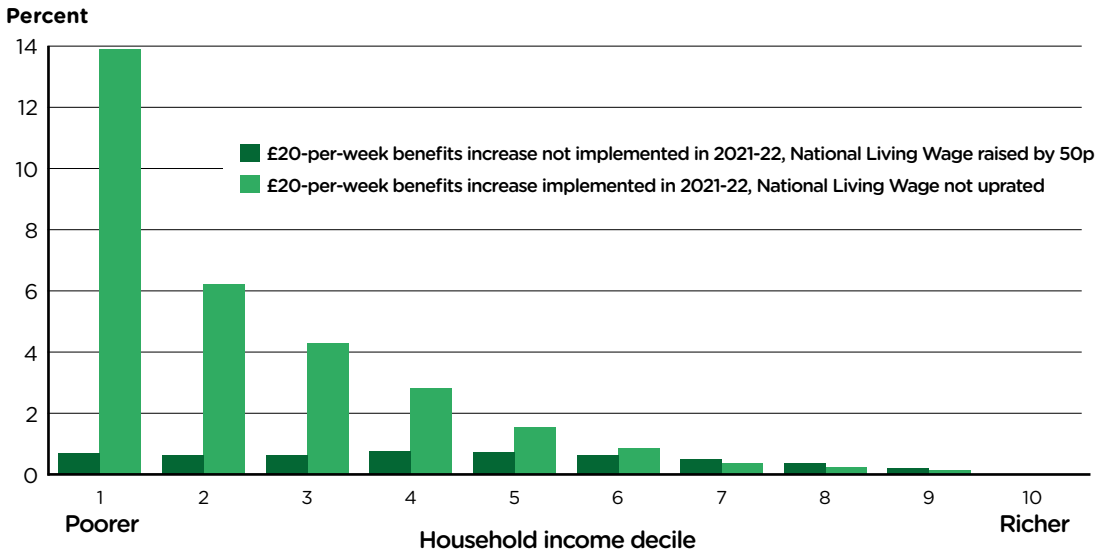
Figure 6.13. Percent of households with benefits capped, by family type, from February 2019 to May 2020, UK



Source: *Department for Work and Pensions, 2020 (291).*

Maintaining the £20-per-week benefits increase to Universal Credit, introduced earlier this year would provide a much bigger boost to low-income households than any plausible minimum wage uprating. Figure 6.14 shows that the difference between these two policies for the poorest deciles is clear under a scenario where the £20-per-week increase to benefits is not maintained in 2021–22 (292).

Figure 6.14. Change in net household income under two scenarios, by household income decile in the UK, 2021–22



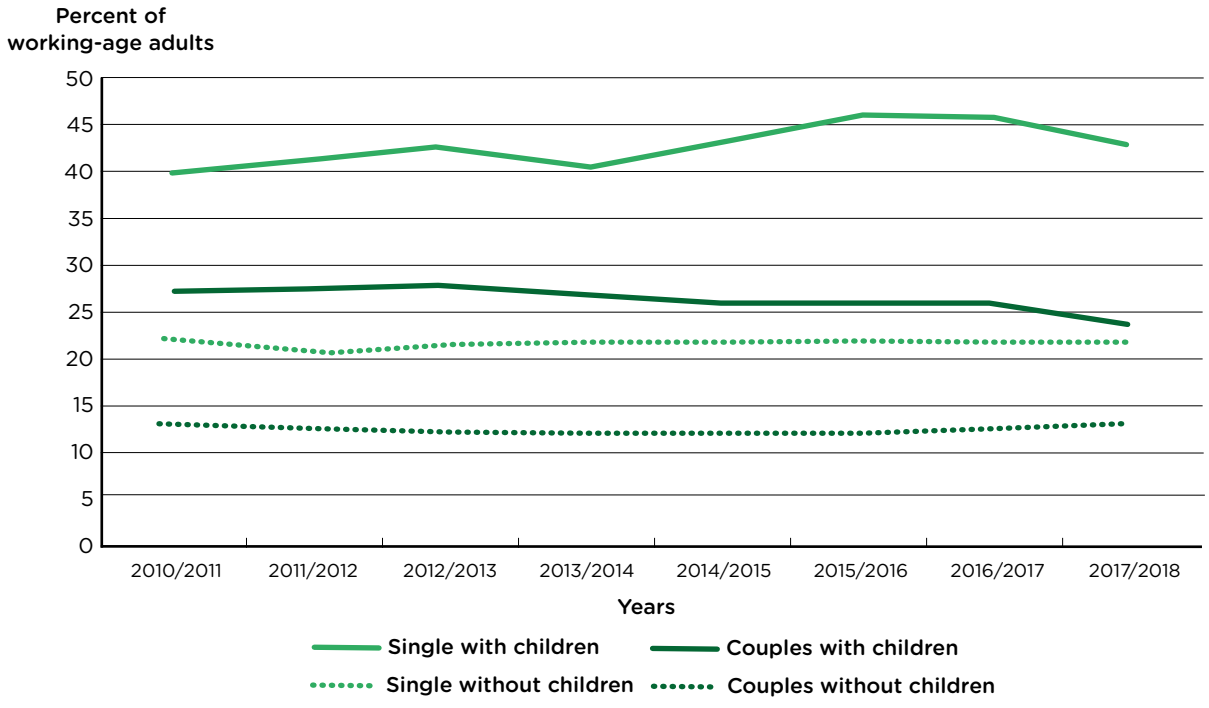
Notes: *Income distribution covers households of all ages. Assumes full take-up of benefits and full roll-out of Universal Credit. Increase in national living wage assumed to have spill-over effects to 30th earnings percentile.*

Source: *Resolution Foundation modelling using IPPR tax benefit model (292).*

6.C IMPACT OF COVID-19 CONTAINMENT ON POVERTY AMONG FAMILIES AND CHILDREN

Before the pandemic, low wages, benefit cuts and the growth of part-time and insecure work led to increased rates of in-work poverty, as shown in Figure 6.15. Rates of single working-age adults with children living in poverty increased by six percentage points between 2010/11 and 2015/16, declining slightly to 43 percent in 2017/18. The percentof single working-age adults with children in poverty was more than three times that of couples without children in 2017/18.

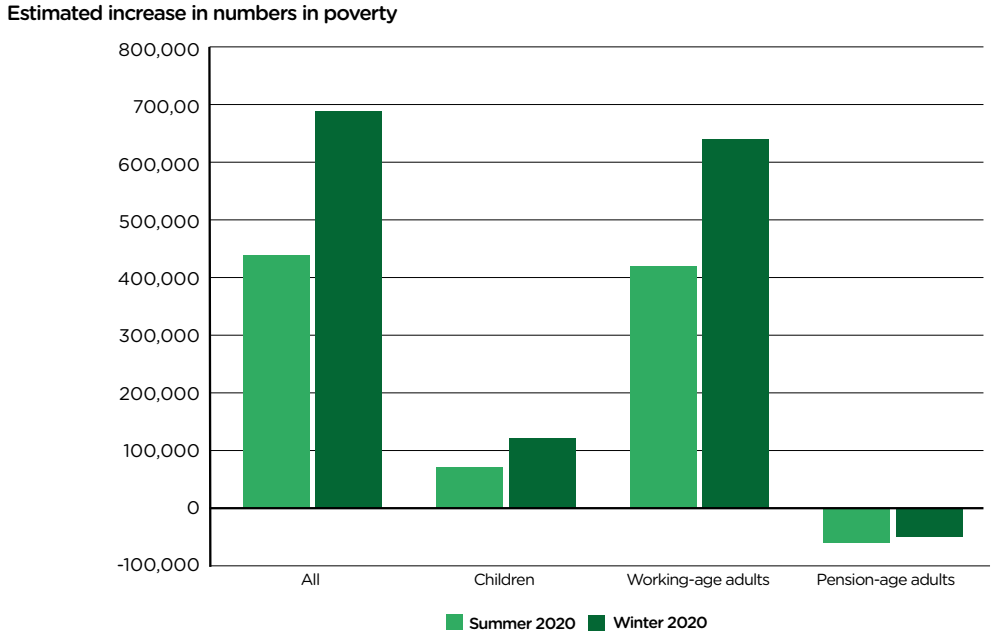
Figure 6.15. Percent of working-age adults living in households with less than 60 percent of contemporary median household income, after housing costs, by family type, UK, 2010/11 to 2017/18



Source: *IHE analysis of Department for Work and Pensions data, 2020 (211).*

The latest data on poverty from the Department for Work and Pensions (DWP) are for 2018/19, data for 2019/20 is due to be released possibly in March 2021. However, the Legatum Institute have calculated poverty using data on employment, earnings and Government policy (including the Coronavirus Job Retention Scheme and its likely distribution amongst different groups of employees), along with a range of assumptions to model the likely level and distribution of poverty in Summer 2020 and Winter 2020 (285). According to this analysis, poverty has risen as a result of the COVID-19 crisis. Figure 6.16 shows changes in numbers of those in poverty for children, working-age adults and pension-age people compared with before the pandemic. Pensioners have seen the lowest increases in poverty, protected by pensions (285).

Figure 6.16. Changes in number of those in poverty in summer and winter 2020, compared with pre-COVID-19, UK



Notes: *The report presents the results of a 'nowcasting' exercise using the most up-to-date data on employment, earnings, and Government policy available, along with a range of assumptions in November 2020, to model the likely level and distribution of poverty in both Summer and Winter 2020. Summer 2020 scenario is the Legatum Institute 5.8 percent unemployment rate scenario. Winter 2020 is the Legatum Institute 7.5 percent unemployment rate scenario. Fall in poverty for pension-age adults is a result of a small reduction in the poverty line due to the median of Total Resources Available falling. Sum of elements may not match totals, due to rounding.*

Source: *Legatum Institute, Family Resources Survey and HBAI dataset (1998/99 – 2018/19), IPPR tax and benefit model (285).*

Analysis by the Institute for Public Policy Research (IPPR) show that at the end of 2020 it is plausible that for over one million more people, including 200,000 children, household income will be below 60 percent of equivalised household income, with unemployment at 9.8 percent, compared with a situation where the pandemic had not occurred (293); see Table 6.1.

Table 6.1. Estimates of additional numbers as a result of COVID-19 having a household income below 60 percent of equivalised household income at the end of 2020

	Assumed unemployment rate	Assumed percent of private sector workers experiencing reduction in hours	Additional children under pre- COVID-19 poverty line	Additional adults under pre-COVID-19 poverty line
Low scenario	9.8	0	100,000	600,000
Central scenario	9.8	10	200,000	1,100,000
High scenario	9.8	25	300,000	1,700,000

Note: *"Having a household income below 60 percent of equivalised household income (adjusting for the composition of the household as is standard in income analysis), had the pandemic not occurred" (293).*

Source: *Parkes H, McNeil C. Estimating poverty impacts of Coronavirus, 2020 (293).*

Poverty depth has also increased compared with before COVID-19 containment, in the UK. 270,000 more people are in the deepest form of poverty (50%+ below the poverty line) and the number of people that are 25-50% below the poverty line has increased by 160,000. The highest increase has been for those that are 0-25% below the poverty line, 370,000 more than pre-pandemic levels (285).

IMPACT OF COVID-19 CONTAINMENT ON POVERTY AMONG BAME GROUPS

As described in the 10 Years On report (211), there are wide variations in poverty rates in England by ethnic group. In 2018, 33 percent of people living in households headed by someone of Bangladeshi ethnic origin were in the most deprived quintile compared with 15 percent of the White population, for example. Table 6.2, with data from before the pandemic, describes high rates of poverty for Bangladeshi, Pakistani and Black people in particular, but all minority ethnic groups had higher rates of poverty than White groups, with housing costs raising poverty rates considerably.

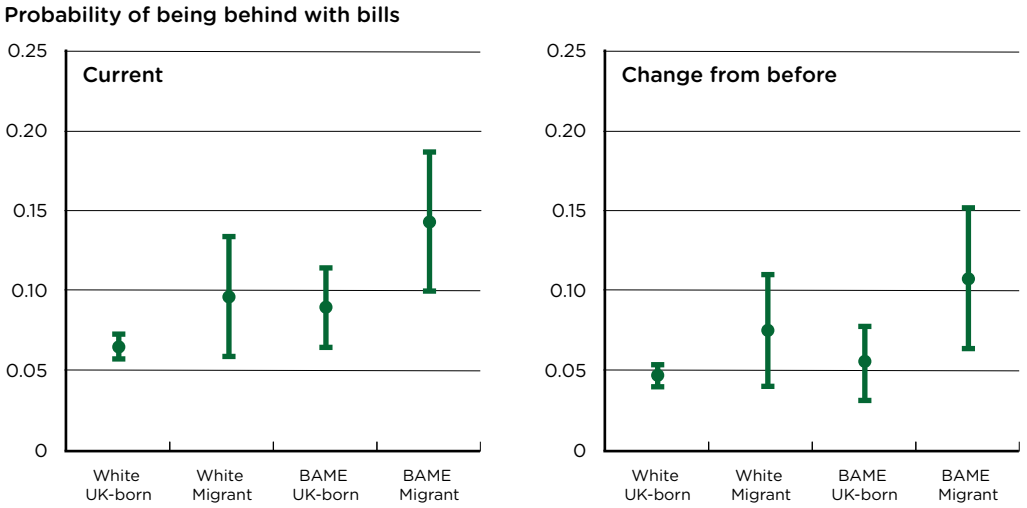
Table 6.2. Percent of individuals living with less than 60 percent of contemporary median household income, by ethnic background of household head, UK, 2016–18 (three-year average)

	Before housing costs	After housing costs
White	15	20
Asian/Asian British	26	36
Indian	17	23
Pakistani	39	46
Bangladeshi	33	50
Chinese	26	33
Black/African/Caribbean/Black British	27	42

Source: *IHE, Health Equity in England: The Marmot Review 10 Years On, based on Department for Work and Pensions, 2020 (271) (294).*

Figure 6.17 shows that BAME migrants were 2.2 times more likely to report being behind with their bills than their White non-migrant counterparts during the first COVID-19 lockdown and 2.3 times more likely to experience an increase in the level of difficulty of keeping up to date with their bills during the pandemic compared with before.

Figure 6.17. Probability of falling behind with bills (A) and the increase in the difficulty of keeping up with bills during the first COVID-19 lockdown compared with before the pandemic (B), by ethnic group, UK

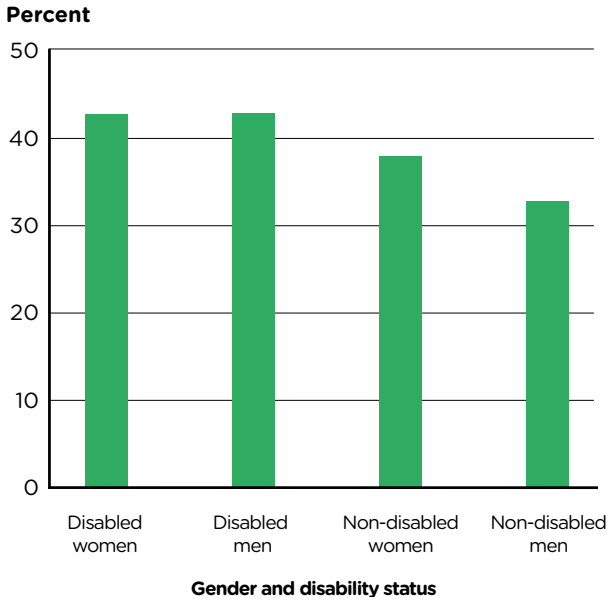


Source: *Based on the study findings by Hu et al. which was based on data from the Understanding Society COVID-19 Survey, 2020 (281).*

IMPACT OF COVID-19 CONTAINMENT ON POVERTY AMONG PEOPLE WITH DISABILITIES

A survey of 3,280 individuals in the UK, conducted by Survation on behalf of the Fawcett Society between 15 and 21 April 2020, included 678 persons with a disability (295). The results suggest that disabled people were more financially affected by containment measures than non-disabled people: 43 percent of both disabled men and disabled women agreed that the COVID-19 pandemic would put them in more debt than they were before, compared with 38 percent of non-disabled women and 33 percent of non-disabled men – Figure 6.18 (295).

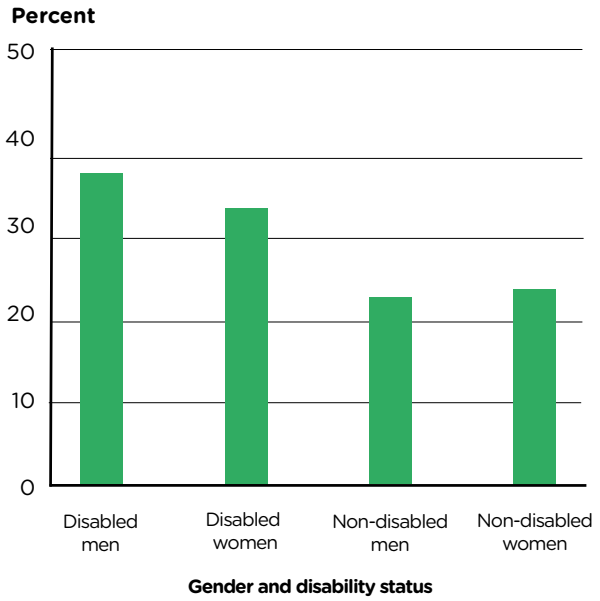
Figure 6.18. Percent who agreed in a survey in the UK between 15 and 21 April 2020 that the COVID-19 pandemic would put them in more debt than before, by gender and disability status



Source: *Based on data collected by Survation on behalf of the Fawcett Society (15-21 April 2020) (295).*

A higher proportion of both disabled men and women than non-disabled people reported that their household had nearly run out of money: 38 percent and 34 percent, respectively, compared with 23 percent of non-disabled men and 24 percent of non-disabled women – Figure 6.19 (295).

Figure 6.19. Percent who reported that their household had nearly run out of money when surveyed between 15 and 21 April 2020, by gender and disability status, UK

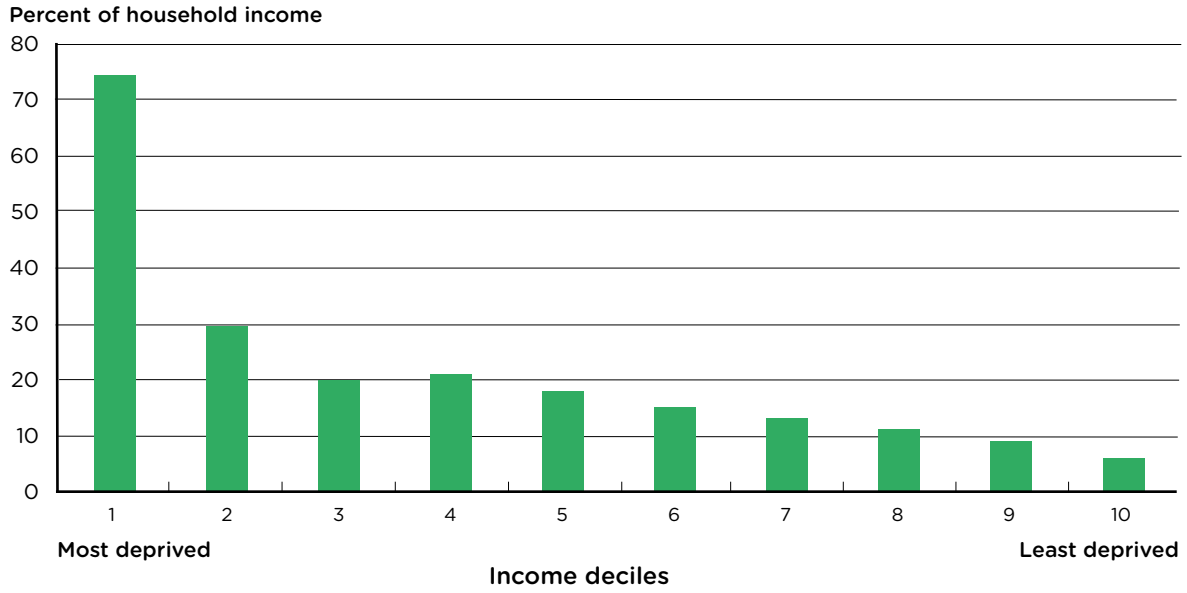


Source: *Based on data collected by Survation on behalf of the Fawcett Society (15-21 April 2020) (295).*

IMPACT OF COVID-19 ON FOOD INSECURITY

Our 10 Years On report outlined that the inability to access affordable and nutritious food, known as food insecurity, is one of the most immediate impacts of poverty (271). Prior to the pandemic, food insecurity was already of significant concern in the UK. For example, a study conducted in 2019 commissioned by the Trussell Trust found that an estimated eight to 10 percent of households in the UK had experienced either moderate or severe food insecurity between 2016 and 2018 (296). The 10 Years On report showed that the poorest 10 percent of English households would need to spend close to three-quarters of their disposable income on food to adhere to the guidelines in the NHS's Eatwell Guide, compared with only 6 percent of income for households in the richest decile (Figure 6.20) (237) (271).

Figure 6.20. Percent of disposable income (after housing costs) used if the Eatwell Guide recommended diet cost was spent by all households in England, by income decile, 2016/17

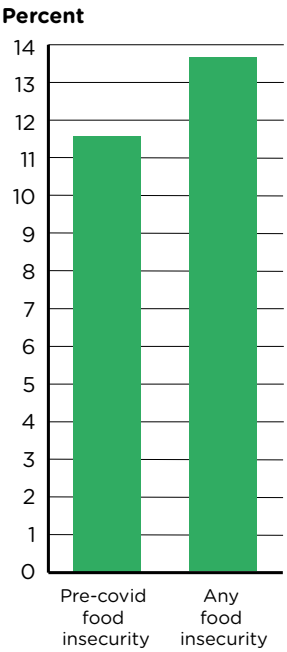


Source: *Food Foundation, 2018 (297).*

The results of surveys conducted during the pandemic suggest that these pre-existing levels of food insecurity have increased further, driven by decreases in and loss of wages, coupled with physical difficulties in obtaining food for those who have needed to self-isolate and increasing demands on households to provide meals during lockdowns and self-isolation. Sosenko et al. indicated that living alone, being a renter, or living in a household which is affected by poor health are all risk factors for food insecurity (296) and a study by Loopstra also found that unemployment, low income and disability were associated with severe food insecurity among adults with children (298). All of these groups have increased in size through the pandemic.

During March to August 2020, 4 million people in households with children, including 2.3 million children, and 14 percent of parents and guardians overall, experienced food insecurity (Figure 6.21). This compares to pre-COVID-19 levels of food insecurity of 12 percent among households with children (174). Campaigns by Marcus Rashford and others have successfully, if temporarily, sought to reduce the problems (299), as described in Chapter 3.

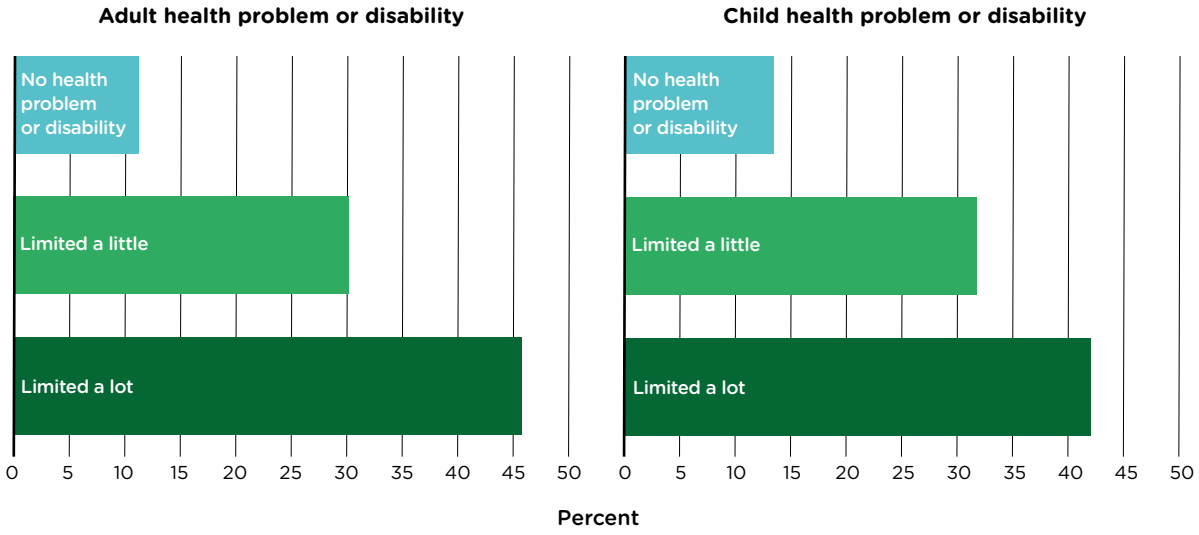
Figure 6.21. Adult food insecurity in households with children, March to August 2020, UK



Source: *The Food Foundation (174).*

Households where either a child or adult has a health problem or disability are at much higher risk of food insecurity and more needs to be done to support these groups, as shown in Figure 6.22.

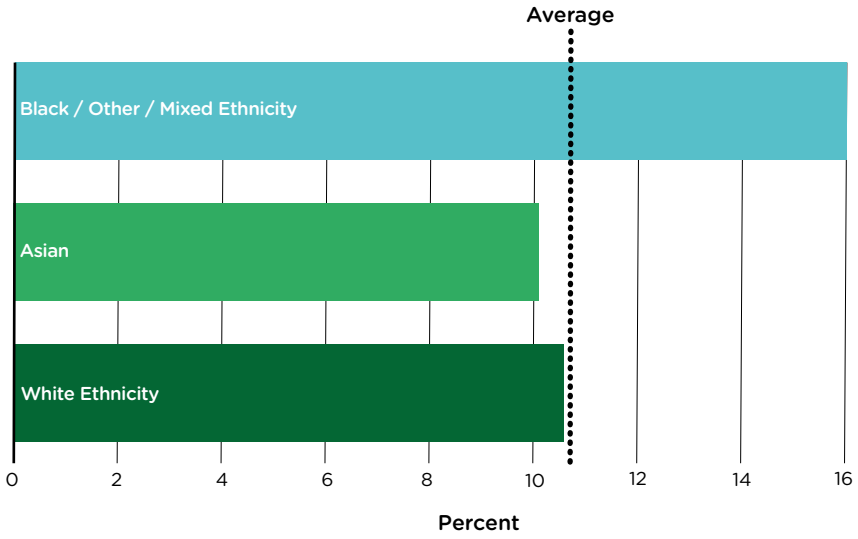
Figure 6.22. Percent of households with children experiencing adult and/or child food insecurity, by limiting health problem or disability, March to August 2020, UK



Source: *The Food Foundation (174).*

During March August 2020, the prevalence of food insecurity in Black and mixed ethnicity households with children was 50 percent higher than in White ethnicity households with children – Figure 6.23 (174).

Figure 6.23. Food insecurity in households with children, by ethnicity March to August 2020, UK



Source: *Based on data from a YouGov survey (14-17 May 2020) commissioned by The Food Foundation (174).*

People who rent their home have also been identified as a group who are vulnerable to food insecurity as a result of the financial impacts of the pandemic. Recent polling has found that six in 10 renters have suffered financially because of the crisis. Of these, one in five had been forced to choose between rent and food or bills, and one in four had felt compelled to leave their home (300).

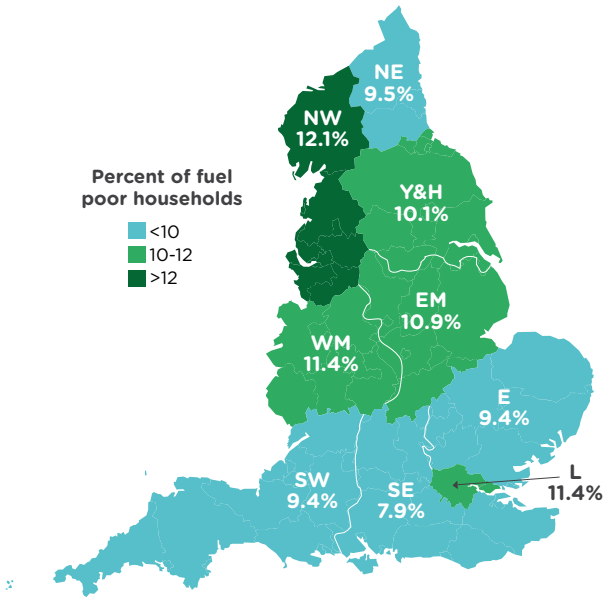
IMPACT OF COVID-19 ON FUEL POVERTY

Fuel poverty in England is measured using the Low Income High Costs (LIHC) indicator. Under the LIHC indicator, a household is considered to be fuel poor if they were to spend the national median level on household fuel they would be left with a residual income below the official poverty line. There are three important elements in determining whether a household is fuel poor: household income, property size, household energy requirements and fuel prices (301).

In 2019 at least 2.4 million households in England were in fuel poverty, affecting 10 percent of the population. In 2018, the average fuel poverty gap (the reduction in the annual fuel bill that the average fuel-poor household needs in order to not be classed as fuel-poor) in England was estimated at £334, a slight increase from £328 in 2017 (301).

The North West has the highest prevalence of fuel poverty at 12.1 per cent, compared to 7.9 per cent in the South East (302), shown in Figure 6.24.

Figure 6.24 Percent of fuel poor households by region, England, 2018



Source: *Department for Business, Energy and Industrial Strategy, 2020 (302).*

Over 200,000 more households are predicted to experience fuel poverty as a result of COVID-19 containment measures, according to new estimates by the End Fuel Poverty Coalition. This is based on an assumption that unemployment rises to affect 1.17 million households in total, and the pre-existing proportion of fuel poverty in households with an unemployed household person remains at 30 percent. Many other households are likely to be forced into fuel poverty due to both reduced income and higher fuel bills arising from fewer working hours and spending more time in the home (303) (304).

Three-quarters of frontline organisations are concerned that there is a high risk that fuel debt will increase this winter as a direct result of the pandemic, while 98 percent believe that there is a moderate or high risk of more households cutting back on their energy use due to lockdown measures (305). One in three British households is concerned about the health impacts of living in a cold home this winter and poor health associated with cold homes is likely to increase and contribute to widening inequalities in health for 2021 and beyond if mitigating measures are not undertaken (305) (306).

Due to the lockdowns, the rate of smart meter/ECO installation has slowed down. The Department for Business, Energy and Industrial Strategy shows that ECO installations fell sharply in April and May compared with March, by more than 55 percent, meaning that almost 30,000 fewer measures were installed in fuel-poor and vulnerable households than expected (304).

An advice organisation in London for private renters, Advice4Renters, has reported that if the Government delivers its full manifesto pledge to invest £9.2 billion in building energy efficiency, extend the Warm Home Discount and introduce wider Home Upgrade Grants, this will help towards reducing fuel poverty. Fuel Poverty Action stated that Introducing a Fuel Poverty Debt Relief, not deferral of payment, programme would ensure fewer people will have to choose between heating and eating (303).

6.D IMPACT OF COVID-19 ON DEBT

The changes to many households' incomes as a result of the pandemic are likely to push many more people into debt and poverty. Figure 6.25 shows trends in the percent of households with financial debt by English region. In 2018, the North East, East Midlands, Yorkshire and the Humber and the North West had the highest rates of households with financial debt, while levels of debt in London declined throughout the period described.

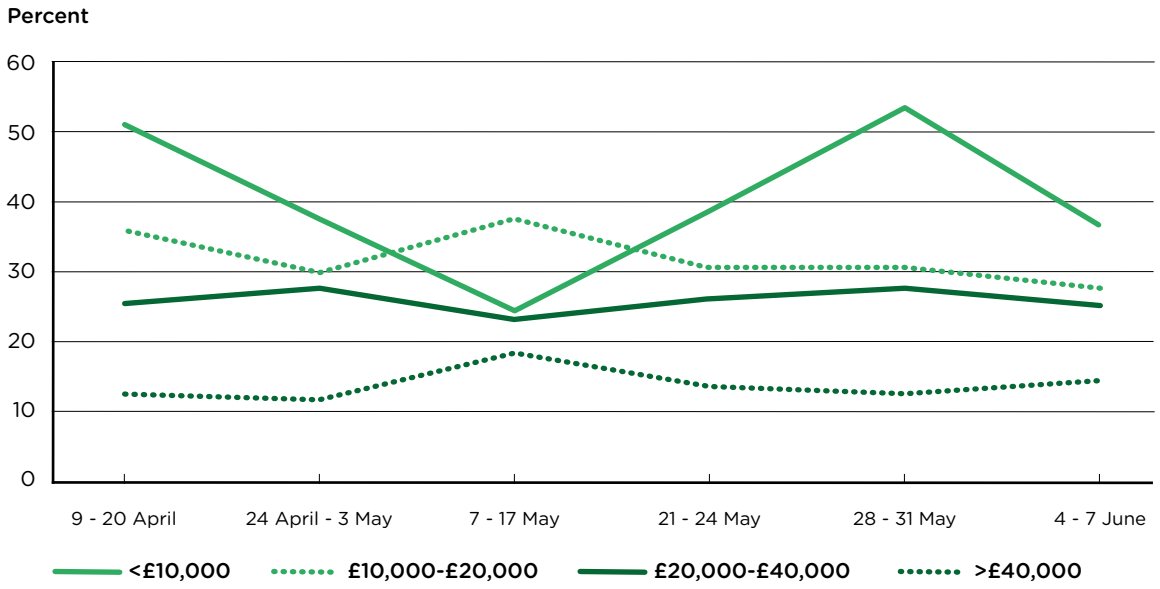
Figure 6.25. Percent of households in financial debt, by region, 2010–18, England

Source: *IHE analysis of Department for Work and Pensions data, 2020 (211).*

The Step Change debt charity has outlined that, even prior to the outbreak of COVID-19, in December 2019, there were 3.2 million people in the UK who had severe debt problems and 9.8 million who were exhibiting signs of financial distress (279). Given the impacts that COVID-19 has had on household income, there is highly likely to be a further increase in the number of people experiencing debt problems. Prolonged financial problems can have knock-on effects, including declines in living standards, increased housing and food insecurity and greater mental stress, which can have potential adverse psychological impacts including anxiety and depression (279) (307). Citizens Advice estimates that 6 million adults in the UK have fallen behind on at least one household bill since the outbreak of the pandemic (250).

Between 9 April and 7 June, a much higher proportion of people in lower earnings brackets than in higher brackets said they would have not been able to pay a one-off necessary expense of £850, as shown in Figure 6.26 (272).

Figure 6.26. Percent of individuals in the UK reporting inability to afford a one-off expense of £850 in the last 7 days prior to survey, by income group, recorded between 9 April 2020 and 7 June 2020

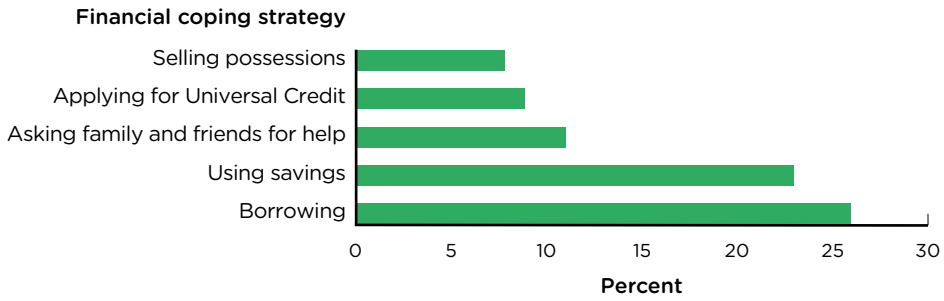


Note: *Income groups based on individual income in £/year.*

Source: *Opinions and Lifestyle Survey (COVID-19 module), 20 March to 7 June 2020 (272).*

Step Change found that in May 2020, borrowing money was the most common coping strategy among those whose finances had been adversely affected by the pandemic in the UK, with 26 percent of those adversely affected using this strategy – Figure 6.27 (279). As of 19 May 2020, the estimated average amount borrowed by adversely affected households was £997 (279).

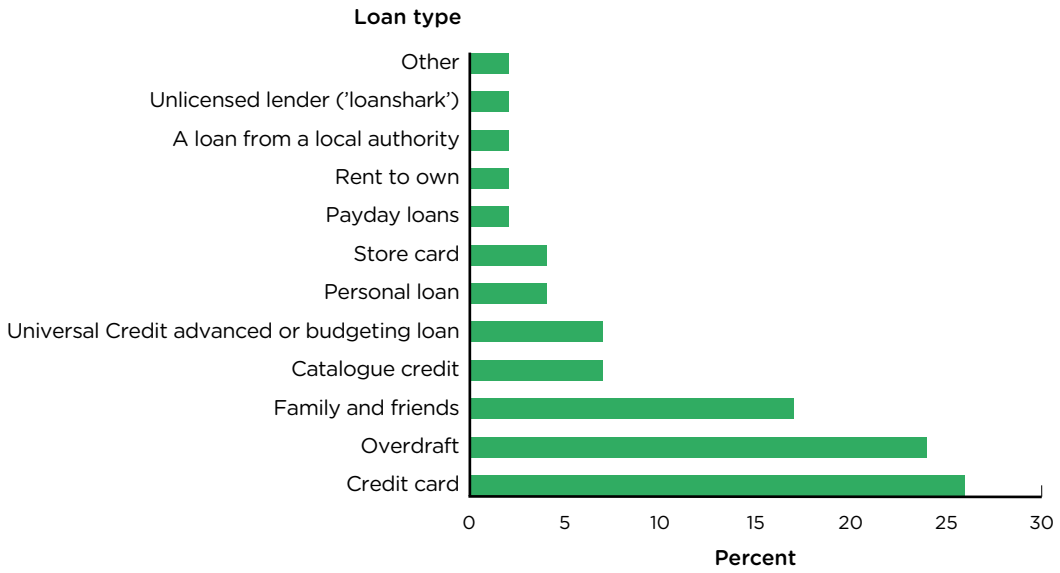
Figure 6.27. Coping strategies used by those who have had their finances negatively affected by COVID-19, as of 19 May 2020



Source: *Based on data from Step Change poll (279).*

Among the 4.2 million people who had borrowed money since the beginning of the pandemic by 19 May 2020, 26 percent used a credit card (1.7 million), 24 percent an overdraft (1.6 million) and 17 percent borrowed from family and friends (1.2 million) (279) as shown in Figure 6.28.

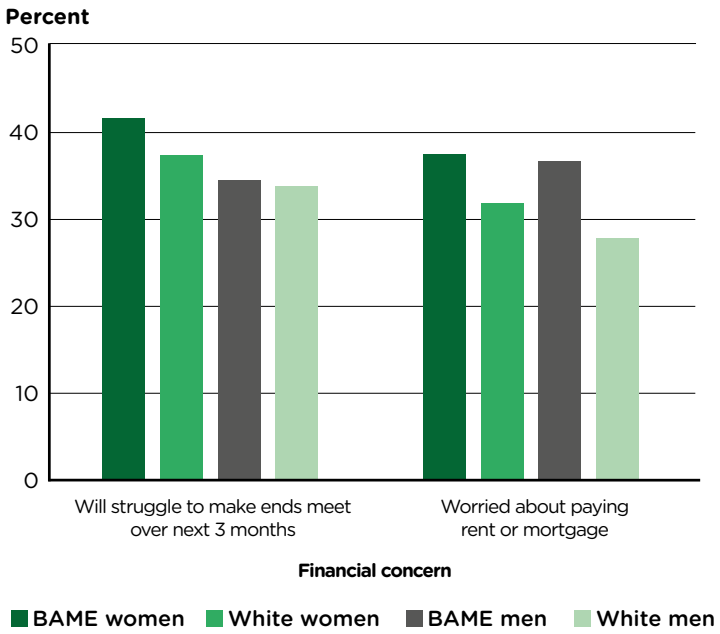
Figure 6.28. Types of borrowing loan used by those who have had their finances negatively affected by COVID-19, as of 19 May 2020



Source: *Based on data from Step Change poll (279).*

Responding to a survey between 15 and 21 April 2020, a higher proportion of BAME women (43 percent) than White women (38 percent) reported concern in terms of making ends meet over the following three months and paying rent and mortgages. For BAME men and White men the proportions were 35 and 34 percent, respectively (Figure 6.29) (168).

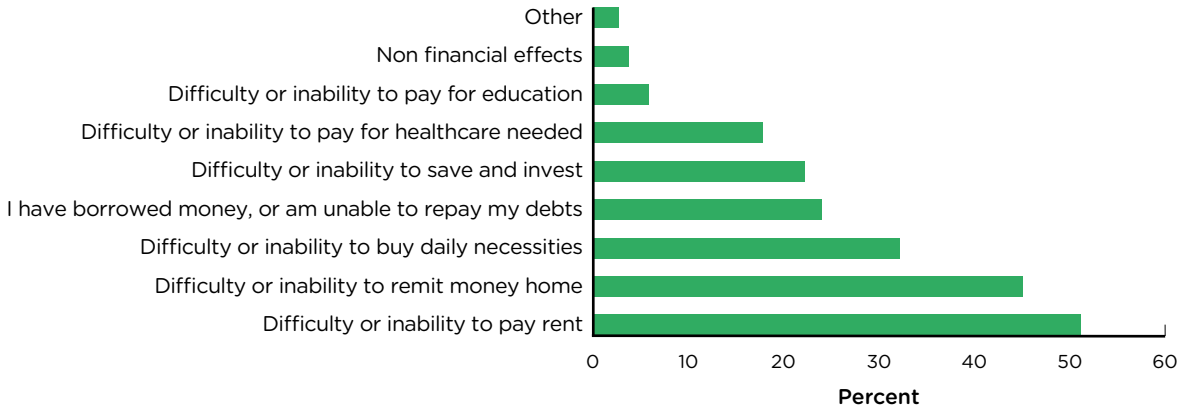
Figure 6.29. Percent of those who agreed that they would struggle to make ends meet over the following three months or were worried about paying their rent or mortgage in the UK, as reported between 15 and 21 April 2020, by ethnicity and gender



Source: *Based on data collected by Survation on behalf of the Fawcett Society (15-21 April 2020) (168).*

A high rate of income loss as a result of the pandemic was found among a sample of Filipino migrants surveyed as part of a study by Parry-Davies (2020). This has evidently impacted their ability to afford basic living expenses, with 51 percent reporting that they had difficulty in paying or were unable to pay their rent and one in five reporting that they were homeless or had no fixed address – Figure 6.30 (264). Thirty-two percent reported experiencing difficulty or inability to buy basic daily necessities and 24 percent had had to borrow money or were unable to make repayments on their debts (264).

Figure 6.30. Percent of those who agreed with the following statements regarding the economic impacts of COVID-19 containment on a sample of Filipino migrant workers in the UK in April 2020



Source: *Data from study by Parry-Davies (2020) (264).*

6.E CONCLUSIONS

Prior to the pandemic, a decade of austerity and stagnating wages had resulted in many households, particularly those with children, being in poverty and suffering ill health as a result. Regional inequalities in wealth had widened and many BAME and lower waged households were struggling to pay housing, food and fuel bills. Increases in in-work poverty, one of the clearest signs of a society which is not meeting the needs of its population, were damaging the health and prospects of working age adults and children. Cuts to benefits had furthered increased rates of those living in poverty and persistent poverty. The increasing impoverishment of many workers and households in England before the pandemic, is affecting the impacts of containment measures.

Increases in unemployment and underemployment and furlough schemes have reduced wages further, and low income groups, who were already struggling before the pandemic are finding themselves in debt and increasingly unable to afford to pay housing costs, utility bills and purchase food. As benefit increases end in March 2021 and unemployment increases, significantly more people will be in poverty and persistent poverty. While the government schemes have supported many people through containment measures, some low income groups have found their wages cut by 20% or have had to sign up to Universal Credit, which, even with the £20 a week increase, is still insufficient to meet many households basic needs.

BOX 6.3. BUILD BACK FAIRER: ENSURING A HEALTHY STANDARD OF LIVING FOR ALL

LONG TERM

- Establish a national goal so that everyone in full-time work receives a wage that prevents poverty and enables them to live a healthy life without relying on benefits.
- Make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living.
- Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
- Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
- Review the taxation and benefits system to ensure they achieve greater equity and are not regressive.

MEDIUM TERM

- Make permanent the £1,000-a-year increase in the standard allowance for Universal Credit.
- Ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty.
- Eradicate food poverty permanently and remove reliance on food charity.
- Remove sanctions and reduce conditionalities in benefit payments.

SHORT TERM

- Increase the scope of the furlough scheme to cover 100 percent of low-income workers.
- Eradicate benefit caps and lift the two-child limits.
- Provide tapering levels of benefits to avoid cliff edges.
- End the five-week wait for Universal Credit and provide cash grants for low-income households.
- Give sufficient Government support to food aid providers and charities.

CHAPTER 7

CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES: INEQUALITIES AND COVID-19 CONTAINMENT

The physical, economic and social characteristics of housing, places and communities have an important influence over people's physical and mental health and wellbeing, and inequalities and these are related to inequalities in health (308). Pre-existing characteristics of communities shape their resilience to the social and economic impacts of COVID-19 containment measures. The levels of restriction, tiers, will lead to further geographic differences in social and economic outcomes and will translate into wider inequalities in health between places.

In this chapter we set out how local authorities, which provide many essential services and community functions, have been seriously affected financially by the pandemic. We also describe how housing and homelessness have been affected by containment measures and relate this to increases in poverty and unemployment, which we have set out in previous chapters.

In the *10 Years On* report we set out how inequalities between places had been widening over the decade 2010-20 (1). Cuts to local government had been regressive, with more deprived local authorities experiencing greater cuts than wealthier areas. Since 2009, net expenditure per person in local authorities in the 10 percent most deprived areas fell by 31 percent, compared to a 16 decrease in the least deprived areas. In the North East spending per person fell by 30 percent, compared to cuts of 15 percent in the South West. Cuts to public services, were also regressive, and negatively impacted more deprived areas the most. In some areas, we called 'ignored places', deprivation was entrenched and deepening.

BOX 7.1. SUMMARY OF INEQUALITIES IN PLACES AND COMMUNITIES (FROM *10 YEARS ON REPORT*)

- There are more areas of intense deprivation in the North, Midlands and in southern coastal towns than in the rest of England. While other parts of England have thrived in the last 10 years, these areas have been ignored.
- Since 2010 government spending has decreased most in the most deprived places and cuts in services outside health and social care have hit more deprived communities the hardest.
- The costs of housing, including social housing, have increased, pushing many people into poverty and ill health.
- The number of non-decent homes has decreased, even in the private rental sector, but this sector still has high levels of cold, damp and poor conditions, and insecure tenures, which harm health.
- Homelessness and rough sleeping have risen significantly, by 165 percent between 2010 and 2017. In 2018 there were 69 percent more children in homeless families living in temporary accommodation than in 2010.
- Harm to health from climate change is increasing and will affect more deprived communities the most in future.
- In London 46 percent of the most deprived areas have concentrations of nitrogen dioxide above the EU limit, compared to 2 percent of the least deprived areas.

The impacts of COVID-19 are exacerbating already perilous conditions in more deprived areas, and these conditions will damage health and widen health inequalities. Without rapid remedial action and allocation of resources that is progressive, inequalities will widen still further.

BOX 7.2. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PLACES AND COMMUNITIES

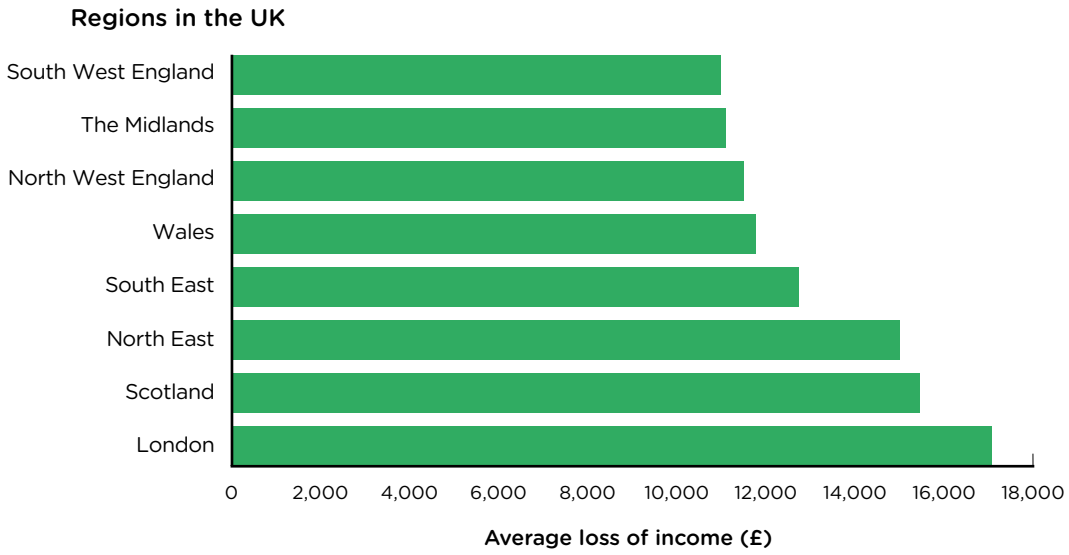
- The same communities and regions that were struggling before the pandemic – more deprived areas and ignored places – are struggling during the pandemic and this will likely continue in its aftermath. Their resilience has been undermined by the effects of regressive reductions in government spending over the last decade.
- Pre-pandemic cuts to local authorities were higher in more deprived areas, leading to greater losses in services there.
- Local authorities are now under even more intense pressure and extra government funding will not make up the shortfall.
- Continuing high costs of housing are pushing even more people into poverty as incomes fall.
- Rough sleeping was eliminated early on in the pandemic, showing what is possible. However, it is already increasing again.
- The number of families in temporary accommodation has increased.
- Private and social renters live in unhealthier conditions and have struggled more with lockdown.

7.A IMPACT OF COVID-19 CONTAINMENT ON REGIONS AND COMMUNITIES

The economic consequences of COVID-19 have been greater in places that entered the health crisis with the weakest economies. This includes many seaside towns and many towns and cities in the Midlands and North of England. Research by the Joseph Rowntree Foundation (JRF) shows that certain outer London boroughs, significant parts of the West Midlands and pockets in the North East and North West are at greatest risk of bearing the full force of the surge in unemployment and poverty, making it harder for them to recover (309). Unemployment in these boroughs is higher than in other boroughs in England.

Small businesses are an important component of economic resilience in local communities in the way they support the local economy and create employment opportunities, and they can have important social impacts (310). However, the COVID-19 pandemic has had significant impacts on small businesses. For example, insurance company Simply Business estimates from the results of a survey it conducted with 3,700 small business and self-employed individuals in Great Britain that the pandemic had cost small business owners an average of £11,799 to June 2020 (311). Simply Business also estimated that the total cost to small and medium enterprises will exceed £69 billion, and an estimated 230,000 of these business already have had to permanently cease trading (as reported in May 2020) (311). Regional differences in the loss of income (which includes loss of earnings, work and loan repayments) of small businesses were also found, with the average loss of income being highest in London, followed by the North East, as shown in Figure 7.1 (312).

Figure 7.1. Average loss of income for small businesses in Great Britain, as reported in June 2020, by English regions, Scotland and Wales



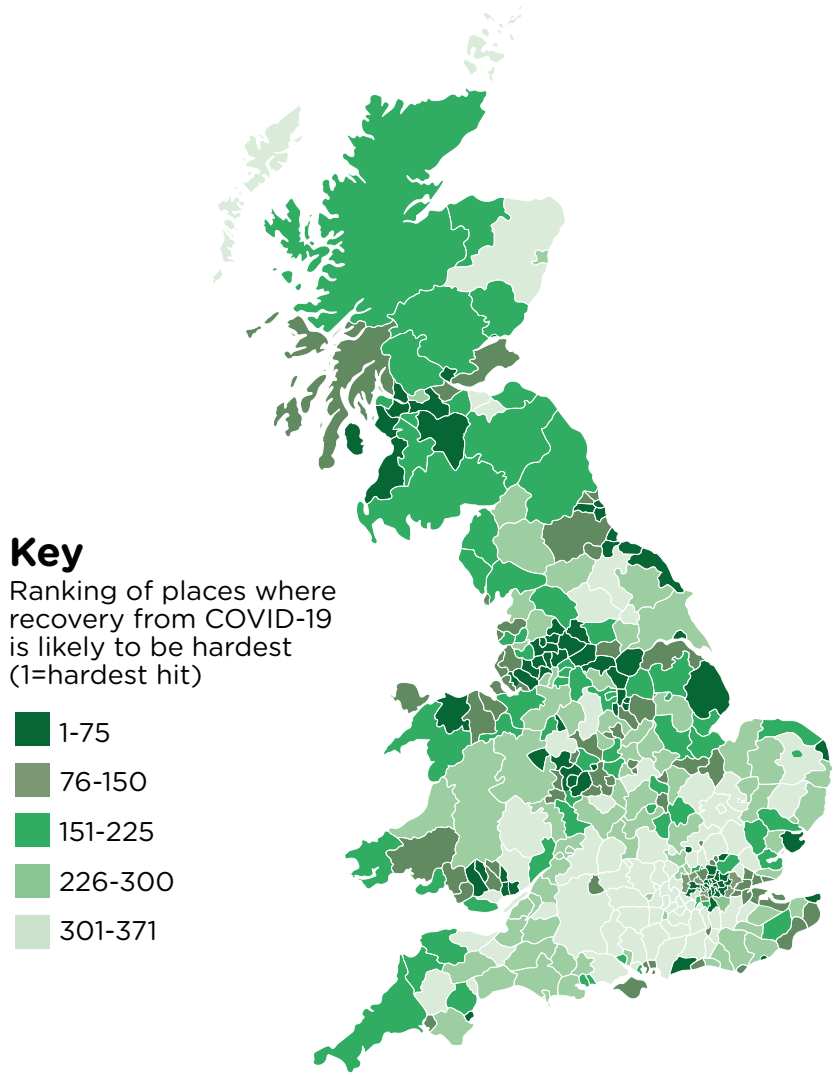
Source: *Based on data from a survey conducted by Simply Business (2020) (312).*

While hard-hit sectors – such as tourism and manufacturing – exist across the country, some places have a greater concentration of jobs in these sectors than others. For example, many tourist destinations have a high share of jobs in accommodation and food – accounting for one in eight jobs in Blackpool and nearly one-fifth in Scarborough, for instance (313). Jobs in these and other vulnerable sectors have been adversely affected by social distancing and containment measures (313) and by falling local spending (309).

A second set of places that may find it hard to recover from COVID-19 are those where local economies and job opportunities were fairly strong before the pandemic but have been significantly affected by social distancing requirements due to having a relatively large share of jobs in local services such as retail, hospitality, arts and recreation (309). Notably, these include densely populated areas in large cities in England and particularly outer London boroughs such as Haringey and Barking and Dagenham (313).

The JRF has produced a map ranking places in England, Scotland and Wales on how difficult recovery from COVID-19 is likely to be (see Figure 7.2) (313). The ranking uses a combined score that estimates how the Office for Budgetary Responsibility's forecast 12 percent peak unemployment is likely to vary across the country, based on the rise places have seen already in the number of people claiming out-of-work benefits (the claimant count), the share of local jobs in the hardest-hit sectors pre-COVID-19, and the share of people currently supported by the Coronavirus Job Retention Scheme (CJRS). This is combined with almost real-time information from the Institute of Employment Studies, funded by JRF, on the number of jobs currently being created (313).

Figure 7.2. Ranking of Local Authorities in Great Britain where recovery from COVID-19 is likely to be hardest



Note: *The ranking uses a combined score based on: the claimant count, the share of local jobs in shut sectors pre-COVID-19, and the share of people currently supported by CJRS. This is combined with almost real-time information on the number of jobs currently being created.*

Source: *JRF analysis of OBR Coronavirus analysis, Business Register and Employment Survey (via NOMIS), Institute for Employment Studies' Weekly vacancy analysis, and ONS claimant count and vacancies time series (313).*

The scale of community action in the UK since the start of the COVID-19 pandemic has been significant. Community-based organisations, national charities, mutual aid groups and thousands of individual volunteers (314), including 750,000 NHS volunteer responders, have provided support to community members who have been made more vulnerable because of the COVID-19 crisis (315) (316). In some areas volunteers have even conducted community-led contact-tracing to support the pandemic response (317).

Figures from the Office for National Statistics (ONS) from the *Coronavirus and the social impacts on Great Britain* publication of May 2020 showed high rates of perceived community support. Sixty-four percent of surveyed adults overall, and 63 percent of key workers, said other local community members would support them if they needed help during the pandemic; 80 percent of adults and 81 percent of key workers said that people in their community were doing more to help others since the COVID-19 outbreak (318). The ONS survey also registered 55 percent of adults saying they had checked on neighbours and 31 percent who said they had gone shopping or done other tasks for neighbours (318).

7.B IMPACT OF COVID-19 CONTAINMENT ON LOCAL AUTHORITIES

Local authorities in England hold or share powers for providing a range of public services including essential services, recreational facilities, social care, public health, housing for their local communities and waste management, among others (319) (320). They are also responsible for promoting social, economic, cultural and community development within their geographical area.

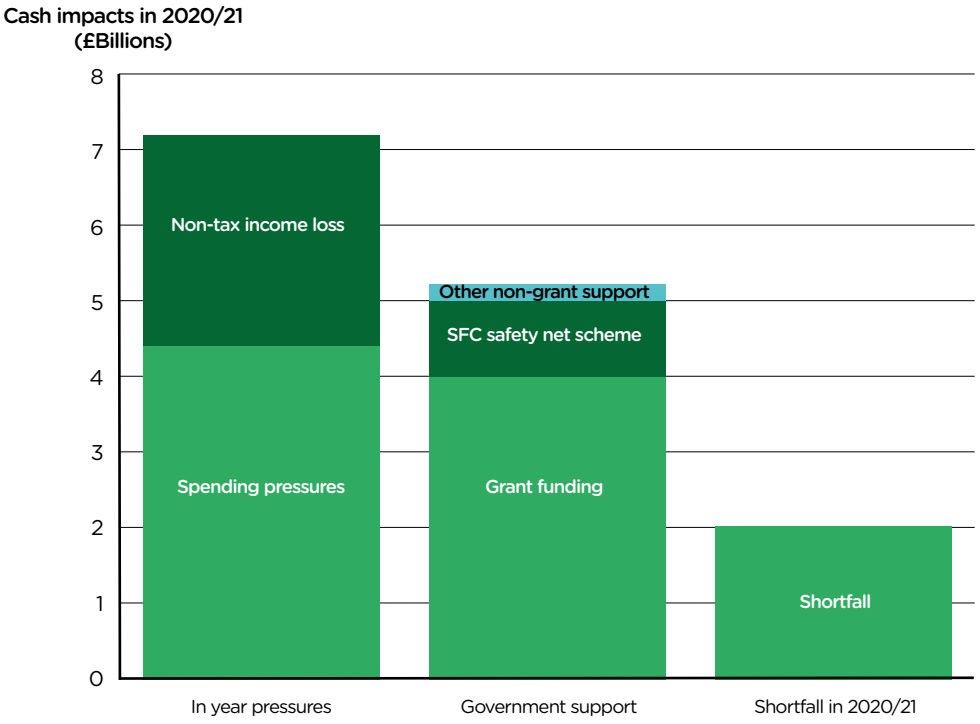
In *10 Years On* we reported that in 2009/10 and 2019/20 the most deprived tenth of councils had their fiscal revenues per person decline by just under 32 percent, or £453 per person, and the least deprived tenth of councils by 16 percent, or £166 per person (321). Cuts over the decade were greater in certain regions than in others: in the North East spending per person fell by 30 percent, compared with 15 percent in the South West (290). The majority of the most deprived neighbourhoods, dealing with the largest cuts, are located in the North of England and in the West and East Midlands. The amount of revenue that could be generated through council tax has also been capped (322).

Thus, even before the pandemic, more deprived local authorities were facing an increasingly dire financial position and much weakened capacity to support their populations and areas. Growing and ageing populations, more complex social care needs, increases in the number of children requiring protection or care, and increases in the costs of service provision were already increasing the demands on local authorities, as they faced the cuts in funding. The pandemic has created additional and huge demand and falling revenue. More deprived local authorities have been adversely affected in terms of public health, housing, family circumstances and rising unemployment and they will face increased demands for a range of services including social care, which will create higher costs and challenges in the long term (323).

The outlook for local government revenues and spending needs in the coming years is highly uncertain. Without additional funding and/or flexibility over council tax rates, it is highly likely that councils will have insufficient revenues to keep pace with rising spending needs. Analysis of councils' forecasts produced by the IFS in October 2020 found that the financial hit as a result of the COVID-19 crisis this year is expected to exceed the financial support provided by central government by £2 billion (324).

Shortfalls in council tax and business rates revenues in 2020 will be reflected in councils' main budgets from 2021 (325). English councils forecast spending pressures of £4.4 billion during 2020–21, with around £1.8 billion estimated to have been incurred between April and June 2020; and adult social care is predicted to account for approximately £1.8 billion of this, as shown in Table 7.1. The IFS also forecasts a £2.8 billion shortfall in non-tax income, with reductions in sales, fees and charges (SFCs) income accounting for almost £2 billion of this (see Table 7.2 for income loss). Taken together, this means in-year pressures are forecast to be £7.2 billion, with billions of pounds more in losses in local tax collections also hitting councils' main budgets from 2021. The £5.2 billion in financial support from the Government still leaves a shortfall of £2.0 billion across local government as a whole relative to current forecasts of pressures, as shown in Institute for Fiscal Studies (IFS) analysis in Figure 7.3 (325).

Figure 7.3. Baseline forecast of unmet spending and non-tax income pressures in England, 2020–21 (£ billion)



Source: *IFS. COVID-19 and English council funding: how are budgets being hit in 2020–21? (325).*

Table 7.1. Estimated increases in expenditure by English councils as a result of the COVID-19 crisis in 2020–21 (£ million)

Pressures	April	May	June	2020-21
Spending pressures				
Adults' social care	248	275	300	1,788
Children's social care	32	33	36	305
Education	15	16	15	254
Transport	9	9	11	62
Public health	3	3	8	96
Housing and homelessness	29	31	31	205
Culture and leisure	20	22	26	192
Environment and regulation	56	40	39	220
Planning and development	2	2	2	15
Police and fire	1	1	0	3
Finance and corporate	43	30	45	274
Other (incl. unachieved savings)	144	121	121	987
Total spending pressures	**603**	**583**	**634**	**4,400**

Source: *IFS calculations using MHCLG data (325).*

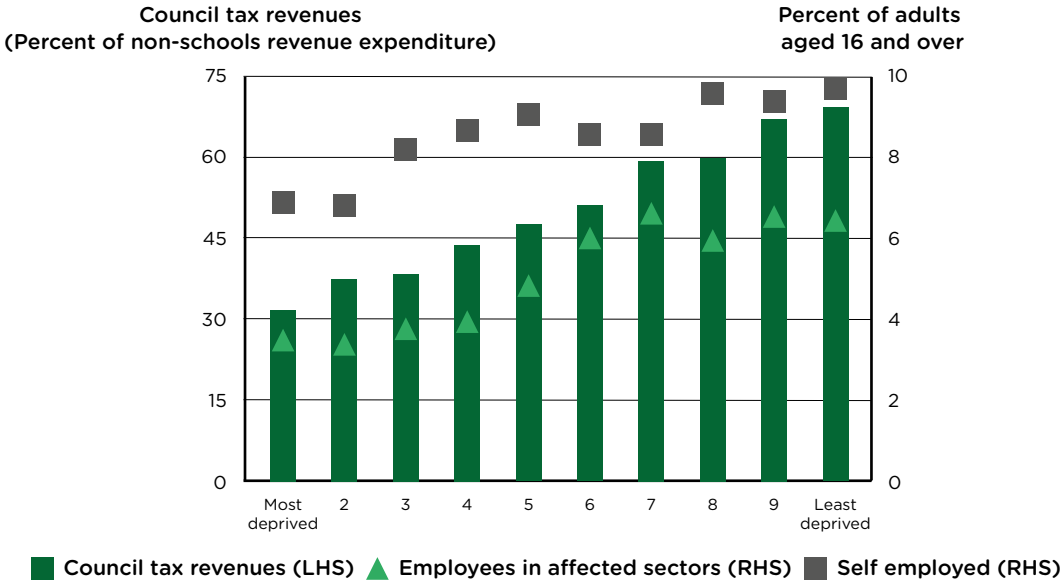
Table 7.2. Estimated increases in expenditure and losses in income by English councils as a result of the COVID-19 crisis in 2020–21 (£ million)

Pressures	April	May	June	2020-21
Income pressures				
Council tax (CT)	236	297	249	1,868
Business rates (BR)	231	247	219	1,849
Transport SFCs	135	140	122	785
Culture and leisure SFCs	65	66	64	484
Planning SFCs	23	22	22	151
Other SFCs	107	93	89	537
Commercial	97	64	68	626
Other	31	38	39	237
Total spending pressures	**924**	**966**	**872**	**6,538**

Source: *IFS calculations using MHCLG data (325).*

The level of reliance on council tax revenues by local authorities differs with the deprivation level of the area, as shown in Figure 7.4. In 2019–20 local authorities in the most deprived decile relied on council tax revenues for just 32 percent of their non-schools revenue expenditure, while in the least deprived decile council tax was used for 69 percent of this expenditure (323). This suggests that the income of local authorities serving more affluent communities is more likely to be adversely affected by the COVID-19 pandemic compared with those that serve more deprived communities. However, the IFS also notes that local authorities in more deprived areas are more likely to be adversely affected by COVID-19 in terms of housing, health and family circumstances and this could mean that they face increased demands for housing and social care, which could create higher costs and challenges in the long term (323).

Figure 7.4. Council tax revenues as a percent of non-schools revenue expenditure in 2019–20, by deprivation deciles



Note: *Deprivation decile based on the average score of the Index of Multiple Deprivation (IMD 2019).*

Source: *Based on data from IFS dashboard of sources (323).*

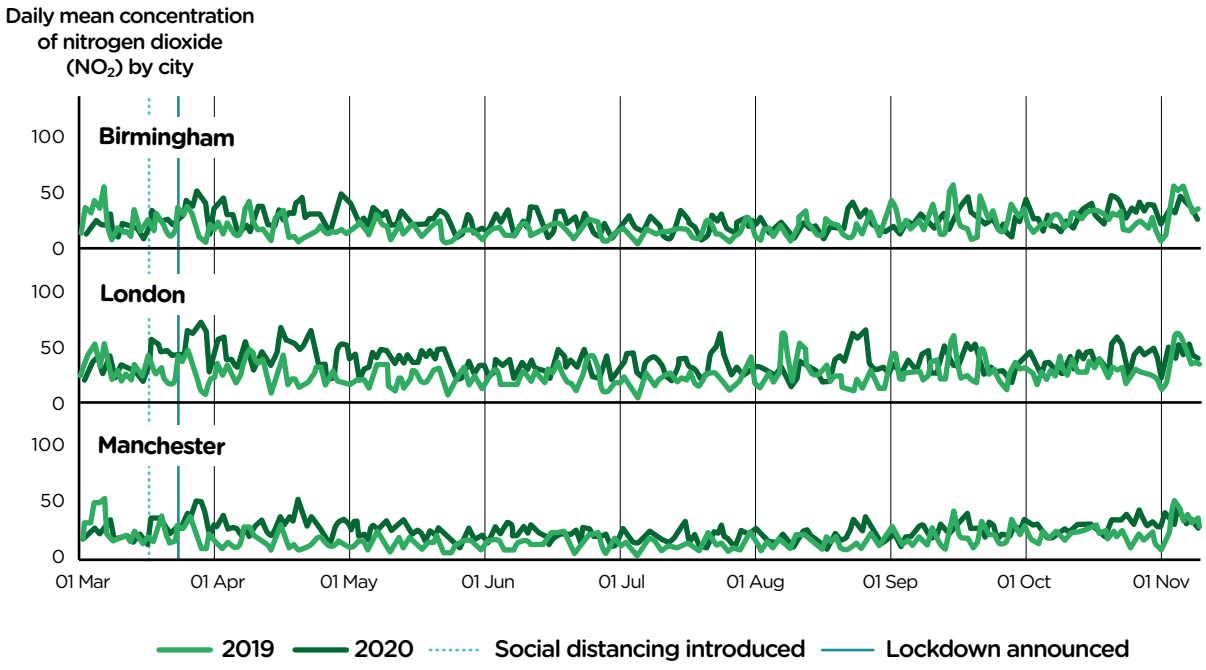
While additional government funding has helped to ease some of the financial pressures experienced by councils, councils will still face very difficult challenges. Given the pre-existing regional and deprivation differences in financial position, and regions' differing demands arising from COVID-19, these financial challenges will be experienced disproportionately by the North of England and more deprived local authorities.

The IFS also finds that increasing funding would allow central government to target funding at more deprived areas. Such an approach would mean councils would have less autonomy over their tax and spend levels, as spending would be specified by grants, and it would require higher taxes, lower spending or more borrowing by central government, with related regional and local impacts (326). Another option would be for the Government to give councils additional tax-reform and/or tax-raising powers. This could include additional powers over council tax and business rate exemptions, discounts and reliefs, but also the power to raise new local taxes. The IFS suggests this would provide councils with incentives to grow local economies and tax bases and the discretion to vary tax and spending levels (326).

7.C IMPACT OF COVID-19 CONTAINMENT ON AIR QUALITY AND CARBON EMISSIONS

A report published by the Greater London Authority in April 2020 showed that in the period around the introduction of the lockdown measures, there was around a 50 percent reduction in the level of harmful nitrogen dioxide (NO_2) around some of the busiest roads in London (327). Figure 7.5 also shows this drop, for London and Birmingham and Manchester, comparing March to November 2020 with the same period in 2019. The figure shows that during periods of lockdown, daily mean concentrations of NO_2 were lower than during the same period in 2019 in all three cities. However, NO_2 concentrations were higher in London during the summer months, possibly due to restrictions on international travel meaning there were higher numbers of people in the city than there normally would be during that time, and because private car use increased with people being more reluctant to use public transport.

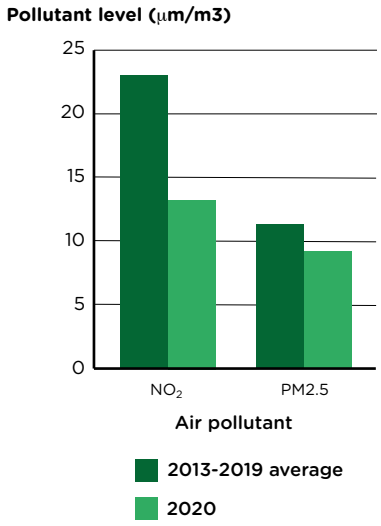
Figure 7.5. Daily mean concentration of NO_2 in Birmingham, London and Manchester, 1 March 2020 to 1 November 2020 compared with the same period in 2019



Source: *PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (328) based on data for from the Automatic Urban and Rural Network (AURN), except for London for which the data is from London Air Quality Network (LAQN).*

Figure 7.6 further illustrates a drop in local air pollution during the early part of the pandemic, this time on a UK-wide basis.

Figure 7.6. Average levels of fine particulate matter (PM2.5) and NO_2 levels in the UK in the 100 days following the start of the first lockdown, compared with the 2013–19 average



Source: *Higham et al. (329).*

There is early research to suggest that air pollution prior to the pandemic and people's exposure to this is associated with a greater risk of experiencing severe symptoms and of death from COVID-19 (330). Furthermore, there are results of studies carried out in the US, Italy and the Netherlands that suggest that small elevations in pollution can raise the number of COVID-19 deaths (330).

Higher mortality rates associated with COVID-19 have been found among people from BAME backgrounds (331), as discussed in Chapter 2.

7.D IMPACT OF COVID-19 CONTAINMENT ON HOUSING INEQUALITIES

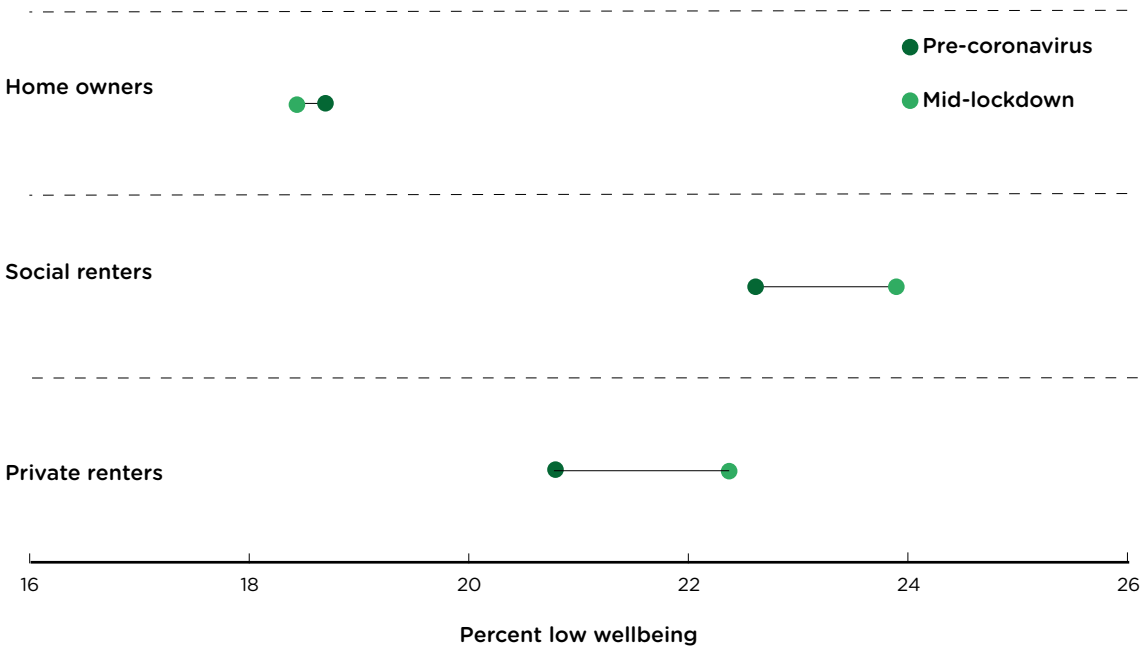
In 10 Years On we set out how cold, damp and overcrowded living conditions and the stress associated with the increasing cost of housing, were causing poor health outcomes and leading to widening inequalities in health. As we set out in Chapter 2, housing conditions are directly related to risk of infection and mortality from COVID-19. Also, as unemployment and poverty increase as a result of the pandemic, unaffordability of housing will rise, and the stress of trying to pay the rent or mortgage payments will lead to mental health harm (332).

HOUSING CONDITIONS, LOCKDOWNS AND INEQUALITIES

People's experiences of lockdown are closely related to the conditions of their homes. Put simply, those living in overcrowded, poor condition housing are more likely to experience stress during a lockdown and to find it difficult to cope. For young people, poor conditions at home make it more difficult to study. More than one child in 10 lives in a home that breaches the 'bedroom standard' and thus is conventionally viewed as overcrowded (332).

Type of tenure is a factor in people's wellbeing. Prior to the onset of the COVID-19 crisis, social renters were four percentage points more likely to report lower levels of wellbeing than home owners, and private renters two percentage points more likely, even when controlling for confounding characteristics (332). Evidence from the Resolution Foundation shows that, during the first lockdown, wellbeing changed little in home owners, but deteriorated in social renters and private renters (Figure 7.7), resulting in increased inequalities (37).

Figure 7.7. Percent of individuals reporting lower-than-usual levels of wellbeing on at least four of 12 General Health Questionnaire variables, controlling for personal characteristics, by tenure in the UK, during 2017–19 (pre-COVID-19) and April 2020 (mid-lockdown)



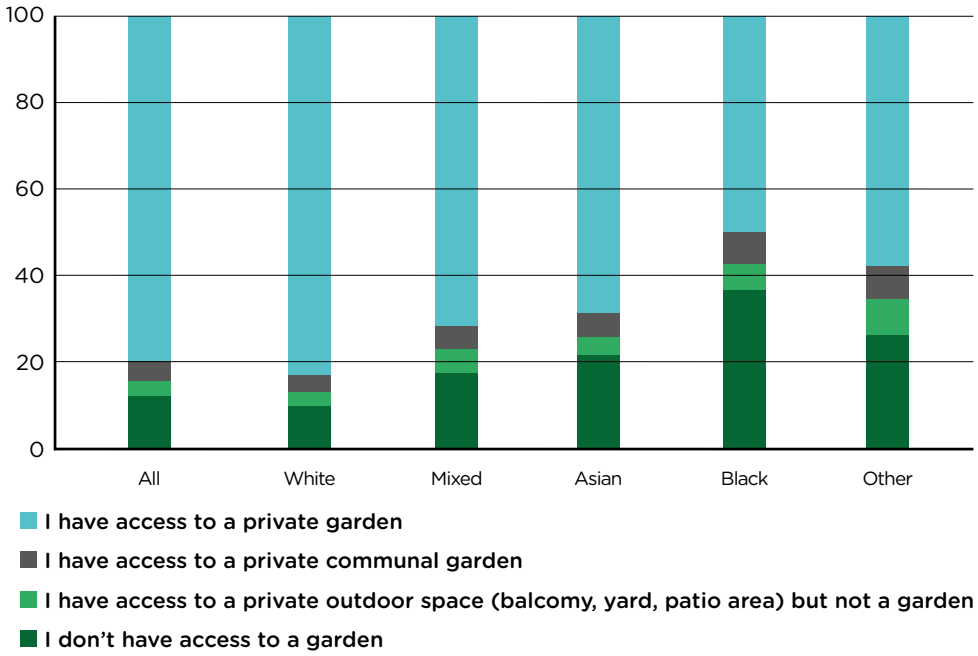
Source: *Judge L. Lockdown living: Housing quality across the generations, 2020 (332).*

ACCESS TO OUTDOOR SPACE

During the first lockdown in March 2020, people could only engage in one form of exercise for an hour outside of the home per day (333). One in eight households (12 percent) in Great Britain had no access to a private or shared garden during the lockdown, according to the ONS's analysis of Ordnance Survey (OS) map data. This rises to more than one in five households in London (21 percent), the highest proportion of any region or country of Great Britain (334). People without access to gardens are more at risk of health harm during lockdowns, and these are disproportionately people who are poorer, metropolitan and from BAME groups (see below). Gray et al. suggest that the mental and physical health of those who were living alone or did not have access to gardens, balconies or green spaces during the first lockdown was disproportionately affected compared with those who did have access to these areas during this period (69).

Survey data from Natural England suggest that in England, Black people are nearly four times as likely as White people to have no access to outdoor space at home, whether it be a private or shared garden, a patio or a balcony (37 percent compared with 10 percent) – Figure 7.8. Even when we compare people of similar age, social grade and living situation and similar area, those of Black ethnicity are 2.4 times less likely than those of White ethnicity to have a private garden (334) (335).

Figure 7.8. Access to a private garden in England, by ethnic group



Source: *ONS using Natural England – Monitor of Engagement with Natural Environment survey, 2020 (334).*

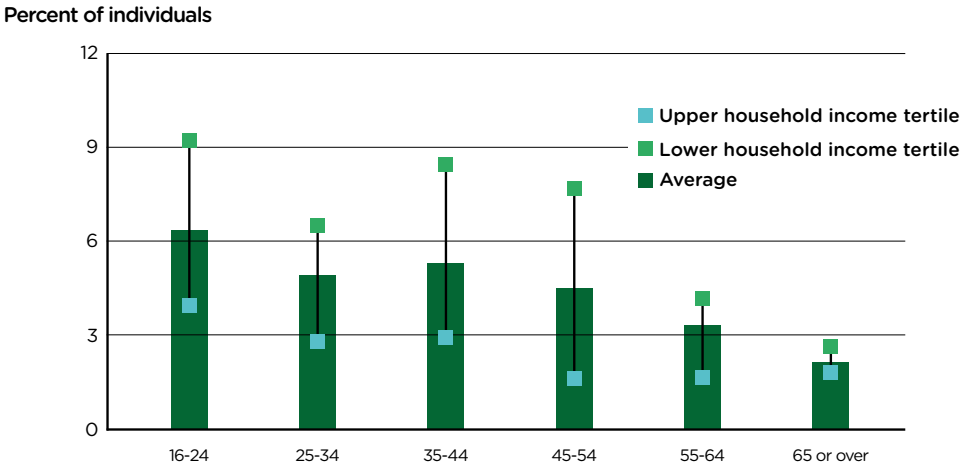
Young people are the least likely age group to have access to a garden. People with lower socioeconomic position and those without children are also less likely to have access (335).

DECENT QUALITY HOMES

For those in poor-quality housing, the lockdowns have meant more time exposed to cold, damp and other hazardous conditions, with consequences for both physical and mental health. Housing conditions are poorest for Britain's 5.5 million private rented sector households (336). In England in 2019, 25 percent of privately rented homes failed to meet the Government's decent homes standard, compared with 13 percent of socially rented homes and 19 percent of owner-occupied homes. Some 670,000 privately rented houses have a Category 1 Hazard, a hazard that is deemed a serious and immediate risk to health (37), and around 600,000 people have had to self-isolate in homes that they know are unsafe and vulnerable to fire (336).

Low-income young people have been more likely than older, high-income populations to live in non-decent homes during the COVID-19 lockdowns. Figure 7.9. shows the proportion of each age group living in a home with a serious damp problem before the pandemic.

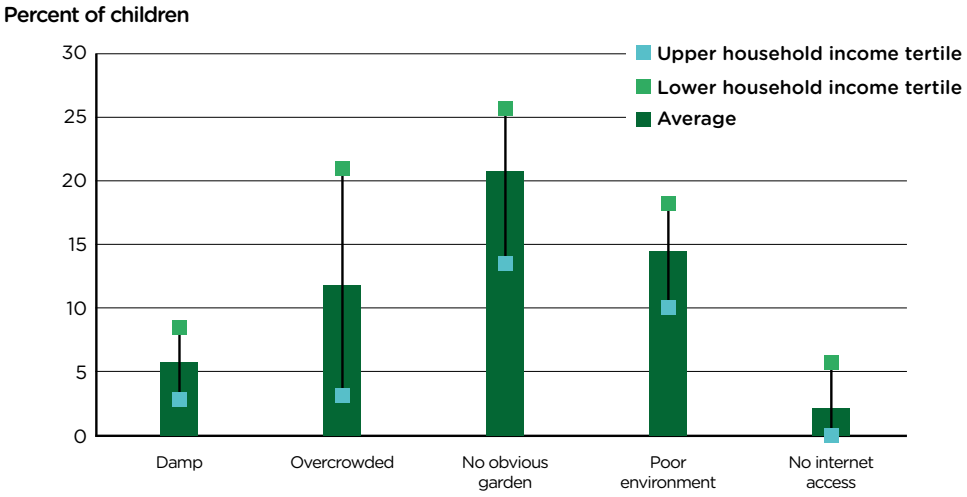
Figure 7.9. Percent of individuals living in damp conditions, by age band and household income tertile in England, 2014–18



Source: *Judge L. Lockdown living: Housing quality across the generations, Resolution Foundation, 2020 (332).*

In 2014–18, one child in 20 was growing up in a damp home. This is a serious issue given the proven link between damp and childhood respiratory conditions. Children in lower-income groups were particularly exposed to these damp and poor housing conditions, shown in Figure 7.10.

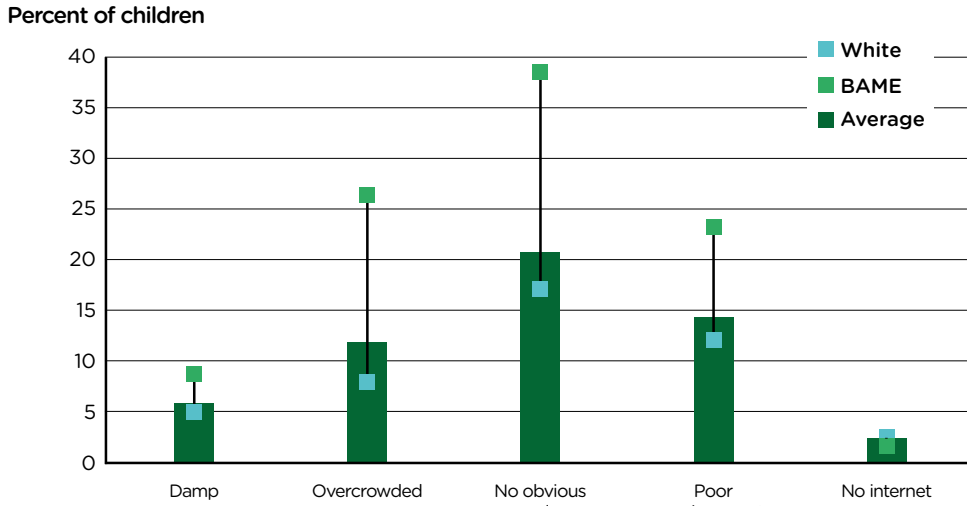
Figure 7.10. Percent of children up to age 15 experiencing housing and neighbourhood quality problems, by household income tertile in England, 2014–18



Source: *Judge L. Lockdown living: Housing quality across the generations, Resolution Foundation, 2020 (332).*

In 10 Years On we set out regional differences in the share of the population living in non-decent homes in 2017. In the West and East Midlands, and Yorkshire and the Humber, more than one in five homes failed to meet the decent homes standard, dropping to 16 percent in the South East and 11 percent in the North East (321). Prior to the pandemic, children from BAME backgrounds were more likely than White children to be living in poor quality housing (Figure 7.11). During the COVID-19 lockdowns they will have been exposed to more health harming conditions than White children, as a result.

Figure 7.11. Percent of children up to age 15 experiencing housing and neighbourhood quality problems, by ethnicity in England, 2014–18



Source: *Judge L, Rahman F. Lockdown living: Housing quality across the generations, Resolution Foundation, 2020 (332).*

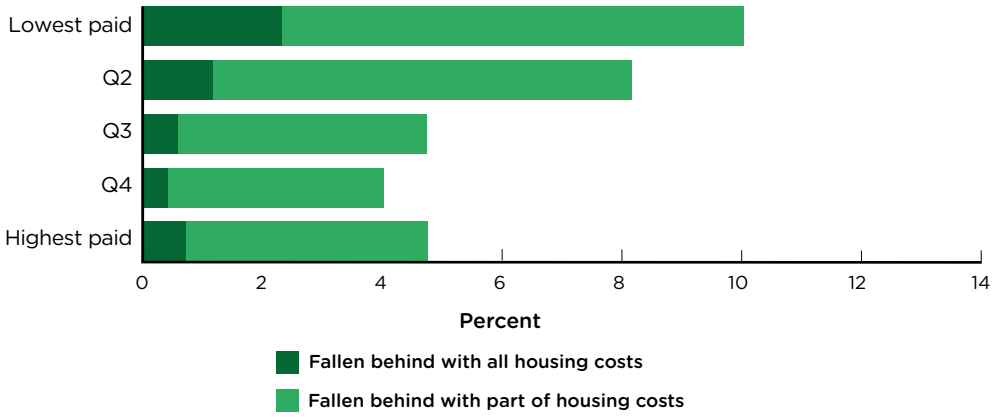
In August 2020, a YouGov survey asked a nationally representative sample of UK adults about the design of their homes and their experiences during the COVID-19 lockdown. Disabled respondents were over three times more likely than non-disabled people to report that the inaccessibility of their home undermined their wellbeing during lockdown and were 17 times more likely than non-disabled people to be unable to carry out all daily tasks and activities at home without assistance during lockdown.

HOUSING AFFORDABILITY

Housing costs significantly increased in England in the decade from 2010, with greater impacts for lower-income than higher-income households and were driving increasing numbers of people into poverty, including families with children (321). High housing costs affect people's ability to lead a healthy life, by reducing the income available for heating, food and other necessities that are essential for good health, and by causing high levels of stress. The impacts of COVID-19 containment measures in increasing unemployment and poverty and lowering income will have added to the considerable burdens and health harm of unaffordable housing.

In March 2020 at the start of the first lockdown, the Government announced a series of measures designed to help people who had been furloughed to continue mortgage payments and manage their rent. The furlough payments and increase in Universal Credit, plus the Local Housing Allowance (used to calculate housing benefit for private-renting tenants partly helped people cover their rent costs through the lockdown (337). Provisions to protect renters in England included suspending eviction processes for three months on absence of payments. Mortgage lenders offered mortgage holidays of three and then six months, allowing homeowners to postpone their mortgage payments (338). Despite these provisions, the COVID-19 crisis is having a detrimental impact on housing affordability among the lowest paid workers. In September 2020 those in the lower pay quintile were twice as likely to be in housing costs arrears than those in the highest quintile (339) – Figure 7.12.

Figure 7.12. Percent of working age adults who have fallen behind in paying for all our part of their housing costs since the start of the pandemic, reported in September 2020 survey in the UK, by pay quintile



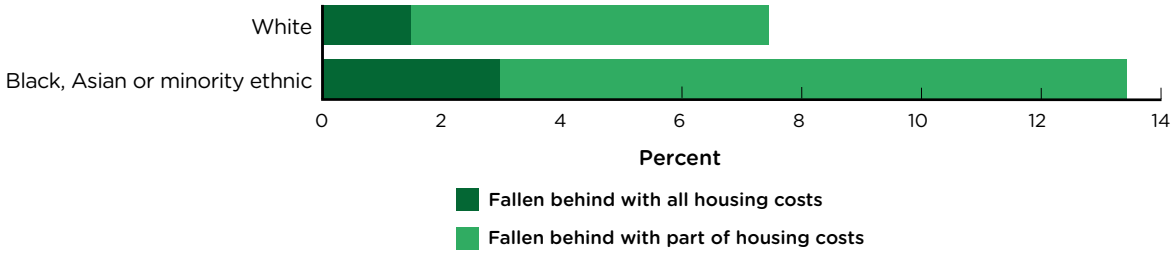
Note: *Pay quintiles are based on weekly net pay prior to the COVID-19 outbreak.*

Source: *Resolution Foundation analysis of YouGov, UK adults aged 18–65 and COVID-19 – September wave (339).*

A study by the Joseph Rowntree Foundation has highlighted the growing number of people facing rent arrears (340) even before the pandemic. Around 2.5m households across the UK said they were worried about paying their rent over the winter 2021, and 700,000 were already in arrears, according to the JRF. It found 350,000 households had been served an eviction notice or spoken to about eviction by their landlord (340).

According to the Resolution Foundation's analysis of YouGov data, Black, Asian and minority ethnic renters are disproportionately more likely to be concerned about paying their rent over the winter 2021 than White renters. Figure 7.13 shows that of households surveyed in September 2020, 13 percent of adults from BAME groups were behind in housing costs compared with seven percent of White adults (339).

Figure 7.13. Percent of working age adults in the UK by ethnicity and level of inability to cover housing costs since the start of the pandemic, reported in September 2020 survey

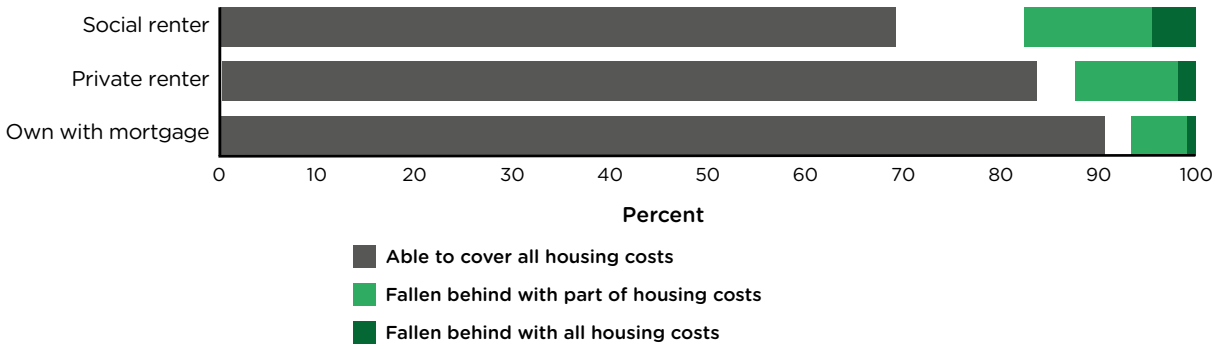


Source: *Resolution Foundation analysis of YouGov, UK adults aged 18–65 and COVID-19 – September wave (339).*

JRF analyses show that families with children that rent privately are more likely to be worried than other households, with four in 10, approximately 600,000 households, worried about paying their rent over winter 2020/21. People who have experienced or expect a drop in income, people who are already unemployed and those on lower incomes are being hit hardest; in JRF survey data reported in November 2020, 61 percent of all renter households in which someone was facing a drop in income that month said they were worried about paying their rent (340).

Figure 7.14 shows that 17 percent of social renters and 12 percent of private renters reported being behind on all or some of their housing costs, according to the same September 2020 survey data. It reflects the rate of households that are struggling and that have exhausted strategies to manage housing costs since the beginning of the COVID-19 crisis.

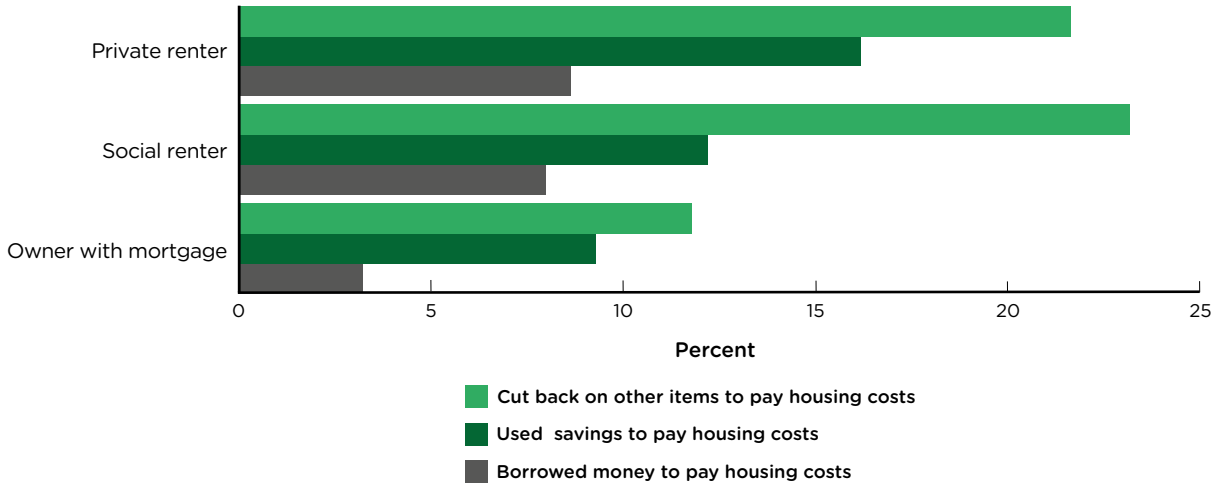
Figure 7.14. Percent of working age adults in the UK by housing tenure and level of ability to cover housing costs since the start of the pandemic, reported in September 2020 survey



Notes: *The gap between bars includes people who responded: 'Other', 'Not applicable' 'Prefer not to say' and Don't have any housing costs'.*
Source: *Resolution Foundation analysis of YouGov, UK adults aged 18–65 and COVID-19 – September wave (339).*

As shown in Figure 7.15, nearly one-quarter of private and social renters are cutting back on other types of spending to meet housing needs and nearly 10 percent are having to resort to borrowing money and running into debt to meet these costs.

Figure 7.15. Percent of working age adults in the UK acting to reduce their housing costs since the start of the pandemic by housing tenure, reported in September 2020 survey



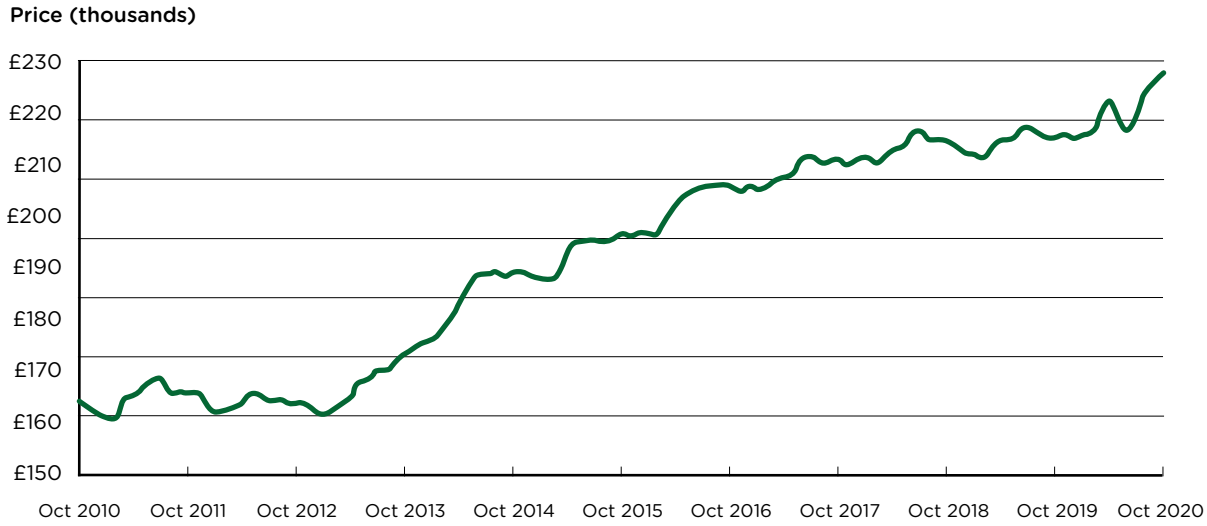
Source: *Resolution Foundation analysis of YouGov, UK adults aged 18–65 and COVID-19 – September wave (339).*

The JRF is calling for a watertight ban on evictions, together with targeted support for rent arrears to prevent a surge of evictions in the spring of 2021, and says that protections put in place at the start of the pandemic are not working for large numbers of renters. Government guidance states bailiffs will not be used before 11 January 2021 in England but campaigners worry that this protection may not be legally binding and may not be well understood by households vulnerable to eviction (340).

Analysis published in November warns that the waiting list for council houses in England will exceed their previous peak following the 2008 financial crisis as more and more people are unable to afford their homes (340). The Local Government Association, the Association of Retained Council Housing and the National Federation of Arm's-length management organisations (Almos), which manage council and social housing, are demanding that the Government sanction the construction of 100,000 properties for cheaper social housing a year as part of its house-building plans. There are wide ranging calls for a Green New Deal, including ambitious green house building and retrofitting plans as a way to provide jobs and work towards the 2050 net zero target (341). Together they say it would also deliver a £14.5 billion boost to the economy by helping the struggling construction sector (342).

Despite the lockdowns and economic slowdown, property prices have climbed through 2020, influenced by a stamp duty 'holiday' which reduces the tax to 0 percent for all properties £500,000 or under until 31 March 2021, and an increase in activity and demand. Annual house price growth accelerated to 3.7 percent in August 2020 from 1.5 percent in July, and reached 5.8 percent in October 2020, the highest annual growth rate since 2015 (343) – Figure 7.16. Despite the economic slowdown, the housing market is now increasingly unaffordable for many, and particularly for younger people.

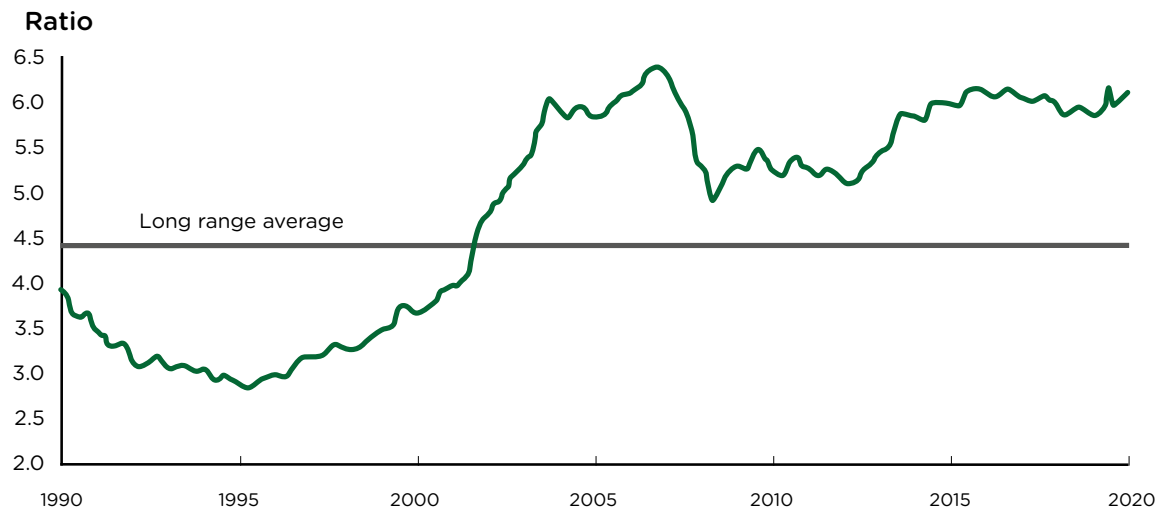
Figure 7.16. Average UK house prices, October 2010 to October 2020



Source: *Nationwide, Annual house price growth reaches five-year high in October, 2020 (343).*

In England in 2019, before the COVID-19 crisis, full-time employees could typically expect to spend around 7.8 times their workplace-based annual earnings on purchasing a home (344) and this ratio continued to increase to October 2020 – Figure 7.17.

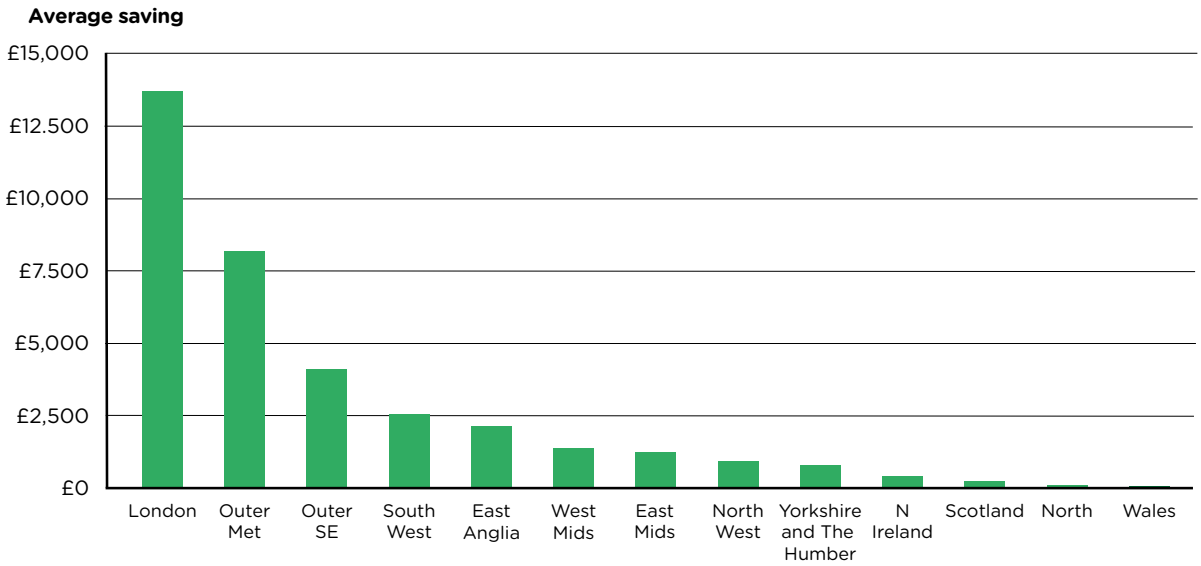
Figure 7.17. UK house prices to earnings ratio, 1995–2020



Source: *Nationwide, Annual house price growth reaches five-year high in October, 2020 (343).*

Beneficiaries from the stamp duty reductions have mainly been wealthier households in more expensive owner-occupied housing, disproportionately in London and the South of England, where average house prices are significantly higher than elsewhere. Savings to be made from the stamp duty holiday are likely to be fairly modest for the majority of buyers in the North of England, Scotland and Northern Ireland (Figure 7.18) (345).

Figure 7.18. Average saving made from stamp duty 'holiday' for properties costing £500,000 or under, by English region and Wales, based on Nationwide regional average house prices, Q2 2020



Source: *Nationwide. House price growth rebounds in July as activity bounces back, 2020 (345).*

HOMELESSNESS AND ROUGH SLEEPING

As described in our *10 Years On* report, homelessness and rough sleeping rates in England increased substantially between 2010 and 2017 (1) (346). Rough sleeping is associated with tri-morbidity – physical and mental ill-health combined with substance misuse. On average, rough sleepers die 30 years younger than the general population (347). There were an estimated 726 deaths of people sleeping rough in England and Wales in 2018, the highest year-to-year increase (22 percent) since records began in 2013. One of the effects of the COVID-19 outbreak was to highlight the extent of poor health amongst the population of people experiencing rough sleeping. Research from 2019 had already shown that at least one third of the deaths of rough sleepers were from treatable conditions, with serious problems in accessing local GP registration, cancer screening and access to treatment for a range of conditions, leading to poor health outcomes (348).

On 26 March 2020 the Government instructed local authorities across the UK to provide accommodation for homeless people sleeping in emergency accommodation and people sleeping rough during the pandemic. Dormitory-style night shelters were subsequently closed due to the risk of COVID-19 infection in communal spaces, night shelters were only be used as a last resort to protect against the risk to health and life of individuals remaining on the streets. The Government announced £3.2 million of emergency funding for rough sleepers and those in temporary accommodation needing to self-isolate (349). The 'Everyone In scheme' saw almost 15,000 rough sleepers and homeless people in night shelters in England moved into COVID-19 safe emergency accommodation such as hotels early on in the pandemic (350).

Health and housing authorities in England developed a plan with two main elements: first, provision of single room, own-bathroom accommodation for homeless adults (called COVID-PROTECT); and second, testing and medically supported accommodation for those with symptoms (called COVID-CARE). COVID-PROTECT accommodation focused on people sleeping dormitory style night shelters and those sleeping rough (351).

On 24 June 2020 the Government announced an additional £105 million to assist local authorities in implementing measures to support people who had been placed in emergency accommodation during the pandemic (352). The scheme also offered access to services that set up shop in the same hotels, such as help with benefits applications and medical prescriptions – the kinds of tasks that can be almost impossible to fulfil when trying to navigate life on the streets. As such, the extraordinary circumstances of the pandemic led to decisive action by the Government on homelessness. According to Crisis, it would cost around £282 million to permanently rehouse and support people housed in the current emergency hotels and hostels for the next 12 months (353).

However, although the Government stated it had temporarily sheltered 90 percent of Britain's rough sleepers, some did not benefit from the scheme, mostly highly vulnerable people with long-term mental health and dependency issues. Some were not identified and were not offered help or did not know how to access help. Others that were rehoused in hotels were either evicted or left of their own accord, as a result of severe mental health issues or drug use (354). In London, in 2019/20 CHAIN recorded 10,726 rough sleepers seen bedded down over the year, over nine times as many as the 1,136 in the snapshot count of Autumn 2019. According to the Local Government Association (LGA) this suggests that, at any time, many more people are at risk of rough sleeping, and will go on to sleep rough, than the number of people actually on the streets at a given date (348).

After the initial Everyone In phase, a number of councils continued to experience high demand for accommodation from homeless people throughout lockdown and subsequently, sometimes involving a greater number of people than those initially accommodated, according to the LGA. How councils responded to this varied. On 29 June 2020 MHCLG amended the homelessness code of guidance to include advice on when to class those who might be vulnerable to COVID-19 as in priority need (348). The London Assembly Housing Committee released data showing there were 4,227 rough sleepers in London from April to June 2020 – a 33 per cent increase on the same period in 2019 and a 63 per cent increase on 2018. It is likely that this can be attributed at least partly to a suspension of London's No Second Night Out (NSNO) service during the pandemic, which has meant that the ability of services to help new rough sleepers off the streets quickly has been diminished, according to the LGA.

As well as causing day centres and night shelters across the UK to close (355), COVID-19 impacted homeless support services for housing, benefits and substance misuse, which had to reduce or cease face-to-face work (355). Many of these services were moved online or to the telephone. Issues around accessing these services associated with a lack of access to digital technology such as computers, phones and phone credit have compounded the difficulties faced by those at risk of becoming homeless or those who already were (355).

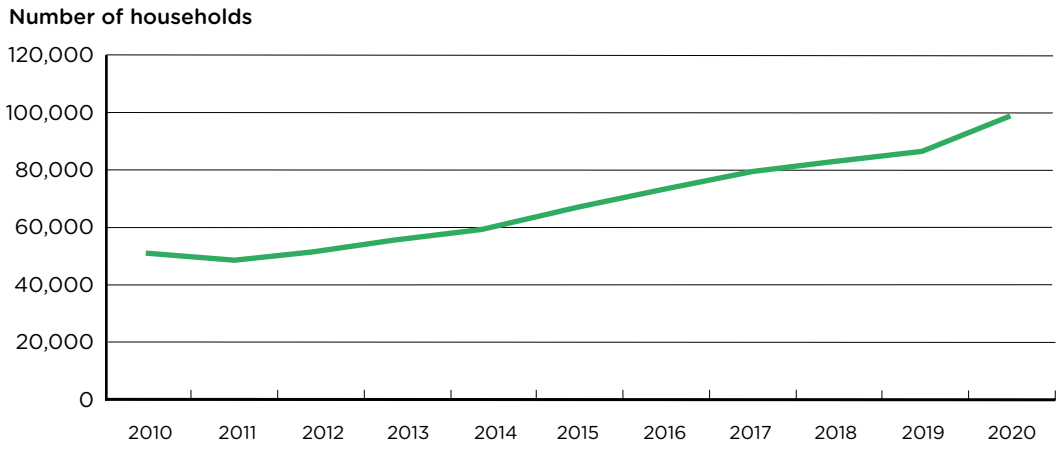
According to the LGA as of November 2020 it was hard to assess the medium to long term impact on rough sleeping, as, in most areas, rough sleeper counts were suspended (348). Other reports show that in quarter 3 2020, compared with the previous year, there was an 82 per cent increase in rough sleepers aged 18 to 25 (447 compared with 246), and a 31 per cent increase in rough sleepers with mental health support needs (1,220 from 934) (356). The finding on young people is backed up by research by The Guardian, which found that COVID-19 has changed the profile of rough sleepers: they include more young people than before, who had been 'sofa-surfing' and could not continue

doing so because of lockdown, and more people who had become rough sleepers as a result of a breakdown in a relationship. Domestic violence increased during the first lockdown and is likely to have done so in the November lockdown too, causing higher numbers of women escaping situations of domestic abuse and becoming rough sleepers (357). A number of homeless support services, such as the No First Night Out project, had to stop taking referrals due to an associated surge in demand (355). This is due to some people returning to the streets, some intermittent rough sleepers not being accommodated during Everyone In because they were not rough sleeping at the time, and some new rough sleepers. The impact of the new English national lockdown has not yet been assessed and there has been a large variation in councils' responses in continuing to accommodate single homeless people who would not be deemed to be in priority since the change in the homelessness code of guidance and due to resource constraints faced by local governments (348).

The economic impact of COVID-19 raises serious concerns about a further escalation in homelessness. The ending of a private tenancy is the leading cause of homelessness. Key workers at risk of contracting the virus because of their employment have found themselves facing eviction because of fears that they will spread the virus to landlords, and difficulty paying rent or mortgage payments, which has increased during the pandemic as described above, can also lead to eviction or foreclosure (336).

Figure 7.19 shows that the number of households in temporary accommodation have increased steadily since 2010 and increased markedly between the second quarter in 2019 and 2020 (358).

Figure 7.19 Number of households in temporary accommodation at the end of the second quarter in England, 2010 - 2020



Households in accommodation arranged by local authorities pending enquiries or after being accepted as homeless under the 1996 Act (includes residual cases awaiting re-housing under the 1985 Act) and as amended by the Homelessness Reduction Act 2018.

Source: *Ministry of Hosing, Communities and Local Government (358).*

7.E CONCLUSIONS

More deprived areas are experiencing higher rates of mortality from COVID-19 and deteriorating circumstances as a result of economic and social impacts of containment. The additional spending pressures, higher need and loss of funding is creating even greater financial pressure on all local authorities, but particularly more deprived ones – which were already facing a funding crisis before the pandemic. To avoid further cuts to local services, additional funding will be needed in the coming years. A greater share of the additional funding should be for more deprived local authorities.

Reductions in air pollution, if they had been sustained, would provide enormous health and health equity benefits. However, since the first lockdown traffic pollution has again increased, and people are understandably reluctant to use public transport if they have an alternative. The clean air during lockdown did afford an opportunity to experience cities and towns with much reduced air pollution and quieter roads with more people walking and cycling. Building Back Fairer requires a sizeable reduction in private car use and greater active travel and use of public transport. Efforts to support this are required urgently and would help to reduce Greenhouse Gas Emissions and lead to a more sustainable environment.

The unaffordability of much of England's housing for lower income groups; a result of increasing costs and insufficient supply over the last decade are compounded by rising poverty and unemployment. This will result in more poor quality housing, financial pressures, debt and evictions, all of which are harmful to health. Services for homeless people, including rough sleepers need greater support.

BOX 7.3. BUILD BACK FAIRER: CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LONG TERM

- Invest in the development of economic, social and cultural resources in the most deprived communities.
- Ensure 100 percent of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
- Aim for net-zero greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.

MEDIUM TERM

- Increase deprivation weighting in the local government funding formula.
- Strengthen the resilience of areas that were damaged and weakened before and during the pandemic.
- Reduce sources of air pollution from road traffic in more deprived areas.
- Build more good-quality homes that are affordable and environmentally sustainable.

SHORT TERM

- Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls.
- Increase government allocations of funding to the voluntary and community sector.
- Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates.
- Remove the cap on council tax.
- Urgently reduce homelessness and extend and make watertight the protections against eviction.

CHAPTER 8

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION: INEQUALITIES AND COVID-19 CONTAINMENT

In the 10 Years On report, we did not focus specifically on health behaviours, but on the causes of these health behaviours – the social determinants of health. We assessed how best to implement action on the social determinants to reduce health inequalities. These principles for governance for health equity and principles for implementing action on health and their social determinants (summarised in the boxes below) are highly relevant to managing public health through the pandemic and critically also in the aftermath, as its impacts will lead to further deteriorations in health and a further widening in health inequalities.

BOX 8.1. PRINCIPLES FOR GOVERNANCE FOR HEALTH EQUITY (FROM *10 YEARS ON REPORT*)

1. Health equity is an indicator of societal wellbeing.
2. The whole of government is responsible for prioritising health equity in all policies.
3. Development of strategies and interventions must involve a wide range of stakeholders.
4. Accountability must be transparent with effective mechanisms.
5. Communities must be involved in decisions about programmes and policies for achieving health equity.

BOX 8.2. PRINCIPLES FOR IMPLEMENTING ACTION ON HEALTH INEQUALITIES AND THEIR SOCIAL DETERMINANTS (FROM *10 YEARS ON REPORT*)

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.
2. Ensure proportionate universal allocation of resources and implementation of policies.
3. Intervene early to prevent health inequalities.
4. Develop the social determinants of health workforce.
5. Engage the public.
6. Develop whole systems monitoring and strengthen accountability for health inequalities.

This report's remit is not to assess the Government's, the NHS's or Public Health organisations' efforts to manage and contain COVID-19 infections. We are, however, assessing how policies leading up to the pandemic laid the conditions for England's high, and geographically and socially unequal, mortality toll and set out how containment measures are leading to a deepening of health inequalities in England. We have made recommendations for immediate action to reduce widening inequities in the social determinants of health in order to mitigate the inequitable impacts of the pandemic.

The pandemic and the containment measures instigated in response have had significant impacts on people's day-to-day lives. There is evidence to suggest that quarantine and social isolation can have adverse effects on mental health and wellbeing and that these impacts can be wide-ranging and long-lasting (1) (2).

There are various stressors arising from the pandemic and lockdown restrictions that could serve to prompt or exacerbate adverse mental health outcomes, including stress associated with financial loss or loss of employment, frustration, loneliness, boredom, fears of infection, worries about the future and concerns about access to goods and services, including support services (3) (1). These can be risk factors for several mental health conditions including post-traumatic stress, anxiety, depression and affective disorders (3). There is evidence that these challenges are being experienced disproportionately across groups based on factors such as ethnicity, socioeconomic backgrounds and pre-existing mental health needs.

The lockdown measures and social distancing orders put in place in England in response to COVID-19 have meant that in-person social contact has been restricted since the outbreak of the pandemic. These drastic changes have caused concerning increases in the rates of loneliness and isolation and the adverse health effects associated with these. The lockdowns have also increased rates of gender violence as a result of women spending longer hours with their partner and/or abuser.

The impact of lockdown measures such as social distancing and school and youth group closures on the mental health and wellbeing of children and young people are described in Chapter 4, along with an increase of domestic/parental abuse of children and teenagers. Other potential contributing factors such as anxiety about becoming infected from COVID-19 are also discussed in that chapter while anxiety and depression as a result of the impact of the COVID-19 crisis on unemployment, reduced wages and income and debt are discussed in Chapters 5 and 6.

In this chapter we assess how containment measures have affected the public's health and health inequalities and assess how public health organisations and their workforces need to be further focussed on reducing inequalities in the social determinants of health and strengthened in terms of capacity and funding. We make recommendations to refocus and strengthen public health in the wake of the pandemic to meet the challenge of reducing widening health inequalities and ensure that the new prioritisation of public health is maintained.

The public's health and the public health workforce have been at the centre of the COVID-19 crisis in a number of ways, as summarised in the box below.

BOX 8.3. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PUBLIC HEALTH

- The priority and importance of public health has increased during the pandemic and public health is now a central concern of the public and Government, with a new focus on the importance of protecting and improving health in England.
- The longer-term health impacts of the containment measures are creating a new public health and health equity crisis.
- Inequalities in health behaviours and health have contributed to inequalities in COVID-19 mortality.
- There have been some significant changes in behaviours during lockdown – including potentially increased inequalities in smoking and obesity, increased consumption of alcohol, declines in mental health and increasing violence and abuse within households.
- We have set out the concept of the causes of the causes: health behaviours are causes of non-communicable diseases (NCDs); social determinants of health are causes of inequalities in these health behaviours. The causes of the causes of NCDs have to be addressed during the pandemic and as part of Build Back Fairer.
- Inequalities in health behaviours should also be a priority area for action.
- The Public Health system needs a strengthened focus on the social determinants of health. Deteriorations in these determinants as a result of containment measures make this focus even more critical.
- The Public Health system needs higher levels of investment and resourcing from central government – sustained cuts of 22% in real terms to the budget since 2015/16 have undermined action on health and health inequalities and will lead to worse health and higher inequality.
- Underfunding and planned reorganisation of Public Health organisations and workforce has undermined capacity to contain the pandemic and improve health through the containment measures.

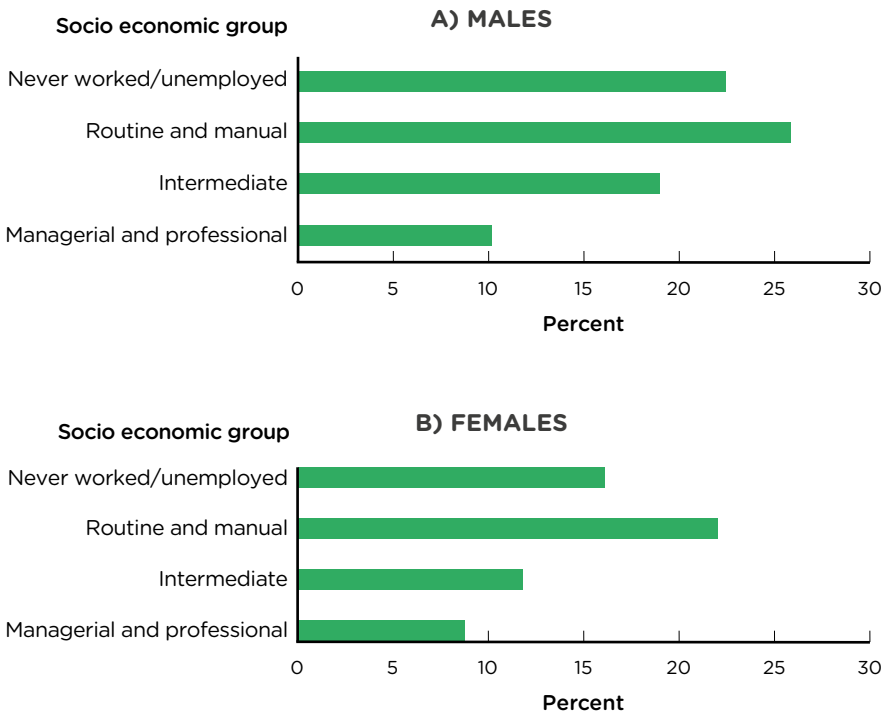
8.A PUBLIC HEALTH AND INEQUALITIES DURING THE PANDEMIC

Public health's overriding concerns during 2020 have been, quite rightly, about management and containment of the pandemic. While the challenges continue to be immense, there have been other public health concerns during this period and continuing efforts to improve health and health inequalities. Conditions in key social determinants of health have deteriorated and COVID-19 containment measures have resulted in some changes to health behaviours such as smoking and diet choices, increasing inequalities and causing concerning deteriorations in mental health.

SMOKING

Smoking is a significant public health challenge: it is the leading cause of preventable disease and premature deaths in England (4). Smoking is more prevalent among low-income groups and the differences in smoking prevalence can translate into differences in disease burdens and death rates between social groups (5). The most recent data, from Public Health England's Annual Population Survey for 2019, indicate that prior to the pandemic, smoking prevalence was generally higher among groups considered to be of lower socioeconomic status according to occupation, as shown in Figure 8.1, with the prevalence being highest among those in routine and manual occupations or in the unemployed or never worked group, for both males and females.

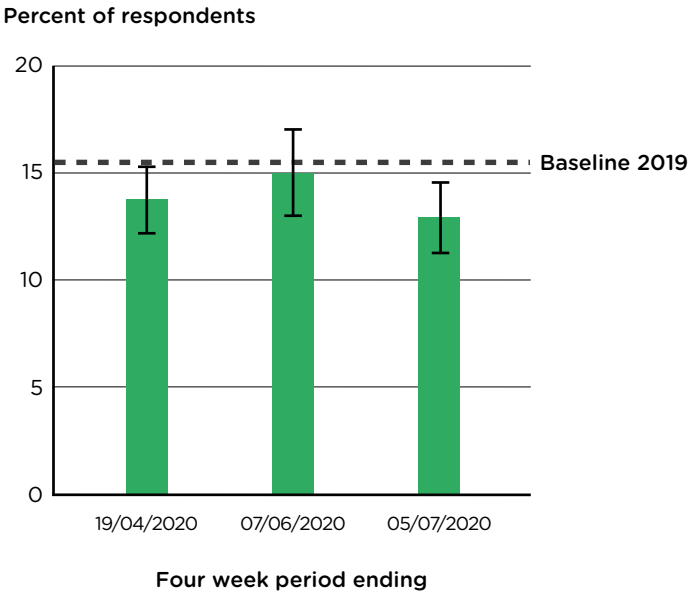
Figure 8.1. Smoking prevalence in adults aged 18–64 years in England, for males (A) and females (B), by socioeconomic group, 2019



Source: *Public Health England Annual Population Survey (2011-2019) (6).*

Stress and anxiety have consistently been found to be risk factors associated with smoking (7; 8; 9). However, a study by Jackson et al found the lockdown was associated with an increase in the rate of quit attempts and cessation among individuals who had been smokers in the past year (11). The data was weighted to match the adult population based on age, social grade, region, and ethnicity and working status. Additionally, data from the PHE monitoring tool based on data from the ONS Opinions and Lifestyle Survey show that smoking prevalence was lower between April 2020 and July 2020 compared with the 2019 average, as shown in Figure 8.2 (12).

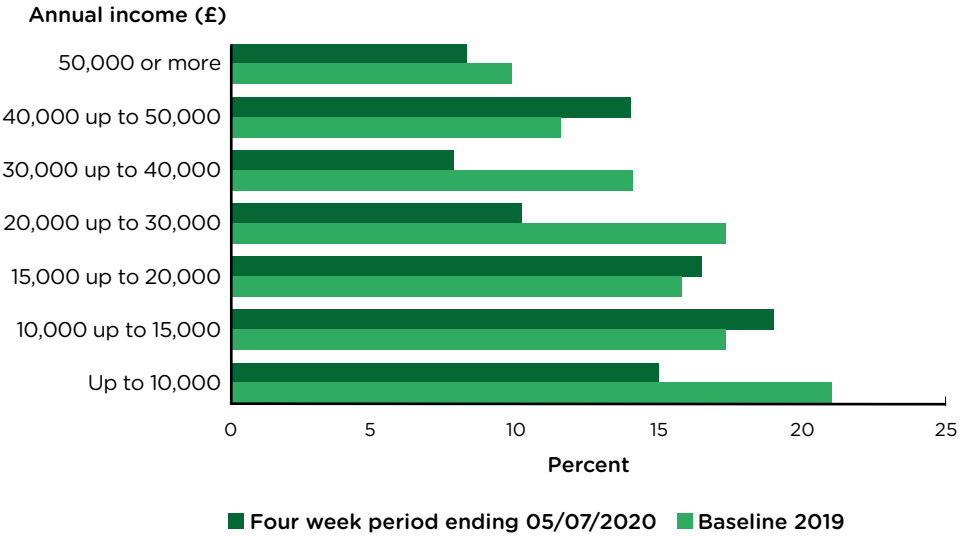
Figure 8.2. Trends in smokers in England from 19 April to 5 July 2020, compared with 2019



Source: *Based on data from ONS Opinions and Lifestyle Survey as presented in PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (12).*

When looking at smoking patterns across income groups, there was a decrease in the percent of respondents smoking in July 2020 compared with the baseline for most income groups with the exception of those in the £10,000–20,000/year and £40,000–50,000/year income groups (12).

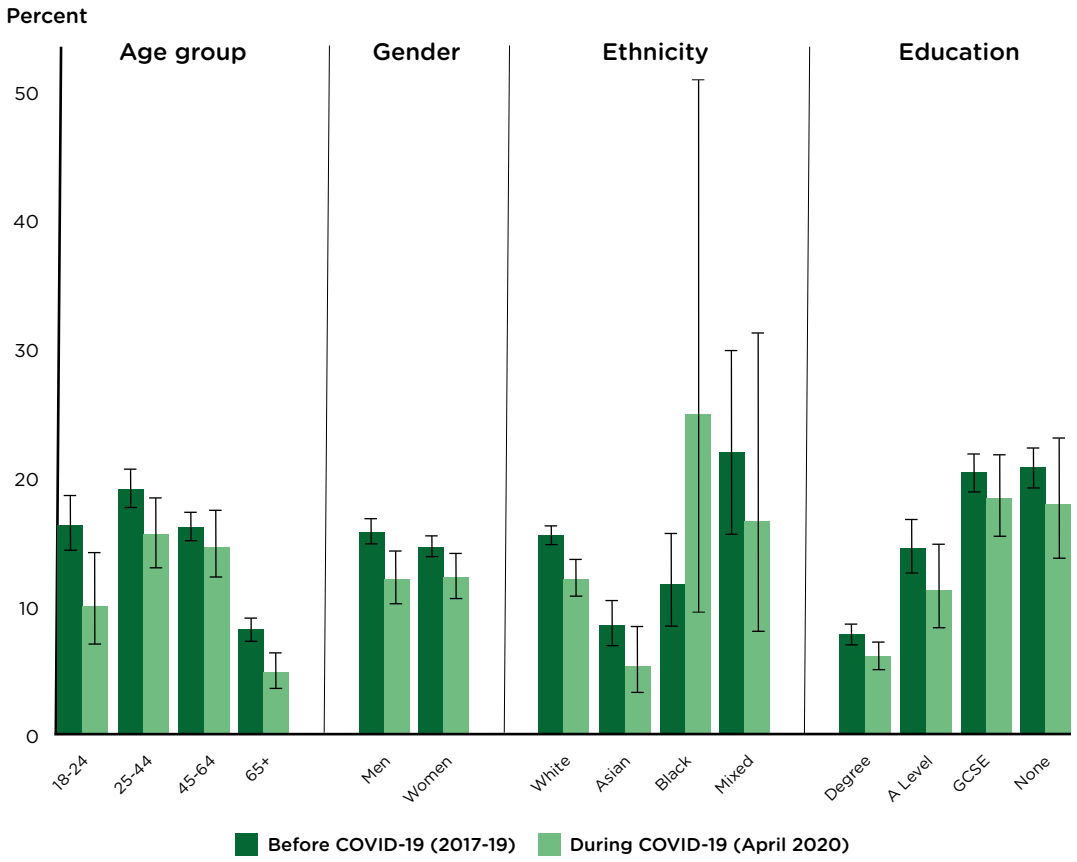
Figure 8.3. Percent of current smokers in England, by annual income, in 2019 and July 2020



Source: *Based on data from ONS Opinions and Lifestyle Survey as presented in PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (12).*

As with the two studies described above, analysis of the UK Household Longitudinal Study showed that cigarette smoking decreased overall during the first lockdown. The decrease in smoking was more apparent in younger age groups and in men, as shown in Figure 8.4. (370)

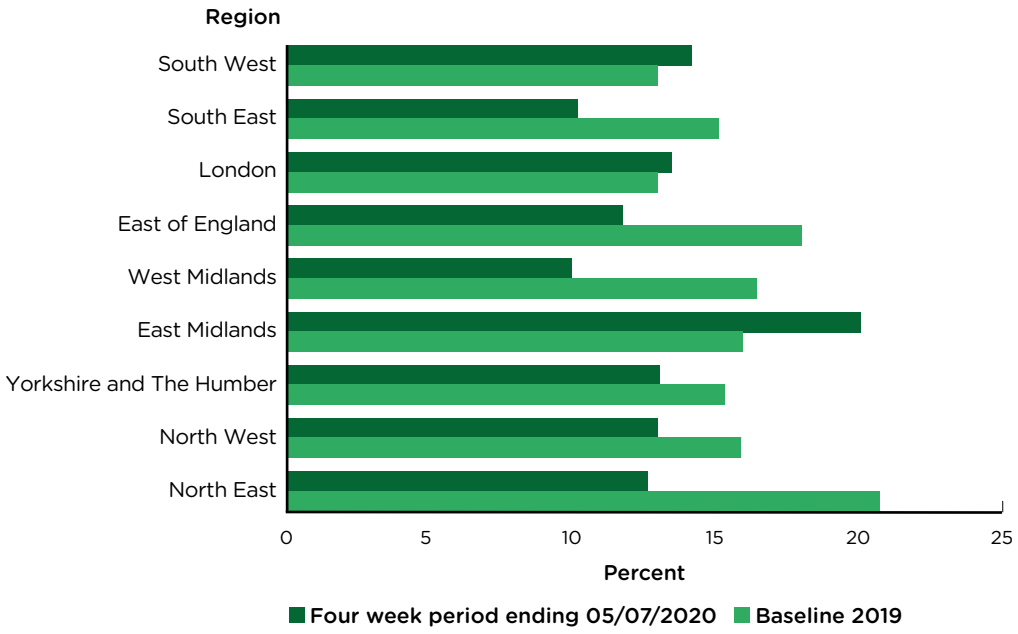
Figure 8.4. Percent smoking before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



Source: *Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (370).*

There was a decrease in the proportion of respondents smoking in most regions in the UK in July 2020 compared with the 2019 baseline, with the exception of the East Midlands, the South West and London, which saw increases (Figure 8.5).

Figure 8.5. Percent of survey respondents who are current smokers in England, by region, in 2019 and July 2020



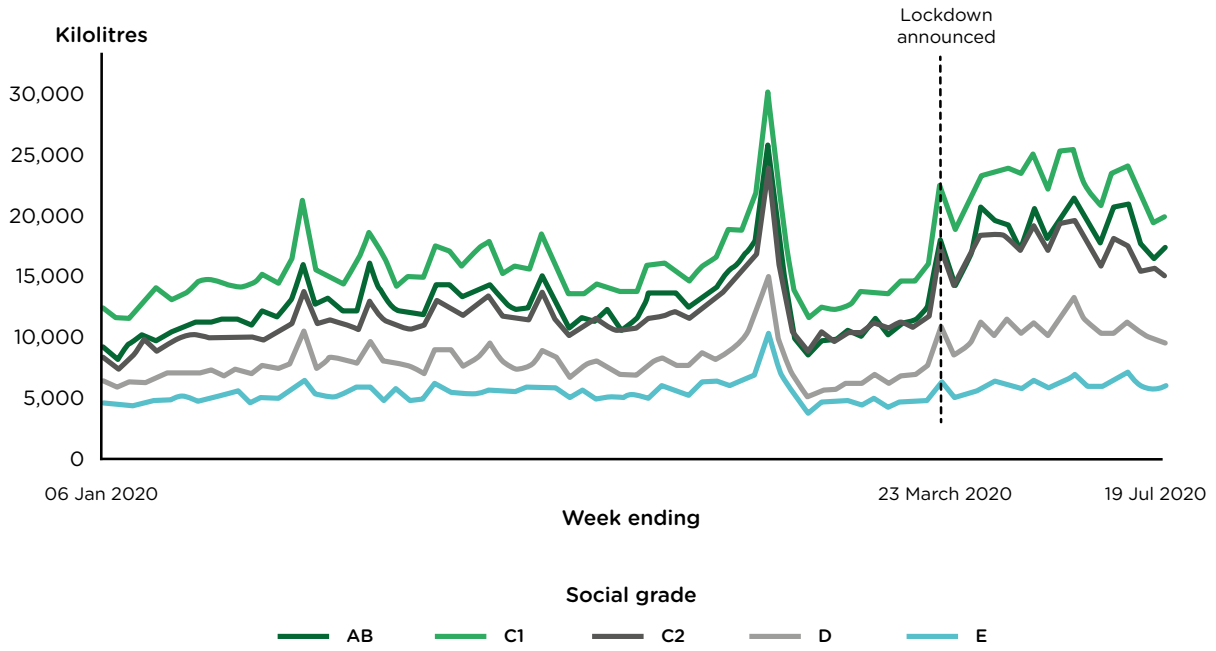
Source: *Based on data from ONS Opinions and Lifestyle Survey as presented in PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (369).*

ALCOHOL

Alcohol misuse has been associated with a number of adverse health and social consequences. Some of the long-term health risks associated with alcohol misuse include high blood pressure, depression, liver disease, certain types of cancer and pancreatitis (371, 372). As outlined in the Marmot Review (2010), there is an inverse social gradient for alcohol consumption, with consumption generally increasing with increasing level of household income however, health harm runs the opposite way with greater harm increasing with decreasing level of household harm (6).

The breakdown of alcohol purchasing data from Kantar World panel data which is available in PHE's WICH tool for up to 19 July 2020 shows that there was an increase in purchasing alcohol after announcement of the first lockdown for all social groups (Figure 8.6), but that higher social grades saw much higher increases, widening social inequalities in alcohol consumption.

Figure 8.6. Trend in alcohol volume sales in Great Britain from 6 January to 19 July 2020, by occupational social grade

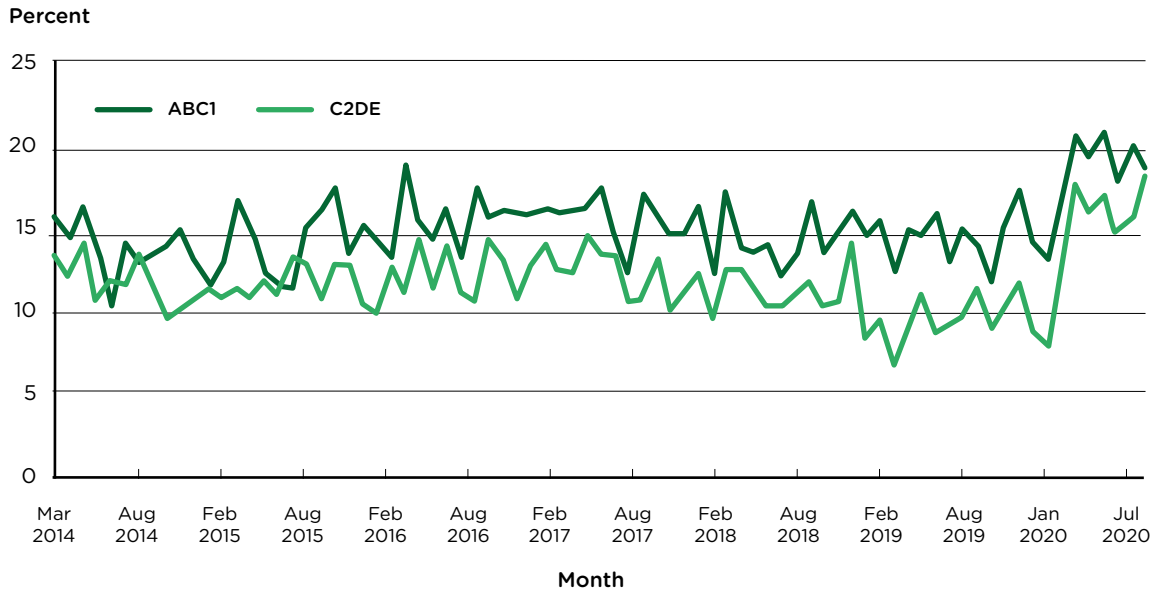


Notes: *AB = higher and intermediate managerial, administrative and professional workers, C1 = supervisory, clerical and junior managerial, administrative and professional workers, C2 = skilled manual workers, D = semi-skilled and unskilled manual workers, E = people on long-term state benefits, casual and lowest grade workers, unemployed with state benefits (including pensions) only.*

Source: *Institute of Alcohol Studies (2020) based on PHE analysis of Kantar Worldpanel Data (373).*

The latest data from UCL's Alcohol Toolkit study (August 2020) show that there has been a sharp increase in the prevalence of higher risk drinking since the beginning of the COVID-19 crisis in England and the introduction of the lockdown measures, to the highest levels seen since March 2014 (374) (Figure 8.7). There was an increase for all social grades as grouped by occupational status. The proportion of higher risk drinking was generally higher in the higher social grades, but increases seen between April and July 2020 in the lower social grades saw these groups come close to parity in terms of prevalence of higher risk drinking in July 2020.

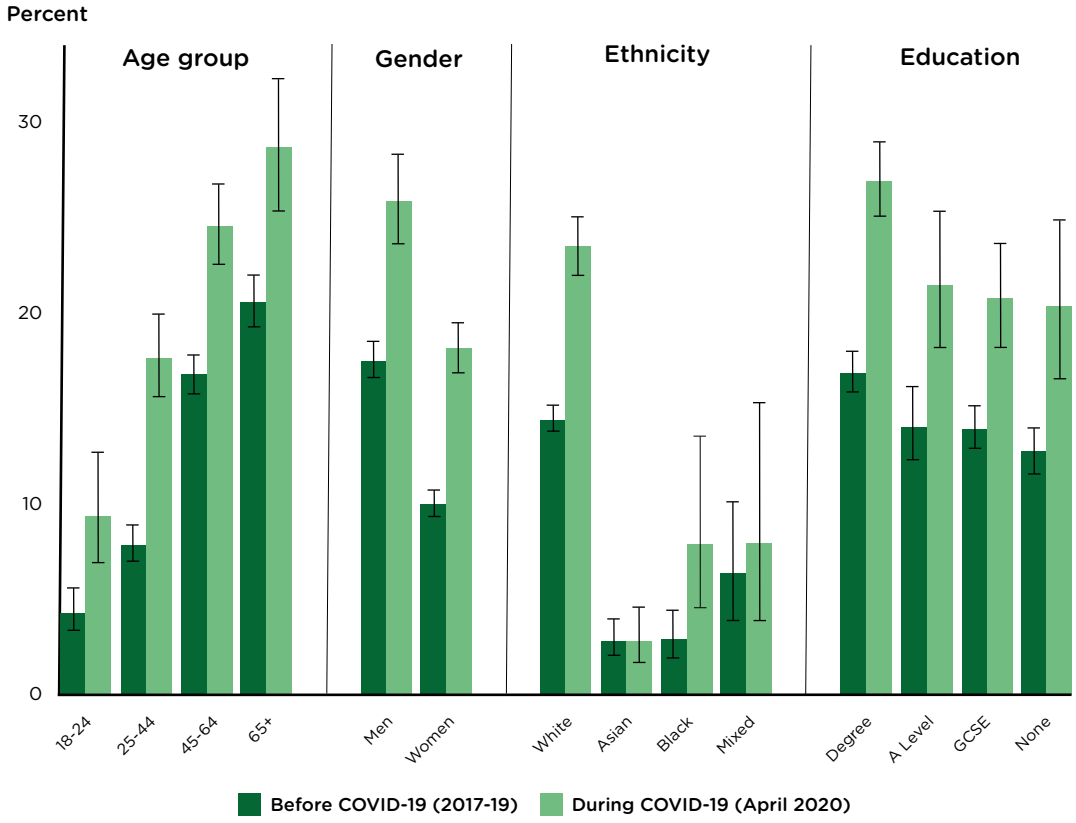
Figure 8.7. Prevalence of increasing and higher risk drinking (Alcohol Use Disorders Identification Test [AUDIT]), by social grade, March 2014 to July 2020



Source: *PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health, based on data from the Alcohol Toolkit Study, UCL (369).*

Frequent drinking, defined as the percent of people reporting drinking four or more times a week, increased during the first lockdown. The increases were higher among women, White ethnic groups and those with degree-level education, as shown in Figure 8.8 (370).

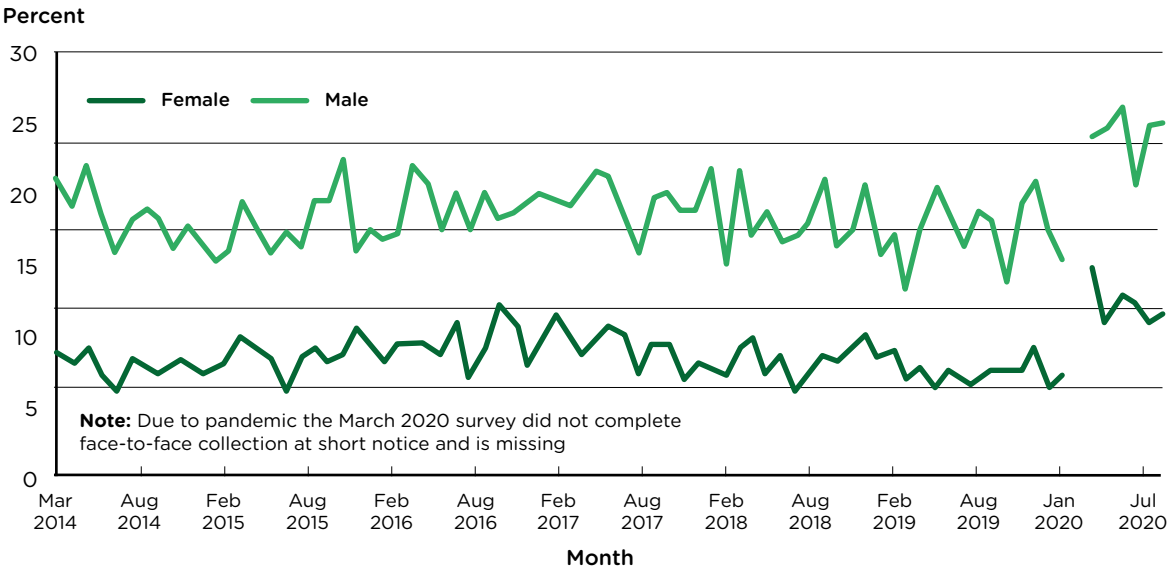
Figure 8.8. Percent with alcohol intake 4+ times/week (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



Source: *Niedzwiedz CL, et al. Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (370).*

The increased prevalence of higher risk drinking was seen for both males and females following the introduction of the lockdown restrictions but the higher prevalence of higher risk drinking among males remained – Figure 8.9.

Figure 8.9. Prevalence of increasing and higher risk drinking (Alcohol Use Disorders Identification Test [AUDIT]), by sex, March 2014 to July 2020



Source: *PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health. based on data from the Alcohol Toolkit Study, UCL (369).*

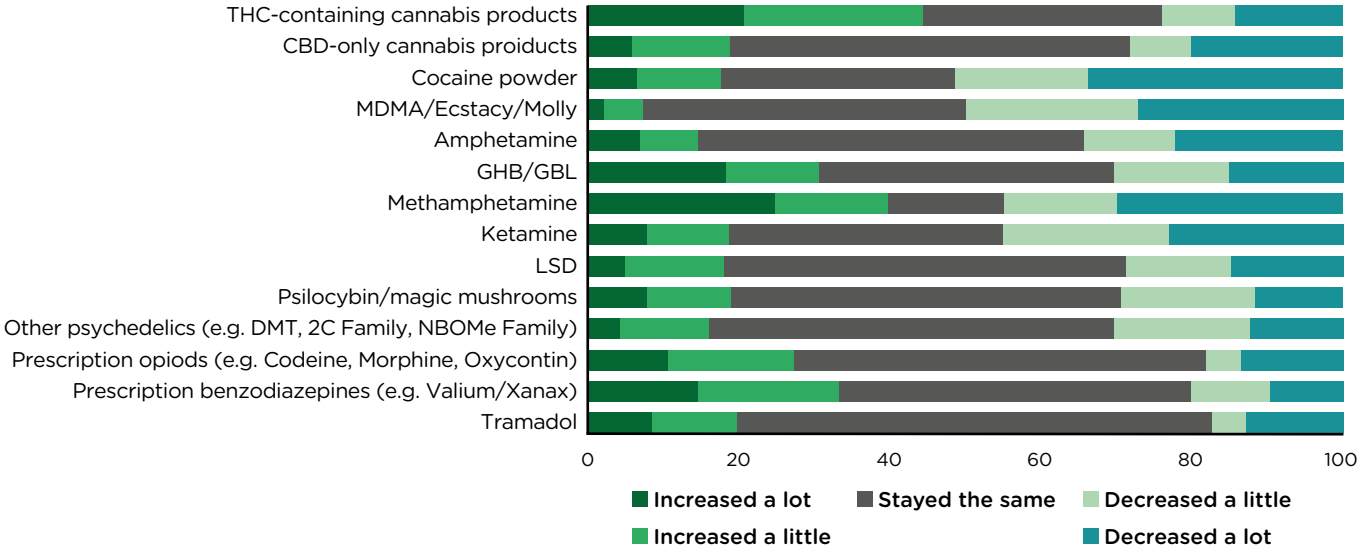
DRUG MISUSE

The association between socioeconomic inequalities and drug use are well recognised in research literature (374). As outlined in the Marmot Review, there is a significant positive correlation between higher deprivation levels and the prevalence of problematic drug users (aged 15–64 years), as well as admission rates for drug-related conditions, in England (6).

The latest drug report from the United Nations Office on Drugs and Crime warned of the potential for the COVID-19 crisis to worsen the drug situation and that increasing unemployment and reduced employment opportunities resulting from the pandemic were more likely to affect poorer individuals, which could consequently make them more vulnerable to drug misuse (375, 376). Lawn et al. have suggested that the COVID-19 pandemic is likely to have had a substantial impact on the use of both legal and illegal drugs, but also highlight that it is difficult to assess how illegal drug use patterns have specifically changed as a result of the pandemic and the introduction of the lockdown measures (376). They point to a number of ongoing surveys globally that could provide greater insight into the COVID-19 crisis's impacts on illegal drug use (377).

Figure 8.10 shows the results of a sample of 2,136 British respondents to the Global Drug Survey from May to June 2020. The results show that 44 percent of respondents increased their use of cannabis, 34 percent their use of prescription benzodiazepines and 28 percent their use of prescription opioids, as shown in Figure 8.10.

Figure 8.10. Change in the frequency of drug use in Britain by selected drug, comparing before the COVID-19 crisis with May–June 2020



Source: *Russell Webster based on data from the Global Drug Survey (May–June 2020) (377).*

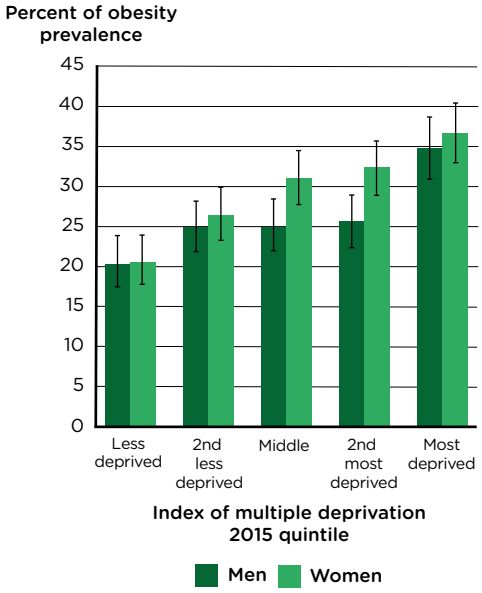
OBESITY

Obesity is highly prevalent in England, with adverse health outcomes and has been causally linked with several chronic diseases including diabetes, hypertension, stroke and certain forms of cancer, and increased risk of mortality (379). As set out in chapter 2, obesity is a risk factor for mortality from COVID-19. Obesity is closely associated with socioeconomic position and there are clear inequalities in levels of obesity related to area deprivation and individual socioeconomic position. It also disproportionately affects some BAME groups, and individuals with disabilities or mental health problems (380).

The lockdown measures instigated in response to the pandemic meant that people were largely confined to their homes. This impacted on people's weight-related behaviours, for example increases in unstructured time and stress and anxiety associated with the pandemic likely increases likelihood of overeating and sedentary behaviour (381). This, combined with the disruptions seen to many health services including weight management services, could potentially lead to increases in the already high levels of obesity in England. Therefore, while the impacts of COVID-19 on long-term weight-related outcomes are so far unclear, they could be substantial.

Obesity prevalence is highest among the most deprived groups at more than 34 percent, compared with just over 20 percent in the least deprived groups. Analysis of Health Survey England data from 2018 show that the prevalence of men and women who were obese increased with each level of deprivation (Figure 8.11).

Figure 8.11. Age standardised prevalence of adults (aged 16-plus) who are obese (BMI ≥30kg/m2) by level of deprivation, England, 2018



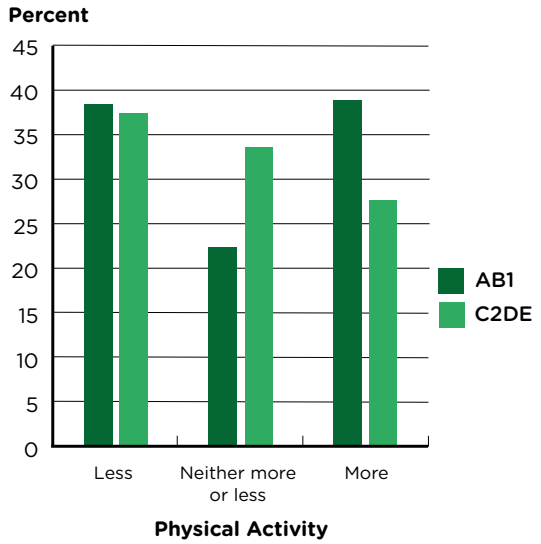
Note: *95% confidence intervals are shown.*

Source: *PHE. Excess Weight and COVID-19, 2020 (382).*

PHYSICAL ACTIVITY

Levels of physical activity are closely related to physical and mental health outcomes. There are pre-existing inequalities in levels of physical activity related to socioeconomic position and more advantaged groups tend to have higher levels of physical activity (6). Physical activity can reduce levels of overweight and obesity which are harmful to health and which are high and increasing. Adults in higher occupational groups increased their levels of physical activity more than adults in lower-occupational grades, as shown in Figure 8.12.

Figure 8.12. Percent of adults doing more, less or the same amount of physical activity in England between 3 April and 11 May 2020 (during the first lockdown), by social grade



Notes: *ABC1 = higher and intermediate managerial, administrative and professional workers, supervisory, clerical and junior managerial administrative and professional workers, C2DE = skilled manual workers, semi-skilled and unskilled manual workers, people on long-term state benefits, casual and lowest grade workers, unemployed with state benefits (including pension) only.*

Source: *Based on survey data from Sport England by Savanta ComRes as presented in PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (369).*

A study by Robinson et al. conducted between 28 April and 22 May 2020 with a sample of 2,364 UK adults (aged over 18) showed that Changes in weight related behaviours were analysed according to certain individual predictive factors such as age, gender, education, household income, ethnicity, having a psychiatric condition or having a high risk medical condition. The results showed that lower education levels, being white, having a diagnosed psychiatric condition, class II obesity or higher and a high-risk medical condition were significantly associated with less favourable weight management behaviours, as shown in Table 8.1 (12). These results suggest that negative changes in weight management behaviours during lockdown have disproportionately affected certain groups. This could consequently increase the risk of obesity among participants with higher BMI.

Table 8.1. Predictors of physical activity, diet quality and overeating during lockdown among a sample of UK adults (aged over 18), April–May 2020

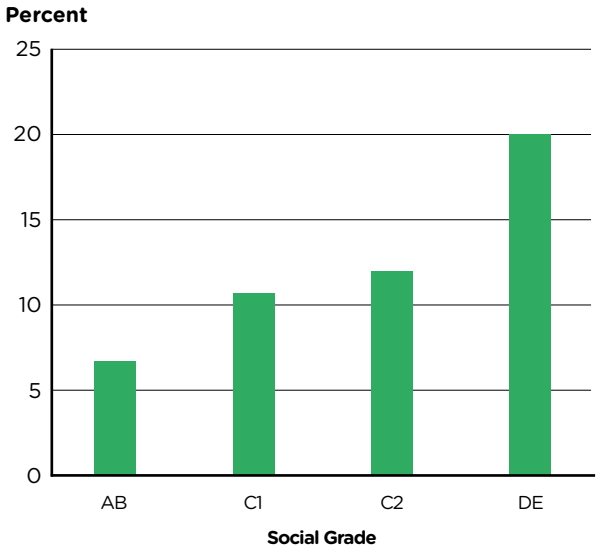
Step 1	Physical activity (MET minutes)	Diet quality (total scoare on FFQ)	Overeating (Appetite drive subscale)
	Adjusted R^2 = .066	**Adjusted R^2 = .092**	**Adjusted R^2 = .156**
Age	β = .049, p = .037	β = .212, p = .001*	β = –.084, p < .001*
Gender (female)	β = –.039, p = .082	β = .150, p = .001*	β = .058, p = .006*
Degree level education (yes)	β = –.024, p = .278	β = .091, p = .001*	β = –.075, p = .001*
Houshold income (£)	β = .072, p = .001*	β = .012, p = .567	β = –.010, p = .628
Ethnicity (not white)	β = –.073, p = .001*	β = .075, p = .001*	β = –.013, p = .548
Previous psychiatric diagnosis (yes)	β = –.049, p = .030	β = –.013, p = .544	β = .067, p = .002*
At risk medical group for COVID (yes)	β = –.066, p = .007*	β = –.019, p = .423	β = –.009, p = .695
Diagnosed/suspected COVID (yes)	β = .039, p = .078	β = –.016, p = .467	β = .059, p = .004*
BMI	β = –.132, p < .001*	β = –.167, p < .001*	β = .361, p < .001*
COVID mental health decline (perceived)	β = –.083, p = .001*	β = –.036, p = .151	β = .075, p = .002*
COVID interpersonal decline (perceived)	β = .011, p = .670	β = –.046, p = .058	β = .032, p = .169*
COVID physical health decline (perceived)	β = –.106, p = .001*	β = –.054, p = .022	β = .013, p = .627
Step 2	**Adjusted R^2 = .065**	**Adjusted R^2 = .092**	**Adjusted R^2 = .155**
BMI* COVID mental health decline	β = –.027, p = .273	β = –.002, p = .926	β = .023, p = .340
BMI* COVID interpersonal health decline	β = –.003, p = .896	β = –.033, p = .183	β = –.008, p = .746
BMI* COVID physical health decline	β = .022, p = .355	β = .023, p = .326	β = .007, p = .760

For BMI categories, BMI 18.5-24.9 is the reference category.
*significant based on planned analysis strategy (p < .05).

Source: *Based on analysis of survey data by Robinson et al. (2020) (381).*

There are inequalities in access to gardens, and this will have impacted on levels of physical activity and wellbeing. Exercising outside can have a more positive mental health impact than exercise of other kinds (378). Lockdowns and social isolation have been much more harmful to those without access to gardens, as shown in Figure 8.13.

Figure 8.13 Percent of respondents who reported that they do not have access to a garden, by social grade (2014–2019)



Notes: *AB = higher and intermediate managerial, administrative and professional workers, C1 = supervisory, clerical and junior managerial, administrative and professional workers, C2 = skilled manual workers, DE = semi-skilled and unskilled manual occupations, unemployed and lowest grade occupations.*

Source: *PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health based on data from ONS – Access to gardens and public green space in Great Britain (from Natural England – Monitor of Engagement with the Natural Environment Survey) (369)*

8.B MENTAL HEALTH

There is increasing evidence about the impact that COVID-19 and the containment measures will have on the mental health of people in the UK. Additionally, certain groups may be at higher risk of adverse mental health impacts based on factors such as mental health status prior to the pandemic, age, ethnicity, vulnerability to the health impacts of the virus and socioeconomic status (384). As such, the COVID-19 pandemic could lead to a widening of already existing mental health inequalities within the UK.

There are various stressors arising from the pandemic and lockdown restrictions that could serve to prompt or exacerbate adverse mental health outcomes, including stress associated with financial loss or loss of employment, frustration, loneliness, boredom, fears of infection, worries about the future and concerns about access to goods and services, including support services (359) (361). These can be risk factors for several mental health conditions including post-traumatic stress, anxiety, depression and affective disorders (361). There is evidence that these challenges are being experienced disproportionately across groups based on factors such as ethnicity, socioeconomic backgrounds and pre-existing mental health needs.

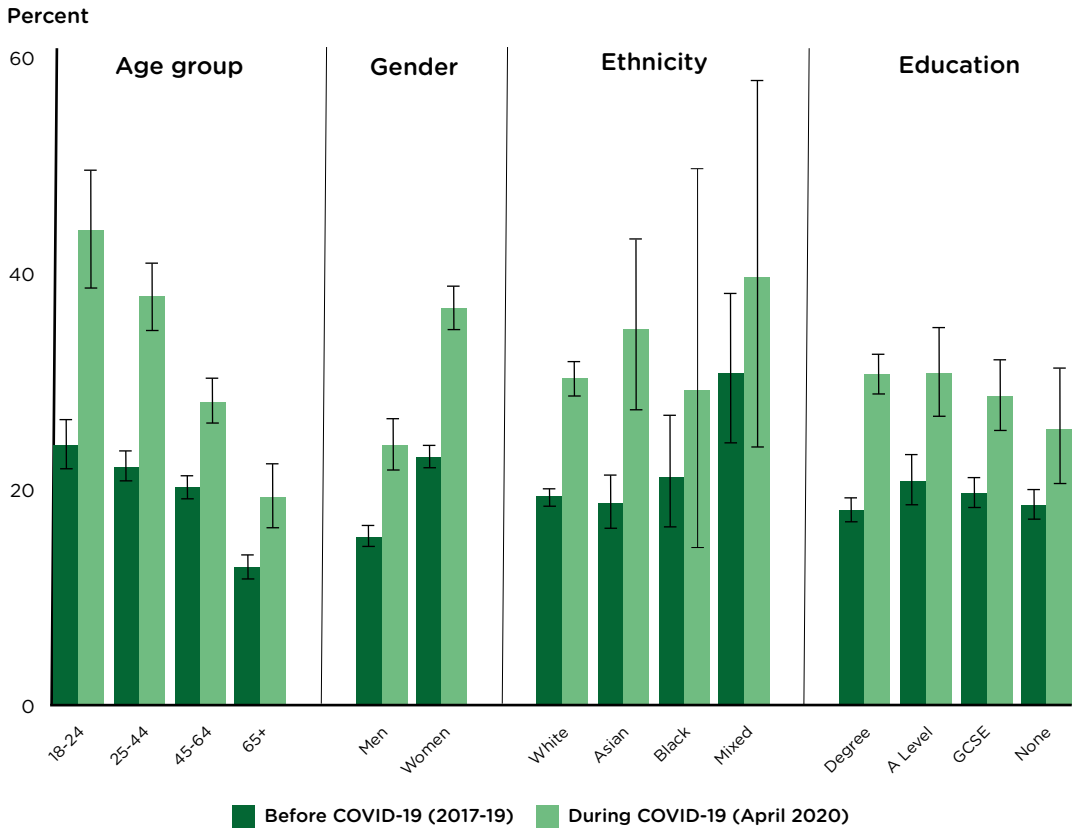
The lockdown measures and social distancing orders put in place in England in response to COVID-19 have meant that in-person social contact has been restricted since the outbreak of the pandemic. These have caused concerning increases in the rates of loneliness and isolation and the adverse health effects associated with these. The impact of lockdown measures such as social distancing and school and youth group closures on the mental health and wellbeing of children and young people are described in Chapter 4.

The economic impact of the pandemic is also likely to cause significant mental health impacts. Based on the outcomes of the 2008 recession, Durcan et al. estimate that an additional 500,000 people would be experiencing mental health problems as a result of the economic crisis triggered by the pandemic, with depression being the most common (385). They predict that the prevalence of such mental health problems will be unevenly distributed, given the different economic impacts that the crisis has had on particular parts of the country and on particular groups (385). These impacts are likely to increase as economic impacts worsen and unemployment and poverty rise in the near and medium term.

An analysis conducted by Banks et al. using longitudinal data from the Understanding Society study, concluded that mental health in the UK had substantially worsened as a result of the pandemic (386). There has been on average, an 8.1 percent decline in mental health (based on an overall measure of mental health General Health Questionnaire [GHQ]-12 score) in the UK as a result of the pandemic (386).

Data from April 2020 show that the increase in psychological distress had been, by that point at least, most pronounced among people aged under 45 years, as well as among those with higher educational attainment. Women had been more adversely affected than men. Mixed minority ethnic groups had experienced the largest increase in psychological distress, followed by Asian groups, as shown in Figure 8.14 (370).

Figure 8.14. Rates of psychological distress (GHQ-12) before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study

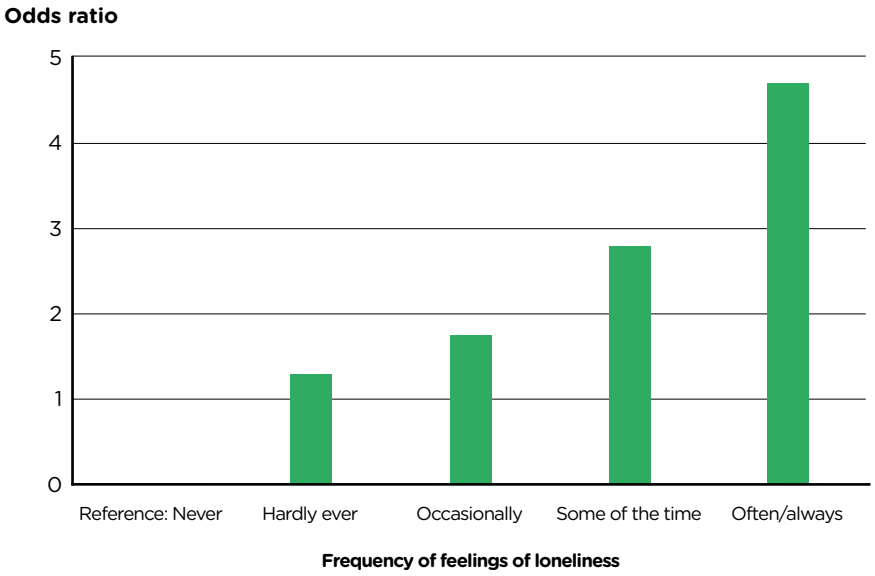


Source: *Niedzwiedz CL, et al. Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (370).*

Data from the ONS Opinions and Lifestyle Survey from 3 April to 10 May 2020 showed that the proportion of people who were experiencing high anxiety had increased sharply since the outbreak of the pandemic in the UK, particularly during the first weeks of lockdown and that feeling lonely was strongly associated with reports of high anxiety (387).

Figure 8.15 shows that those who said they often or always felt lonely were around five times more likely than those who never felt lonely to report to having high anxiety (387). Those who were lonely some of the time were just under three times more likely to experience high anxiety, compared with those who never felt lonely (387). (Section 8.C discusses loneliness in more detail.)

Figure 8.15. Odds ratio of experiencing high anxiety in Great Britain, by frequency of loneliness, 3 April to 10 May 2020



Notes: *Anxiety scores were based on responses to the survey question "Overall, how anxious did you feel yesterday?" Responses were scored on a scale of 0 to 10, where 0 corresponds to "not at all" and 10 refers to "completely". The outcome variable used in the regression analysis was binary in that scores between 6 and 10 represent high anxiety and scores between 0 and 5 are for those who do not have high anxiety. Never feeling lonely was used as the reference category.*

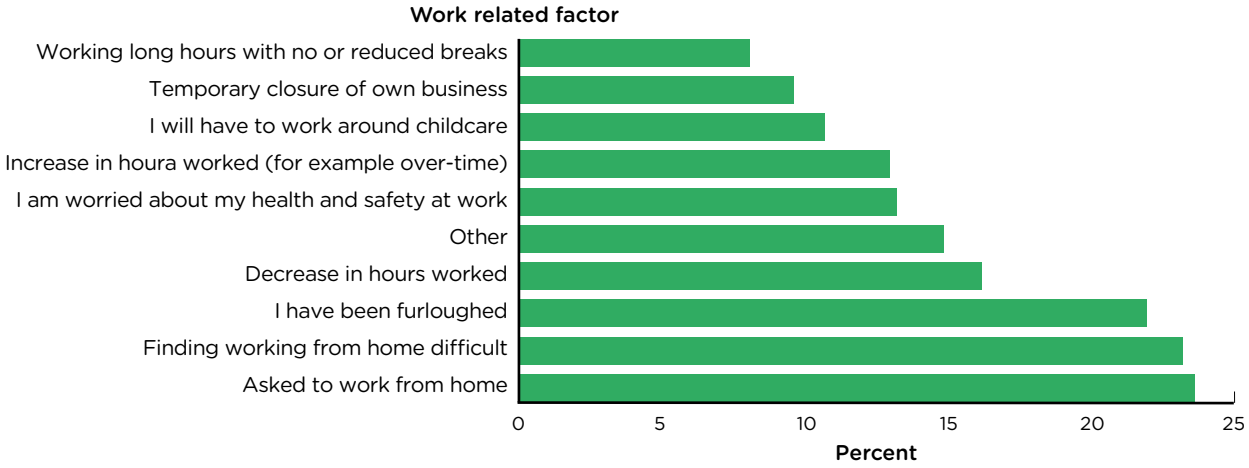
Source: *Based on ONS regression analysis of data from the ONS Opinions and Lifestyle Survey (3 April to 10 May 2020) (387).*

Those who were married or in a civil partnership were more likely to be experiencing high levels of anxiety during the first weeks of lockdown, despite having the lowest proportion of high anxiety pre-pandemic. There was a 20 percent increase in the proportion of those who were married or in a civil partnership experiencing high anxiety between October to December 2019 and April to May 2020, from 19 to 39 percent (387). The added pressures of homeschooling during these first few weeks of lockdown could be a contributing factor to the higher anxiety levels reported among those who were married or in a civil partnership (especially for women, as described below), with 25 percent of those in those categories having homeschooled during that period, compared with 10 percent of respondents who were single, divorced or separated (387).

Prior to the lockdown restrictions coming into effect, anxiety was generally higher among women than men (387). This continued during the early weeks of lockdown, with average anxiety scores for women throughout the period of 20 March to 10 May 2020 being 4.7 out of 10, compared with 3.9 out of 10 for men (387). Potential factors contributing to this higher anxiety among women based on data from the ONS Opinions and Lifestyle Survey include the higher proportion of women finding working from home, being more concerned about their health and spending more time doing unpaid housework (387). The pressure of homeschooling was also experienced disproportionately by women, who conducted 60 percent of it (387).

The pandemic has impacted on the mental health of working people. Banks et al. found that key workers had less of a deterioration in mental health, while those who had lost their jobs had more of a deterioration (controlling for other factors) (386). Other factors in declining mental health include decreases in household earnings from February 2020 and having COVID-19 symptoms (386). The ONS identified six variables that were most strongly associated with high levels of anxiety, one of which was whether a person's work had been affected by the pandemic (387). Of those experiencing high anxiety, being asked to work from home and finding it difficult to work from home were the most commonly reported ways in which their work had been affected (Figure 8.16).

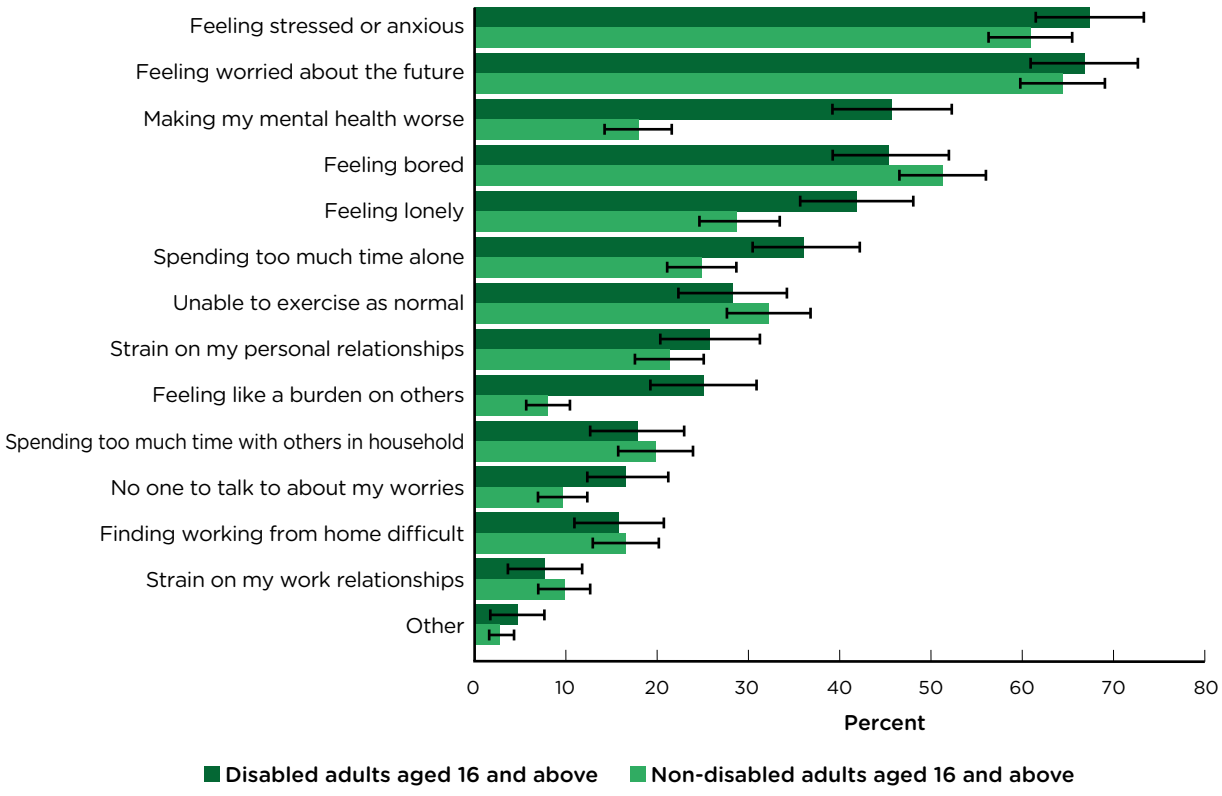
Figure 8.16. Ways in which work had been affected for those experiencing high anxiety during the pandemic in the UK, 9 April to 3 May 2020



Source: *Based on ONS Opinions and Lifestyle Survey data as reported in the ONS Coronavirus and anxiety report (387).*

Analysis of data from the ONS Opinions and Lifestyle Survey found that having a disability was significantly associated with reports of high anxiety following the outbreak of the COVID-19 pandemic. Data for July 2020 showed that higher proportions of disabled than non-disabled people stated a range of aspects of their mental health were being made worse by COVID-19. For example, 42 percent of disabled versus 29 percent of non-disabled people said they were feeling lonely, and 17 percent versus 10 percent said they had no one to talk to about their worries (Figure 8.17) (388).

Figure 8.17. Percent of disabled and non-disabled adults (aged over 16) reporting adverse impacts of COVID-19 on their mental health, Great Britain, July 2020



Note: *"*" indicates a small sample size of either disabled or non-disabled respondents that selected this way in which coronavirus (COVID-19) was affecting their well-being, as such these estimates and comparisons made using them should be interpreted with caution.*

Source: *ONS, Coronavirus and the social impacts on disabled people in Great Britain: July 2020 (388).*

8.C SOCIAL ISOLATION AND LONELINESS

Since the outbreak of COVID-19 in the UK, social distancing, quarantine and stay-at-home orders have been implemented as some of the main measures for containing the transmission of the virus. These measures, which promote physical separation to prevent viral spread, have isolated many people from their usual social contexts and connections. Given the significant change in 'normal' social functioning that has occurred as a result, there are concerns over increasing numbers of people experiencing social isolation and the adverse associated health impacts, such as poor mental health. Loneliness is a common psychological manifestation of social isolation, and if prolonged it can have adverse impacts on an individual's physical and mental health and wellbeing (389).

The Local Government Association highlighted existing risk factors for loneliness or social isolation that could be exacerbated by the COVID-19 pandemic, as well as new risk factors arising from the pandemic (390). Existing factors include age, where a person lives, whether a person lives alone, household income, poor physical and mental health, and digital exclusion (390). Emerging factors include the need to shield due to being extremely medically vulnerable and reduced contact or access to statutory services (390). Challenges that can exacerbate loneliness include a reduction in support, a lack of meaningful contact and increased anxiety (391). As such, the containment measures to control the virus have disproportionate impacts on social isolation for particularly vulnerable groups according to such risk factors.

Due to the increased vulnerability to the adverse health impacts of COVID-19 among older people, those over 70 years of age were advised from 20 March 2020 to adhere particularly stringently to social distancing guidelines by the Government (392). As a large proportion of the elderly population live alone,; the ONS reported in 2017 that there were 3.8 million individuals in the UK who were 65 years or older and living alone, and 58 percent of them were over the age of 75 (393). Even prior to the pandemic, social isolation among the elderly was a significant public health concern, with Fakoya et al. stating that 50 percent of people aged over 60 were at risk of social isolation (394, 395). Thus, while the self-isolation advised by the Government in March has reduced the risk of exposure to the virus among this group, these measures will have also compounded social isolation among older adults (396, 397). This risk is often heightened by digital exclusion, with poor access and digital literacy being contributing factors (394). For example, the Manchester Urban Ageing Research group stated that nearly half of those aged over 75 do not have access to the Internet (398).

The Local Government Association has also highlighted that digital exclusion is a key influencing factor in social isolation, across age groups (390). While technology has been instrumental in allowing people to stay connected with others during the pandemic, there are inequalities in access, with nearly one-fifth of the UK population estimated not to have access to a smartphone or laptop and an estimated 1.9 million households lacking access to the Internet (396, 399). 25.9 million have a pay-as-you-go mobile phone (399), with the elderly and low-income households identified as groups who are particularly vulnerable to expensive pay-as-you-go tariffs, often due to not being able to afford home WIFI or fixed-term contracts (396). Education is another factor contributing to unequal digital access, with higher levels of educational attainment generally being associated with better use of new information and adaptation to new technologies (400). Overall, inequities in access to technology are likely to compound the risk of social isolation among certain groups as a result of the pandemic.

Loneliness, as defined by the Jo Cox Commission and in the Loneliness Strategy for England, is: "A subjective, unwelcome feeling of lack or loss of companionship. It happens when we have a mismatch between the quantity and quality of social relationships that we have, and those that we want." This is based on a definition first suggested by Perlman and Peplau in 1981 (402). Loneliness can occur among those who are not socially isolated. Inequities in the experiences of social isolation, however, are likely to influence inequities in loneliness and related adverse health consequences (401).

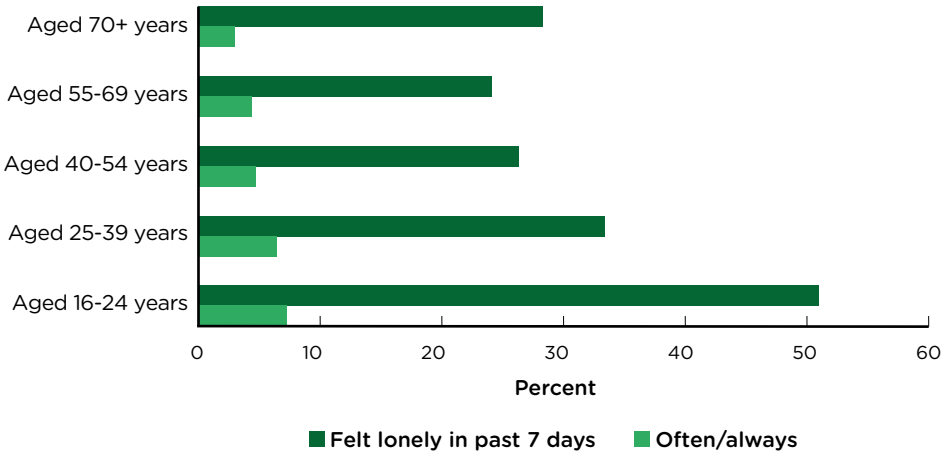
Holmes et al. described that loneliness was already increasing prior to the outbreak of the COVID-19 pandemic in the UK (397). As such, the containment measures instigated in response to the virus have exacerbated an already existing problem with regards to loneliness, 35.9 percent of survey respondents to wave 1 of Understanding Society COVID-19 Study (24–30 April 2020) said they were feeling lonely (403). The ONS Opinions and Lifestyle Survey between 3 April 2020 and 3 May 2020 showed that around 5 percent of the population in the UK reported

often or always feeling lonely, which is a similar proportion to those reporting the same pre-lockdown (401). This group was classified in the ONS report as being "chronically lonely" (401). Between 3 April and 3 May 2020, 31 percent of respondents (7.4 million adults) reported that their wellbeing had been affected by feelings of loneliness in the previous seven days (401). The ONS labelled this group the "lockdown lonely" and estimated them to be equivalent to 14.3 percent of the population of Great Britain if adjusted to be representative (401).

The study by Li et al. investigated the prevalence of loneliness in the UK in April 2020, by sociodemographic factors (403). The frequency of loneliness did not differ significantly across regions in the UK, but it did differ in terms of gender, age, whether the individual lived with a partner or not and by employment status (403). Women were significantly more likely to report loneliness than men (Odds Ratio of 1.79), and those who do not live with a partner were more likely than those who did (OR 3.22) (53). Those who were not employed also had higher odds of loneliness compared with those who were employed (OR of 1.40) (403). Younger people were nearly twice as likely as older people to report being lonely (see Figure 8.18) (401).

Fancourt et al. explored the risk factors for loneliness before and during the pandemic and found that the factors were similar in both periods (404). The results showed similar groups at risk of loneliness to those in Li et al. and their analyses found that those of lower education and on low incomes were also at higher risks of being lonely (54). Students, who are usually not considered to be of high risk of loneliness, were identified as a new high-risk group during the pandemic (404).

Figure 8.18. Percent of people who feel lonely, by age, Great Britain, 3 April to 3 May 2020

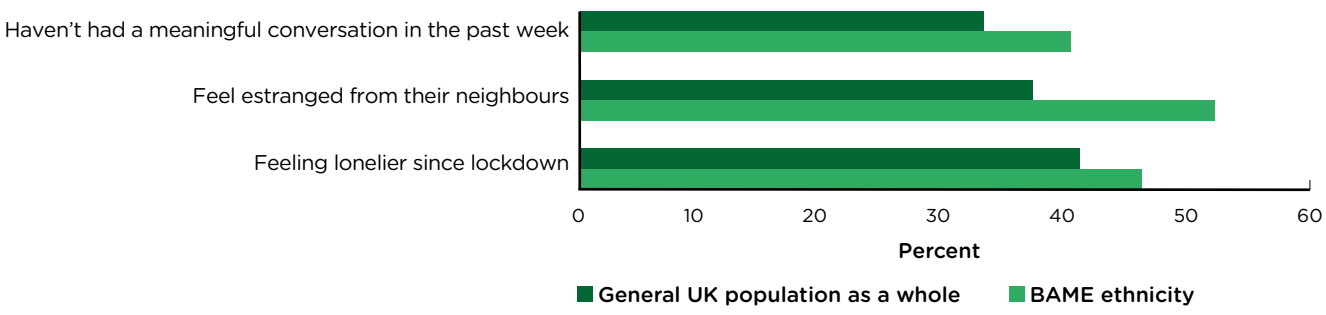


Notes: *All respondents were asked 'How often do you feel lonely?' and 'In the past seven days, how has your wellbeing been affected?' giving the option for noting 'Feeling lonely' if they have already noted that they were 'very worried' or 'somewhat worried' about the 'effect that Coronavirus (COVID-19) is having on their life right now'.*

Source: *ONS Opinions and Lifestyle Survey (401).*

Results of a survey conducted by the British Red Cross suggest that a higher proportion of those of BAME ethnicity have experienced feelings of loneliness during lockdown, compared to the experiences of UK adults as a whole (391). Specifically, 46 percent of respondents who were of BAME ethnicity reported to feeling lonelier since the beginning of lockdown, compared with 41 percent of all UK adults (391) in May 2020 – Figure 8.19.

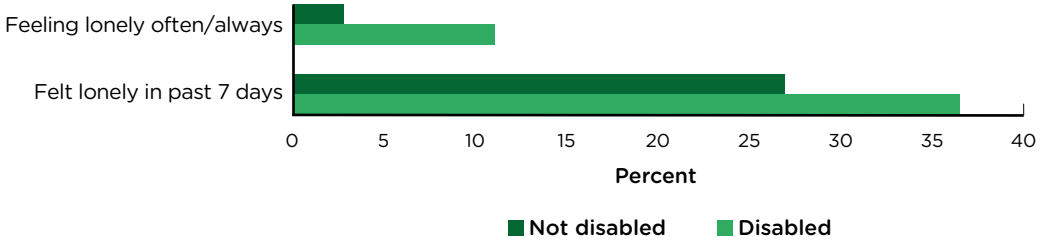
Figure 8.19. Feelings of loneliness, estrangement from neighbour or lack of meaningful conversations during lockdown among a sample of UK adults, by ethnicity (14–18 May 2020)



Source: *Based on data from the British Red Cross (2020) (391).*

An analysis conducted by the ONS on the results of its Opinions and Lifestyle Survey for 3 April to 3 May 2020 suggested that there were particular groups who were at higher risk of both chronic loneliness (who reported to being lonely often or always) and lockdown loneliness (401). Specifically, working-age adults who were living alone, in 'bad' or 'very bad' health, living in rented accommodation or who were single, divorced or separated from their partner were more likely to report to being 'often or always' lonely (chronic loneliness) or to have experienced loneliness in the the past seven days (lockdown loneliness) (401). The analysis suggests that persistent health concerns are more likely to be associated with chronic than lockdown loneliness (401) – Figure 8.20.

Figure 8.20. Percent of people who reported feeling lonely, by disability status, Great Britain, 3 April to 3 May 2020



Notes: *All respondents were asked 'How often do you feel lonely?' and 'In the past seven days, how has your wellbeing being affected?' giving the option for noting 'Feeling lonely' if they have already noted that they were 'very worried' or 'somewhat worried' about the 'effect that Coronavirus (COVID-19) is having on their life right now'.*

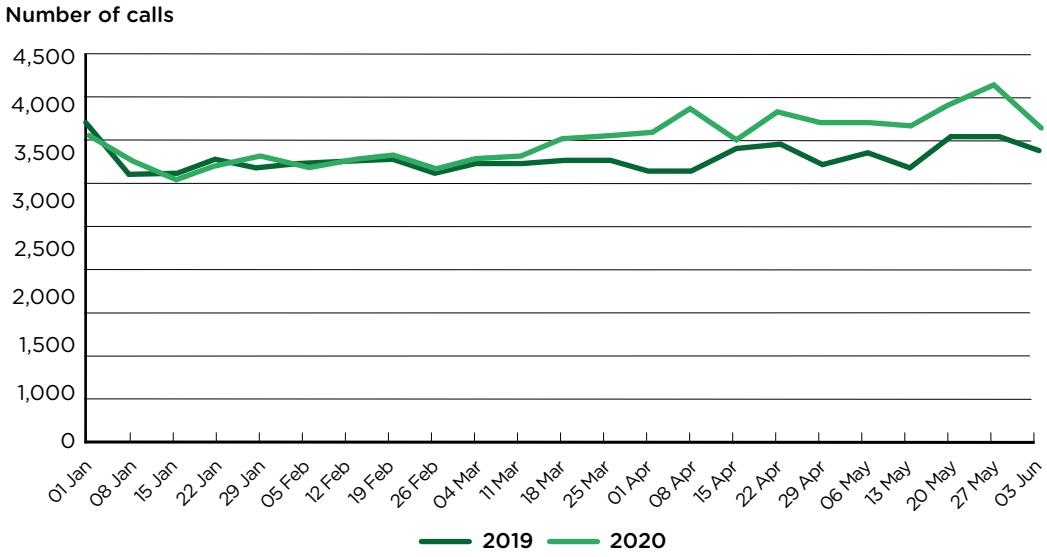
Source: *ONS Opinions and Lifestyle Survey (401).*

8.D DOMESTIC AND GENDER VIOLENCE AND ABUSE

Social isolation policies increase vulnerability to domestic abuse. There is a risk that in isolation, perpetrators will intensify their controlling behaviour, further restricting their partners' freedoms and threatening their safety during COVID-19 lockdowns. Financial dependence and poverty are both primary risk factors that diminish resilience when experiencing domestic abuse and can prevent people from leaving an abusive partner (405).

The London Metropolitan Police Service received a total of 41,158 calls-for-service for domestic incidents between 25 March (following the lockdown restrictions imposed on 23 March) and 10 June 2020, a 12 percent increase on the same period in the previous year, as shown in Figure 8.21 (406).

Figure 8.21. Weekly number of calls-for-service for domestic incidents, recorded by London Metropolitan Police Service, Greater London, 1 January to 10 June 2019 and 2020

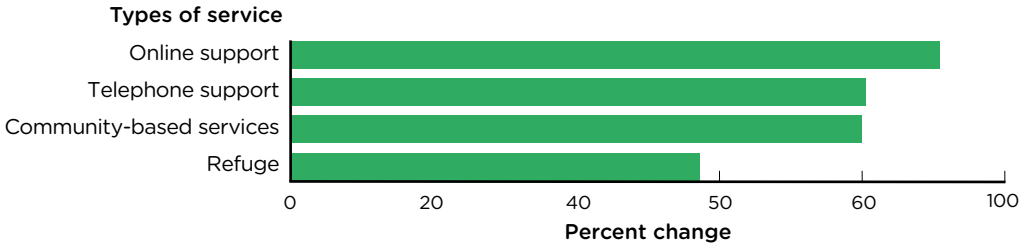


Note: *Dates in the horizontal axis refer to date of when week commenced.*

Source: *Changing patterns of domestic abuse during COVID-19 lockdown (406).*

COVID-19 containment measures such as lockdown and school closures increased the need for domestic violence support services, as shown in Figure 8.22. Increased confinement, working from home, higher intake of alcohol and drugs, children not attending school and lack of access to support networks increased women's exposure to domestic violence. Women's Aid research showed that containment measures also restricted women's ability to access support services and support from friends, relatives and work colleagues (407) (in chapter 4 we discussed children's increased exposure to abuse and neglect).

Figure 8.22. Percent change in the need for domestic abuse services during lockdown in England, June to July 2020



Source: *Women's Aid. A perfect storm: The impact of the COVID-19 pandemic on domestic abuse survivors and the services supporting them, 2020 (407).*

8.E PUBLIC HEALTH ORGANISATIONAL AND WORKFORCE CAPACITY AND FUNDING

Public Health has been at the forefront of efforts to reduce infection and mortality from COVID-19 and is trying to continue its essential work to improve health and reduce inequalities in health under hugely difficult circumstances. In the decade before the pandemic, funding for Public Health declined and a series of major reorganisations took up organisational capacity, leaving Public Health systems and workforces without the necessary resources and capacity.

Prior to the pandemic there was a slowdown in life expectancy "of a duration not witnessed in England for 120 years and that has not been seen to the same extent across the rest of Europe or in most other OECD countries" and "health ... deteriorated for the population as a whole" (1). While there has been limited action on health inequalities nationally, many local authorities have taken forward the recommendations and approaches outlined in the 2010 Marmot Review (6). However, since 2010, the most deprived communities and places have lost more funding than less deprived communities. As well as the need for greater investment in more deprived areas and for those on lower incomes in order to reduce health inequalities, the Public Health workforces nationally and in local authorities require resources to enable them to do this: to improve the nation's health overall with greater investment and action where it is needed most, through proportionate and universal action.

A core component of government support to help tackle poorer health outcomes is the Public Health Grant. It is provided to local government for a range of services including sexual health, stopping smoking, tackling obesity and children's services for under-5s (which includes health visitors) (408). The Department of Health and Social Care pays the 'Public Health Grant' to local authorities so that they can deliver these services. There is evidence that the returns on further public health spending are greater than those on further health care spending (408). However, this grant has been reduced substantially in recent years, and despite an increase in 2020/21, is now 22 percent lower in real terms compared with 2015/16. NHS England and NHS Improvement also receives a budget of around £1.3 billion per year to commission public health services such as immunisation and screening. Public Health England had a budget of £1 billion in 2018/19 to fund its work (409).

In March 2020, the Government reversed the trend of successive years of real-terms cuts, increasing the grant for 2020/21, but only by £80 million. That reversed only a fraction of the overall cuts made since 2015/16. Restoring real-terms per capita spending to the same levels as 2015/16 would require the equivalent of an additional £900 million a year. For 2021/22, an increase above this level to the Public Health Grant would help provide additional emergency support to offset the negative health impacts caused by higher unemployment, increased poverty and social restrictions. It would also accelerate the long-term restoration of the grant (408). However, even this increase would not ensure that the grant is allocated to local authorities in a way that best meets need, without making some areas worse off than they are now. Levelling up public health grant allocations, by taking account of local need for different public health services and demographics (in line with the formula developed by the Advisory Committee for Resource Allocation) would require an additional £2.5 billion a year (in 2020/21 prices) as the longer-term funding goal for 2023/24 (408).

In August 2020 the Government announced a major reorganisation of the Public Health system. A new National Institute for Health Protection will be established to focus on tackling the pandemic and, in due course, on preparing for future threats to public health. As part of the planned changes Public Health England will be disbanded and its prevention and health improvement functions will be reallocated to other organisations (409). According to the King's Fund, this decision risks causing significant uncertainty and disruption at a time when the Public Health community should be fully focused on responding to the pandemic (409). The new Institute will not be responsible for health improvement, but these functions and their funding – currently £180 million a year – must not be lost

in the reforms. A resilient public health system will be crucial to safeguard the nation's health in the recovery phase of the pandemic. As a minimum funding should be restored to bring total funding up to £235 million a year to support health improvement functions (408).

Wider reductions in local authority budgets since 2010/11 have also had an impact on services that support the health and wellbeing of the whole community – such as education, early years services, housing, transport, leisure centres and green spaces. This will make it harder to realise the Government's ambitions to prioritise prevention (409). (410).

While spending on health care is projected to increase, public health funding is still woefully inadequate, with further cuts planned (411). As the president of the Association of Directors of Public Health stated in November 2020:

> "COVID-19 has shone a light on the knowledge, expertise, and skills of Directors of Public Health and their teams. In the current circumstances, and following years of cuts to local public health, it is completely incomprehensible that the Government is not increasing the public health grant. … During 2021–22, local public health teams will continue to have a key role in the management of COVID-19 – and being prepared for any future epidemics. In addition, if we are serious about learning the lessons of how existing health inequalities have driven and exacerbated the impact of COVID-19, we must address the socio-economic determinants of health and invest in local public health teams." (412)
>
> **President of the Association of Directors of Public Health**

The decision to reorganise public health at the national level in 2021 will undermine public health leadership focus and capacity at a time when it is needed more urgently than ever. Existing public health organisations need further support and a stronger focus on social determinants of health and health inequalities. As we said in *10 Years On*:

> "It is imperative that the Government, NHS England, PHE and other organisations charged with reducing health inequalities, work more effectively to improve the conditions in which people are living, and the structural drivers of these conditions, as well as positively influencing the choices that people make about health behaviours. The Government has the evidence about the overwhelming impacts of social determinants on health but it has largely not acted on it and certainly not at sufficient scale (1)."
>
> **10 Years On report**

These imperatives are even more critically important during, and following, the pandemic, as the country struggles with the health impacts of containment measures. Underfunding and undermining capacity of public health run completely counter to meeting these challenges.

8.F CONCLUSIONS

Public Health organisations and workforce must be at forefronts of efforts to contain the pandemic, while continuing efforts to improve health and reduce health inequalities. These efforts are undermined by insufficient government funding and planned reorganisations and weakening of public health leadership. As we have documented throughout the report, health in England was already in a poor state before the pandemic and the pandemic and associated containment measures are further damaging health and significantly increasing health inequalities. For these deteriorations to be reversed it is essential to have a better resourced, flourishing Public Health system. Without this it will be impossible for England to build back fairer.

Action on the social determinants of health is necessary to reduce health inequalities. Hence, we have set out the need for an Inequalities Strategy to be at the centre of recovery from the pandemic, which should involve the whole of Government, and be led by the Prime Minister. Public Health has a crucial role, centrally and locally in providing the expertise, helping shape policies, monitoring and evaluation. The pandemic has reemphasised the importance of Public Health experts' clear and effective communication with the public. While there has been a welcome focus on social determinants among Public Health systems in recent years, this still needs to be strengthened.

BOX 8.4. BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LONG TERM

- A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health.
- Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities

MEDIUM TERM

- Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities.
- Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.

SHORT TERM

- Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient
- Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

CHAPTER 9
CONCLUSIONS

In 2017, Hurricane Maria hit Puerto Rico. Two months afterwards, mortality had risen – but far from uniformly: it shot up sharply for the lowest socioeconomic group, increased somewhat for the middle group, but the highest socioeconomic group saw far less impact (76). A huge external shock had thrust the underlying inequalities in society into sharp relief. So it has been with COVID-19 – a central message of this report. Documenting the pandemic's impact on inequalities in the social determinants of health, and in health, is a first step to achieving a more important goal: to Build Back Fairer. To do this, it is necessary to have the evidence of what has gone wrong and how to put it right.

In February 2020 we published Health Equity in England: The Marmot Review *10 Years On*, a review of what had happened to health and health inequalities in the decade since the publication of the 2010 Marmot Review, Fair Society, Healthy Lives (77). The picture was bleak: stalling life expectancy, rising health inequalities between socioeconomic groups and regions, and life expectancy declining for people in the most deprived areas. We made a series of recommendations, addressing the social determinants of health, for how things could and should improve.

Since then, with the COVID-19 pandemic, the world has changed dramatically. But in England the changes have been entirely consistent with its existing state when the pandemic hit in February. We set out at the beginning of this report the proposition that England's comparatively poor management of the pandemic was of a piece with England's health improvement falling behind that of other rich countries in the decade since 2010. We offered four likely reasons why: the quality of governance and political culture which did not give priority to the conditions for good health; continuing increases in inequalities in economic and social conditions, including a rise in poverty among families with children; a policy of austerity and consequent cuts to funding of public services; and a poor state of the nation's health that would increase the lethality of COVID-19.

Addressing all of these needs to be at the heart of what needs to change if we are to build a fairer, healthier society as we emerge from the pandemic.

One striking feature of health in the time of COVID-19 is the high mortality rate of members of Black, Asian and minority ethnic groups. Much of this excess mortality can be attributed to living in more deprived areas, working in high-risk occupations, living in overcrowded conditions and, in the case of Bangladeshi and Pakistani groups, a greater prevalence of relevant pre-existing conditions. Structural racism means that some ethnic groups are more likely to be exposed to adverse social and economic conditions, in addition to the everyday experiences of discrimination – causing a "robbery of resilience", as Marvin Rees, the Mayor of Bristol, put it. The spreading of the Black Lives Matter protests to the UK has raised the visibility of these issues. Building Back Fairer will entail addressing this fundamental cause of social injustice, in addition to the social and economic inequalities that are so pervasive.

With vaccines coming on stream there is talk of getting back to 'normal'. As our *10 Years On* report made clear, 'normal' is not acceptable, if that means where we were in February 2020. The pandemic must be taken as an opportunity to build a fairer society. In Building Back Fairer we must accept the growing recognition, worldwide, that economic growth is a limited measure of societal success. We note the example of the New Zealand Treasury which in its 2019 policy statement put wellbeing at the heart of its government's mission.

Building a society that puts fairness at the heart of policy-making, from birth – equity from the start – through every stage of the life course, to flourishing later life, means building a society that no longer fares poorly by comparison with other rich countries. Whether it is ranking only 27th out of 38 countries on child wellbeing or having the slowest improvement in life expectancy of any rich country bar Iceland and the USA, or having the highest excess mortality in Europe during the COVID-19 pandemic, or having unacceptably high social and ethnic inequalities in health, we can do better.

But the problems we lay out here are not unique to England. In the USA, for example, both the widening economic inequalities and the high mortality associated with race and ethnicity are much in evidence. It was estimated that, from March to September 2020, the wealth of the United States' 643 billionaires increased by 29 percent. Over the same period the hourly pay of the bottom 80 percent of the workforce declined by 4 percent. The inequalities in the UK may be less dramatic than that, but how is that gross level of inequality compatible with a fair and healthy society? The answer is: it is not. In the UK, with the NHS, inequities in access to health care are not compounding the race/ethnicity disadvantage on anything like the scale that they are in the USA and elsewhere.

Fortunately, England, and the other countries of the UK, are blessed with having a strong scientific tradition and excellent high-quality data. We have drawn on these in this report. The scientific approach taken here has benefited from evidence from around the world. The insights could flow the other way, too. The evidence we have compiled here for England will have relevance more broadly.

We suggest that to Build Back Fairer we need commitment at two levels. First is the commitment to social justice and putting equity of health and wellbeing at the heart of all policy-making, nationally, regionally and locally. The pandemic has shown that when the health of the public is severely threatened, other considerations become secondary. The enduring social and economic inequalities in society mean that the health of the public was threatened before and during the pandemic and will be after. Just as we needed better management of the nation's health during the pandemic, so we need national attention to the causes of the causes of health inequalities.

The second level is to take the specific actions needed, as we lay out in this report, to create healthier lives for all.

This report has not dealt with the climate crisis. But as we stated at the outset, there is a companion report from the Institute of Health Equity, commissioned by the Government's independent advisory body, the Committee on Climate Change: Sustainable Health Equity: Achieving a Sustainable UK (2). The recommendations in that report are consistent with those contained here. To build back fairer, society needs to deal both with inequalities and with the climate crisis.

It is worth, perhaps, dealing with two objections. The first is money. Reversing the cuts to Children's Centres, to per-student funding in schools, to local governments, to the health service will take public spending. So, too, will paying care workers a living wage and having more generous safety nets that do not consign people and their families to dire poverty. At a time of huge national debt, can the country afford it? Britain has tried the austerity experiment, in the decade from 2010. It did not work, if health and wellbeing are the markers of success. Phrases like "maxing out the nation's credit card" are neither helpful nor based on sound economics. At a time of zero interest rates, with a tax rate that is at the low end among European countries and with control of its own currency, a nation can borrow for the purpose of building a better society. We should not be asking if we can afford for our children's wellbeing to rank better than 27th out of 38 countries, or to pay for free school meals during holidays so that eligible children do not go to bed hungry. Social justice requires it.

A second objection is that people make their own choices. Much of the ill health of the poor, it is argued, can be traced back to the poor choices they make. We have refuted this elsewhere (78). The evidence suggests that poverty leads to poor choices; not poor choices to poverty. For example, we have cited data from the Food Foundation that households in England in the bottom 10 percent of household income would need to spend 74 percent of household income on food were they to follow official healthy eating advice. We repeat: the problem is not poor 'choices'; the problem is poverty. During the pandemic this has become even more clear. Frontline workers were at high risk because they were doing essential work. People did not feed their children well not because they were spending money on the wrong things, or because they hadn't taken cooking classes, but because they lost their jobs. The rhetoric of the "undeserving poor" as justification for harmful social policies should have no place in Building Back Fairer.

We end this report on a hopeful note. The evidence is clear. There is so much that can be done to improve the quality of people's lives through the life course. Inequalities in health is a tractable problem. It is in all our interests to Build Back Fairer.

CHAPTER 10. RECOMMENDATIONS

BOX 2.3. IN SUMMARY:

PREVIOUS HEALTH CONDITIONS	Specific health conditions suggest a worse prognosis and higher rates of mortality. These higher risk health conditions are associated with living in more deprived areas and being in a lower income group and are therefore exacerbating existing health inequalities. Evidence presented in our *10 Years On* report showed that there had been a deterioration in health in England, specifically in more deprived areas in some regions; COVID-19 has exacerbated this situation.
DEPRIVATION OF AREA OF RESIDENCE	Living in more deprived areas is associated with a greater risk of mortality from COVID-19. The reasons for this are associated with the other risk factors we describe: worse living conditions and type of employment. It is clear that in some areas conditions have.
REGION	While the pandemic is affecting different regions differently over the course of the pandemic, the close association between underlying health, deprivation, occupation, ethnicity and COVID-19 makes living in more deprived areas in certain regions particularly hazardous. Given the widening health and social determinants inequalities between regions in England prior to the pandemic, described in our *10 Years On* report, it is to be expected that mortality rates will be higher in regions outside London and the South – particularly in the North West and North East – and that has indeed been the case since the end of the first wave of the disease.
LIVING CONDITIONS	Overcrowded living conditions and poor quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and inhabited by people with lower incomes. Evidence from the *10 Years On* report showed that housing conditions had deteriorated for many and that regional inequalities in health and the social determinants had widened in the 10 years to 2020.
EMPLOYMENT	Some occupations have a higher risk of mortality than others – these include occupations that do not facilitate working from home or social distancing. Close proximity to other people is a clear risk factor for mortality from COVID-19. All the occupations with above-average mortality rates are lower paid and lower status. The health and care workforce are particularly at risk, especially nursing and care staff.
ETHNICITY	BAME groups are experiencing higher rates of mortality from COVID-19. This is related to their disproportionate experience of high-risk living and working conditions. These are partly the result of longstanding impacts of discrimination and exclusion associated with systemic racism. There is also evidence that the BAME workforce in highly exposed occupations are not being sufficiently protected with PPE and safety measures.
RELIGIOUS GROUP	Most major religious groups have higher rates of mortality from COVID-19 than people who do not follow a religious faith. Some of this is explained by high numbers of BAME groups following a faith, and by attendance at religious gatherings.

BOX 3.3. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EARLY YEARS

LONG TERM

Reduce inequalities in early years development as a priority for government

MEDIUM TERM

- Increase levels of spending on early years and as a minimum meet the OECD average and ensure allocation of funding is proportionately higher for more deprived areas.
- Improve availability and quality of early years services, including Children's Centres, in all regions of England.
- Increase pay and qualification requirements for the childcare workforce.

SHORT TERM

- Early years settings in more deprived areas are allocated additional Government support to prevent their closure and staff redundancies.
- Improve access to availability of parenting support programmes
- Increase funding rates for free child childcare places to support providers

BOX 3.4. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EDUCATION

LONG TERM

- Put equity at the heart of national decisions about education policy and funding.
- Increase attainment to match the best in Europe by reducing inequalities.

MEDIUM TERM

Restore the per-pupil funding for secondary schools and especially sixth form, at least in line with 2010 levels and up to the level of London (excluding London weighting).

SHORT TERM

- Inequalities in access to laptops, are addressed and the programme designed to enable provision of laptops to more deprived pupils is expanded and adequately resourced.
- Significantly greater focus on achieving equity in assessments for exam grading.
- Catch up tuition is fully rolled out for children in more deprived areas urgently
- Additional support is provided for families and pupils with SEND
- Excluded pupils are urgently given additional support and enrolled in Pupil Referral Units

BOX 4.3. RECOMMENDATIONS TO BUILD BACK FAIRER FOR CHILDREN AND YOUNG PEOPLE

LONG TERM

- Reverse declines in the mental health of children and young people and improve levels of well-being, from the present low rankings internationally, as a national aspiration.
- Ensure that all young people are engaged in education, employment or training up to the age of 21.

MEDIUM TERM

- Reduce levels of child poverty to 10 percent – level with the lowest rates in Europe.
- Increase the number of post-school apprenticeships and support in-work training throughout the life course.
- Improve prevention and treatment of mental health problems among young people.

SHORT TERM

- Reduce child poverty:
  - Remove the 'two-child' and benefit cap
  - Increase child benefit for lower income families to reduce child and food poverty
  - Extend free school meal provision for all children in households in receipt of Universal Credit.
- Urgently address children and young peoples mental health with a much strengthened focus in schools and teachers trained in mental first aid.
- Increase resources for preventing identifying and supporting children experiencing abuse.
- Develop and fund additional training schemes for school leavers and unemployed young people.
- Further support young people training and education and employment schemes to reduce NEET and urgently address gaps in access to apprenticeships.
- Raise minimum wage for apprentices and further incentivise employers to offer such schemes.
- Prioritise funding for youth services.

BOX 5.4. BUILD BACK FAIRER: RECOMMENDATIONS FOR CREATING FAIR EMPLOYMENT AND GOOD WORK FOR ALL

LONG TERM

- Establish a national goal so that everyone in full time work receives a wage that prevents poverty and enables them to live a healthy life.
- The social safety net must be sufficient such that people not in full time work receive a minimum income for healthy living
- Engage in a national discussion on the balance of the work-life balance including consideration of a four day week.

MEDIUM TERM

- Reduce the high levels of poor-quality work and precarious employment.
- Invest in good quality active labour market policies
- Increase the national living wage to meet the standard of minimum income for healthy living

SHORT TERM

- Provide subsidies or tax relief for firms that recall previously dismissed workers
- Coronavirus Job Retention Scheme to be extended to cover 100% of wages for low income workers
- Enforcement of minimum wages so that the large number of workers who are currently exploited earn their entitlement

BOX 6.3. BUILD BACK FAIRER: ENSURING A HEALTHY STANDARD OF LIVING FOR ALL

LONG TERM

- Establish a national goal so that everyone in full-time work receives a wage that prevents poverty and enables them to live a healthy life without relying on benefits.
- Make the social safety net sufficient for people not in full-time work to receive a minimum income for healthy living.
- Put health equity and wellbeing at the heart of local, regional and national economic planning and strategy.
- Adopt inclusive growth and social value approaches nationally and locally to value health and wellbeing as well as, or more than, economic efficiency.
- Review the taxation and benefits system to ensure they achieve greater equity and are not regressive.

MEDIUM TERM

- Make permanent the £1,000-a-year increase in the standard allowance for Universal Credit.
- Ensure that all workers receive at least the national living wage as a step towards achieving the long-term goal of preventing in-work poverty.
- Eradicate food poverty permanently and remove reliance on food charity.
- Remove sanctions and reduce conditionalities in benefit payments.

SHORT TERM

- Increase the scope of the furlough scheme to cover 100 percent of low-income workers.
- Eradicate benefit caps and lift the two-child limits.
- Provide tapering levels of benefits to avoid cliff edges.
- End the five-week wait for Universal Credit and provide cash grants for low-income households.
- Give sufficient Government support to food aid providers and charities.

BOX 7.3. BUILD BACK FAIRER: CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LONG TERM

- Invest in the development of economic, social and cultural resources in the most deprived communities.
- Ensure 100 percent of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
- Aim for net-zero greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.

MEDIUM TERM

- Increase deprivation weighting in the local government funding formula.
- Strengthen the resilience of areas that were damaged and weakened before and during the pandemic.
- Reduce sources of air pollution from road traffic in more deprived areas.
- Build more good-quality homes that are affordable and environmentally sustainable.

SHORT TERM

- Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls.
- Increase government allocations of funding to the voluntary and community sector.
- Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates.
- Remove the cap on council tax.
- Urgently reduce homelessness and extend and make watertight the protections against eviction.

BOX 8.4. BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LONG TERM

- A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health.
- Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities

MEDIUM TERM

- Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities.
- Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.

SHORT TERM

- Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient
- Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

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