BMA

Mitigating the impact of Covid-19 on health inequalities

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To mitigate the impact of Covid-19 on health inequalities across the UK, the government should focus on

- Reducing overall transmission of the virus
- Ensuring vaccine access for groups most vulnerable to the virus
- Improving financial security
- Protecting the long-term health outcomes of children living in deprivation
- Investing in a strong public mental health response

Introduction

The impact of the Covid-19 pandemic on the UK has been enormous, but not everyone has borne the brunt equally. The impact of the virus, as well as the restrictions designed to reduce its spread, have affected and will continue to affect different groups to varying degrees of severity. It is not too late for governments across the UK to take comprehensive action to reduce the negative impact of the Covid-19 pandemic on those groups most socially disadvantaged and vulnerable to the virus. Beyond the moral imperative for taking such action, mitigating the impact of Covid-19 on health inequalities will be vital for an inclusive long-term socio-economic recovery.

Every policy decision has an impact on population health and it is crucial that all UK government departments and public bodies adopt a mandatory 'health in all policies' approach.[1] The importance of such an approach has been shown every single day of the Covid-19 pandemic: health inequalities kill. This paper examines the direct impact of Covid-19 on health inequalities and what short- to medium-term action must be taken to mitigate any negative impact.

It is important to recognise that the pandemic has to a large extent exposed and exacerbated existing health inequity. Addressing longstanding health inequity requires prevention of ill health. This approach must acknowledge that many of the causes of health inequality which contribute most to chronic disease, including smoking and unhealthy diets, follow the social gradient, leading to pervasive inequity.[2]

In the long-term, plans to tackle health inequalities must also include investment by local and national government in programmes to create healthier physical environments, such as reducing air pollution and facilitating active travel. As a member of the Inequalities in Health Alliance, comprising of more than 170 organisations, as part of this paper we are calling on the UK government to develop a comprehensive cross-government strategy to reduce health inequalities as a matter of urgency.

Health Inequality refers to differences, variations, and disparities in the health outcomes of individuals and groups.

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When Covid-19 arrived in the UK, health inequalities in the UK were too high and were getting worse

Before Covid-19 reached the UK, the nation's health was in a precarious position. From 2010 to 2020, increases in life expectancy in England had slowed, while in other comparable economies people were living longer and longer (date 2011-2017).[3] In the most deprived areas of the country improvements in life expectancy slowed the most, and in fact stagnated or fell for some groups.[4] For example, between 2010 and 2020, life expectancy fell among the poorest 10% of women in the Yorkshire and Humber region, and in the north-east of England.[5] By 2019, there was a nearly 20 year gap in healthy life expectancy between women living in the richest versus poorest areas of the country.[6] Between 2012-14 and 2016-18 in Northern Ireland rates of healthy female life expectancy also decreased in the most deprived areas.[7] Scottish healthy life expectancy has also been decreasing according to latest figures.[8] In Wales, it has been calculated that over a third of years of life lost are related to socioeconomic inequality.[9]

Prior to the Covid-19 pandemic, destitution in the UK was rapidly growing in scale and intensity with more households 'pushed to the brink' since 2017.[10] Professor Sir Michael Marmot's revisited report on health inequalities in the UK showed that by 2020 the most deprived areas and communities had experienced the greatest declines in funding in almost all social, economic, and cultural areas. Poverty, poor health, and socioeconomic inequalities had increased disproportionately in these communities over the same period.[11]

Health inequalities are felt most directly by individuals and communities, but they also place a considerable burden on our health service. One study put the cost of socio-economic inequality for the NHS at £4.8 billion a year.[12] Successive governments' inaction on tackling avoidable differences in health outcomes (health inequity) placed the country in a vulnerable position. This was the situation the UK found itself in when the virus hit in January 2020.

Socially disadvantaged and vulnerable groups were particularly impacted by Covid-19

In Marmot's Covid-19 Review, he concluded that inequalities in social and economic conditions before the pandemic contributed to the UK's high and unequal death toll from Covid-19.[13] The pandemic has not created new inequalities, but rather caused further hardship to those who were already suffering health inequity.

People living in the most deprived areas of the country are twice as likely to die from Covid-19 as those in the least deprived areas.[14] The north of England has suffered disproportionately during the pandemic with some of the highest infection and death rates in the country. A report by the Northern Health Science Alliance cited a decade of spending cuts to explain such inequity.[15]

The same pattern is seen in other nations of the UK. In Scotland, the death rate from Covid-19 is more than twice as high in the most deprived areas than in the least deprived areas.[16] In Wales, Rhondda Cynon Taf is the upper tier local authority with the highest death rate in the UK, and also one of only two areas of Wales with more than 30 people unemployed and claiming benefits per vacant job available after the pandemic had hit.[17] This points to a deeper problem of an already socially disadvantaged area being disproportionately impacted by Covid-19.[18]

Throughout the pandemic we have witnessed stark health inequalities along racial lines, with people from Black and Asian backgrounds more likely to both contract and die from the Covid-19 virus than any other ethnic group in the first wave.[19] For Pakistani and Bangladeshi men, deaths were still disproportionate in the second wave.[20] Government figures confirm that cramped housing is far more likely to be a problem for ethnic minorities, making social isolation to restrict the spread of the virus harder. 24% of the UK Bangladeshi population are considered to live in overcrowded housing compared to just 2% among the white British population. 16% of Black African people also live in overcrowded conditions, as do 18% of Pakistanis.[21]

Disabled people have also suffered disproportionately. Provisional analysis found that disabled people made up almost six in 10 of all deaths in England involving Covid-19 between March and November 2020.[22] The death rate for people aged 18 to 34 with learning disabilities was 30 times higher than the rate in the same age group without disabilities.[23] It is important to note that health outcomes were worse for these groups even before the outbreak of the virus.

If groups socially disadvantaged before the pandemic are more likely to contract the virus, we can also expect to see higher rates of 'Long-Covid' and other long-term adverse outcomes. This has the potential to greatly increase rates of long-term disability within these groups, deepening health inequalities among people who were at greater risk of poor overall health before contracting Covid-19. This provides a strong rationale for the reduction of overall transmission of the virus to avoid further exacerbating existing health inequalities.

This briefing will set out key recommendations for governments across the UK as part of plans to address health inequalities both for the remainder of the pandemic and in its wake. The UK has a chance to build back better after the pandemic and this must centre on taking long overdue action on health inequalities.

Recommendation:

1

The UK government must develop a comprehensive cross-government strategy to reduce health inequalities as a matter of urgency.

Urgent and comprehensive action is needed to mitigate the future impact of Covid-19 on health inequalities in the UK

Transmission of the virus must be reduced, while mitigating the impact of restrictions

Reducing overall transmission of the virus is the most effective way of protecting both the short- and long-term health of those groups most socially disadvantaged and vulnerable to the virus. The BMA has called for a coordinated UK-wide prevention approach to be set out well before exiting the current lockdown, with specific measures to contain transmission until widespread vaccination is achieved.

Whilst restrictions designed to reduce the spread of the virus have been and will continue to be necessary, their negative impact on the social determinants of health (conditions outside of clinical influence in which people are born, grow, work, live, and age) cannot be ignored. Research shows that these social determinants can be more important than health care or lifestyle choices in influencing health – accounting for between 30–55% of health outcomes.[24] Poverty, for example, impacts negatively on health outcomes.[25] As unemployment increased during the pandemic, and bills became harder to pay, income insecurity has already become increasingly common.[26, 27] This will impact most on those who were already struggling, or just managing, before the outbreak of the pandemic.

Our path out of the pandemic must factor in the lowest socioeconomic groups, who are more vulnerable to the virus. A universal programme of restrictions, or a 'one size fits all' approach, will not work to reduce health inequity. The occupational risk of those in the lowest socioeconomic groups (taxi drivers, security guards, low paid health and social care workers) is too high, and adequate protection is needed for these groups when Covid-19 is circulating. While the UK governments are preparing for the end of the pandemic, we still need clearer guidance, support, and enforcement on making businesses Covid-secure so that workers and the public can return safely.

There is public appetite for Government intervention to ensure that existing differences in health outcomes are not made worse by the restrictions imposed to control the virus. A survey of public attitudes found the Government's decision to spend money on keeping people in jobs, and on increasing welfare benefits for those without one, matches a change in public mood that was already shifting before the pandemic.[28] In light of the restructure of public health delivery and commissioning in England, future plans must have addressing health inequalities at its heart. The response to and recovery from the pandemic provide an opportunity to address any newly exposed or exacerbated health inequalities across social, ethnic and economic divides across the UK.

Recommendations:

2 **Governments across the UK must take a cautious approach to easing current restrictions and put in place coordinated preventive measures to sustainably control transmission of the virus until widespread vaccination is achieved. This approach will protect public health while ensuring the NHS has capacity to provide both Covid-19 and non-Covid care.**

3 **This approach must be complemented by a range of targeted support programmes, set out in detail in the following sections, to alleviate the impact of such restrictions on those groups most socially disadvantaged and vulnerable to the virus.**

Vaccines must be accessible for groups most vulnerable to the virus

A vaccination programme that ensures equity of access is essential to mitigating the unequal impact of Covid-19. The UK has made good progress on its national vaccination programme to date. The BMA is concerned, however, that progress is not as standardised across the UK and across different populations as it should be. Uptake of the vaccination must be as universal as possible by making the vaccine as accessible as possible.

Multiple barriers to accessing the vaccine exist. Physical access to the site of vaccination, ability to get to the site via appropriate transport, the financial ability to take the time off from work to attend, and the risk of information that is not culturally or linguistically appropriate or accessible, all need to be considered. Governments across the UK must put in place supportive arrangements to overcome these barriers, which could include patient transport, specific access arrangements, and tailored messaging for certain groups alongside engagement through community leaders.

The homeless population is an all too visible representation of health inequity and inequity of access to health services in the UK. Priority access for this group is welcome, and vaccination should be seen as an important opportunity to engage this group in health services. People without an NHS number, including many people in the homeless population as well as vulnerable migrants such as asylum seekers and those without a regular immigration status, also risk being forgotten. Neglecting to vaccinate these groups and engage them with health services could be catastrophic for some of those communities most vulnerable to the virus.

In England, everyone is entitled to register and consult with a GP, free of charge, regardless of their immigration status, ID or proof of address. While the BMA welcomes the Government's efforts in reminding people to register with a GP practice to receive Covid-19 vaccinations, there are long-standing policies and practices in place that, all too often, deter people with no fixed address or an irregular immigration status from seeking or accessing healthcare. The BMA is working with GP practices to reduce barriers to registration. However, we believe that the Government must go further, and commit to suspending NHS charging and data sharing with the Home Office for the duration of the pandemic at the very least, so that everyone feels safe and able to come forward to receive the vaccine.

It is notable that many of the groups impacted most severely by the virus experience not only barriers to access but also high levels of vaccine hesitancy. Despite Black and Asian communities being more vulnerable to contracting and dying from the virus, in a recent survey 72% of Black people in the UK said they were unlikely to want to be vaccinated – the highest rate of vaccine hesitancy found in the study.[29] Among Pakistani and Bangladeshi groups this figure was 42%.

Structural racism means that people from marginalised groups have had or continue to have negative experiences of healthcare and may therefore be less trusting of medical professionals.[30] In tackling vaccine hesitancy and mistrust to ensure universal uptake of vaccines, it is important that people from these communities are involved in decisions and mechanisms to improve equitable access. Urgent analysis is needed to clearly set out any identified barriers to ensuring good vaccine access and uptake across all groups who share protected characteristics. It must also be made clear how barriers will be overcome and how progress will be monitored to ensure that the vaccine programme is successfully reaching these groups.

4

Recommendation:

Governments across the UK must ensure that detailed and transparent Equality Impact Assessments for their national vaccination programmes are conducted, published, and kept under continual review to anticipate and mitigate any negative impacts on groups who share protected characteristics.

More needs to be done to improve income insecurity among vulnerable groups

In its third biennial report, *Destitution in the UK*, The Joseph Rowntree Foundation revealed that before the Covid-19 outbreak, destitution was rapidly growing in scale and intensity with more households 'pushed to the brink' since 2017.[31]

As of January 2021, almost two million workers had been unemployed or fully furloughed for at least six months.[32] The UK's lowest-paid workers are more than twice as likely to have lost their jobs in the pandemic than higher-paid employees.[33] As women, ethnic minorities and disabled people are more likely to work in lower paid jobs, people in these groups risk higher rates of deprivation as a result of the pandemic.[34, 35, 36] Findings from the Institute for Public Policy Research confirm that people from an ethnic minority background are more than twice as likely to have lost their jobs or otherwise stopped paid work during the crisis.[37]

With more than one in five people living in poverty in the UK before the pandemic arrived, and two in five families already below the poverty line having lost income during the crisis, many families now face increased risk of destitution.[38] Analysis indicates that rates of homelessness are likely to increase as a result unless urgent action is taken to address income insecurity.[39] Not only does this threaten the UK Government's target to eliminate rough sleeping in England by 2024, but it will also significantly worsen the health outcomes of socially disadvantaged groups, in turn exacerbating health inequity.

Income security is also an important factor in compliance with public health measures to contain transmission of Covid-19. Self-reported full adherence to self-isolation among respondents in a recent cross-sectional population survey who had a symptom of the virus was 29%.[40] Non-adherence to self-isolation has been associated with lower socio-economic grades.[41] One explanation could be financial constraints. If people feel financially unable to self-isolate after being contacted by NHS Test and Trace, or equivalent NHS tracing schemes outside of England, they may feel they have no other choice but to 'take the risk', thereby significantly increasing the chances of otherwise preventable transmission. Many may be reluctant to get a test the first place.

The success of the Westminster Government's roadmap out of lockdown for England relies on testing, tracing, and isolating to bring down transmissions and hospitalisations adequately in order to move on to the next stage. If people feel financially unable isolate following a positive test, or to test in the first place, this key part of exiting lockdown will be jeopardised significantly.

Those less well-off should not be disadvantaged by the act of having to self-isolate, and all UK Governments must ensure that they receive the practical and financial support necessary to do so. Statutory sick pay (SSP) can help in some cases, but it is frequently inadequate for those who need it most to cover rent, essential utilities, and food. While some targeted financial support currently exists, around two thirds of those trying to access the £500 self-isolation support are rejected, with huge discrepancies between local authorities.[42] Governments must commit to continue providing local authorities with sufficient financial resource to support those asked to self-isolate and make the requirements for the scheme clear and accessible.

The furlough scheme and temporary uplift in Universal Credit have also been a lifeline for many during this period. The added security these measures have provided serve as excellent examples of how to mitigate worsening health inequalities, and their total and sudden removal would be disastrous. It is likely that the UK will still face significant disruption beyond September, and it is imperative that support for people most financially affected by the pandemic continues.

In all cases, public welfare and Government support offered to reduce people's financial insecurity must be as easily accessible as possible. This should include proactive signposting from health services to welfare support. This will also be important for those suffering from Long-Covid. In December 2020, a large-scale survey of confirmed and suspected patients found that nearly half were still unable to work at full capacity six months after infection.[43] As those from socially disadvantaged backgrounds are more likely to contract Covid-19, these groups are likely to be disproportionately affected by being unable to return to work due to long-term effects of the virus. Identification of Long-Covid as well as access to specialist services and a clear pathway into financial support for those unable to return to work must be facilitated. This would ensure adequate support for those groups most socially disadvantaged and vulnerable to the virus.

Recommendations:

5 **The Universal Credit uplift must be made permanent, to reduce the high levels of income insecurity that predated the pandemic and continue to exacerbate health inequity across the UK in the context of Covid-19**

6 **Routes to receive financial support from government must be as accessible and easy to navigate as possible.**

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Children in deprivation must be better supported as we emerge from the pandemic

Education has been described as 'the most important modifiable social determinant of health,'[44] with childhood education having lifelong impacts on health outcomes, economic wellbeing and overall life expectancy. The scale of disruption to education seen across the UK is therefore likely to have significant consequences for children's health over the long-term. Emerging evidence suggests the negative consequences of school closures and disrupted learning are likely to affect children unequally – as those more well off tend to have better home learning environments (for example dedicated spaces for learning and computer equipment).

With more than one in four children in the UK affected by poverty, it is particularly concerning that socially disadvantaged children are more likely to have experienced disruption as a result of school closures over the past year.[45] When the crisis began, the Government stated that children on Education Health and Care Plans (EHCPs), who have high levels of need, should be classified as 'vulnerable' and allowed to attend school during lockdown. But the attendance figures show that only 6% of children with EHCPs attended school on average from the start of lockdown until the end of May. This rose to 28% on average in July, which means that 72% of children with EHCPs were still not in school.[46]

Before the pandemic, disadvantaged children in England were already 18 months behind their wealthier peers in their learning by the time they finished their GCSEs, with no improvements made since 2017.[47] There will now be a second year of predicted grades for examinations, this time in the context of students having missed at least half an academic year. Evidence shows that pupils from low-income families are more likely to have their grades incorrectly predicted compared to their more affluent peers.[48,49] Moreover, as a result of remote learning, parental education at home – already a key predictor of a child's educational attainment – has grown in importance. The educational gap risks widening further as digital exclusion and capacity of parents to support remote learning jeopardise successful learning from home before schools were allowed to reopen.

Socially disadvantaged children are also more likely to be studying from home in challenging environments. Before the crisis struck, there were 2.2 million children in England living in households affected by any of the so-called 'toxic trio' of family issues: domestic abuse, parental drug and/or alcohol dependency, and severe parental mental health issues.[50] As life inside the home has increasingly become the only option during the pandemic, these issues are likely to have been compounded. Whilst all children can experience an adverse childhood experience (ACE), such as growing up in a household with substance misuse, children living in deprivation were more likely to experience multiple ACEs.[51] The concentration of life in the home, where most ACEs are experienced, means mitigating the impact of these adverse experiences will be essential.

Beyond academic learning missed, school attendance plays an important part in children's access to crucial drivers of good health, such as exercise and oral healthcare. The number of children under 16 following Chief Medical Officer exercise guidelines (of taking part in sport or physical activity for an average of 60 minutes or more every day) had dropped from 47% before the pandemic to 19% in July 2020.[52] Children with special educational needs and looked after children are also those most likely to be at risk of poor oral health. As previously discussed, these groups of children are well-represented among those who have not been attending school during the pandemic, even when allowed.[53] Oral health inequality is therefore likely to have increased as access to oral health improvement programmes received in nurseries and schools was lost for many.

The pandemic's impacts on younger children who are not yet in education have also been severe, as the first 1,001 days of life are of significant public health importance. Parents living on the lowest incomes have reported changes brought about by Covid-19 affecting their unborn baby, baby or young child at higher rates.[54] The first 1,001 days (the length of pregnancy and first two years of life) matter significantly in terms of forming social relationships, building up immune systems and establishing a safe upbringing. Disruption to services that can support such factors has been significant and must not be forgotten in local authority social care and welfare commissioning.

Just before the pandemic, the BMA found that spending on children's public health services for ages 5-19 in England had declined by 6% since 2016/17, and for mandated 0-5 children's public health services by 5%. There is now clearly even greater need to reverse such cuts.[55]

Recommendation:

7

All UK Governments must urgently take steps to mitigate the effects of Covid-19 on socially disadvantaged and vulnerable children, including committing to providing more funding for support programmes for those children who have been particularly disadvantaged by school closures. Cuts to local authority children's services must be reversed to ensure children and families can get access to the social care and welfare support they need.

Demand on mental health services must be mitigated

Covid-19 is expected to have a significant negative impact on people's mental health, which is likely to exceed the ability of existing mental health services to cope with demand. The NHS Strategy Unit produced a model at the end of 2020 to help local services in England plan their response to Covid-19.[56] Using this model, they estimated that there will be around 11% more new referrals to mental health services each year for the following three years. These figures are in addition to the approximately 500,000 people that were not able to access services during the first national lockdown.[57]

A 33% rise in demand over the next three years is not something mental health services are currently equipped for. The money the UK Government announced in Autumn's 2020 comprehensive spending review to reduce mental health waiting times is a one-time funding injection and is therefore an inadequate commitment for the anticipated increase in need for care. Spending on mental health services should be doubled over the period of the Long-Term Plan and dedicated funding should be made available to CCGs (Clinical Commissioning Groups) in light of the anticipated increased demand created by COVID-19.

According to emerging evidence, groups which previously faced barriers to accessing mental health services appear to be those struggling most with their mental health during the pandemic. There is a risk of deepening inequity for these groups if such access to care does not improve, or worsens, due to insufficient service capacity. For example, services for children were inadequate before the pandemic. In England, the vacancy rate of consultant psychiatrists in child and adolescent mental health services is almost double that of the national average.[58] A survey of 2,279 parents further found that emotional difficulties were consistently more elevated among children from low-income backgrounds during lockdown compared to those from higher income households.[59]

According to a report from Northern Ireland, the inequality gap for suicide widened between 2012-14 and 2016-18, with the rate in the most deprived areas almost three and a half times that in the least deprived areas.[60] Clearly those who are the most socially disadvantaged in society are those most vulnerable to worsening mental health.

There have been particular concerns about the mental health consequences on Black and Asian populations who are experiencing the death of loved ones at higher rates.[61] Indeed, research has suggested that the mental health of men from Black and Asian backgrounds has been hardest hit overall by Covid-19.[62] Disabled people have also more frequently indicated that the pandemic is negatively affecting their mental health more than non-disabled people (41% versus 20% report a negative impact, respectively).[63]

Many of the factors that influence people's mental health lie outside of the sphere of clinical influence and are shaped by the social, economic and physical environment in which they live. Supporting improvements in mental health therefore requires a comprehensive public health approach which addresses these determinants and prevents mental ill health during childhood, education, employment and into later life.

There is a lack of clarity over responsibility for supporting public mental health, which in England falls to local authorities, with little guidance available as to what services and interventions should be provided, or how spending in this area should be categorised. In 2019, local authorities in England reported spending less than 1.7% of their total public health budget on 'public mental health'.[64] Whilst we acknowledge this indicator represents a narrow definition of public mental health spending, of which wider investment in the social determinants of health is a critical part, it nevertheless suggests insufficient investment in tackling the anticipated mental health crisis facing the UK.[65] The fact that many local authorities in England report no spending on public mental health activity at all further illustrates the ambiguity around their role to invest in public mental health, and variation in the way such spending is categorised. This lack of clarity must be urgently addressed.

The principle issue undermining local public health delivery in England has been severe cuts to the local public health grant which have occurred since 2015/16. In the Government's own estimate, every £1 spent on public health prevention returns £14 in related benefits, meaning that such cuts are a false economy.[66] Whilst some of this benefit comes directly from delivery of public health programmes, there is significant added value from having a properly resourced and embedded local public health function which can look across the system to identify opportunities to intervene. This is particularly relevant in the case of public mental health, as many policies that contribute to mental wellbeing may fall under other budgeting categories, such as education and infrastructure.

Reversing these damaging cuts and ensuring a robust public health approach is at the heart of local decision-making will require a funding increase of £1 billion to return the public health grant to 2015/16 levels. This must be accompanied by additional investment year on year, increasing to £4.5 billion by 2023/24. Restoring the public health grant would give local authorities the financial confidence to develop and coordinate a mental health framework according to local need. This is a crucial step in accommodating the longer-term mental health impact of Covid-19.

Recommendations:

8 **The UK Government must immediately commit to re-establishing the local authority public health grant in England to 2015/16 levels, with a view to increasing this further in future years. With this money, public health teams within local authorities will have reach and the financial confidence to develop and coordinate a mental health framework according to local need.**

9 **Spending on mental health services should be doubled over the period of the Long-Term Plan and dedicated funding should be made available to CCGs (Clinical Commissioning Groups) in light of the anticipated increased demand created by Covid-19.**

10 **Dedicated funding must be made available to study both the short- and long-term mental health impact of the pandemic in real time, with particular focus on gathering the evidence base to inform Equality Impact Assessments and ensure that appropriate mental health support is tailored to the needs of groups who share protected characteristics.**

Access to healthcare must be ensured for everyone who needs it

Marginalised groups that have experienced inequality in accessing health services are likely to be further disadvantaged by Covid-19. For complex reasons, those in more deprived areas are more likely to access healthcare only in emergencies, with an overreliance on hospital care and an underuse of preventative medicine. Disadvantaged populations need more health care than advantaged populations, but receive less.[67] Covid-19 is likely to have exacerbated this disparity as people become warier of leaving the house and attending GP appointments.

Access to the services that can prevent the need for emergency care must be better facilitated. In particular, presentation at primary care stage results in more chance of preventative medical care for those who need it. Treatment for conditions at an advanced stage is also far more extensive and expensive than preventive care or early intervention.[68] People who share protected characteristics under the Equality Act may face specific additional barriers to accessing appropriate health care during the pandemic. In view of this, we recognise the significant challenges in ensuring health and care services remain accessible to all. For example, for people with learning disabilities and autism it will be particularly frightening to go to hospital at this time without the support of a familiar carer or family member. The BMA have produced guidance to inform doctors of the importance of making reasonable adjustments for people with learning disabilities and autism, enabling them to have someone who can support and help them to take part in decisions about their treatment.[69]

Moving vital public health communications and access to health services online can act as an additional barrier, with ONS (Office for National Statistics) data showing that around one in 10 people in the UK is digitally excluded.[70] NHS bodies across the UK recognise that some groups may be more likely than others to be digitally excluded, including older people, disabled people and those in low-income groups.[71] These are also some of the groups who are particularly vulnerable to Covid-19. If those most in need of these resources are unable to access them, health inequity is likely to grow.

The increase in telephone only services, for example for booking GP and hospital appointments, can also exclude some groups, such as D/deaf people. It is important that options for people who cannot use the phone are retained, and that those people are consulted on the best alternative arrangements. It is vital that any changes made in the long-term, such as more telephone appointments being offered, do not discriminate against people for whom this would mean more limited access to health services. It is also important that the legally mandated Accessible Information Standard is being consistently met by both primary and secondary healthcare services. We have written to the UK Government about the critical importance of making information accessible in plain English as well as alternative forms and languages during the Covid-19 pandemic.[72]

Recommendation:

11

All UK Governments and NHS services must actively promote alternative and inclusive methods of communication to reach groups which are socially disadvantaged and vulnerable to the virus, particularly if the switch towards digital services persists in the longer term, to avoid widening existing health inequalities.

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