



BMA Covid Review 5

The impact of the pandemic on population health and health inequalities

Executive summary

How significantly has COVID-19 impacted population health and health inequalities in the UK? In late 2021, the BMA conducted a call for evidence survey to set out the experience of the medical profession during the pandemic and to learn lessons for future pandemics. We found that the pandemic has harmed people's physical and mental health and worsened health inequalities:

- Poor population health and worsening health inequalities before the pandemic made the UK's experience of COVID-19 worse. Opportunities had been missed before the pandemic to improve population health and address health inequalities.
- By July 2022, more than 200,000 people had lost their lives, while millions have seen their quality of life affected by long COVID. Many people have also reported poorer mental health because of the pandemic. However, none of this has been felt equally, with ethnicity, age, disability status, and other factors meaning some social groups have been more affected than others.
- The pandemic also affected the social determinants of health. As workplaces and schools closed, and business stalled, people's financial security and future career prospects were threatened. Those already struggling before the pandemic were often worse affected.
- We must learn from the positive developments during the pandemic such as the speedy development, approval, and NHS-led roll out of the COVID-19 vaccines, and the hugely effective schemes to house rough sleepers – although there has been variability as to how well both programmes have been sustained and benefited their target population.

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Acknowledgments

We would like to thank everybody who responded to our survey detailing their experiences of the pandemic. The BMA understands the immense sacrifice that continues to be made by medical professionals. If you do not see any of the text from your response included in our reports, please do know that every response was read and used to inform our conclusions. We are very grateful indeed.

Our fifth COVID review report is the work of Olivia Clark, Margot Kuylen, Claire Chivers, Duncan Bland, Emily Wester, Sarah Arnold, Isabelle McLaren, Suzanne Wood, Lena Levy, Alex Gay, and the BMA Wales, Scotland, and Northern Ireland teams.

Foreword



The devastating impact of the COVID-19 pandemic, the largest threat to public health we have seen for over a generation, continues to leave its mark on us all. People's specific characteristics and circumstances, their ethnicity, gender, disability status, where they live, and even the size of their bank balance are just some of the factors that have determined each individual's specific experience of the pandemic.

When the pandemic arrived on our shores, some people were already struggling with their mental health, financial situation, educational attainment, or myriad other factors that influence our chances of living a long and healthy life. Health inequalities and poor population health were problems in the UK long before the pandemic, which has only worsened them.

Black African men in England were 3.7 times more likely to die from the virus in the first wave. Across the UK, disabled people were not only much more likely to die of COVID-19 than non-disabled people, but also more likely to experience poor mental health. Children from deprived backgrounds were more likely to fall behind on their learning, jeopardising their educational attainment – a significant indicator of life expectancy. While everyone's experience has varied, it's clear that people who had a worse experience during the pandemic were often those who faced significant inequalities before March 2020.

Nevertheless, it is important the public inquiries into COVID-19 also look at what has gone well over the past nearly two and a half years. There must be room for examining positive developments and their impact on population health so these can be learned from and sustained in non-pandemic times, as well as emulated if the UK is faced with something similar in future years. The programmes to reduce homelessness were swiftly executed and effective, the pandemic helped some people increase their physical activity and the national vaccination programme was one of the greatest triumphs of the NHS since its inception.

I hope this report serves as a reminder that these hardships cannot have been completely in vain – they serve as a call to action for governments across the UK to tackle the stark inequalities laid bare by the pandemic.

I urge all UK governments to heed the recommendations made in this report, and for the public inquiries to adopt its proposed questions. The story of the impact of the COVID-19 pandemic on population health and health inequalities is not yet over but the time for learning is now. Let us not waste this opportunity presented to us.

A handwritten signature in black ink, appearing to read 'Phil Banfield', with a long horizontal line extending to the right.

Phil Banfield, BMA council chair

The BMA's COVID-19 review and research included in this report

Throughout the pandemic, the BMA has been critical of many elements of the UK governments' decisions and handling of the pandemic response for patients, the population's health, and healthcare workers. The handling of the pandemic was [described by a cross-party select committee](#) last October as 'one of the most important public health failures the United Kingdom has ever experienced', reflecting on inadequate supplies and procurement of PPE; a test and trace system that failed to deliver; and delays in implementing public infection control measures to prevent the virus spreading.

It is important to learn lessons from the pandemic response so that action can be taken in the immediate future – as the UK's health services grapple with several pressures because of the pandemic and the biggest backlog of care in their history – and to be best prepared for future pandemics and avoid repeating past mistakes.

During November and December 2021, the BMA contacted its members and other key stakeholders, including Royal Colleges and leading think tanks, to understand the impact of the UK and devolved governments' handling of the COVID-19 crisis. We wanted to hear how it affected the lives of doctors, the health service, patient care, and the public's health. Our survey was largely qualitative, providing us with the voices of frontline doctors that we quote verbatim in this report, while we also include quantitative data from other research conducted by the BMA during the pandemic, including COVID tracker surveys and viewpoint surveys (more information about these resources can be found in Appendix A). Overall, we want to help inform a robust review into the handling of the pandemic, ahead of the statutory inquiries starting in 2022.

We are publishing five reports, each focusing on a particular aspect of the pandemic response.

- Protection of the medical profession from COVID-19
- Impact of the pandemic on the medical profession
- Delivery of healthcare during the pandemic
- Effectiveness of the public health response by UK Governments to COVID-19
- Impact of the pandemic on population health and health inequalities

Introduction

It would be a challenge to find someone in the UK today who has not been affected by the COVID-19 pandemic. The biggest threat to public health in living memory has spread illness, killed loved ones, and plunged families into poverty. It has also encouraged reflection, brought communities closer together, and forced people to slow down their busy lives. Whether big or small, devastating or life-affirming, the impact of the pandemic on the UK population has been omnipresent and inescapable.

There has been a popular saying in the past two years to describe people's experiences of the COVID-19 pandemic: 'We are all in the same storm, but not in the same boat.' This saying amassed popularity to the point of cliché as it so well captured what everyone in the UK could see around them – that some people were struggling more than others. Moreover, those who were and continue to be struggling most during the pandemic have invariably been those already struggling before the pandemic hit. Rather than creating new inequalities, the pandemic often made existing ones worse. This is certainly true for health inequalities. For those from lower socio-economic groups, for example, health outcomes were poor before the pandemic, and this trend was compounded after March 2020.

At the start of the pandemic, the fault lines of health inequality were already evident in the UK, with some groups living shorter and unhealthier lives than others. When the SARS-COV-2 virus arrived on our shores, some of these groups were in a very precarious position. Yet there is little evidence that public policy decisions to combat the pandemic have fully considered and addressed the differential impact on various groups. Opportunities were missed for targeted interventions that could have mitigated the impact on these groups once relevant information was available, and such opportunities continue to be missed. The devastation caused by COVID-19 has shown us all too clearly the dangers of failing to consider health inequalities, both before and during the pandemic.

Population health is defined as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group'. Health inequalities are defined as 'avoidable and unfair differences in health status between groups of people or communities.' Health inequalities are largely the result of non-medical factors, such as deprivation, poor housing, and education.

This report considers the impact of both the virus and our response to it on the population's mental health, physical health, and health behaviours. The report also considers the influence of the pandemic so far on some of the wider determinants of health, including employment and income security and education. Throughout, it pays attention to inequalities in the pandemic's impact on different groups in society. Finally, the report examines what positive lessons can be learned from the vaccine rollout and efforts to end homelessness. While widespread vaccination coverage has changed the nature of the pandemic in the UK, the high number of cases of COVID-19 continues to have a [detrimental impact on population health and continues to have an inequitable impact](#).

This report should be read alongside the other reports in this series, particularly [report four](#), which examines the UK governments' public health response to the pandemic and [report three](#), which examines the impact of the pandemic on healthcare delivery.

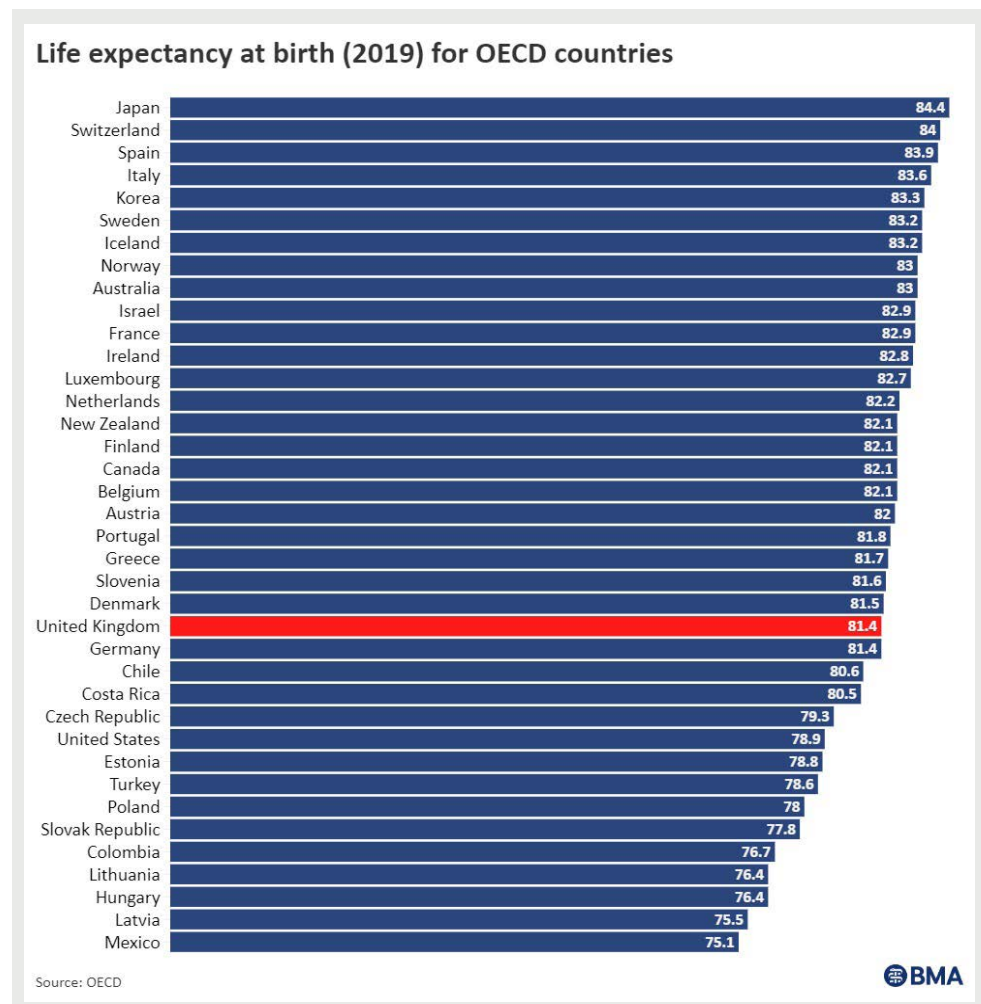
The scale of inequality and poor population health in the UK before March 2020 has made the impact of the pandemic worse

Any pandemic will inevitably impact population health in some way, and nothing could have been done in the COVID-19 pandemic to protect everybody from any consequences whatsoever. However, a nation's capacity to weather the storm of a pandemic is dependent largely on the state of its population health; a healthier population is a more resilient population. Unfortunately, in this respect, the UK entered the pandemic on the back foot: the state of population health was poor, and health inequalities were high. The failure of governments across the UK to adequately fund the services which support people's health over the previous decade hampered efforts to address such widespread problems.

The state of population health in the UK in March 2020 was poor

The scale of poor population health in the UK before March 2020 has made the impact of COVID-19 worse. When the UK entered the pandemic, improvements in life expectancy – a key measure of population health – had started to stagnate. Increases in life expectancy were slowing before the pandemic, while in other comparable economies life expectancy was increasing at a faster pace.¹ In 2009, life expectancy in the UK ranked 14th out of 38 OECD countries, but by 2019 it had fallen to 24th place, falling even below the median (see Figure 1 (Source: OECD)).²

Figure 1 (Source: OECD)



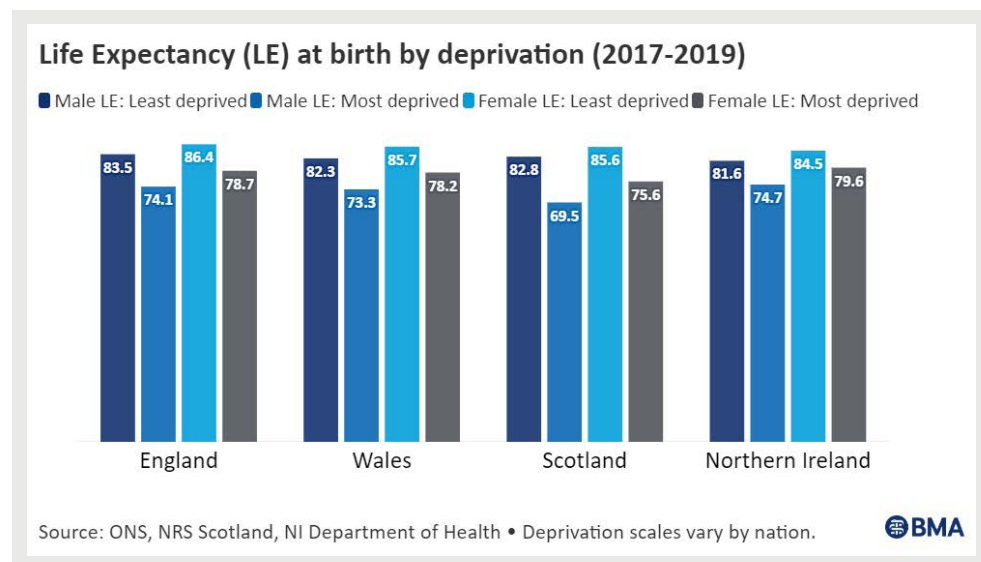
Those factors responsible for the UK's low life expectancy also made the UK population more vulnerable to the impact of COVID-19

Some of the main drivers of poor population health are obesity, smoking, substance abuse, and low physical activity. Of all European countries, the UK has the fourth-highest number of overweight and obese adults,³ and smoking is the leading cause of preventable death and disease in the UK.⁴ Not only do these drivers make people unhealthier and less able to withstand threats to their health, but some, like obesity and smoking, are also direct risk factors for a new respiratory illness like COVID-19.

Aside from poor overall population health, high levels of health inequality have further jeopardised the UK's ability to withstand COVID-19. Just as life expectancy is a good measure of the state of population health, differences in life expectancy between groups are a good measure of the extent of health inequalities.

Life expectancy follows the social gradient, which means the more deprived a background someone comes from, the less likely they are, on average, to live a long life. Before the pandemic, there were already disparities in life expectancy in the UK. For example, a man born in one of the most deprived areas of Scotland⁵ could expect to live 69.5 years, compared with 82.8 years for a man born in one of the least deprived areas, a gap of over 13 years (see Figure 2).

Figure 2



Groups with poorer health outcomes are at higher risk during a health crisis. Those who have been most at risk of infection, severe symptoms, and death during the COVID-19 pandemic are those with the worst health outcomes before the pandemic. Had these inequalities been addressed before March 2020, the impact of COVID-19 on population health and health inequalities is likely to have been less severe.

Opportunities were missed before the pandemic to ensure the UK was a healthier nation with fewer health inequalities

While it was inevitable that a public health crisis of this scale would have a significant impact on population health, better population health and fewer health inequalities before the pandemic would very likely have reduced the number of deaths and rates of illness. In our call for evidence, many respondents pointed to the importance of good long-term population health as a buffer against health crises like the COVID-19 pandemic.

'The UK needs to really invest in healthy lives, addressing all the problems which cause illness. Prevention please, not sticking plasters.'

(GP locum, Northern Ireland)

'I would like to see it made very clear that these inequalities made [a] real tangible difference and this is why we need to work to reduce these. I would like to see a better emphasis in both public health and healthcare on preventative medicine, looking at lifestyle, work environments, the differences between groups and how society can do things better to benefit those who have the most disadvantage.'

(Salaried GP, Scotland)

'There needs to be an effort to improve social and public health measures to try and improve housing, education, etc. [...] efforts to "level up" are needed before our next crisis.'

(Medical academic/GP, Wales)

Some respondents to our call for evidence also emphasised the need for long-term strategies to reduce health inequalities.

'In terms of ethnic minorities – highlighting the importance of primary prevention of diabetes, metabolic conditions including obesity and weight gain and ensure improved education in schools for children.'

(Salaried GP, Scotland, Pakistani)

'Invest in low socioeconomic status areas in order to lift those individuals out of poverty and reduce inequalities. Once again, listen to what we say and don't just make random policies that do nothing but make things worse.'

(Medical student, studying not working, England, Asian/Asian British)

'[Need to have] positive investment into areas where health inequalities exist, [a] combination approach for health and care and the wider determinants of health. Otherwise it will just repeat itself with the next health crisis.'

(GP contractor/principal, England)

Despite widespread recognition of the importance of improving population health and reducing health inequalities, the UK's public health functions have been hampered in their ability to do so due to various barriers, such as a lack of funding, pressure from industry, and a lack of cross-government accountability for health.

The long-standing inadequate investment in public health has meant that organisations with public health responsibility have found it increasingly hard to plan and commission public and preventative health interventions. The policy of austerity implemented for much of the decade preceding the pandemic saw a significant decrease in funding for both public health and UK healthcare spending more broadly. For example, in England, the UK Government enacted a series of public health funding cuts from 2015, with the public health grant being cut by 24% in real terms between 2015/16 and 2020/21, taking into account population growth and inflation.⁶ Meanwhile, the Public Health Agency in Northern Ireland saw its budget decrease by approximately 2% in real terms from 2016/17 to 2018/19,⁷ but this is in the context of significant shortfalls in public health specialist staff. The Faculty of Public Health estimated that Northern Ireland needed a percentage increase of 96.6% to meet the recommended target of 30 FTE (full-time equivalent) public health specialists per million people.⁸ Without adequate resourcing and staffing, those responsible for public health at local and national levels are severely limited in their ability to improve population health and reduce health inequalities. These funding cuts and staffing shortages are outlined in more detail in [reports three](#) (the impact of the pandemic on healthcare) and [four](#) (the public health response by UK governments) of this series.

Legislative efforts to improve public health and reduce health inequalities through market regulation, such as limits on foods high in sugar or salt, have also been met with industry resistance.

The UK Government has often scaled down their ambitions or rowed back on promises, as seen recently in the [delay to the introduction of UK-wide restrictions on junk food marketing, despite these being enshrined in law](#). Such measures are vital for population health, as they address factors that make it harder for people to eat healthily. Tackling obesity also helps address health inequalities, with children in the most deprived areas more than twice as likely to have obesity than those living in the least deprived areas.

A lack of clear accountability has made tackling poor population health and health inequalities harder still. Supporting improvements in population health requires a comprehensive public health approach which [addresses the social determinants of health and prevents ill health during childhood, education, employment, and into later life](#). Social determinants of health are the factors that influence people's health which lie outside of the sphere of clinical influence and are shaped by the social, economic, and physical environment in which they live. While clinical care helps us when we are already ill and need treatment, social determinants of health have the strongest influence on people's ability to live healthy lives. In 2019, it was estimated that a third of premature deaths in England are attributable to social inequalities.⁹ Similarly, in Wales, it has been calculated that over a third of years of life lost are related to socioeconomic inequality.¹⁰ As the BMA and others have consistently stated, the scope of these social determinants of health requires a cross-government strategy to improve the population's health and reduce health inequalities, with a focus on population-level interventions that make it easier for us to live healthier lives. This requires clear lines of accountability across the government and a move beyond the common default position that responsibility for health lies solely with health departments and ministers.



Recommendations

- All UK governments should adequately fund public health infrastructure and services across the UK. This includes reversing any cuts made in recent years.
- The pandemic has shone another light on health inequalities and the importance of social determinants of health. Governments must seize the opportunity to take meaningful action to address these now.
 - The UK's governments must develop a cross-government strategy to improve the nation's health and reduce health inequalities.
 - The impact that government actions have on physical and mental health must be central to all government decision-making, following a '[health in all policies](#)' approach.
 - Drivers of ill health, including [obesity](#), [smoking](#), [alcohol consumption](#) and [poverty](#) must be addressed more ambitiously, in line with previous BMA recommendations.



Questions for the inquiries to answer

- How did the poor state of population health and high level of health inequalities affect the UK's ability to mitigate the impact of the COVID-19 pandemic?

The physical and mental health of the population was affected, with a worse impact on certain groups

The pandemic has affected nearly every aspect of our lives, and its effects range far and wide. But above all else, it is our health which has been most profoundly affected. The virus has infected millions, caused long-term illness in many, and tragically killed more than two hundred thousand people. But beyond this immediate impact, the health of the UK public has been further affected. Struggling health services meant that not everyone could access timely care for non-COVID issues, and lockdowns have changed the way we exercise and eat, as well as our smoking and drinking habits. In addition, living through a global pandemic has negatively impacted the mental health and wellbeing of many.

As outlined above, due to pre-existing inequalities, these impacts have not been equally distributed across the population. Certain groups, often those with poor health outcomes before the pandemic, have been disproportionately affected. This section outlines the general effects of the pandemic on the population's mental and physical health, before discussing several groups who have experienced some of the worst outcomes.

The COVID-19 pandemic affected the UK's physical health severely

COVID-19 has significantly affected the physical health of the UK population. The most direct and acute impact has been the physical effect of the virus itself, but the various restrictions designed to mitigate its spread, such as lockdowns, have also influenced our health.


The COVID-19 virus has infected millions of people, causing widespread illness

At the time of writing, there have been at least 22 million COVID-19 infections in the UK, with over half of the population having contracted COVID-19 since the start of the pandemic (see Table 1).¹¹ The total number is likely higher as some people will have been asymptomatic or remained untested, though estimates differ.

Table 1

Percentage of the population that has been infected at least once with COVID-19		
Nation	Percentage of population	Period
England	70.7%	27 April 2020-11 February 2022
Wales	56.0%	30 June 2020 - 11 February 2022
Scotland	51.5%	22 September 2020 - 11 February 2022
Northern Ireland	72.2%	27 July 2020 - 11 February 2022

Source: ONS Coronavirus (COVID-19) latest insights: infections • Figures show percentage of the population that has been infected at least once.



Too many people lost their lives

For most people who contract COVID-19, the illness is only mild, but not everyone is as lucky. At the time of writing, over 200,000 people in the UK have lost their lives to COVID-19, and this number continues to increase.¹² An important measure to understand the full extent of the impact of COVID-19 on deaths is excess mortality. This is calculated by subtracting the number of deaths that would have been expected under normal circumstances from the number of deaths during the COVID-19 pandemic to date, which includes deaths directly attributable to the virus itself and those resulting from indirect effects, such as reduced presentation in emergency care, or delayed diagnoses or treatment.¹³ Deaths attributable to some specific causes during the pandemic were lower – for example, traffic accidents¹⁴ – but there has been a large net increase in overall deaths in the UK during this period. This means there were more deaths than usual: by December 2021, the total number of excess deaths in the UK since the start of the pandemic had reached 148,897.¹⁵

The pandemic has left many people managing symptoms of long COVID

After initial infection with COVID-19, some people develop a condition known as long COVID. While there is no internationally agreed definition, patients with long-term effects after contracting COVID-19 report symptoms ranging from more common post-viral complaints such as fatigue, brain fog, and depression, to more immediately life-threatening symptoms such as prolonged respiratory problems, blood clots, and new cardiac conditions.

Long COVID has affected a significant number of people across the UK. As of June 2022, an estimated two million people (3.1% of the UK population) were experiencing self-reported symptoms of long COVID, after having had (or suspecting they had) COVID-19 at least four weeks previously.¹⁶ This has become an important public health issue in the UK and represents a new, significant challenge for the health system.

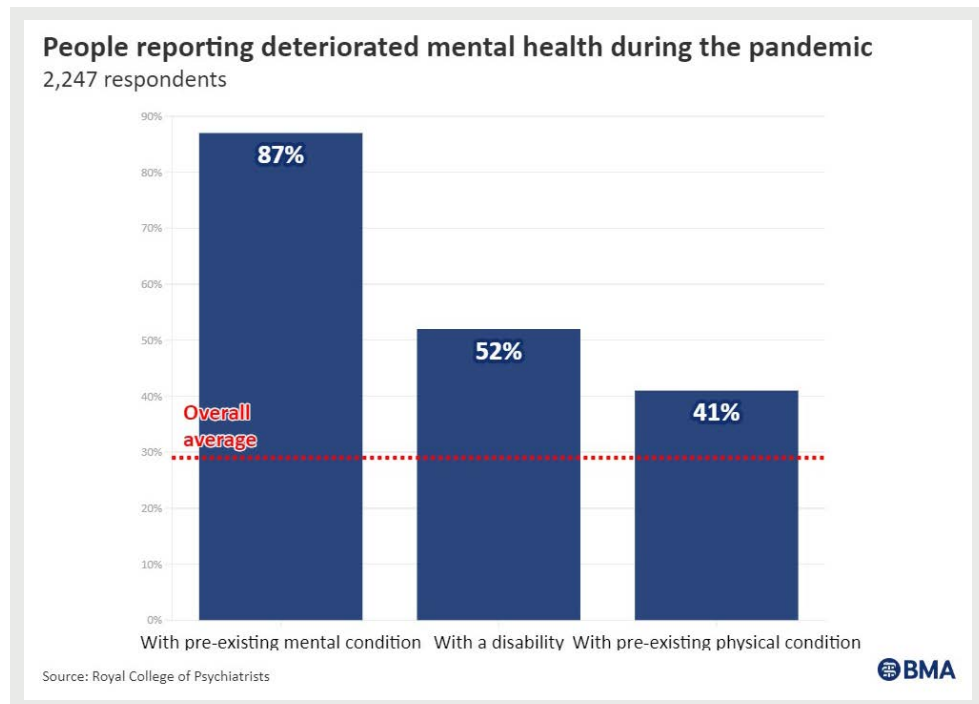
Furthermore, the prevalence of long COVID in the UK population seems to be affecting economic activity. Since comparable records began in 1971, there have been falls in the economic inactivity rate (the proportion of working-age people who are unable to work or have withdrawn from the labour market, such as the long-term sick or disabled). However, economic inactivity has generally increased during the pandemic.¹⁷ The most recent data (for the three months up to April 2022) shows an additional 447,000 economically inactive people aged 16-64 in the UK compared to the previous three months, of which 225,000 were long-term sick.¹⁸ The number of people developing long COVID, alongside the overall impact of the pandemic, is likely a contributing factor to increases in economic inactivity. Treating long COVID must therefore be a priority for economic recovery in all UK nations.

The COVID-19 pandemic also affected the nation's mental health significantly

As well as the physical health of the UK's population, the pandemic has also considerably affected its mental health and wellbeing. Measures like lockdowns, social distancing, and the closure of communal and social spaces meant that many lost their support networks, and concerns about their own health and that of others (feelings of poor psychological safety) caused stress and anxiety. Meanwhile, the economic impact of the pandemic has caused considerable financial worry for some.

The numbers of people whose mental health has been impacted are staggeringly high. In March 2022, one-third of UK adults reported that their mental health had deteriorated because of the pandemic. This includes people with pre-existing mental illness, almost nine in 10 (87%) of whom reported that their mental health had deteriorated since the start of the pandemic (see Figure 3).¹⁹

Figure 3



This is especially concerning as mental health services struggle to cope with existing demand, let alone additional demand. While not everyone whose mental health has been impacted by the pandemic will seek or need treatment, many will, and mental health services across the UK are ill-equipped to meet this need. Mental health services in England, for example, received a record 4.3 million referrals during 2021, and latest data showed 1.6 million people were on the waiting list in 2021, including 374,000 under-18s.^{20,21} Meanwhile, Mind Cymru Wales reported that hundreds of people in Wales were waiting for more than a year for help with their mental health,²² and reports from Northern Ireland express concerns about growing waiting lists too.²³ Although mental health services in Scotland seem to fare better overall, one in five people in Scotland referred for psychological therapy still have to wait for more than 18 weeks.²⁴ As such, the urgent need to better resource mental health services across the UK is clear.

The true extent of the damage done by the pandemic to the nation's mental health remains to be seen, as this type of impact can manifest over a long time.²⁵ It is likely most people will only have experienced a short, transitory shock to their mental health. But for others, the impact will be long-lasting. Such deeper, long-term mental health effects will likely be linked to inequalities, as discussed later in this report. Ongoing research, monitoring, and support will therefore be crucial in the years ahead.

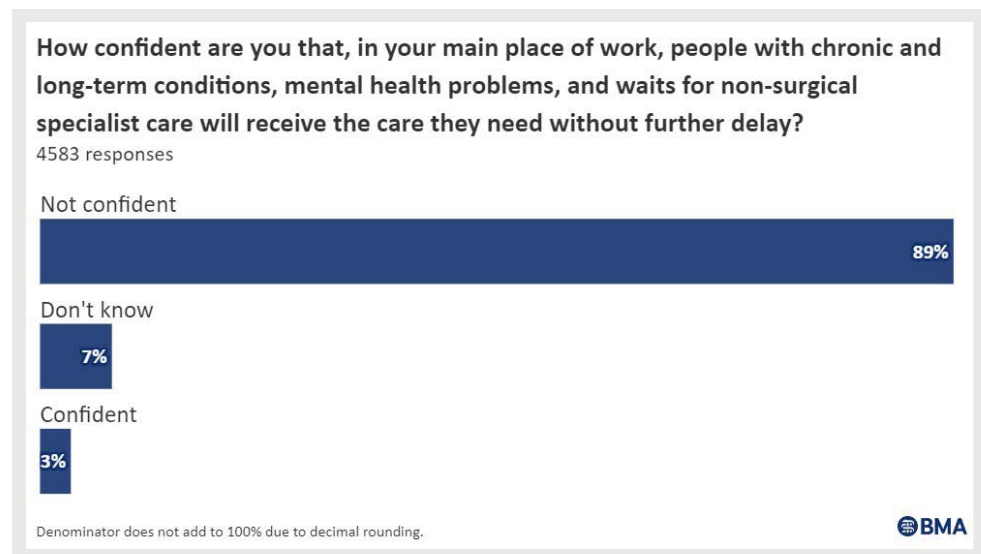
The pandemic made accessing care more difficult for those with physical or mental health needs

[As report three in this series examines in more detail](#), access to care was difficult even before the pandemic. When COVID-19 care was prioritised in hospitals across the UK, delivery of non-COVID healthcare became even harder. While reprioritisation of care in secondary care was necessary to create the capacity to look after COVID-19 patients in the UK's under-resourced and under-staffed healthcare systems, the impact of reduced availability of treatment and medical advice cannot be ignored. Unmet need has grown and continues to grow, with 7.8 million people in the UK currently on waiting lists for care.²⁶ There are also growing numbers of people waiting for longer than four hours in A&E in all four UK nations.²⁷ However – contrary to media narratives around primary care – [GPs continued to offer in-person appointments](#) throughout the pandemic for patients who needed them. TV press briefings, which took place in all four UK nations, also emphasised that those needing access to medical care should continue to seek it, with medical need being one of the reasons people were permitted to leave home during lockdown restrictions.²⁸

The true scale of unmet need – the hidden backlog – caused by the pandemic is yet to be determined. However, there is reason to believe it will be significant. The BMA estimates that, in England alone, there were 4.55 million fewer elective procedures and 31.39 million fewer outpatient attendances between April 2020 and March 2022 than would otherwise have been expected.²⁹ This resulted in widespread issues for people with long-term health and care needs, such as anxiety, reduced access to medication, and cancellations of medical appointments needed to manage health conditions.³⁰ Growing backlogs and long waiting lists in all four UK nations before the pandemic mean that because of these additional delays, some people have now waited for care for a long time. This represents a considerable burden on patients, as well as the clinicians who continue to support them.

Medical professionals are deeply concerned about this situation. In April 2021, nearly all respondents (97%) to our UK-wide COVID tracker survey³¹ were either very or somewhat concerned about the health outcomes of patients who have had to wait longer than before the pandemic to be seen or treated. More recently, in April 2022³², nine in 10 respondents (89%) in England, Wales and Northern Ireland indicated that, compared to one year ago, they were now *more* concerned that patients may suffer avoidable harm to their health from delayed admission or arrival at hospital. Equally, nine in 10 respondents (89%) told us they were 'not confident' that people with chronic diseases, long-term health issues, mental health problems, and waits for non-surgical medical specialist care will receive the care they need without further deterioration (see Figure 4).

Figure 4



While in most cases the pandemic has made accessing care more difficult, in some areas, the pandemic has also improved access to healthcare. A key example is access to abortion – the introduction of telemedical abortion in England, Wales and Scotland has allowed women to be counselled and receive pills for early medical abortion without attending a hospital, removing an important barrier to access.³³ A large-scale poll showed a majority (65%) of women in the UK would like permanent access to telemedical abortion,³⁴ which has recently happened in Wales (February 2022) and England (March 2022). Scotland has announced an extension to their temporary arrangements.³⁵



Recommendations

- The pandemic will have an ongoing impact on the nation's physical and mental health, the scale of which remains unknown. There must be research into the long-term impact the pandemic and pandemic-related restrictions had on physical health, including long COVID, mental health, and subsequent effects on the economy.
- There must be improved treatment and support for those with long COVID.
- Both physical and mental health services across the UK must be adequately resourced and staffed to respond to the impact of COVID-19. Mental health services must not be neglected in efforts to reduce the backlog of care relating to physical ill-health.
- There must be research into the impact of unmet needs and longer wait times for diagnosis and treatment during the pandemic.



Questions for the inquiries to answer

- Why was there such a high number of excess deaths in the UK and what could have been done to minimise excess deaths?
- To what extent was the likely mental health impact considered in governments' responses to the pandemic?

The impact of the pandemic on people's health has not been equal

The effect of the pandemic on people's health, both physical and mental, has not been equal. The remainder of this section discusses the health impact of the pandemic on specific groups who have been disproportionately affected. As many of these groups already had poorer health outcomes before the pandemic, the unequal toll COVID-19 has taken on their health was perhaps expected, if not inevitable. Had health inequalities been better addressed before March 2020, the impact of COVID-19 may not have been so devastating.

However, while we have tried to discuss those most deeply affected, the list of groups covered in this report is not exhaustive. Many other groups were also hit hard by the pandemic. This includes parents on the verge of burnout who had to juggle full-time jobs with home schooling; people who lived on their own who went for days or even weeks without social interaction; victims of domestic abuse who remained behind closed doors and were less likely to be identified by public services or family members whilst their abuse grew worse; or key workers who were unable to stay at home and feared for their safety at work ([report two](#) in this series examines the impact of the pandemic on one such group: doctors).

Older people experienced worse physical and mental health, and some continue to struggle to access care

Older people are especially vulnerable to COVID-19, and considerably more likely to be hospitalised or die because of infection. Of the total number of people in the UK who died from COVID-19 during 2020 and 2021, over 87% were people older than 65.³⁶

Beyond the immediate impact of the virus, older people suffered in other ways during the pandemic. Staying at home for long periods has contributed to reduced mobility, muscle weaknesses and joint pain, which in turn has had knock-on consequences for functional capacity and the ease of undertaking daily activities.³⁷ Research by Age UK found that one in three older people reported less energy, one in four said they were unable to walk as far as before the pandemic, and one in five felt less steady on their feet.³⁸ Reduced social interaction can also contribute to cognitive and functional decline.³⁹ Given that one in three people aged 65 and over in the UK live on their own,⁴⁰ many people in this age group experienced the health impact of reduced social interaction during the pandemic. This issue has been observed by respondents to our call for evidence:

'Elderly have retreated and their health deteriorated – many remain anxious and have aged dramatically in the last 2 years because of lack of stimulation and increased isolation. Vaccination has helped to get them out and about again, but we are continuing to catch up with our elderly patients and they often need a very thorough review both physically and socially.'
(GP contractor/principal, England)

Loneliness and isolation have been a particular issue for many older people throughout the pandemic, and consequently they have been vulnerable to poor mental health. One longitudinal study found that depressive symptoms in adults aged 52 and over had doubled by December 2020, alongside increases in loneliness, and decreases in quality of life.⁴¹ Many older people live alone, and they have also been disproportionately represented on UK shielding lists. In Scotland, for example, more than half of the shielding list consisted of people aged 65 and over.⁴² Shielding meant that many people in this group spent large amounts of time by themselves over the past two years and often continue to do so out of fear of the virus. In one study from summer 2020, older adults on the shielding list reported higher levels of depression, anxiety, and loneliness than their peers who were not on the list.⁴³

Some older people have also struggled to access the health and social care they need. The Health Foundation reported that 25% of older adults in the UK had healthcare appointments cancelled or postponed.⁴⁴ Data from England shows a drop of 32,000 requests for social support from older people in 2020/21 compared to the previous year, likely because older people tried to minimise infection risk by avoiding contact with social care services.⁴⁵ Similarly, in Scotland almost 7,000 fewer people aged 65+ received support from social care services in 2020/21 compared to the previous year.⁴⁶ Another factor has been the rapid switch to remote consultations, which may have disproportionately affected older people. At the start of the pandemic, only 80% of households in Great Britain with someone aged 65 and over living on their own had an internet connection.⁴⁷ Furthermore, an estimated 11% of adults aged 65-74 and 39% of adults aged 75 and over in the UK had never used the internet when the pandemic began.⁴⁸ While many older people are confident accessing the internet, for those who feel less confident or who do not have any access, the rapid move to digital-first healthcare delivery was undoubtedly more difficult to navigate. This would have been even more challenging for those with limited support networks.

'Access to primary healthcare was so difficult for the elderly in terms of phones and IT access, those who had hearing/visual impairment or those who didn't have English as their 1st language.'
(Retired doctor (not currently working), England)

As such, there may be significant unmet need among older people. However, recent analysis indicates higher rates of face-to-face GP appointments for older people, those taking multiple medications and those living in more deprived areas,⁴⁹ demonstrating that GPs continued to prioritise these groups as needed.

People living in care settings suffered higher death rates, isolation, and sometimes cognitive and functional decline

Care home residents have also borne the brunt of the pandemic. During the first wave, 40% of all COVID-19 deaths in England were among care home residents.⁵⁰ Between March 2020 and January 2022, there were over 46,000 deaths involving COVID-19 among care home residents in England, Wales, and Northern Ireland.⁵¹

The UK-wide decision to discharge thousands of untested patients into care homes – a decision [which has since been ruled unlawful](#) – and the lack of access to PPE in care homes early in the pandemic, likely led to increased deaths in care homes. In addition, there were concerns in all four UK nations about the inappropriate practice of applying blanket DNAR (do not attempt resuscitation) decisions to patients' medical records by care providers. These issues are explored further in [report three](#) in this series.

Care home residents also suffered beyond the immediate impact of the virus itself. Care homes in all four UK nations were subject to particularly stringent pandemic-related restrictions, and though they were designed to protect care home residents from the virus, they had an adverse impact on residents' health and wellbeing in other ways. For example, limits on visits in care homes have since been linked to reduced nutritional intake and weight loss, loneliness and isolation, and reductions in quality of life.^{52,53} For residents with cognitive impairments (who comprise a substantial proportion of the care home population) these restrictions have had a particularly adverse impact, as restrictions and a lack of social contact have contributed to confusion and cognitive decline.⁵⁴

In addition, care home residents could not always access hospital care during the pandemic. During March and April 2020 for example, there was a substantial reduction in hospital admissions from care homes in England: elective admissions for this group reduced to 58% of the 5-year historical average, and emergency admissions to 85% of the five-year historical average⁵⁵ (comparable data is not available in the devolved nations). Reducing admissions of at-risk patients to high-risk hospital settings was important to reduce virus transmission but may have resulted in significant unmet need amongst those living in these settings.⁵⁶ Whilst a reduction in access to healthcare was a problem for many groups, it was of particular concern for this group considering their significant health needs.

People with a disability experienced worse health outcomes

People with disabilities, including learning disabilities, suffered worse health outcomes during the pandemic. Data from all four UK nations shows that disabled people have been more likely to die of COVID-19 than non-disabled people, with the risk of death during the first wave being up to three times as high for those with a disability.⁵⁷ In all four UK nations, disabled people made up around six in 10 of all deaths involving COVID-19 during the first months of the pandemic.⁵⁸ Whilst the total death rate for disabled people varied significantly from wave to wave after that, available data from England and Scotland shows that mortality rates involving COVID-19 remained higher for disabled people compared with non-disabled people throughout the pandemic.⁵⁹

Several factors likely contributed to this outcome. Many disabled people live in communal settings, or more heavily rely on health and social care services, which made social distancing measures harder to implement. However, the subsequent risk of exposure should not have been so high. Lack of adequate PPE and access to testing, especially in the early stages of the pandemic, no doubt compounded this risk – as examined further in the [first](#) and [third](#) reports in this series.⁶⁰

Poor health outcomes for disabled people are also a reflection of pre-existing inequalities and issues. Many disabled people already suffered poorer health outcomes before the pandemic due to lack of access and discrimination within healthcare settings. For example, it was estimated in 2013 that, in England alone, 1,200 people with a learning disability die every year who could be saved by timely access to good quality healthcare,⁶¹ and disabled people have reported issues navigating inaccessible care environments.^{62,63} It is likely that the pandemic further exacerbated issues of discrimination, including failure to make appropriate adjustments to ensure services were accessible to all.

The possibility of discrimination understandably caused a lot of anxiety among disabled people and their loved ones. In the early stages of the pandemic, there were concerns that rapidly developed guidelines and guidance proposing triage based on clinical frailty would result in disabled people being deprioritised for treatment if shortages of resources, such as ICU beds, occurred⁶⁴. Though the guidelines were challenged and subsequently adjusted, the message may have stuck and reinforced the harmful notion that disabled people are less worthy of saving.⁶⁵ Similarly, media reports on inappropriate use of DNAR decisions (mentioned before and explored further in [report three](#)) raised further concerns that people with disabilities were subject to discrimination within life-saving treatment.⁶⁶ It is vital that we learn from this.

For deaf people and people with learning disabilities, there were also issues of discriminatory and inaccessible communication. For example, the UK Government failed to provide sign language interpreters during live COVID briefings, unlike Scotland which had provisions from the start. By not doing so, the UK Government put deaf and disabled people at risk by not providing access to the information they would need to protect themselves.⁶⁷ In June 2020, a group of disabled activists wrote to the UK Government asking for more easily understandable communications on how to follow distancing guidelines after they felt their disability had not been factored into those communications, leaving them 'terrified'.⁶⁸ In July 2021, the high court ruled that the UK Government's failure to provide British Sign Language interpreters was discriminatory and breached equality legislation.⁶⁹

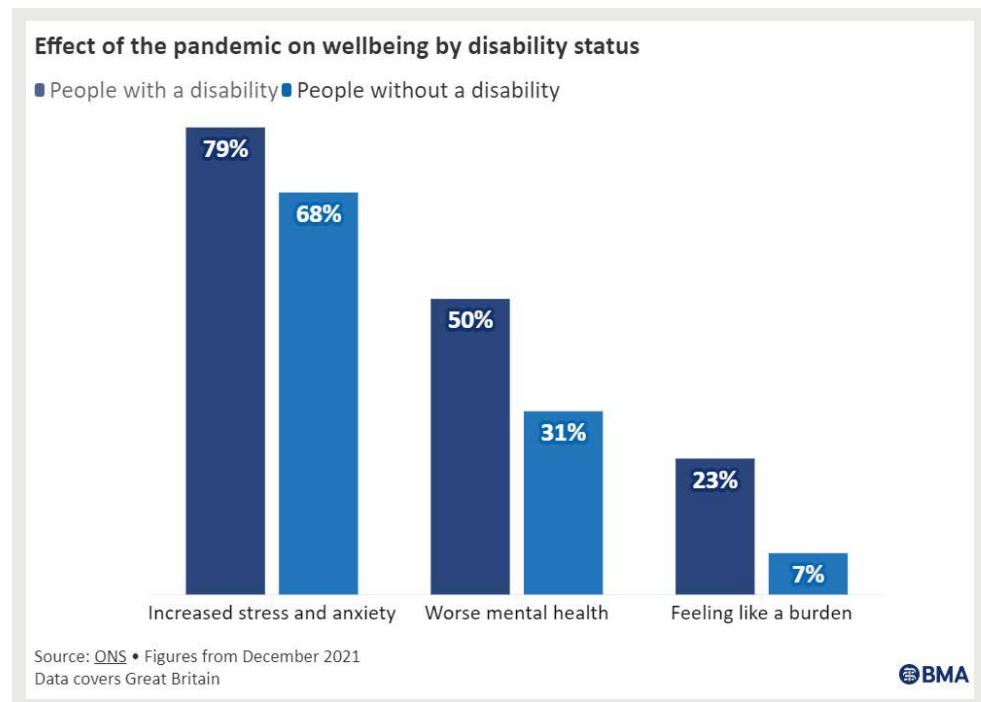
Respondents to our call for evidence highlighted the need for providing accessible public health communications.

*'Provide information in multiple languages – not even sign language or subtitles in the Coronavirus briefings – how serious were they?'
(Consultant, England)*

There were also issues regarding adequate PPE for disabled people. For example, the lack of provision of clear masks in healthcare settings was a problem for those relying on lip reading, which disrupted patient communication and impacted care.

In addition to the increased risk of physical harm, those with a disability were also more likely to have poor or steadily deteriorating mental health during the pandemic.⁷⁰ In an ONS survey measuring the impact of the pandemic on wellbeing in Great Britain, people with a disability were more likely to report feeling stressed or anxious (79% compared with 68% for people without a disability), worse mental health (50% compared with 31%) and feeling like a burden on others (23% compared with 7%) (see Figure 5).⁷¹

Figure 5



One factor that probably contributed to this outcome is the fact that people with certain disabilities (e.g., certain cancers, cystic fibrosis, or sickle cell anaemia) were more likely to be shielding,⁷² and others may have been more anxious about their health during a pandemic because of their underlying conditions.⁷³ However, the experiences and fears of discrimination, mentioned above, likely compounded this and made the pandemic more distressing than it could have been.

Finally, certain disabled people found it harder to access care during the pandemic. [The Health Foundation reported](#) that disabled people were more likely to experience disruptions to their medical treatment during the pandemic,⁷⁴ and [ONS figures](#) show that 58% of people with a disability in Great Britain had a harder time accessing non-COVID healthcare, compared to 31% of non-disabled people.⁷⁵ In addition, as mentioned before, disabled people risk being discriminated against in health and care settings through the failure of services to remove barriers that prevent them from accessing care in a timely and equitable fashion. The move to remote consulting and telemedicine was not always fully accessible to this group of people either.

People classified as clinically extremely vulnerable (CEV) were disproportionately affected, and were not protected and supported as quickly as they should have been

People classified as CEV (clinically extremely vulnerable) are a newly defined group of people who are particularly vulnerable to COVID-19 because of one or more characteristics, often a disability or long-term health condition. Often, people classified as CEV are immunocompromised – for example, people undergoing certain cancer treatments that suppress their immune system – which increases their risk of severe illness and means that vaccines against COVID-19 are less effective.⁷⁶ People across the UK who were identified as CEV were placed on the shielding list, meaning they were advised to avoid all close contact with other people to avoid COVID-19 infection. Definitions such as ‘clinically extremely vulnerable’, while a cause of some confusion early in the pandemic, ultimately enabled the provision of practical advice to a group that needed it, including when and how to shield. For some in this group, such terminology and guidance may have provided additional psychological safety.

For many people classified as CEV, the pandemic continues to be an exceptionally challenging and frightening time. Due to their health conditions, this population already had a higher risk of hospitalisation and mortality before the pandemic. The combination of datasets used to identify someone as CEV (see below) means that excess hospitalisations and deaths during the pandemic cannot be reliably determined for this population, but it is clear they have been hit particularly hard. One sample study indicated that during the first wave, people in England categorised as CEV were more than twice as likely to be admitted to hospital due to COVID-19, and more than twice as likely to die of COVID-19.⁷⁷

At the start of the pandemic, after the clinical criteria for putting somebody on the shielding list were jointly agreed by the four UK chief medical officers, efforts were made to rapidly identify those who were CEV and advise them to shield, and shielding guidance was developed quickly. Concerns were raised, however, about the effectiveness of the shielding programme. Firstly, not every person who is CEV has swiftly been identified as such. At the start of the pandemic, there was no single mechanism for identifying patients that were CEV and needed to be included on shielding lists. Across the four UK nations, a combination of datasets from multiple sources was used instead, some of which contained inaccurate or out-of-date information.⁷⁸ This systems-led approach was later supplemented through local identification by GPs and clinicians, but this hybrid identification process resulted in significant local variation as to who was identified as CEV due to differences in how lists were compiled and in the quality of data available in each area.⁷⁹ Across the UK, some people who were CEV were not identified until mid-May 2020⁸⁰ while others were initially identified incorrectly and were removed in June and July 2020.⁸¹ These variations and delays created confusion, with some people unsure whether they needed to shield, and raised concerns that not everyone who was clinically vulnerable could access the required support.⁸² Moreover, in February 2021, a change in the risk assessment tool used in England resulted in a further 1.7 million people being added to the shielding list who had not previously been categorised as such⁸³. In future, further

investment in high-quality linked data is key, so that similar systems-led approaches can operate more efficiently – alongside increased capacity in general practice to ensure the most at-risk patients can be spotted quickly.

In addition, not everyone who received a shielding letter could read and understand its contents. Research conducted by Public Health Scotland identified an initial lack of available translations and easy-read versions, and delays where people were unable to read and understand the letter without help from a family member or carer.⁸⁴

'Make sure that those who are most vulnerable have everything possible done to assist them with shielding, isolating and vaccinations etc.'
(GP contractor/principal, Scotland)

Since restrictions were eased, people classified as CEV seem to have been left to fend largely for themselves, with little ongoing support or guidance on how to keep safe in a world in which COVID-19 is still prevalent. Since COVID-19 will remain endemic, it is crucial that people classified as CEV – many of whom are now expected to go back to work and live their lives normally – are appropriately supported and protected. But efforts to continue supporting this group have also been flawed. For example, although symptomatic testing remains available to the public in Wales and Northern Ireland at the time of writing, access to a test in England and Scotland is only available to some of those who were classified as CEV and not for those who may be interacting with them.⁸⁵ For whom it is clinically appropriate, anti-viral and therapeutic drugs must be available if needed.

Many people classified as CEV also saw their mental health impacted. Figures show that around one in three (35%) people categorised as CEV reported worsening mental health during shielding periods,⁸⁶ and the CEV population had a higher risk of anxiety or depression than the general population.⁸⁷ Their high level of clinical vulnerability likely contributed to fear and anxiety.⁸⁸ In addition, stories about blanket DNAR (do not attempt resuscitation) decisions being made for at-risk people⁸⁹ and triage policies disadvantaging those with a disability⁹⁰ left many feeling as though society considered them expendable. Indeed, the reaction to the higher death rates among those with a disability or long-term condition has often been that because of their underlying conditions, their deaths were inevitable or easier to accept. Similar hurtful and damaging narratives have been observed in previous investigations and reviews into the deaths of people with learning disabilities,⁹¹ and were warned against by respondents to our call for evidence.

'Society and the health service need to consider those with "underlying conditions" as people whose lives are of value. Too often the messaging in the media has been that most of the people dying have underlying conditions, but many of us provide your healthcare, pay taxes and were living normal lives until COVID-19 came along. It's unacceptable to consider some lives as easier to accept as losses than others, but policy borne of this mindset is always going to be discriminatory and widen disparities, with a knock-on effect on mortality in those groups.'
(Resident doctor, England, has a disability)

'[There needs to be] a move away from messaging that people with "pre-existing medical conditions" are somehow expendable in the eyes of the government and society.'
(GP trainee, England)

In addition, the more stringent restrictions placed on those shielding compared to the general population – while deemed necessary at the time due to concerns about the impact of the virus on these groups – likely caused feelings of loneliness and isolation.⁹² Many were also unable to work as a result, which often caused financial stress.⁹³

People classified as CEV also experienced reduced access to healthcare. They tend to have complex health needs and require higher levels of medical attention than the general population. Though GPs maintained a focus on people with chronic conditions,⁹⁴ the reprioritisation of care in hospital settings had a disproportionate impact on people categorised as CEV. During the first wave of the pandemic, there was a higher absolute reduction in secondary health care use for those classified as CEV than for the rest of the population.⁹⁵

Ethnic minority groups saw higher death rates and worse mental health outcomes

For certain ethnic minority groups, COVID-19 posed a greater threat – [a differential impact highlighted early on by the BMA](#). Most notably, the risk of death was 3.7 times greater for Black African men than for their White British counterparts during the first wave (see Figure 6), and during the second wave Bangladeshi men were nearly five times more likely to die than White British men (see Figure 7).⁹⁶

Figure 6

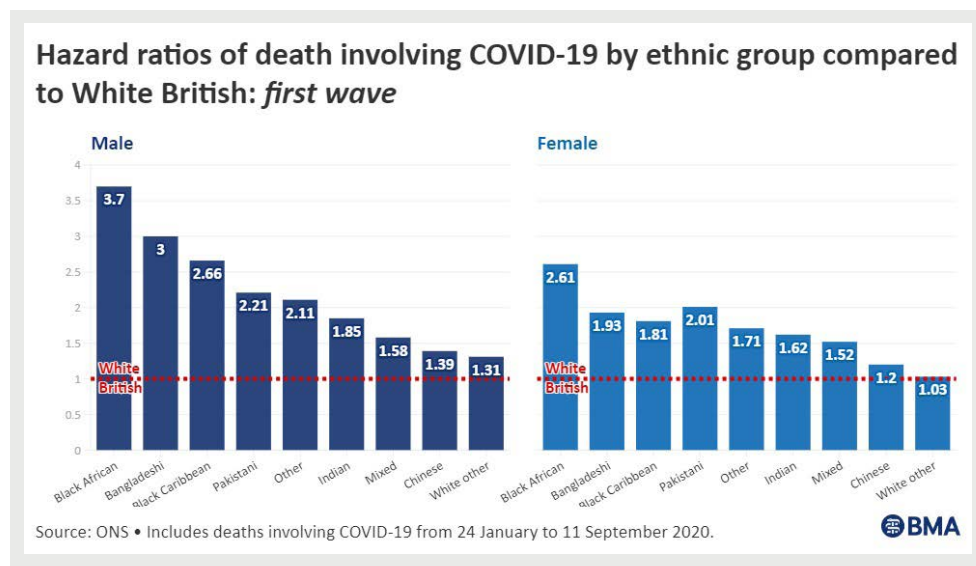
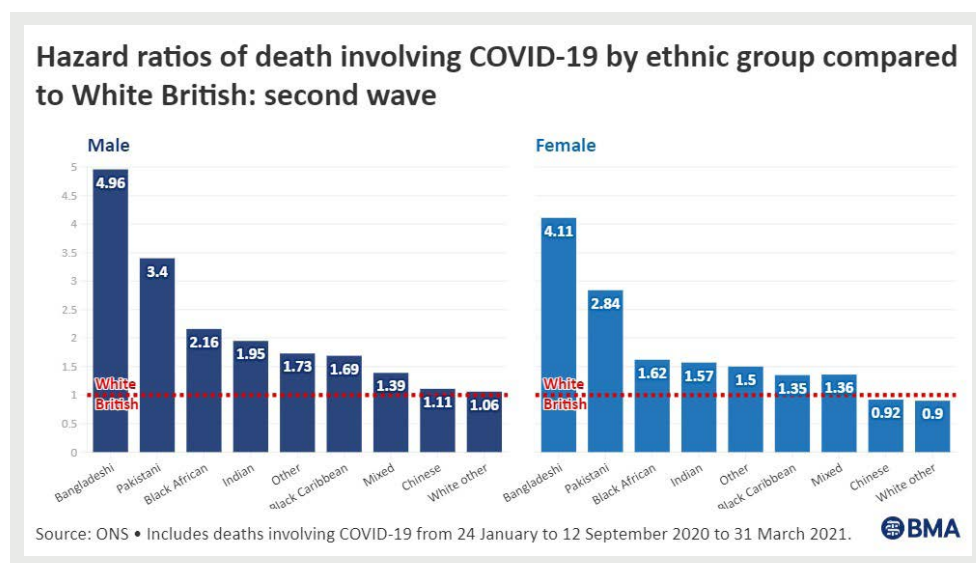


Figure 7



Ethnicity intersects with a variety of risk factors for exposure to infection, including occupation, geography, and deprivation.⁹⁷ For example, Black and South Asian people are more likely to work in jobs that involve exposure to others, such as healthcare; they are

also more likely to live in more densely populated and deprived urban areas.⁹⁸ Another related risk factor is overcrowding. In all four UK nations, cramped housing is far more likely to be a problem for ethnic minorities⁹⁹, making social isolation to restrict the spread of the virus harder. In England, for example, 24% of the Bangladeshi population live in overcrowded housing compared to just 2% of the white British population, and 16% of Black African people live in overcrowded conditions, as do 18% of Pakistanis.¹⁰⁰

In our call for evidence, respondents highlighted some of these issues.

'The pandemic impacted hugely on people who were in poor housing or overcrowded housing, as it is virtually impossible to isolate in overcrowded housing, and damp and cold accommodation worsens people's overall health. In response I would like to see investment in social housing, including where necessary replacing some of the poorest inner-city housing with new builds with high specification insulation, space for recreation, and better access to GP surgeries and health promotion activities.'
(Consultant, England)

Structural racism cannot be ignored when discussing racial health inequalities, as noted by the BMA in its [response to the controversial Commission on Race and Ethnic Disparities report, better known as the Sewell report](#).¹⁰¹ In particular, the above factors contributing to increased exposure in these groups are likely due to structural inequalities at least partially influenced by race. In addition to these, the risk of COVID-19 was compounded by various forms of discrimination. For example, there have been reports of discrimination within the UK's health services, which have resulted in increased exposure and poorer protection for ethnic minority workers¹⁰² – an issue explored more closely in [report two](#) of this series. Moreover, historic and structural racism [has caused distrust of UK health services for some ethnic minority groups](#). This has contributed to poorer vaccine uptake for these groups during the pandemic¹⁰³ (as discussed later in this report), with negative consequences for health outcomes.

'Racism exists in the UK and active teaching of biases needs to occur. Too often I hear "it's multifactorial" as the end of the discussion, it is the start and you need to then ask, "which factors [do] I need to address?"'
(SAS doctor, Scotland, Asian/Asian British)

There were missed opportunities to protect these groups better. Access to high-quality PPE would have been one such measure. Another area for improvement concerns the timely translation of public health communications into languages other than English or Welsh. In summer 2020, several charities and advocacy groups wrote to the UK Government's health secretary and communities secretary, noting that the UK Government had failed to provide translations of COVID-19 guidance and that the few existing translations were not updated as guidance changed.¹⁰⁴ Accessible and up-to-date information on how to protect themselves from a fast-spreading disease such as COVID-19 likely would have allowed ethnic minority groups whose first language isn't English or Welsh to better protect themselves.

'Communication must ensure to be conducted [sic] in ways that will reach all various groups in our society.'
(Resident doctor, Wales)

Besides adequate translations of public health messages, building trust within different communities is an important way to reduce mistrust of health services. The importance of getting this right was also highlighted in our call for evidence.

'We must get messaging right. We need to consider which community leaders to involve at a very early stage, so that they can talk to their own local people about their particular fears. We need a clear cascade system ready to go immediately [if] anything like this happens again.'
(Retired doctor not currently working, country not stated)

'Involve ethnic minorities to manage test/trace and vaccine roll out to boost confidence in the authorities and acceptance of vaccine, role of mask etc.'
(Consultant, England)

It is not clear that governments have been able to fully establish the required trust. For example in June 2020, [a Public Health England report](#) raised concerns that public health advice was not reaching these groups and called on decision-makers to 'enhance the depth of reach' into ethnic minority communities through cooperation with local leaders.¹⁰⁵ The lower vaccine uptake in certain groups despite targeted efforts to increase it (discussed later in this report) is a cause for concern in this context.

Finally, and no less importantly, ethnic minority groups have been at greater risk of poor mental health outcomes. Before March 2020, they were already at higher risk of poor mental health,¹⁰⁶ and data suggests the pandemic has reinforced this discrepancy.¹⁰⁷ This is likely due to several factors, as many determinants of poor mental health, such as increased financial insecurity and long COVID, have been more common among certain ethnic minority groups. In addition, the anxiety and stress caused by the awareness of themselves and loved ones being at higher risk of the virus undoubtedly contributed to these outcomes.

Those without an official immigration status faced additional barriers to accessing healthcare
The pandemic highlighted the importance of ensuring that everyone, regardless of their immigration status,¹⁰⁸ feels safe coming forward for timely screening and treatment. The inclusion of COVID-19 on the list of conditions exempt from charges for those not ordinarily resident in the UK has thus been very welcome.¹⁰⁹

However, this does not mean all migrants have sought the care they needed, even when entitled to it. Wider [charging regimes](#) for non-COVID care – through which 'overseas visitors' accessing health care services are charged – have remained in place in all four nations. Moreover, in some nations, data sharing policies between health services and the Home Office have created a legacy of fear and, although these policies did not apply to COVID care, they continued to apply to non-COVID care. As such, people were reluctant to access care for fear that they would incur charges related to any non-exempt comorbidities, or that interaction with the UK's health services could lead to them being targeted by immigration services. A poll by the Joint Council for the Welfare of Immigrants showed that almost half of the migrants surveyed (43%) have been scared to access healthcare during this pandemic.¹¹⁰ Indeed, some people were reluctant to seek care even for 'exempt' conditions such as COVID-19, with [reports](#) of people dying at home as a result.

From the outset of the pandemic, the BMA, along with a broad coalition of health and care organisations, [raised concerns](#) that the UK Government's hostile environment policies would constrain public health efforts by deterring migrants from accessing healthcare even if they were entitled to it¹¹¹. We called for the immediate suspension of health service charging regulations for non-COVID care, and associated immigration checks and data sharing with the Home Office, along with a public information campaign reassuring migrant communities that it would be safe for them to access care during the pandemic.

People living in deprived areas in the UK were more negatively affected by the pandemic than those in the least deprived areas

The impact of COVID-19 varied by area and region. ONS data shows that, in mid-2020, the COVID-19 mortality rate in the most deprived areas of England and Wales was roughly twice as high as in the least deprived areas.¹¹² For example, the north of England has suffered disproportionately during the pandemic, with some of the highest infection and death rates in the country.¹¹³ Similarly, COVID-19 infection and death rates have generally been higher in more deprived areas in Scotland and Northern Ireland.¹¹⁴

A variety of factors have contributed to these outcomes. Not only did deprived areas have poorer health outcomes to start with, as discussed already, they also typically have a high concentration of key workers and more people living in crowded spaces. Since deprivation is more common among certain ethnic minority groups, deprivation and ethnicity are also

intersecting factors. For example, UK-wide nearly half (46%) of people living in families with a Black household head live in poverty, compared to just under one in five (19%) of those living in families where the head is white.¹¹⁵ However, there are also white working-class neighbourhoods that have experienced, and continue to experience, very poor outcomes. Further, deprived areas have been disproportionately affected by spending cuts, reducing the ability to address or ameliorate geographical inequalities. A report by the Northern Health Science Alliance, for example, cited a decade of spending cuts to explain the inequity in pandemic impact between the north and the south of England.¹¹⁶ Whilst spending cuts affected the whole of the UK, when looking at how different parts of England were affected, deprived communities with higher rates of poverty and weaker economies in the North of England saw the largest reductions in their local authority budget.¹¹⁷

With levels of infection higher among people living in deprived areas, rates of long COVID are also higher, as ONS data confirms.¹¹⁸ In the four weeks ending 1 May 2022, the estimated percentage of people in the UK with self-reported long COVID was 3.84% for the most deprived areas compared to 2.67% for the least deprived areas. As such, the prevalence and manifestation of long COVID along inequality lines present a significant challenge to reducing overall health inequalities in the UK.

Those living in more deprived areas of the UK also experienced a disproportionate impact on their mental health¹¹⁹. For example, those in more deprived areas reported a greater decline in their mental wellbeing than those living in less deprived areas¹²⁰. They more commonly experienced anxiety and depression¹²¹, and were more likely to be concerned about their finances¹²². Abuse, self-harm, and thoughts of suicide/self-harm were also more commonly experienced by those who were socioeconomically disadvantaged¹²³.

Exposure to the virus was also higher for those working in sectors with traditionally low-paid roles that could not be done from home, such as the care, retail, or service sectors¹²⁴. Cases of long COVID are, consequently, more common among these groups.¹²⁵

Underlying the inequalities experienced by deprived communities, there are inequalities in access to healthcare. [The inverse care law](#) refers to the problem that those who need healthcare the most are less likely to receive it. In addition, those in more deprived areas (and so with worse health outcomes) tend to have more difficulties accessing care early on, and subsequently are more likely to access healthcare only in emergencies¹²⁶, with an over-reliance on hospital care and underuse of preventative medicine¹²⁷. During the pandemic, these trends have been reinforced. The backlog of care has been larger in deprived areas, with [analysis by the King's Fund](#) showing that those living in the most deprived areas of England are 1.8 times more likely to experience a wait of more than a year¹²⁸. Hospitals in more deprived areas of Scotland also saw greater use of critical care beds during the pandemic.¹²⁹

As respondents to our call for evidence noted, strategies targeting health inequalities should include mechanisms to ensure healthcare systems in more deprived areas receive adequate funding.

'Age old concept of those in poorest areas of society in poorest health. Channel resources here first. Educate in lifestyle choices, find barriers to accessing healthcare and break these down.'
(Resident doctor, England)

'Distribute greater resources to areas where healthcare needs are greatest but will require so much more resources to deliver in a meaningful way.'
(Salaried GP, England)

Many children and young people lost the health benefits provided by schools or struggled with their mental health

Since COVID-19 tends to cause more severe illness in older and clinically vulnerable people, for most children and young people infection was only mild or asymptomatic. However, very sadly, some young people lost their lives to COVID-19. There have also been young people in the UK who developed long COVID. By 1 June 2022, the ONS estimated there were 240 people between 2 and 24 years old in the UK experiencing long-term symptoms after infection.¹³⁰

Furthermore, many children and young people saw their physical health affected in other ways. For example, concerns have been raised that social restrictions during the pandemic have limited young children's exposure to germs and bugs overall.¹³¹ Such exposure is crucial during our early years to strengthen our immune systems. The long-term impact on these children's health is not yet clear and is something that will need to be monitored closely.

While the decision of the UK governments to close schools to control the spread of COVID-19 was sensible given how little we knew about the transmission or impact of the virus, it has affected children's health in many ways. Schools provide opportunities for socialisation, physical activity, and healthy eating, which improve the health of children, and which may not be as accessible at home for some.¹³² School closures limited access to free school meals, health services delivered in school settings, and the ability of teachers to identify those whose health may have been at risk from violent or abusive home settings. Prior studies into the effects of summer holidays suggest some of the negative impact longer school closures due to COVID would have on many children and young people. For example, research has shown child physical activity levels fell below national guidelines during the COVID-19 crisis and did not recover when lockdowns ended.¹³³

While those eligible for free school meals continued to receive meals or vouchers during school closures, this was initially only available during term-time – a policy which had severe consequences for families whose livelihoods would often have been impacted already by the pandemic (see also below). The Welsh Government made an early commitment in April 2020 to continue this support outside term-time, yet in England, Scotland, and Northern Ireland it took a campaign by footballer Marcus Rashford before this provision was eventually agreed upon in June 2020 after several high-profile U-turns by the UK Government.¹³⁴

Equally, schools provide access to school nurses and health education, including oral hygiene. While the health function that schools provide was inaccessible for all children, for those from deprived backgrounds with poorer health outcomes, the loss of such a function will have been more keenly felt. This was highlighted by respondents to our survey.

'Schools closed early in the lockdown, fair enough, but it was not a priority to open them again [...] Nearly two years in, my children are stressed, fallen behind on school work, limited in social interactions. And these are privileged, white children, with professional parents, with no financial concerns. I don't dare to think about children who relied on school for getting fed, getting talked to, getting read to, getting safe relationships.'
(Consultant, Scotland)

Beyond the immediate effects on child physical health, pandemic disruptions will likely also impact the physical health and development of children in the long term, which will be discussed later in this report.

Children and young people's mental health has also been affected during the pandemic. Most notably, declines in mental health occurred for both primary and secondary school pupils during the periods in which schools were closed.¹³⁵ Data indicates that children were more likely to experience higher levels of depression and PTSD (post-traumatic stress disorder) during these times.¹³⁶ There was also an increase in young adults having suicidal thoughts in the weeks after the UK-wide lockdown was introduced in March 2020.¹³⁷ It is difficult to say with certainty if it was school closures or living through such a disruptive

pandemic which contributed to children's poor mental health, but most probably it was a combination of the two. Associated factors with both phenomena, such as reduced social interaction, increased isolation, academic stress, and disrupted support structures¹³⁸ likely contributed to the change.

While the mental health of many children and young people improved once schools reopened and restrictions eased, there was significant variation depending on certain characteristics. There are indications that worse mental health outcomes were experienced by girls and young women, those with SEN (special educational needs), those eligible for free school meals, those with long-term physical health conditions and those aged between 16 and 24.¹³⁹

The impact on mental health extends beyond the effects of restrictions. Thousands of children across the UK lost a parent, grandparent, or caregiver during the first year of the pandemic. Bereavement in childhood is associated with high levels of stress, anxiety, depression, and poorer long-term mental health.¹⁴⁰ This means the high death toll of the pandemic will likely have mental health consequences for years to come. The financial impact of the pandemic (discussed later in this report) will also have had a significant negative effect on children and young people's mental health: it is well established that parental financial stress can impact children's mental health. It is thus unsurprising that this was also an issue during the pandemic, with studies finding connections between parental financial difficulties and child anxiety.¹⁴¹

It is too soon to know the longer-term impact of the pandemic on children and young people's mental health, and whether existing health inequalities in this context will widen. However, in 2021, the proportion of children with a probable mental health condition remained at higher levels than before the pandemic.¹⁴² This is reflected in the increased levels of demand in children and young people's mental health services. For example, April–September 2021 saw referrals increase by 81% in England and 13% in Scotland, compared to the same period in 2019.¹⁴³ Demand was particularly high in relation to eating disorders, with England experiencing record numbers of these referrals.¹⁴⁴

Decisions to close schools and reopen them are finely balanced, and not easy to make. Knowing what we know now about the impact of school closures (further examined later in this report) it is critical that steps are taken to ensure the UK is better equipped to keep schools open safely in future. For example, there were reports of children being forced to learn in freezing classrooms after schools without electric ventilation systems had to open windows and doors in winter to keep schools well ventilated.¹⁴⁵ In August 2021, it was announced that 350,000 CO₂ monitors (backed by £25m funding) and 9,000 high-efficiency particulate air cleaning units would be provided in education settings. This was an encouraging step, and for schools to remain open, safe, and comfortable in any future pandemics, this is the sort of intervention that would be necessary.



Recommendations

- The UK governments must take action to support the physical and mental health of those from socially disadvantaged and vulnerable groups who have been unequally impacted by the effects of the pandemic, including:
 - ensuring those who are particularly vulnerable to COVID-19 are supported and protected, as COVID-19 becomes endemic, by providing access to free tests for themselves and those they closely interact with, timely access to healthcare, and access to antivirals;
 - addressing the unacceptable regional variation in health outcomes by ensuring health and care systems in more deprived areas and communities are adequately resourced to counteract the 'inverse care law';
 - addressing inequalities in access to care when tackling the backlog by ensuring health services are resourced adequately to deal with the additional burden of ill health;
 - conducting ongoing research and monitoring to understand the long-term impact on the health of different groups and use this to inform future policy and care decisions.
- The UK governments must ensure the country is better prepared to manage a future pandemic in a way that considers the impact on inequalities, including:
 - ensuring systems can quickly and effectively identify those who are clinically vulnerable through further investment in high-quality linked data;
 - increasing capacity in General Practice to ensure patients most at risk can be spotted quickly at a local level;
 - building trust with groups who have historically had low levels of trust in governments and health services;
 - improving systems for inclusive and accessible up-to-date public health communications, in a variety of languages including sign language;
 - ensuring future pandemic planning includes strategies for providing timely practical and emotional support to those required to shield;
 - Ensuring rapid identification of any unequal impact between social groups in real-time.



Questions for the inquiries to answer

- Why were excess deaths inequitable across different groups?
- When decisions to introduce or relax restrictions were made, to what extent was the impact of those decisions on health inequalities considered?
- Did governments across the UK make efforts to mitigate health inequalities where possible? How successful were they?
- How could data systems have more accurately and swiftly identified:
 - those who were CEV to improve the accuracy of the shielding lists, and to mitigate the local variations and delays in support that some people classified as CEV experienced?
 - other at-risk groups who may not necessarily have needed to shield (such as those from ethnic minority groups) but whom more support could have benefited?

The pandemic also affected people's health behaviours

Beyond the direct impact of the virus on people's physical and mental health, the pandemic also influenced the population's health behaviours. These effects have been very mixed. For some, the pandemic brought opportunities for positive lifestyle changes, whereas for others, factors largely outside their control made healthy behaviours harder to follow.

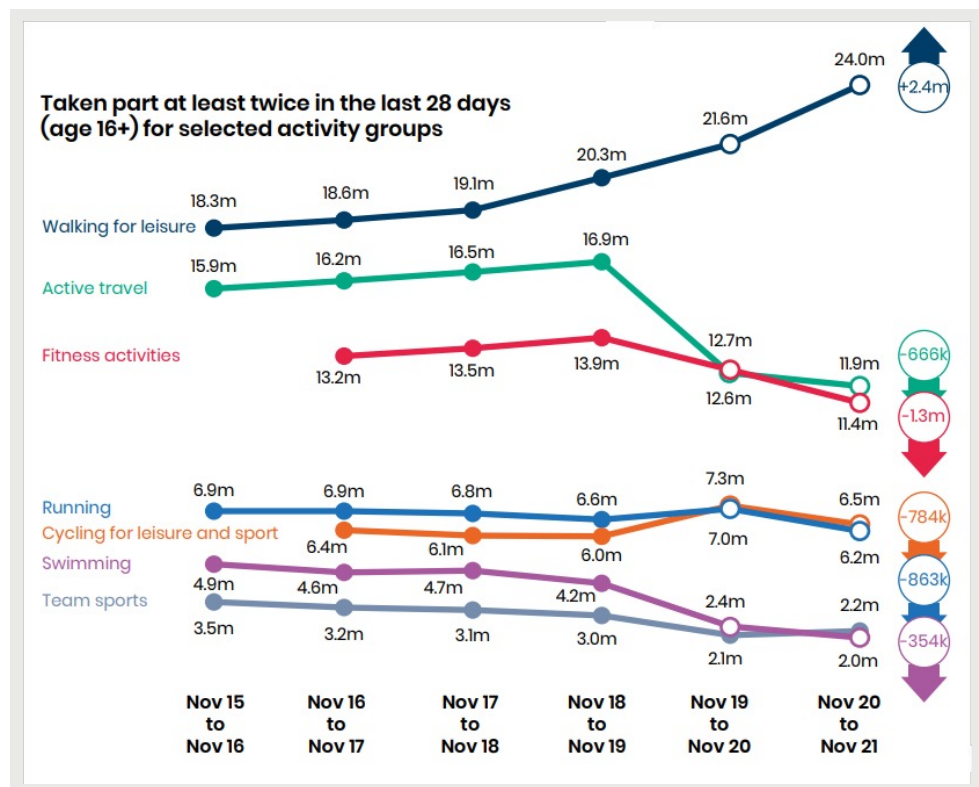
Lockdowns caused changes in physical activity levels, with a negative impact felt on certain groups

One area of our lives that has been affected by the pandemic is physical activity. Overall, evidence suggests that lockdowns caused a decline in physical activity, as sports and leisure centres closed, people stayed at home and social distancing was enforced.^{146,147} In addition, there has been a reduction in active travel as many people ceased commuting.

People's experience of physical activity differed considerably, with some of the groups most at risk of worse health outcomes at the start of the pandemic finding it harder to be active. For example, a study has shown that adults with a higher BMI (body mass index) were more likely to report lower activity levels during lockdown, as well as people on a lower income, those from ethnic minority backgrounds, and those suffering from a high-risk medical condition.¹⁴⁸ Data from Scotland shows that adults who had been advised to shield also reported lower physical activity levels.¹⁴⁹ Some of these groups already faced barriers to physical activity before the pandemic,¹⁵⁰ and it seems that the pandemic exacerbated these. For example, for people with a disability or long-term condition, barriers to physical activity during the pandemic included fear of contracting COVID-19 and not having adequate practical support.¹⁵¹ Other barriers people faced include poor access to nearby green spaces, which is associated with affluence,¹⁵² and lack of resources: higher-income families were better positioned to undertake a variety of other sports, since they often had more time and space to exercise, and more money to buy equipment for training at home.

Nevertheless, the pandemic has had some positive effects on the nation's physical activity. A few studies suggest that some people became more physically active during lockdown,¹⁵³ and recreational walking became more popular than ever. Evidence from Scotland and Wales, for example, suggested that recreational walking levels increased during the first lockdown,^{154,155} and data from England shows that this activity has become increasingly popular throughout the pandemic (see Figure 8 (Source: *Sport England 2022*)).¹⁵⁶ This suggests that many people have been developing new, healthy habits.

Figure 8 (Source: Sport England 2022)



To ensure people maintain health-supporting habits, including walking for fitness and leisure, barriers to physical exercise must be reduced for all groups, for example by improving access to green spaces. For those commuting to work, active travel should be encouraged. [As previously noted by the BMA](#), this requires the reversal of budget cuts to funding for open spaces and recreation facilities, especially in the most deprived local areas. There also needs to be an increase in the cross-departmental budget for active travel and encouragement to undertake physical activity from an early age, including as an essential part of the school curriculum, and support for inclusive programmes for physical activity such as the [Inclusive Activity Programme](#) in England and the [Inclusive Walking Programme](#) in Northern Ireland.

The pandemic has changed the way we eat

There are also indications that the pandemic has changed the way we eat. Several studies suggest that, as pubs and restaurants closed, home cooking became more popular¹⁵⁷ and people in the UK improved their diets.¹⁵⁸ The European Institute of Innovation and Technology found there was a 31-33% increase in the consumption of fresh fruit and vegetables in the UK in 2020,¹⁵⁹ and similar findings were reported by the FSA (Food Standards Agency), who found that one-third (32%) of UK respondents ate healthier main meals during the first year of the pandemic.¹⁶⁰

Evidence suggests the pandemic may have provided an 'impetus to improve healthy behaviours'¹⁶¹ as people in the UK grew more concerned and conscious about their health and diet.¹⁶² Moreover, this positive impact may be long-lasting, as nearly one in three people questioned by the FSA reported an intention to continue to cook home-made meals (27%) and to eat more varied foods (30%) after the pandemic,¹⁶³ and 84% of those who ate healthier main meals expected this change to continue.¹⁶⁴

Diet improvements, where they did occur, were again more common in certain groups of people. The FSA found a strong correlation between increased free time and healthier eating habits, with three-quarters of those who ate more healthy main meals (75%) saying they had more free time.¹⁶⁵ They also found that healthier eating was more common among those in full-time employment (36% versus 24% of unemployed people) and

higher-income groups (28% of those earning up to £20,000 versus 36% of those earning between £60-80,000).¹⁶⁶ Evidence also suggests that for those with a higher BMI, the pandemic may have had a disproportionately large and negative influence on eating behaviours, such as snacking and overeating.¹⁶⁷

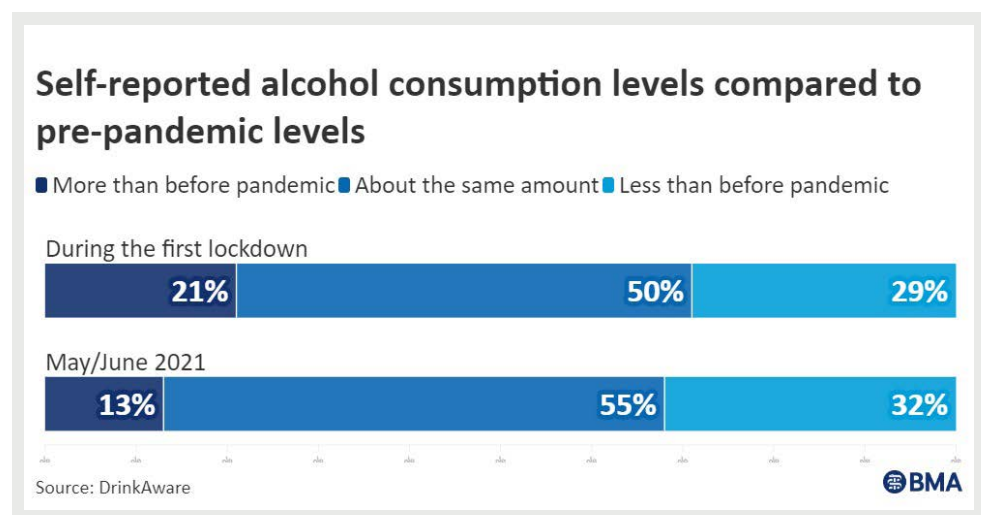
The pandemic has forced people to cook at home more, creating new and healthier habits, and many people in the UK have the intention to continue doing so. Now would be the time for governments to capitalise on this momentum and tackle the country's high obesity levels with measures that will help the public in their efforts. Obesity in children is a significant public health concern in the UK. For example, demand for care for children with type 2 diabetes at paediatric diabetes units across England and Wales has increased by more than 50% in the last five years, according to Diabetes UK analysis published in June 2022.¹⁶⁸ The analysis found that children in the most deprived parts of England and Wales are 'disproportionately affected' by the disease, with four in 10 children and young people with type 2 diabetes living in the poorest areas, compared with only one in 19 from the richest.

Tackling obesity, however, requires addressing the ubiquity and appeal of unhealthy foods.¹⁶⁹ In this respect, the UK Government's recent decision to delay the introduction of already announced UK-wide regulations of multi-buy promotions and the advertising of unhealthy foods,¹⁷⁰ is a counterproductive move, as the BMA and other health experts have repeatedly stressed.¹⁷¹

Alcohol consumption, risky drinking behaviour and alcohol-related deaths increased

Drinkaware UK data suggests that during 2020, alcohol consumption in the UK increased, with around one in five adults (21%) who consume alcohol drinking more than usual in the first national lockdown. This was due to factors such as increased stress and anxiety, loss of alternative coping mechanisms, and a reduction of barriers to drinking.¹⁷² However, by July 2021, drinking levels had already dropped, with around one in eight (13%) drinking more than pre-pandemic levels. For some, the pandemic led to reduced alcohol consumption, with around one in three people (32%) drinking less than before (see Figure 9).¹⁷³

Figure 9



Among those who were still drinking more than usual in July 2021, certain groups were overrepresented. This included furloughed workers and those that were or were being made redundant, and those struggling with their mental health or work-related stress.¹⁷⁴

For most, drinking more than before the pandemic was unhealthy, but did not pose immediate risks to their health. Some, however, may have increased their consumption to the point that their drinking behaviour was considered high-risk. As well as the

immediate impacts of increased consumption such as increased risky behaviours, the longer-term effects of alcohol on health are well evidenced. This includes increased risk of seven types of cancer, cardiovascular disease, stroke and high blood pressure.¹⁷⁵ The UK Government has reported that such high-risk drinking behaviour became more prevalent during the pandemic. Between March 2020 and March 2021, there was a 58.6% increase in the proportion of UK respondents drinking at increasing risk and higher-risk levels¹⁷⁶ – consuming large volumes of alcohol that causes mental or physical damage.¹⁷⁷ Notably, high-risk drinking during the pandemic is associated with other unhealthy behaviours – high-risk drinkers were also more likely to have gained weight or smoked more during the pandemic. This demonstrates that some groups have experienced several pandemic-related negative health outcomes at once.

Tragically, high-risk drinking can result in death. Since the pandemic, there have been more deaths caused by higher-risk drinking, as the UK saw a 18.6% increase in alcohol-specific deaths in 2020 compared to 2019.¹⁷⁸ Here too risk factors are intersecting: alcohol specific-deaths in the most deprived areas occur at a rate three times higher than in the least deprived areas for females, and over four times for males.¹⁷⁹

More people stopped smoking successfully during the pandemic, but some groups smoked more or more heavily

Finally, the COVID-19 pandemic may have led to an overall decline in smoking in the UK, although this trend was not experienced by all groups.

During the first UK-wide lockdown, the percentage of adults smoking reduced from 14% in 2018/2019 to 11% in April 2020.¹⁸⁰ It is estimated that, by July 2020, one million people in Great Britain had stopped smoking since the start of the pandemic.¹⁸¹ Data from 2021 shows that this reduction persisted.¹⁸² For example, in England, the percentage of successful quitters went up from 51.5% in 2019/2020 to 58% in 2020/2021.¹⁸³ These changes may be due in part to concerns about associated risks of severe COVID-19 symptoms, as well as improved awareness and public conversation surrounding personal health.¹⁸⁴

However, while more people overall quit smoking during the pandemic, there was an increase in smoking among certain groups – data from England indicates that there was an increase in smoking among adults aged 18-34.¹⁸⁵ Moreover, while lighter smokers were more likely to quit, there was no change in those who already smoked more than 20 cigarettes a day.¹⁸⁶ As such, the positive effects of the pandemic on smoking were not equally distributed.

It is important to recognise the intersection between smoking and inequalities. Around 14% of adults in the UK smoke, with rates far higher among people living in local authority or housing association rented accommodation (30%), people without educational qualifications (29%), people who are unemployed (27%) and people working in routine and manual occupations (23%).¹⁸⁷ Those with mental health conditions are also more likely to smoke, with smoking rates increasing with the severity of poor mental health.¹⁸⁸ In addition to the impact of smoking on physical health, there is a strong correlation with mental health conditions such as anxiety and depression.¹⁸⁹

Efforts must now be made to reduce smoking even further as the pandemic subsides, especially among groups where it is most prevalent. Currently England¹⁹⁰ and Wales¹⁹¹ have a target of being smoke-free (only 5% of the population smoking) by 2030, while Scotland has the same target but with a deadline of 2034.¹⁹² In contrast, Northern Ireland does not have any target.¹⁹³ However the recent [independent review into tobacco consumption in England led by Javed Khan](#) found that without further action, England will miss its 2030 target by at least seven years, and for the poorest parts of society, it will be missed by 14 years. Similarly, forecasts by Cancer Research UK suggest that Scotland will miss its target by more than 16 years if no further action is taken.¹⁹⁴



Recommendations

- Ensure people maintain health-supporting habits, including walking for fitness and leisure, in the long term, by facilitating conditions such as improved access to green spaces.
- Increase physical activity levels in the UK in line with previous BMA recommendations.
- The UK government must reverse its decision to delay the legislation to restrict junk food marketing and implement its July 2020 obesity strategy in full.
- There must be increased efforts to prevent people from smoking in the UK, as previously recommended by the BMA, such as improving awareness of the dangers of smoking tobacco, and to support people to stop, by investing in targeted smoking cessation services.
 - In England, the Government must accept the independent review's recommendation to invest £125m in tobacco control to deliver its smokefree 2030 ambition, promptly consult on the wider review recommendations, and publish the Tobacco Control Plan before the end of 2022.
 - Scotland and Wales must take urgent action to reach their smokefree target of 2034 and 2030 respectively, and Northern Ireland should set their own smokefree target.
- An MUP (minimum unit pricing) for all alcoholic products of at least 50p should be introduced in England to bring it in line with other areas of the UK. MUP should be reviewed regularly and revised in line with inflation. Duty on all alcohol products should be increased by at least 2% above the rate of inflation.



Questions for the inquiries to answer

- What is the evidence for barriers to engaging in healthy behaviours during the COVID-19 pandemic, and what might this mean for efforts made to improve population health and reduce health inequalities?

The pandemic profoundly affected the social determinants which are key to good health

Our health is influenced by factors that lie outside the clinical sphere, including housing, education, and employment. Beyond its immediate impact on the physical and mental health of the population, the pandemic has also affected these wider determinants of health, often widening existing socio-economic inequalities and affecting certain groups more than others. In this report, we will discuss two key determinants: education and employment. Though there are many others, we focus on these two as they are likely to have a significant and long-term impact on society, there are significant inequalities in how these affected different groups, and they are crucial to people's ability to live healthy lives.

Cuts to local government funding in the years preceding the pandemic made it harder for local governments to mitigate the impact of COVID-19 on social determinants like education and employment. Spending on local government has fallen in real terms across the UK since 2010, with the largest drop in England, where councils cut spending by roughly 21%.¹⁹⁵

The health and development of children were affected by school closures as well as other factors, with some children affected more than others

Children have been affected by COVID-19 in several ways, from disruptions to their early development – including speech development and socialisation outside their immediate household – to disruptions to their education, all of which can impact their chances of a healthy life.

Pre-school children's health and development have been affected by pandemic restrictions

The first 1001 days of a child's life, which includes pregnancy and the first two years, are crucial in determining health outcomes and wider life chances.¹⁹⁶ There is compelling evidence that this is a significant and influential phase in a person's development, laying the groundwork for a healthy life. Lockdowns have had a significant impact on early development in young children, causing a sharp rise in developmental issues. For example, fewer opportunities to interact with people outside their household had a detrimental impact on their psycho-social and language development.¹⁹⁷ Notably, nurseries and childminders were allowed to stay open during school closures after the first UK-wide lockdown in England, Wales, and Northern Ireland, but this was not the case in Scotland.¹⁹⁸ It was the right decision to keep nurseries and childminders open in later phases of the pandemic. However, the official inquiries into the pandemic should consider why, meanwhile, schools remained closed.

The public services which could have ameliorated the negative impact of the pandemic on very young children had been cut and, in some cases, dismantled ahead of the pandemic. Cuts to Sure Start and early years services in England, Wales, and Northern Ireland, for example, put the UK on the back foot. These services play a significant role in helping disadvantaged families by bringing together a range of support including health services, parenting support programmes, and access to childcare and early education for families with children under five. These cuts, therefore, reduced the ability of these services to mitigate the negative impact of the pandemic on young children. In the years preceding the pandemic, early years services saw a real-terms budget decrease of 3% in Northern Ireland,¹⁹⁹ 16% in Wales²⁰⁰ and 44% in England²⁰¹ between 2015/15 and 2019/20.

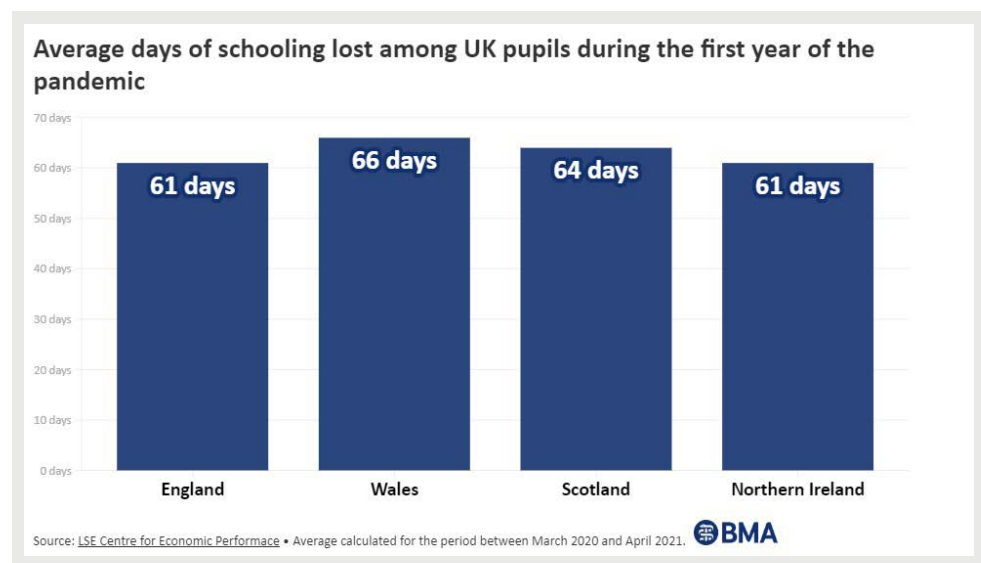
The scale of disruption to education seen across the UK is likely to have significant consequences for children and young people's health over the long term

Education has been described as 'the most important modifiable social determinant of health'.²⁰² In pre-pandemic England, by the age of 30, those with the highest levels of education were expected to live four years longer than those with the lowest levels of education,²⁰³ with similar trends across the UK.

Education can affect health in various ways. For example, it can bring better career and financial prospects, mitigating the risk of deprivation, which in turn is associated with poorer health outcomes. Education can also help individuals develop coping resources and strategies allowing them to better manage their health.²⁰⁴ Consequently, the disruption to schooling, and further and university education in the UK, represents a significant risk to the health of children and young people, the full extent of which is unlikely to be known for some time.

Though some children – for example, the children of key workers – could attend school throughout the pandemic, the majority missed out on in-person schooling for substantial periods. This has significantly impacted their education. One 2020 study found that children at home during lockdowns in the UK spent an average of only 2.5 hours each day doing schoolwork, and one-fifth of pupils did no schoolwork at home, or less than one hour a day.²⁰⁵ Pupils in England and Northern Ireland lost an average of 61 days of schooling, whilst those in Scotland lost 64 days and pupils in Wales lost 66 (see Figure 10).²⁰⁶

Figure 10



The closure of schools in the UK during the lockdowns has therefore likely had a significant impact on children and young people, including on their long-term health. Respondents to our call for evidence raised concerns about the impact on children's education and health.

'Children are [...] being most affected in terms of mental health and impacts on education/life chances.'
(Consultant, England)

'My biggest concern was the dreadful impact on children's education. I think there needs to be a very serious review of how to minimise risks to children from impact on their education.'
(Medical academic (consultant), England)

Despite this, per pupil, education recovery spending in response to the pandemic in the UK is much lower than in comparable countries. UK nations are spending between £200-£400 extra per pupil, whereas similar economies like the US and the Netherlands are spending much higher amounts (\$1,800 and £2,100 respectively).²⁰⁷

As with most of the harm caused by the pandemic, the disruption of education did not impact all groups equally. Research suggests that those from deprived backgrounds have been at higher risk of poorer educational and health outcomes.²⁰⁸ Conversely, children from more affluent families were more able to compensate for the loss of education and access virtual education once schools shifted to online teaching, drawing on additional tutors, laptops, and better, less noisy studying environments. Consequently, the closure of schools and failure to mitigate the negative impact have worsened poorer children's life prospects and economic and health inequalities.

'The reliance on [...] online resources has impacted negatively on my socially and educationally disadvantaged patient group. Many have low literacy levels and digital poverty, so struggled to access the necessary support. Their children have been particularly hard hit, with so much of learning being online and dependent on parental support. I should like to see much more access to regular school attendance for this vulnerable group of children if we faced a similar situation in the future...many children who could have been supported in schools were not, and these were often the most disadvantaged. This will probably have a permanent negative impact on their education and therefore life chances, which is a national shame.'
(Consultant, Scotland)

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.²⁰⁹ Evidence suggests the negative consequences of disrupted learning since March 2020 have widened this gap. Digital exclusion and variable capacity of parents to support remote learning for example jeopardised successful learning from home. The Education Policy Institute concluded in October 2021 that pupils from disadvantaged backgrounds have 'been amongst the biggest losers from the pandemic [...] disadvantaged pupils have fallen behind even further and are catching up at a slower rate to their peers'.²¹⁰ Concerns have also been raised about the gap in attainment between state and independent schools, which has widened after the first year of the pandemic.²¹¹

The pandemic affected employment and financial security for many people, and this has been unequal

Secure employment and financial security are both key determinants of health, and a failure to secure these for the population puts people's health at risk.

People's experience during the pandemic has been deeply influenced by their employment, and there has been considerable variation in how people have experienced their work life since March 2020. While the UK Government introduced a range of welcome, and often generous, financial support measures (as discussed below) the state of financial insecurity in the UK before and during the pandemic continued to impact public health and health inequalities.

The pandemic caused financial insecurity for many, especially for those in insecure employment or heavily affected sectors

Many 'non-essential' workers, especially those who could not work from home and were furloughed during the pandemic, experienced reduced income. Those who are self-employed or working in certain sectors, such as the hospitality industry, or on zero-hour contracts, have often faced huge financial losses. Workers in hospitality and retail also faced regular changes in their employment status due to the regularly changing Government restrictions.

Moreover, income security has been a key determinant of how well people were protected from infection. Those on zero-hours contracts or who are self-employed have had to make very difficult choices about whether to take on work, even if potentially sick with the virus or if work meant greater exposure, to secure their livelihoods.

Those in working poverty before the pandemic have been more likely to experience negative employment impacts during the pandemic. Nearly two in three (65%) of those in the UK employed before COVID-19 who were in deep poverty (defined as those with income more than 50% below the poverty line as measured by the Social Metrics Commission) have experienced a negative change such as reduced hours, reduced earnings, or job loss – compared to one in three (35%) of those who were employed and at least 20% above the poverty line before COVID-19.²¹²

In addition to variation according to sector, income and employment status, the pandemic has also impacted the livelihoods of demographic groups differently. For example, ethnic minority groups are often overrepresented in more precarious employment. Another group that has been affected particularly are women, who also often work in more precarious forms of employment or sectors that have been disproportionately affected by the pandemic. A [Women and Equalities Committee report in February 2021](#) noted that women are traditionally underrepresented in sectors that have been singled out for government investment as part of plans to support recovery from the pandemic.²¹³

Young people represent a particular concern. They are at increased risk of experiencing the negative effects of economic downturns, as labour market entry is more challenging during such times. Young people are also more likely to be in lower-paid entry level or insecure work, at higher risk of having their education and skill development curtailed, and more likely to enter low-skilled work to contribute to household income.²¹⁴ The economic downturn caused by the pandemic is no different, with unemployment among this age group rising – creating a risk of long-term scarring effects.²¹⁵ Job prospects have also been threatened, with many young people working in sectors of the economy that were hit the hardest, such as retail and hospitality.²¹⁶ [One survey](#) of 22- to 26-year-olds in the UK reported that 86% said the pandemic had negatively impacted their opportunity to achieve the right skills and qualifications for their chosen career. 86% also felt that the pandemic had affected their ability to develop the right relationships and networking opportunities to enter or progress in the working environment. Since employment is a key building block for good health, the consequences of this will likely be far-reaching, not only affecting the living standard of those affected but also their health outcomes.

There have also been differences in changes to youth employment among different ethnic groups, widening the inequalities that existed before the pandemic. The unemployment rate for people aged 16-24 from Black ethnic backgrounds [increased by nine percentage points \(from 25% to 34%\)](#) between March 2020 and January 2021, but only increased by three percentage points (from 10% to 13%) for their peers from White ethnic backgrounds.²¹⁷ If those who have lost employment or lost out on career opportunities are those already underrepresented in higher paid and stable employment, this presents a significant risk of widening health inequalities.

Support packages offered by the UK Government were crucial, but did not do enough to protect those most at risk of financial insecurity

Poverty is a key driver of ill-health, meaning that financial support packages were a critically important tool to mitigate the impact of COVID-19 for the millions of people for whom further financial struggle would spell crisis and poorer health. The start of the pandemic saw the UK Government introduce welfare and employment support packages at an unprecedented volume and speed. These provided a lifeline for many, but their impact was not felt equally, and they often did not go far enough, or last long enough, to protect those most at risk of financial insecurity. Moreover, questions remain about the decision to remove such lifelines at a time when COVID-19 continues to circulate in the community.

The job retention scheme (known as furlough) and the self-employment income support scheme were both vital lifelines for those who would otherwise have been pushed into, or further into, financial hardship. Employees on furlough received 80% of their wages, while those eligible for the self-employment support had a more varied experience (including waiting two months after lockdown began before the first payment arrived,²¹⁸ receiving a reduced level of support for three months in summer 2020, and having two months in 2021 not covered by financial support).²¹⁹ Throughout both schemes, there were multiple points of confusion over their continuation, with the UK Government making last-minute announcements and U-turns. Furthermore, the closure of these schemes in September 2021 marked a premature end to support. The pandemic was far from over, and the furlough scheme alone had 1.2 million people still receiving support on the day the scheme ended.²²⁰

The £20 a week uplift in Universal Credit was another critical way to prevent people from falling into, or further into, poverty during the pandemic. It is estimated that this temporary increase to Universal Credit and Working Tax Credits, as well as the temporary suspension of the Minimum Income Floor (for which Universal Credit calculations are based on expected rather than actual earnings), protected 690,000 people from poverty by the winter of 2020.²²¹ However, when the Universal Credit uplift ended in October 2021 – despite protests from the BMA and others – there were more than 5.8 million people across England, Scotland and Wales claiming it, which is more than double the number seen pre-pandemic.²²² This decision made by the UK Government represents a significant threat to the improvement of population health and the reduction of health inequalities.

To encourage self-isolation and to mitigate against the loss of income during self-isolation periods, those living in England, Scotland and Wales who were unable to work from home were able to receive a self-isolation payment (ranging from £250 – £750 depending on the country and period of the pandemic). However, many felt they still did not have the financial stability to self-isolate. Concerns about insufficient self-isolation payments were a common theme in our call for evidence.

'[Higher] self-isolation payments would have reduced the pressure on low paid workers to attend work when symptomatic.'

(Medical academic/GP, England)

'Economic support measures have been inadequate. I have had numerous patients who refused to countenance a diagnosis of Covid for economic reasons and therefore refused to be tested.'

(Salaried GP, England)

Analysis of self-isolation payments found that, due to eligibility criteria, they were only available to one in 8 workers, with two million of the lowest paid workers not covered by either the self-isolation or statutory sick payments.²²³ Moreover, restrictive eligibility criteria, difficult application requirements, and a lack of funds for discretionary payments meant large numbers of applications were rejected, leaving many at risk of financial hardship while self-isolating to protect themselves and others.²²⁴ To provide adequate support for both individual and population health during future pandemics, self-isolation payments need to involve a larger payment, have broader eligibility criteria and be easy to access.

The UK Government's public inquiry into the pandemic needs to investigate why the UK Government did not continue the furlough and self-employment support schemes and the Universal Credit uplift. It also must examine whether the impact on population health and health inequalities was being considered in these decisions.

The long-term impact of COVID-19 on poverty and financial insecurity is likely to be significant. The anticipated increase in the number of people living in poverty is a concerning projection, not least in terms of what it means for public health. Coupling this with the worsening cost-of-living crisis, projections for population health seem bleaker still. Further, poorer households are currently experiencing higher inflation on average

than better-off households, meaning the burden of the cost-of-living crisis is falling more significantly on those from lower income households.²²⁵ To reduce inequalities and improve public health, bold action is needed by the UK Government to ameliorate the impact of COVID-19 and the cost-of-living crisis. This includes an improvement in benefits payments and sick pay, as well as further support to ameliorate the rising cost of living beyond the package announced in May 2022, and in particular a halt on an increase in the energy price cap in October 2022.



Recommendations

- There should be research into the long-term impact of the pandemic on children and young people, with findings made widely available as early as possible so they can be immediately acted upon.
- Easily accessible and well-funded support schemes must be put into place in any future pandemic so that people can comply with public health measures such as isolating at home when infected.
- The UK Government must take action to ameliorate the impact of COVID-19 and the cost-of-living crisis on households, especially those most at risk. For example:
 - the Universal Credit uplift that was cut in Autumn 2021 must be made permanent, to improve household income and reduce the high levels of poverty that predated the pandemic and continue to exacerbate health inequity across the UK in the context of COVID-19;
 - improvement in benefits payments and sick pay must be introduced.
- Future pandemic preparedness must consider the critical importance of household financial security in the UK's ability to contain the virus.



Questions for the inquiries to answer

- What measures should be taken to ensure schools and nurseries can remain open in another pandemic and how can these environments reduce the spread of any infection effectively?
- What will be the longer-term impact on people's health of the economic downturn the pandemic caused and how far were support schemes able to mitigate them?
- How did resource shortages within the welfare system impede the ability to provide sufficient economic support to households?
- What economic support measures should be taken in a future pandemic to ensure the spread of a contagious virus can be contained effectively?

We saw some positive developments during the COVID-19 pandemic, and these must be learned from

Alongside the multitude of ways the pandemic negatively impacted physical and mental health and exacerbated pre-existing inequalities, there were also positive developments, which supported good population health. This includes the examples discussed earlier on in this report, such as the increases in healthy behaviours for some groups, but also the opportunity for reflection that the pandemic provided and the strengthening of community relationships and support networks. It is important to build on these developments and reflect on how they can best be supported to continue in the future. This section does not look at all of these in detail but focuses instead on two of the biggest achievements of the pandemic: the vaccination rollout and the efforts to reduce homelessness.

Positive lessons can be learned from the vaccination rollout in the UK

The speed and scale of the rollout was an unprecedented success

The speedy development and authorisation of COVID-19 vaccines, followed by the NHS-led rollout, was the biggest success story of the pandemic. As [report three](#) in this series examines in more detail, the UK's health services mobilised at unprecedented speed. The list of priority groups created by the JCVI (Joint Committee on Vaccination and Immunisation) was effective at ensuring the greatest reduction in COVID-19 mortality as quickly as possible with the available data and, alongside the risk presented by age, also included people who were classified as CEV, had other underlying health conditions, or who worked in health and social care.²²⁶ As of May 2022, 93% of the UK population aged 12 and over had received at least one vaccine dose.²²⁷

As further explored in [report four of this series](#), vaccination changed the context of the pandemic and allowed governments to move towards reopening society as COVID-19 became less of a risk for most of the population. As of September 2021, the UK Health Security Agency estimated that the vaccines had prevented more than 24 million infections and over 121,000 deaths.²²⁸

There were inequalities in vaccine uptake

While the overall uptake of the vaccine programme was momentous, the figure of a 93% vaccination rate masks significant disparities, particularly along lines of deprivation and ethnicity. Indeed, for some of the groups most at risk of infection and severe symptoms, rates of vaccination were lower than for those groups less at risk.

Data from 2022 shows that across England, Scotland and Wales, vaccine uptake was higher in areas of greater affluence and gradually decreased along deprivation lines.²²⁹ This gap in uptake was largest in Wales, with a 10-percentage point difference in uptake between the areas with the highest and lowest levels of deprivation.²³⁰ The picture in Northern Ireland is more complex, although the chief scientific adviser acknowledged deprivation was a factor in vaccine uptake.²³¹

In terms of ethnicity, vaccine uptake in England, Scotland, and Wales has been highest among those from a White ethnic background, with an uptake of around 89-90%²³² (ethnicity breakdown is not available in Northern Ireland). Those from ethnic minority groups have tended to have lower rates of vaccine uptake. For example, in Wales, those from ethnic minority groups have an uptake of 74% compared to 89% among those from White ethnic backgrounds. However, a more complex picture is revealed by the more granular data available in England and Scotland, indicating wide variation between ethnic groups. In England, for example, vaccine uptake is lowest among Black or Black British (Caribbean) communities (55%),²³³ while in Scotland uptake is lowest among people who are White Polish (58%) and Black African (59%).²³⁴ This contrasts to, for example, those from Asian or Asian British backgrounds, who have comparatively higher rates of uptake in both England (77%) and Scotland (81%).

Significant efforts have been made to address barriers to allow more people to benefit from vaccination, and it's important we build on this

In a bid to mitigate racial disparities, efforts were made by health services, local governments, and community leaders to address the historic mistrust of the health services amongst ethnic minority groups who had been let down by institutional racism. This included using places of worship as vaccination centres, developing targeted videos with faith and business leaders, and holding webinars in partnership with community associations.²³⁵ While some groups remained distrusting, these efforts likely meant that levels of vaccination among these groups were higher than they otherwise would have been.

It is important that tailored approaches such as these are continued to ensure as many people as possible can benefit from the protection vaccination offers from COVID-19, while learning vital lessons for any population-wide vaccine rollouts that may be required in the future.

Firstly, vaccine hesitancy and levels of trust in other medical interventions must continue to be addressed. While efforts to reduce vaccine misinformation have been somewhat effective, structural racism within the NHS and other UK public services means that people from marginalised groups continue to have negative experiences of healthcare services. Recognising the complexity in vaccine hesitancy and regaining the trust of ethnic minority groups, who have had and continue to have negative experiences, needs to be a priority of the NHS.

Respondents in our call for evidence emphasised the need for vaccine programmes to be culturally sensitive.

'More direct engagement with the population [is needed], particularly the most affected groups and those most reluctant regarding vaccination. Education to be carried into the social meeting areas and working with community leaders (for example religious groups, Youth Clubs, cultural establishments etc.)'

(SAS doctor, Scotland)

'An apolitical communication team [is needed], skilled in cascading messages in many languages and collaboration with BAME community groups.'

(GP contractor/principal, England)

There have also been other barriers to accessing the vaccine: for example, physical barriers to accessing vaccination sites or reaching the sites via appropriate transport, financial barriers to taking time off from work to attend the appointment (especially for those on lower pay, such as those working in the social care sector), and barriers posed by information that is not culturally or linguistically appropriate or accessible.

Respondents to our call for evidence emphasised the need for a vaccine programme that ensures everybody can get it regardless of support needs or geographical location.

'Adequate staffing would have allowed a more pro-active approach to vaccination of people in care homes, those unable to leave home to attend for themselves, and the vulnerable.'

(Consultant, England)

'Working in a rural area my frailest patients were forced to travel significant distance to be vaccinated. Planning for this was urban centric.'

(GP contractor/principal, England)

'The use on online stuff and smart phones is great for those with access and that feel comfortable using it but there is a large proportion of the population that don't and this means there is inequity at accessing services including vaccinations.'

(Consultant, England)

Furthermore, there are long-standing policies and practices in place that often deter people with no fixed address or an irregular immigration status from seeking or accessing healthcare, including vaccines. Efforts made to encourage these groups to access the vaccine – such as park-based pop-up vaccination clinics requiring no documentation – were positive in this regard, and their effectiveness should be thoroughly assessed to learn from them.

Lastly, those working in health and social care were offered the vaccine in the early stages of the rollout (though, as outlined in [report one](#) in this series, there was some variation between groups of medical professionals regarding the ease of accessing the first dose). Beyond the health and social care sector, however, the healthcare system couldn't identify other key workers, who also were at a heightened risk of infection, yet not prioritised. Measures such as including patients' occupation and place of work in GP records may be one way to address this issue in the future and should be considered.

Homelessness in the UK was finally addressed during the pandemic, but these measures must now be sustained

People experiencing homelessness and rough sleeping have some of the worst health outcomes in the UK. In England and Wales, there is a thirty-year life expectancy gap between homeless people and the general population.²³⁶ Homeless people are three times more likely to experience a chronic health condition including respiratory conditions such as COPD (chronic obstructive pulmonary disease), a risk factor for severe symptoms of COVID-19.²³⁷ Protecting such an at-risk group and preventing the exacerbation of such considerable health inequalities was therefore paramount.

All four UK nations prioritised the homeless and made commitments to minimise evictions during the pandemic

The response of the UK and devolved governments to protect the homeless and those at risk of homelessness was swift and effective, and all four UK nations introduced measures to prioritise the homeless during the pandemic and made commitments to minimise evictions.

For example, in England, the 'Everyone In' scheme temporarily housed the rough sleeping and homeless population who could not self-isolate in shelters and hotels at the outbreak of the virus, a scheme which was immediately successful. By May 2020, more than 90% of rough sleepers and those in unsuitable sheltered accommodation had been offered accommodation by local authorities.²³⁸ Figures published in January 2021 estimate that about 37,430 people were helped into some form of accommodation under the scheme.²³⁹

Similar decisions to tackle homelessness were made in the devolved nations. In Wales, an emergency statutory guidance note was set out in housing legislation, expanding the definition of vulnerability to include COVID-19. This resulted in nearly 19,000 people being brought into emergency accommodation since the start of the pandemic.²⁴⁰ Meanwhile, the Scottish government took measures to tackle rough sleeping, resulting in unprecedentedly low rough sleeping levels during the first year of the pandemic.²⁴¹ The Scottish Government also set up three [Housing Resilience Groups](#) to share learning about tackling homelessness and ensure that people could be moved into accommodation.²⁴² In Northern Ireland, the Supporting People programme, which provides housing support and helps people to live independently, [received £10m in funding](#).

In addition, bans on evictions were introduced in all four UK nations to reduce people's risk of becoming homeless at a time of such public health crisis²⁴³. Eviction bans were initially due to come to an end in June 2020 but were extended first to August 2020 and then to September 2020²⁴⁴. The BMA and others [successfully campaigned](#) for a further extension to May 2021. Before the eviction bans were lifted, all four UK nations introduced temporary legislation requiring landlords to give longer notice periods to tenants for evictions.²⁴⁵

Beyond the actions of governments, local community interventions were developed to address the often complex needs of vulnerable groups such as homeless people. This included, for example, the face-to-face triage of patients who were unable to make a GP or healthcare appointment via phone and the distribution of leaflets in a variety of languages and outreach visits in the community. The use of peer advocates with lived experience of homelessness and/or the asylum seeker process within healthcare settings also offered practical support. Engaging with a marginalised population with whom public services have historically failed to do so required improved collaboration between commissioning bodies, public health, local authorities, and housing departments. The public inquiries into the pandemic must examine whether these relationships have been maintained since, as local collaboration across different sectors has clearly been an effective way to improve population health.

However, the positive steps to support homelessness have not been sustained

Regrettably, the engagement with rough sleepers that initially arose from the schemes outlined above was not sustained throughout the pandemic. In Northern Ireland, for example, there was an initial reduction in the number of households presenting as homeless during the first wave, but this trend was then reversed in the following three months from July – September 2020.²⁴⁶ Similarly, in England, there were concerns that the ‘Everyone In’ scheme did not offer the same level of protection beyond May 2020, with some rough sleepers no longer being eligible for support.²⁴⁷

Looking beyond the first year of the pandemic, more than three-quarters of those initially accommodated in England were in insecure accommodation by February 2021, such as emergency or temporary accommodation or staying with friends, making them more likely to return to homelessness.²⁴⁸ Data in Scotland indicates that, while the number of rough sleepers is still currently lower than pre-pandemic, there have been signs of more recent increases, with a greater number of homelessness applications and households assessed as homeless between April–September 2021 compared to the same period in 2020.²⁴⁹

The eviction bans introduced across the UK in early 2020 also came to an end between May and June 2021,²⁵⁰ leaving people at risk of eviction when the acute phase of COVID-19 was not yet over. Moreover, the additional protections afforded by the introduction of longer notice periods for tenants have also not been sustained in England, Scotland, and Northern Ireland, with these measures coming to an end between September 2021 and May 2022.²⁵¹ As a result of these two policies being reversed, thousands of people will not have received the benefit of this protector against worsening health. The economic impact of COVID-19 is far from over, and this was a missed opportunity to reduce the negative effects of the pandemic on population health and health inequalities. Notably, however, the Welsh Government has announced that its six-month notice period will become permanent in December 2022²⁵² and has also proposed legislative changes that would improve the ability of some rough sleepers to access emergency accommodation.²⁵³ For the UK Government to achieve its aim of ending rough sleeping by 2024, there must be sufficient funding to ensure enough permanent homes are provided, alongside support that enables individuals to keep these homes.



Recommendations

- Ongoing efforts must be made to learn positive lessons from the pandemic to improve population health and reduce health inequalities, as well as to prevent as far as possible failures during COVID-19 being made again in any future pandemics.
- The vaccine rollout was effective in engaging local communities who had historically not had much contact, or negative experiences, with health services. This positive engagement must be sustained, and the institutional racism of the NHS tackled to reduce levels of mistrust and hesitancy among ethnic minority communities when engaging with the UK's health services.
- Any future vaccination programmes should consider the range of potential barriers to access which could be experienced by some groups and identify ways to ensure access is equitable.
- For the UK to avoid rough sleeping returning to pre-pandemic levels and for the UK Government to achieve its objective of ending rough sleeping in England by 2024, more resources are needed to secure safe and stable accommodation.



Questions for the inquiries to answer

- What can be learned from the enormous success of the vaccine rollout and critical role played by the NHS and medical profession to better facilitate future public health campaigns?
- What lessons can be learned about what went well and what did not regarding the sustainability of homelessness support initiatives across the UK during the pandemic, and whether homeless people and rough sleepers have been helped long term by these schemes?

Conclusion

The evidence in this report makes a clear case for the significant and unequal effects of the COVID-19 pandemic on population health and health inequalities. The pandemic has affected, and continues to affect, us all – whether through the virus itself or the measures to restrict its spread. The impact, however, has not been felt equally by everyone. Those who were struggling most with, for example, their health, employment, financial stability, or educational attainment before the pandemic have found matters worsening.

Learning from the COVID-19 pandemic in a way that benefits the health of the UK cannot be done without an examination of the positive developments. The UK governments' programmes to accommodate rough sleepers at the beginning of the pandemic were effective, and while they have not continued as the BMA had hoped, there is much that can be learned for future efforts to end homelessness in the UK. The national vaccination programme, meanwhile, has been a lesson in what the NHS can achieve, although this had a significant effect on what else the NHS could deliver given its under-resourcing before the pandemic.

The recommendations in this report must be carefully considered, and the questions raised adopted by the inquiries. It is an essential public service for these public inquiries to do so.

Appendix A

Overview of BMA COVID research

Title	Date	Responses	Coverage
Covid Tracker survey 1	6 April 2020	1,924	UK wide
Covid Tracker survey 2	16 April 2020	6,126	UK wide
Covid Tracker survey 3	30 April 2020	16,343	UK wide
Covid Tracker survey 4	14 May 2020	10,328	UK wide
Covid Tracker survey 5	28 May 2020	8,455	UK wide
Covid Tracker survey 6	18 June 2020	7,497	UK wide
Covid Tracker survey 7	9 July 2020	5,905	England/Wales
Covid Tracker survey 8	13 August 2020	4,279	England/Wales
Covid Tracker survey 9	22 October 2020	7,820	England/Wales/Northern Ireland
Covid Tracker survey 10	17 December 2020	7,776	England/Wales/Northern Ireland
Covid Tracker survey 11	8 February 2021	8,153	UK wide
Covid Tracker survey 12	19 April 2021	5,521	UK wide
Viewpoint survey 1	8 July 2021	2,478	England/Wales/Northern Ireland
Viewpoint survey 2	2 September 2021	1,749	England/Wales/Northern Ireland
Viewpoint survey 3	26 November 2021	2,424	England/Wales/Northern Ireland
Viewpoint survey 4	4 February 2022	1,320	England/Wales/Northern Ireland
Viewpoint survey 5	8 April 2022	1,194	England/Wales/Northern Ireland
Call for evidence	17 December 2021	2,484	UK wide

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