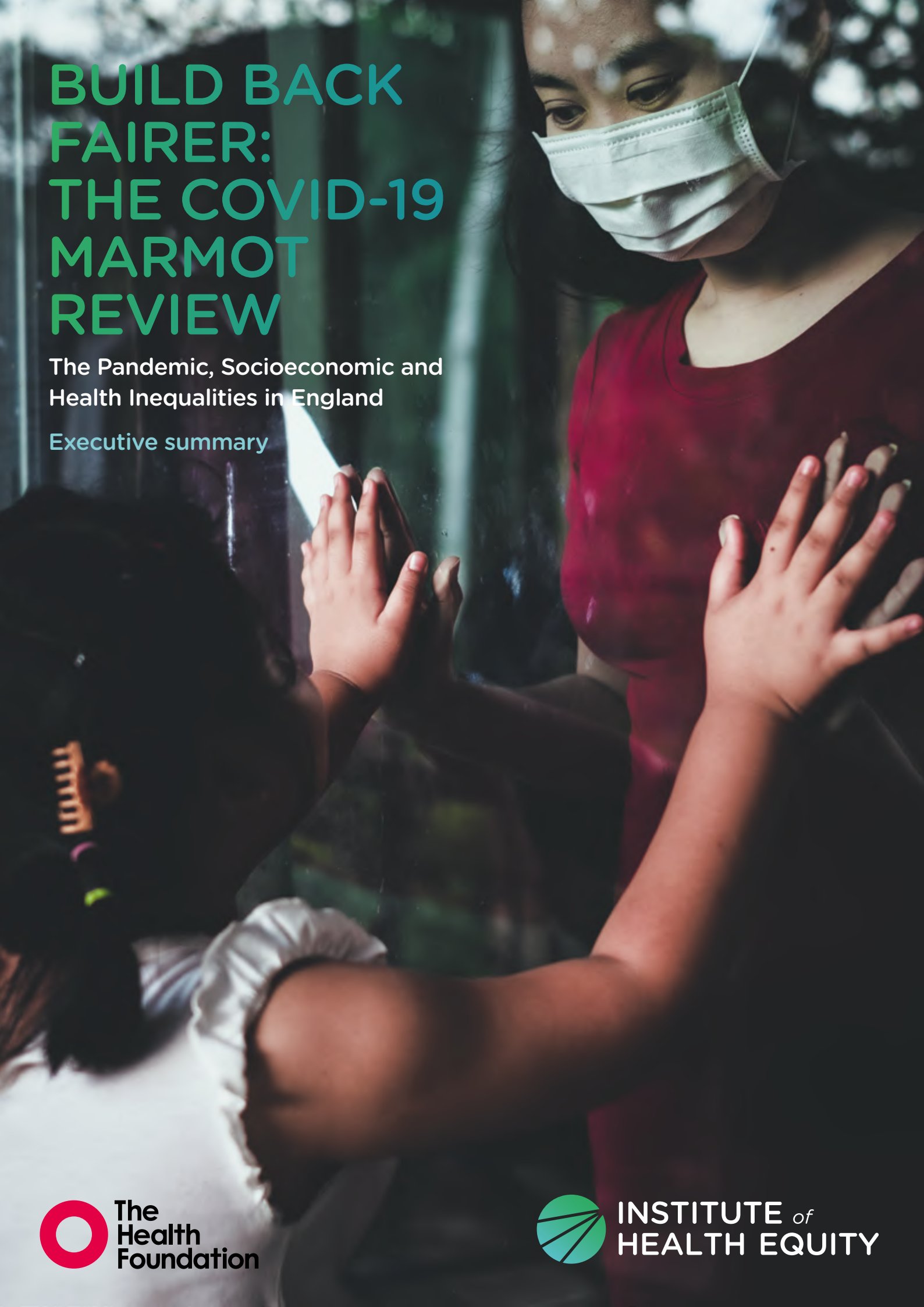

BUILD BACK FAIRER: THE COVID-19 MARMOT REVIEW

The Pandemic, Socioeconomic and Health Inequalities in England

Executive summary

The Health Foundation

INSTITUTE of HEALTH EQUITY

CONTENTS

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CHAPTER 1
INTRODUCTION

'Build Back Better' has become the mantra. Important, but we need to Build Back *Fairer*. The levels of social, environmental and economic inequality in society are damaging health and wellbeing. As the UK emerges from the COVID-19 pandemic it would be a tragic mistake to attempt to re-establish the status quo that existed before – a status quo marked in England, over the past decade, by a stagnation of health improvement that was the second worst in Europe, and by widening health inequalities. That stagnation, those social and regional health inequalities, the deterioration in health for the most deprived people, are markers of a society that is not functioning to meet the needs of its members. There is an urgent need to do things differently, to build a society based on the principles of social justice; to reduce inequalities of income and wealth; to build a wellbeing economy that puts achievement of health and wellbeing, rather than narrow economic goals, at the heart of government strategy; to build a society that responds to the climate crisis at the same time as achieving greater health equity.

It was precisely those principles of fairness and the need to do things differently that animated the concrete recommendations we set out in Health Equity in England: *The Marmot Review 10 Years On*, published in February 2020, just before the pandemic hit with such devastating intensity (1). The COVID-19 crisis, the pandemic and associated social and economic response, have made such action even more important. The UK has fared badly. Not only does England vie with Spain for the dubious distinction of having the highest excess mortality rate from COVID-19 in Europe, but the economic hit is among the most damaging in Europe too. The mismanagement during the pandemic, and the unequal way the pandemic has struck, is of a piece with what happened in England in the decade from 2010.

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

The main features of health before the pandemic are summarised in Box 1.

BOX 1. HEALTH IN ENGLAND BEFORE THE PANDEMIC (FROM THE *TEN YEARS ON* REPORT)

- Since 2010 improvements in life expectancy in England have stalled; this has not happened since at least 1900. If health has stopped improving it is a sign that society has stopped improving. When a society is flourishing health tends to flourish.
- The health of the population is not just a matter of how well its health service is funded and functions, important as that is. Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.
- The slowdown in life expectancy increase cannot for the most part be attributed to severe winters. More than 80 percent of the slowdown, between 2011 and 2019, resulted from influences other than winter-associated mortality.
- Life expectancy follows the social gradient – the more deprived the area, the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010–12 and 2016–18.
- There are marked regional differences in life expectancy, particularly among people living in more deprived areas. Differences both within and between regions have tended to increase. For both men and women, the largest decreases in life expectancy were seen in the most deprived 10 percent of neighbourhoods in North East England and the largest increases in the least deprived 10 percent of neighbourhoods in London.
- There has been no sign of a decrease in mortality for people under 50. In fact, mortality rates have increased for people aged 45–49. It is likely that social and economic conditions have undermined health at these ages.
- The gradient in healthy life expectancy is steeper than that of life expectancy. It means that people in more deprived areas spend more of their shorter lives in ill health than those in less deprived areas.
- The amount of time people spend in poor health increased across England in the decade from 2010. Inequalities in poor health harm individuals, families and communities and are expensive to the public purse. They are also unnecessary and can be reduced with the right policies.
- Large funding cuts have affected the social determinants across the whole of England, but deprived areas and areas outside London and the South East experienced larger cuts than wealthier areas and their capacity to improve social determinants of health has been particularly undermined.

As we set out in this report, COVID-19 has exposed and amplified the inequalities we observed in our *10 Years On* report and the economic harm caused by containment measures – lockdowns, tier systems, social isolation measures - will further damage health and widen health inequalities. Inequalities in COVID-19 mortality rates follow a similar social gradient to that seen for all causes of death and the causes of inequalities in COVID-19 are similar to the causes of inequalities in health more generally. While health behaviours contribute to the causes of non-communicable diseases (NCDs), it is the social determinants of health that cause inequalities in these health behaviours – the causes of the causes.

The links between ill health, including COVID-19, and deprivation are all too familiar. Less so have been the findings of shockingly high COVID-19 mortality rates among British people who self-identify as Black, Bangladeshi, Pakistani and Indian. Much, but not all, of this excess can be attributed to living in deprived areas, crowded housing and being more exposed to the virus at work and at home – these conditions are themselves the result of longstanding inequalities and structural racism. There is also evidence that many people from Black, Asian and Minority Ethnic (BAME) groups have not been well protected at work, and less well protected than their White colleagues.

As this report will document, the economic and social effects of containment measures will worsen physical and mental health in the long term and make health inequalities worse. Without urgent action, inequalities in health and other social and economic domains will rise considerably, from an already very concerning starting point. We set out ways to Build Back Fairer – to protect England from the inequitable health impacts of the pandemic and containment measures.

The aim of this report is three-fold:

- To examine inequalities in COVID-19 mortality. Focus is on inequalities in mortality among members of BAME groups and among certain occupations, alongside continued attention to the socioeconomic gradient in health – the more deprived the area, the worse COVID-19 mortality tends to be.
- To show the effects that the pandemic, and the societal response to contain the pandemic, have had on social and economic inequalities, their effects on mental and physical health, and their likely effects on health inequalities in the future.
- To make recommendations on what needs to be done.

In the first part of the report we set out the inequities in risk of mortality from COVID-19 – which include those related to underlying health conditions and disability, levels of deprivation, housing conditions, occupation, income and being from BAME groups; further, these risks accumulate. Conversely, the likelihood of mortality from COVID-19 is lower among people who are wealthy, working from home, living in good quality housing, White and have no underlying health conditions.

We then examine the impact of the COVID-19 crisis – the pandemic and associated economic and social inequalities – on key social determinants of health. It is important to state that there is a false opposition between health and the economy. It is not the case that enacting early containment measures harms economic progress. In fact, the reverse is true: countries that have managed the pandemic more effectively have also had less economic impact from COVID-19 containment measures and in the longer run will also have less damaging impacts on health.

The message of our *10 Years On* report was that the status quo in England was not desirable. As judged by the health situation, society was failing its population in important ways. If, as we argue, health is a measure of how well society is meeting the needs of its members, then the UK's poor management of the pandemic may similarly be a marker of a society that is not functioning in a socially cohesive and supportive fashion. In Box 2 we set out how this might operate to lead to health inequalities before, during and post-pandemic.

BOX 2. WHY IS ENGLAND'S TOLL FROM COVID-19 SO HIGH?

There are potentially four ways that the pre-pandemic situation in England relates to the high and unequal toll on health during and likely after the pandemic:

1. The governance and political culture both before and during the pandemic have damaged social cohesion and inclusiveness, undermined trust, de-emphasised the importance of the common good, and failed to take the political decisions that would have recognised health and well-being of the population as priority.

2. Widening inequities in power, money and resources between individuals, communities and regions have generated inequalities in the conditions of life, which in turn, generate inequalities in health generally, and COVID-19 specifically. They augur badly for health inequalities as we emerge from the pandemic.

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

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

Relevant to Building Back Fairer, a number of highly significant insights come out of the pandemic, with the potential to alter public and government priorities, as summarised in Box 3.

BOX 3. SUMMARY OF LESSONS LEARNT FOR BUILDING BACK FAIRER

Health matters: Good health is recognised as of the utmost importance for the whole population and ensuring good health should be the highest priority for government.

Good governance is critical: Good governance will increase trust, social cohesion and effective responses to the pandemic and will support Building Back Fairer.

Commitment to the common good: A socially cohesive society with concern for the common good is likely to be a healthier society. Government has both a clear enabling role and is a crucial source of accurate information and advice.

There should be no trade-off between the economy and health: Managing the pandemic well allows the economy to flourish in the longer term, which is supportive of health.

Long-term policies: Reducing health inequalities requires long-term strategic policies with equity as the focus.

Multi-sector action: Action is needed from national, regional and local governments, in collaboration with civil society.

Inequalities in social and economic conditions damage health: The unequal conditions into which COVID-19 arrived contributed to the high and unequal death toll from COVID-19 in England.

Containment measures will damage health: Containment measures have been essential but a failure to control the pandemic promptly means that containment measures have lasted longer and damaged economic and social domains, which will worsen health and health inequalities.

Austerity harmed health: Policies that prioritised repaying the debt over the needs of the population have harmed health and laid the ground for a more prolonged pandemic with high mortality and great inequality. Here the lesson for the future is do not reimpose austerity when the economy is struggling.

Societal change: The enormous societal changes in patterns of working and living during the pandemic must lead to considerations of societal functioning post-pandemic. Considerations must be given to changing patterns of work, such as a four-day week, provision of universal basic income and universal basic services.

Investment – whatever it takes: The pandemic needs to be controlled and economic and social infrastructure need to be supported. Governments can spend, and they must, if we are to Build Back Fairer. The spending announcements from the Government in November 2020 will not be sufficient to mitigate the unequal impacts of containment.

Investment in public health: This investment needs to be increased and must go hand-in-hand with economic and social progress.

Key workers: During the pandemic there has been a high correlation between low pay and having to continue to work in frontline occupations. We need to recognise the value of these contributions to society. Building Back Fairer has to value people who play such a vital role in society.

Green economy: The temporary reductions in air pollution, and in the rate of greenhouse gas emissions, needs to be sustained and will have benefits for health equity as well as employment and the economy.

Overall, we urge that the Government learns the lessons of the pandemic, prioritises greater equity and health, and works urgently to reduce the severity of the health crisis caused by the economic and social impacts of the pandemic and the societal response. We build on recommendations in the 10 Years On and Marmot 2010 reports, which were to:

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

In each of the sections that follow – on inequalities in the risk of mortality from COVID-19, inequalities as a result of containment measures for children in the early years and for young people, during working lives, and impacts on income, living conditions, communities and public health – we include recommendations to Build Back Fairer in the short, medium and long term.

Most important are our **recommendations for the long term**. We must ask ourselves, as we emerge from the pandemic, what sort of society do we want to build? The message of our *10 Years On* report was that the status quo – before the pandemic hit – was not desirable. Building Back Fairer will require fundamental thinking about the nature of society in light of two major challenges facing the global community in general and England in particular: the climate crisis and inequality – both of which have profound implications for health equity (2).

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

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

The early signs from the Government's spending review in autumn 2020 present a mixed picture. There will be a permanent scarring effect on the economy, an estimated 3 percent smaller than expected by 2025, meaning it will take longer for the average family to recoup their losses (3). Amid welcome dedicated spending made necessary by the pandemic, there will be a reduction of £10 billion in 'normal public sector spending' next year (4). Public sector pay outside the NHS will be frozen, and the temporary boost of £20 a week to Universal Credit is not set to continue beyond March 2021. The measures will be insufficient to reduce the inequitable impacts of the containment measures – from widening inequalities in early years development, educational attainment and prospects for young people, to rising unemployment and low pay and increasing poverty, to deepening deprivations in certain communities and regions and deteriorating public health. All of these are harbingers of a long-term health and healthy equity crisis in England.

Our recommendations to Build Back Fairer recognise the challenges and realities of public finance but prioritise a more equitable, socially cohesive and healthy society. We make recommendations relevant to the management of the pandemic and in each of the key social determinants of health we cover. The Government must start by aiming for significant reductions in societal, economic and health inequalities. A vital first step is an Inequalities Strategy for England that lays out the ambition and provides practical steps to achieve it. The recommendations in this report could lay the foundations for such a strategy. This and other priorities are outlined in Box 4.

BOX 4. SUMMARY OF POLICY APPROACHES TO BUILDING BACK FAIRER

Inequalities strategy: Based on national and international evidence, in the *10 Years On* report we recommended development of a national strategy for action on the social determinants of health with the aim of reducing inequalities in health. This should now be extended to become a national strategy on inequalities, led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments.

Proportionate universalism: To deal with inequalities in health, particularly the social gradient, we need universal solutions but with effort proportionate to need.

Regional inequalities: In *10 Years On* we documented widening health inequalities between regions, largely a result of widening social and economic inequalities. The COVID-19 crisis is adding to these. If levelling up is to be achieved, reducing these regional inequalities must have high priority.

CHAPTER 2

INEQUALITIES IN RISK OF MORTALITY FROM COVID-19

There will be reports, much needed, that examine the Government's pandemic containment responses, the speed and clarity of decision-making, the failure to set up a properly functioning test, trace and isolate system, the stop/start approach to restricting the public's activities, the lack of communication between central government and cities and regions, the fatal delays in supplying personal protective equipment (PPE) to health and social care staff, and the mistakes that put people in care homes at such high risk. All of these will have played a part in the UK's high mortality rate from COVID-19. These factors are notable too in countries such as the USA and Brazil that also have had a high toll in the pandemic. It is not our purpose here to examine these aspects of the pandemic. Rather, we make the case that conditions and inequalities in key areas of life prior to the pandemic – including education, occupation and working conditions, income, housing communities and health itself – relate to England's high and unequal mortality rate from COVID-19. We point out that deteriorating conditions and widening regional and socioeconomic inequalities in all these areas exposed many groups to particularly high risk for COVID-19.

Ideally, we would examine rates of infection, severity of disease and mortality. Because of the lack of widespread testing for COVID-19, much of the analyses on which we draw is limited to mortality rates. Although all three, infection, severity and mortality, are important for controlling the pandemic, there is much to be learned from an examination of the social determinants of mortality rates.

The risk factors for higher COVID-19 mortality are summarised in Box 5. These risks accumulate. Many people are experiencing all of these conditions, making them particularly vulnerable to infection and mortality. These cumulative high risks should be considered in the roll-out of vaccinations and treatments and in efforts to prevent spread. Key workers and those living in deprived areas may be considered to be priority recipients of vaccinations and any other preventive treatments.

BOX 5. SUMMARY OF FACTORS IN INEQUALITIES IN COVID-19 MORTALITY IN ENGLAND

International comparison: England had higher mortality from COVID-19 and higher excess deaths in the first half of 2020 than other European countries for which comparable data are available. In addition to specific failures to control the pandemic, this may relate to the policy decisions and socioeconomic conditions prior to the pandemic (see Box 2 above).

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

Deprivation and inequality: The more deprived a local authority, the higher the COVID-19 mortality rate has been. Mortality rates from other causes follow a similar trajectory.

Regional inequalities: While the pandemic has affected different regions differently over the course of the pandemic, the close association between underlying health, deprivation, occupation and ethnicity and COVID-19 have made living in more deprived areas in some regions particularly hazardous. Mortality has been particularly high in the North West and North East since the end of the first wave.

Living conditions: Overcrowded living conditions and poor-quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and experienced by people with lower incomes. Evidence from analysis in *10 Years On* showed that housing conditions deteriorated for many in the last decade.

Occupation: There are clear differences in risks of mortality related to occupation. Being in a key worker role, unable to work from home and being in close proximity to others put people at higher risk. Occupations at particularly high risk include those in the health and social care, as well as those requiring elementary skills such as security guards and bus and taxi drivers. While mortality risks are closely linked to occupation, area of residence has an important bearing on the extent of occupational risk. Managers living in deprived areas have above-average risk for their occupation and workers in the elementary occupational group living in the least deprived areas have a lower risk of COVID-19 mortality.

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

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

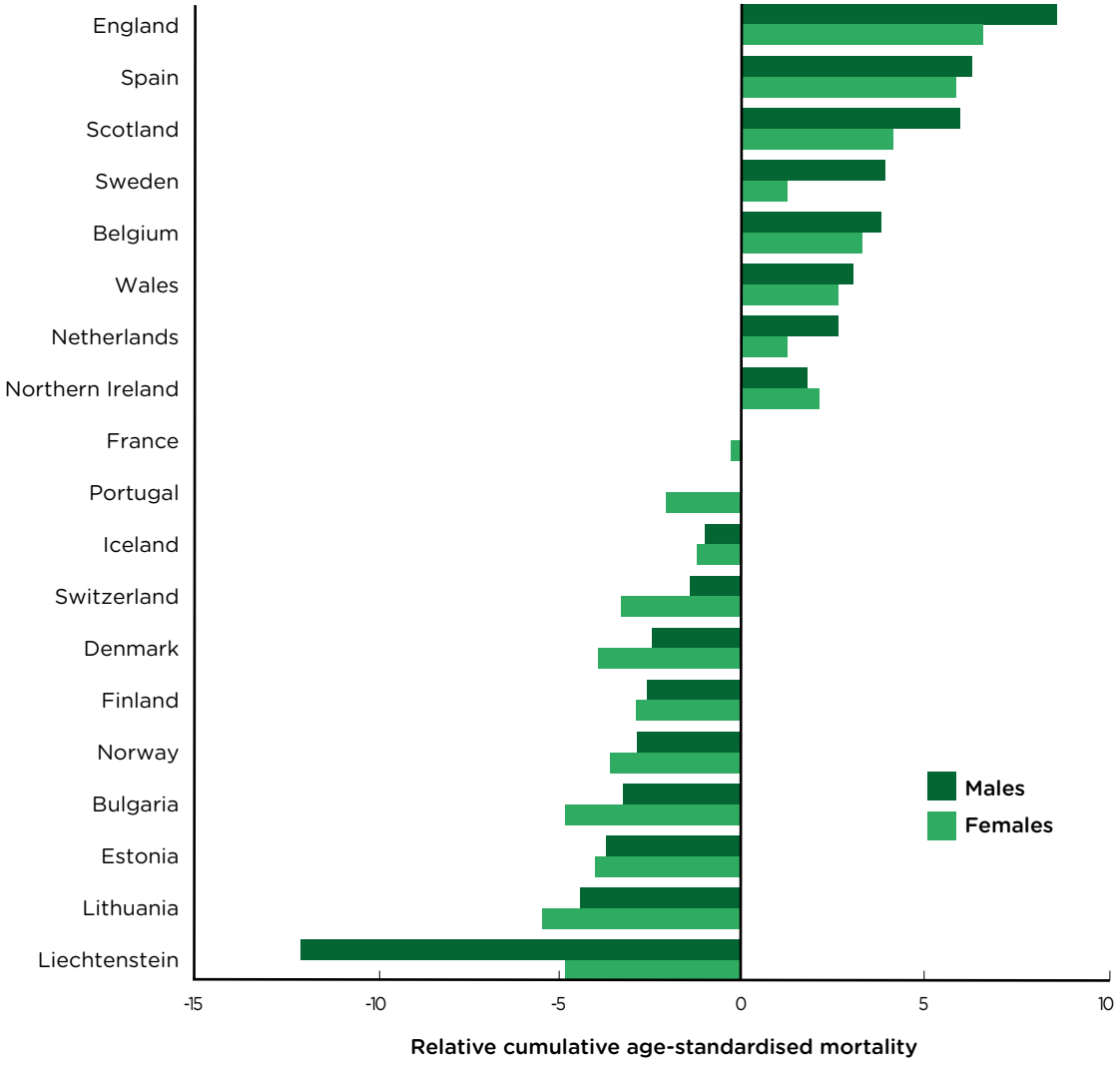
ENGLAND COVID-19 MORTALITY RATE: INTERNATIONAL COMPARISON

Excess mortality during the pandemic included deaths where COVID-19 appeared on the death certificate but also others where it did not. Excess 'non-COVID' deaths include those where COVID-19 went undiagnosed, particularly where testing was not being carried out routinely, as well as deaths from other conditions caused by reduced access to health care (e.g. the suspension of some cancer treatments), and resulting from a reluctance among some to visit GPs and hospitals for serious conditions (e.g. suspected heart attacks) (5) (6). Further analysis is needed to understand which of these factors has predominated in producing high levels of excess deaths (7). On average over the period March to November 2020, both the ratio of deaths registered to those expected and the number of excess deaths where COVID-19 did not appear on the death certificate were highest at ages 45-64 – although both were higher in older age groups during the peak of the epidemic in April. Similarly, on average over the period, both these figures were highest in the most deprived area quintile.

England has had higher mortality from COVID-19 and a greater number of excess deaths in the first half of 2020 than other European countries for which comparable data are available. This is not just a factor of population age structure, or of high rates of employment in particular sectors, nor is it solely to do with the management of the pandemic, although that is important. It relates to conditions prior to the pandemic, which we set out in *10 Years On*. England's poor position in relation to excess mortality in other countries is not unexpected, given that the UK's life expectancy improvement between 2011 and 2018 was the lowest among OECD countries apart from Iceland and the USA.

International comparisons of excess mortality rates between January and June 2020, compared with each country's average excess mortality over the previous five years, are shown in Figure 1.

Figure 1. Relative cumulative age-standardised all-cause mortality rates by sex, selected European countries, week ending 3 January to week ending 12 June 2020



Note: *Relative cumulative age-standardised mortality rates (rcASMRs) were developed by the Continuous Mortality Investigation (CMI) and described in working paper 111 (8). Rather than absolute values of death counts, rcASMRs sum all age-standardised mortality rates between two time points. In this figure, rcASMRs are calculated cumulatively from week 1, 2020 until week 24, 2020 and are relative to the 2015-2019 average cumulative age-standardised mortality rate for that time period in each country.*

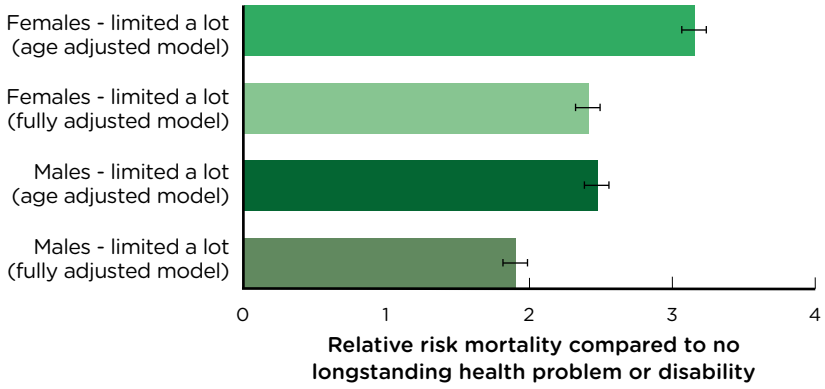
Source: *January to June 2020 (8).*

PREVIOUS HEALTH CONDITIONS AND RISK OF MORTALITY FROM COVID-19

Many people who have experienced severe COVID-19 disease, and who have died with COVID-19, have pre-existing conditions such as dementia, Alzheimer's disease, diabetes, cardiovascular disease and other chronic diseases such as chronic obstructive pulmonary disease and kidney disease. Some of these, such as dementia, reflect the ages at which COVID-19 deaths occur, while others such as diabetes, have been identified as risk factors for adverse outcomes of COVID-19 infection. Many of the underlying health risk factors for COVID-19 are the result of poor conditions associated with the social determinants of health.

Figure 2 shows "fully adjusted" mortality ratios, adjusted for age, region, population density, socio-demographic, household characteristics and occupational exposure. Based on these, the relative difference in mortality rates in England and Wales between those whose day-to-day activities were limited a lot because of a longstanding health problem or disability and those whose were not was 2.4 times higher for females and 1.9 times higher for males (from 2 March to 15 May 2020) for all those living in private households in 2011 (9). The 'fully adjusted' ratios are intended to show the relevance only of health problems and disability to mortality from COVID-19.

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



Notes:

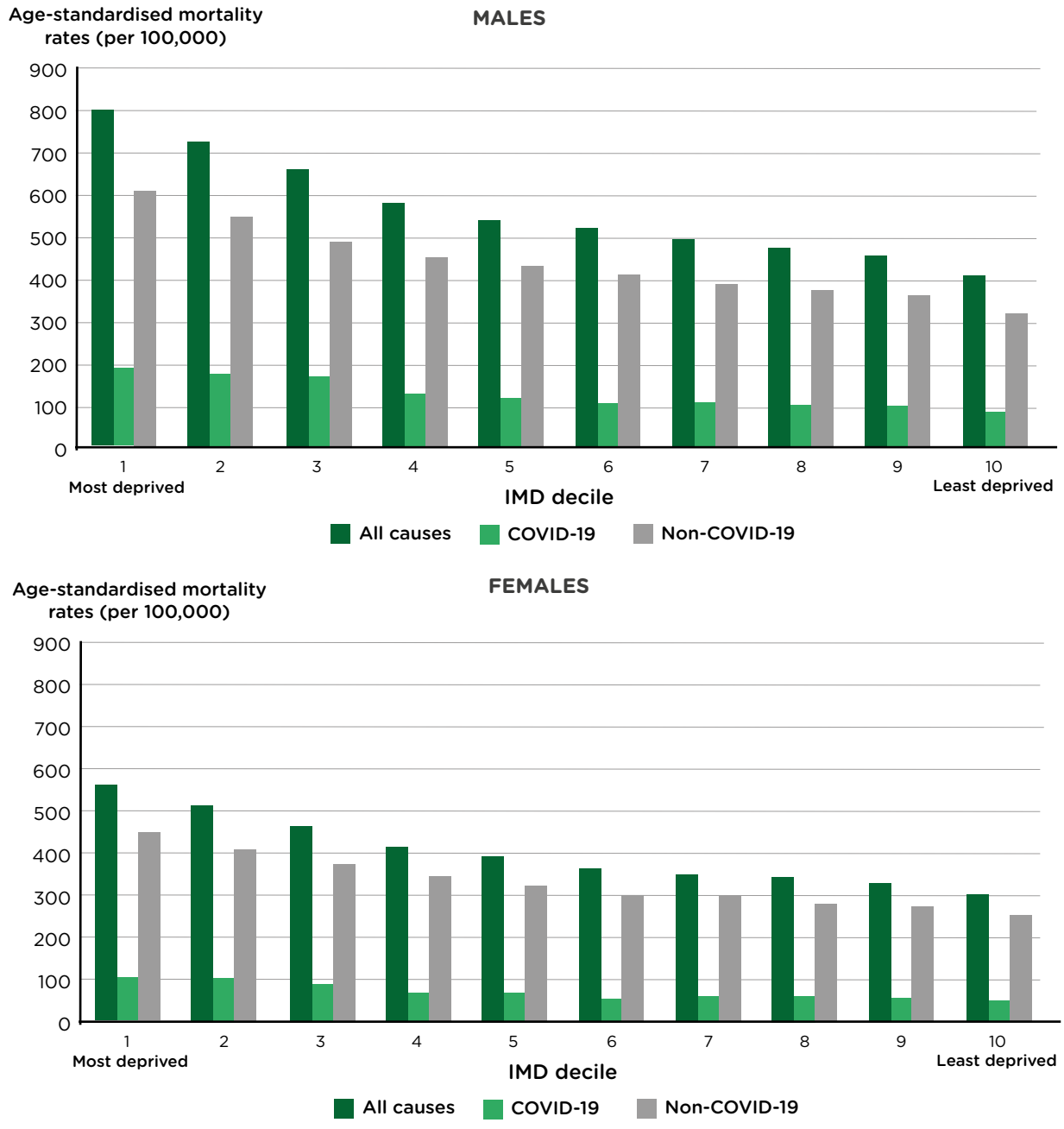
1. *Cox proportional hazards models adjusting for age and the square of age. Fully adjusted models also include region, population density, area deprivation, household composition, socio-economic position, highest qualification held, household tenure, multigenerational household flags and occupation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

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

AREA DEPRIVATION AND COVID-19

In England, as across the world, mortality rates from all causes are higher in more deprived areas, and prior to the pandemic health inequalities related to deprivation had been increasing. COVID-19 follows a similar trajectory to inequalities in mortality from other causes – the more deprived the area of residence, the greater the mortality from COVID-19. Figure 3 shows that rates of mortality from COVID-19 in England between March and July 2020 were double in the most deprived areas compared with the least and there is a clear gradient in mortality rates related to deprivation. These relative differences in COVID-19 are marginally greater than those for non-COVID-19 deaths, although absolute numbers of non-COVID-19 deaths are substantially greater.

Figure 3. Age-standardised mortality rates from all causes, COVID-19 and other causes (per 100,000), by sex, deprivation deciles in England, between March and July 2020



Note: *IMD = Index of Multiple Deprivation*

Source: *ONS. Deaths involving COVID-19 by local area and socioeconomic deprivation, 2020 (10).*

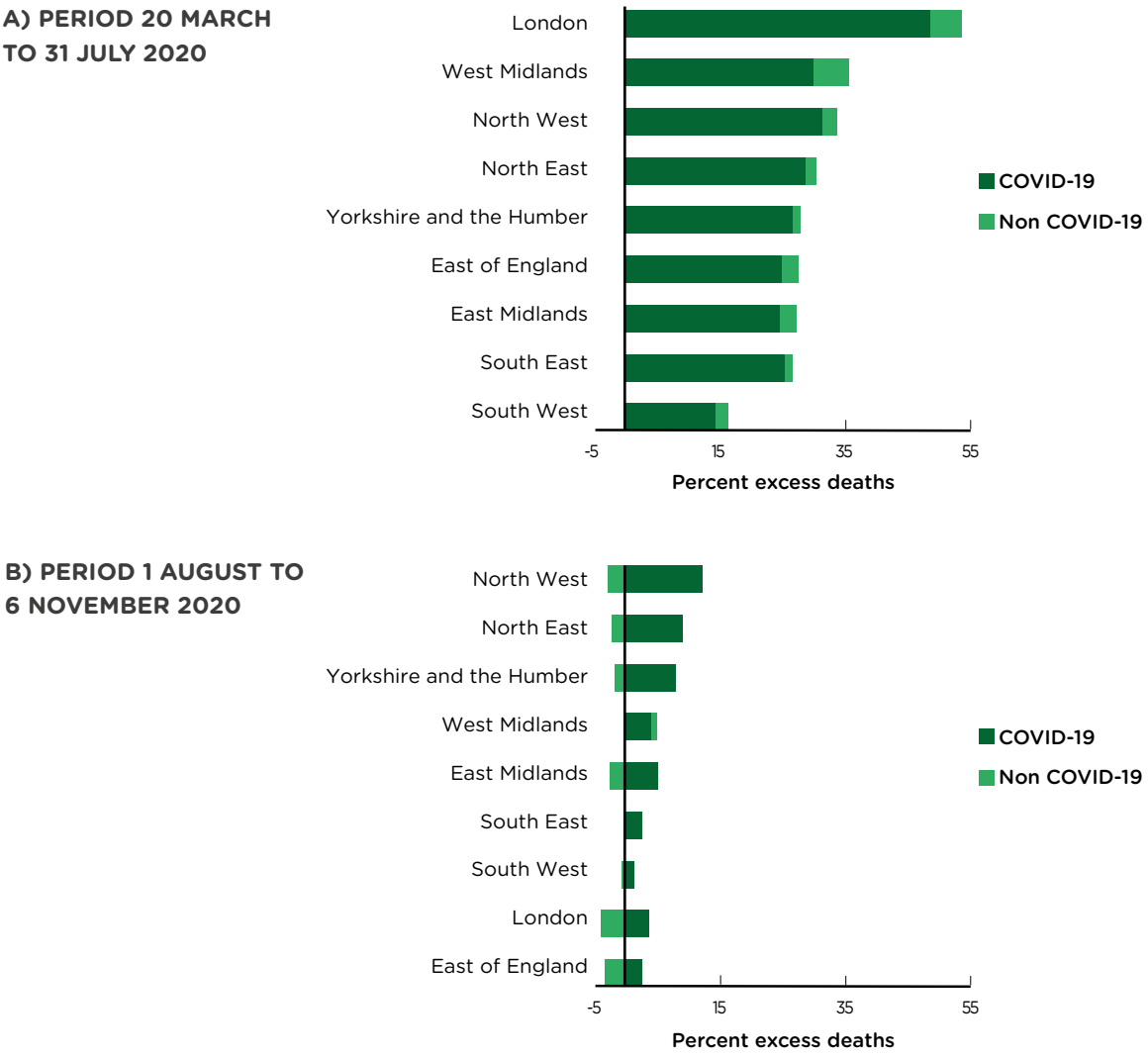
Clearly, levels of deprivation and health within an area have an enormous impact on mortality rates from COVID-19.

REGIONAL INEQUALITIES AND COVID-19

In *10 Years On* we showed that inequalities in health between regions were large and increased from 2010–20. This widening related to growing inequalities in wealth, income, employment and unequal government funding cuts between regions (1).

There are regional differences in rates of mortality from COVID-19, which relate to levels of poverty, occupational structure, ethnicity, age and housing conditions. In the first wave, London experienced the highest mortality rate, and in the second wave Northern regions have experienced higher mortality than the England average. The South East and South West had lower than average mortality during both waves, although overall rates in both Regions were slightly above their expected values in November 2020 compared to the low levels seen in August to October.

Figure 4. Percentage excess mortality compared with the trend in each region of England in the previous five years, by region and time period, 20 March to 6 November 2020



Source: *PHE Excess mortality in English regions - 20 March 2020 to 06 November 2020 (11).*

INEQUALITIES IN LIVING CONDITIONS AND MORTALITY FROM COVID-19

Overcrowded living conditions and poor-quality housing are associated with higher risks of mortality from COVID-19 and these are more likely to be located in deprived areas and inhabited by people with lower incomes. Evidence from the *10 Years On* analysis showed that housing conditions had deteriorated for many in the decade from 2010 and overcrowding had increased in the rented sectors. It remained at the highest rate it has been in the social rented sector since this information was first collected in the 1990s (13). Figure 5 shows the close association between COVID-19 mortality rates and overcrowding by local authority in England (10) (14).

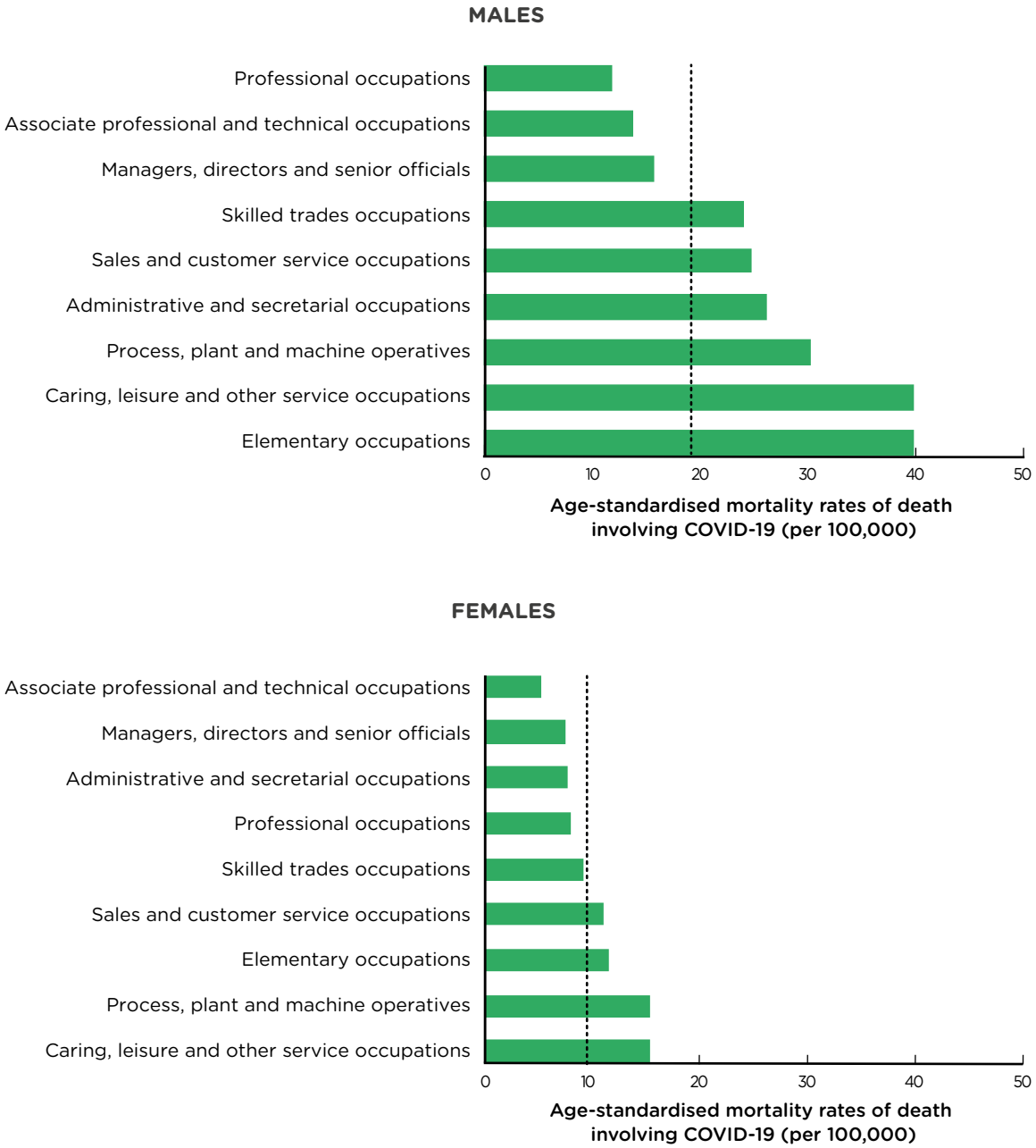
Figure 5. Age-standardised COVID-19 mortality rates and percent of overcrowded households, local authorities in England, deaths occurring between March and July 2020

Source: *ONS. COVID-19 age-standardised mortality rates by local authority and percent of overcrowding, 2020 (10) (14).*

OCCUPATION AND MORTALITY FROM COVID-19

Some occupations have particularly high rates of mortality from COVID-19. These include jobs that cannot be done from home, those that require being in close proximity to others, lower grade occupations, jobs with a higher-than-average percent of older workers, and jobs more likely than others to be occupied by those from a BAME group.

Figure 6. Age-standardised mortality rates at ages 20 to 64, by sex, and major occupational group, deaths involving COVID-19 registered in England and Wales, between 9 March and 25 May 2020



Notes: *Elementary occupations are those that require the knowledge and experience necessary to perform mostly routine tasks. Most occupations in this major group do not require formal educational qualifications but will usually have an associated short period of formal experience-related training.*

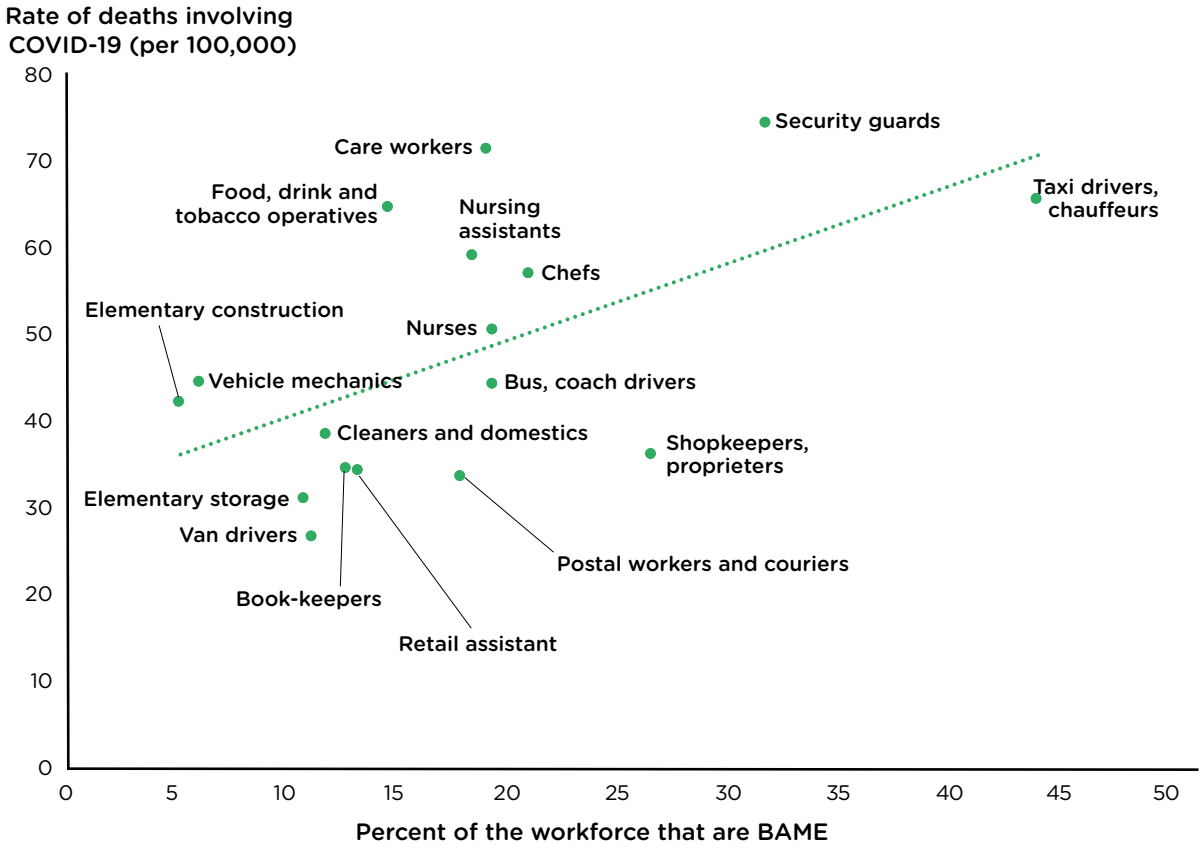
The vertical line represents the average death rate at ages 20 to 64 in England and Wales, for men and women with an occupation, respectively.

Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (15).*

The Office for National Statistics (ONS) assessed 17 occupations as being particularly high-risk for COVID-19 mortality. Security guards and related occupations, care workers and home carers, and taxi and cab drivers and chauffeurs had the highest mortality rates. Most of the occupations considered high risk had double the COVID-19 mortality rates expected based on mortality rates during the four previous years and all were occupations that necessitate being within close physical proximity to other people (15).

Figure 7 shows that some of the occupations with the highest mortality rates from COVID-19 – taxi drivers, chauffeurs and security guards – comprised a high proportion of BAME workers (15). Many BAME groups tend to work in occupations with high levels of proximity to others and this partly accounts for higher rates of mortality among these groups.

Figure 7. Percent of the workforce in 17 occupations with significantly raised risk of COVID-19 mortality that come from BAME groups, by age-standardised COVID-19 mortality rates at ages 20 to 64, England and Wales, 9 March to 25 May 2020

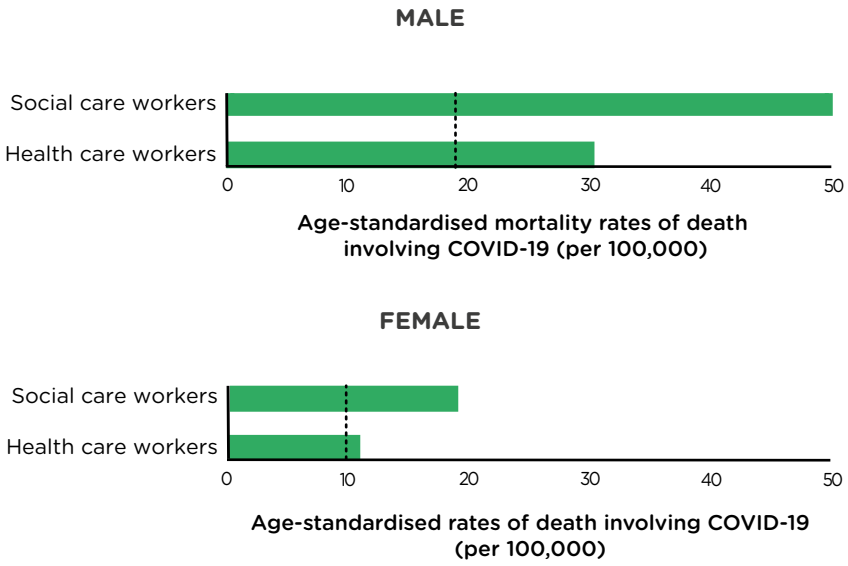


Source: *ONS 2020 (15).*

Workers from BAME groups have had more negative experiences related to discrimination and safety in the workplace during COVID-19 than White British workers. Specifically, those who identify as Black African, Bangladeshi and Pakistani have been less likely than White British workers to have been given adequate PPE. Higher proportions of Pakistani (20 percent) and Indian (20 percent) key workers, reported having had safety complaints ignored during the first lockdown (16). Poor treatment in the workplace has been highlighted as a key problem and described as a longstanding issue prior to COVID-19. Many BAME respondents to a survey about these issues said that they were concerned about raising them because of past experiences and fear of the consequences of speaking up (17). This issue has been particularly highlighted among health care workers during the pandemic.

Social care and health care workers had particularly high rates of deaths involving COVID-19 between 9 March and 25 May 2020 compared with those in other professions. For both men and women, the rates were higher for social care workers than health care workers and higher than average COVID-19 mortality rates in England and Wales at 19.1 deaths per 100,000 for men and 9.7 for women.

Figure 8. Age-standardised mortality rates at ages 20 to 64 for social care and health care workers by sex, deaths involving COVID-19 registered in England and Wales between 9 March and 25 May 2020



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

Source: *ONS, Coronavirus (COVID-19) related deaths by occupation, England and Wales 2020 (15).*

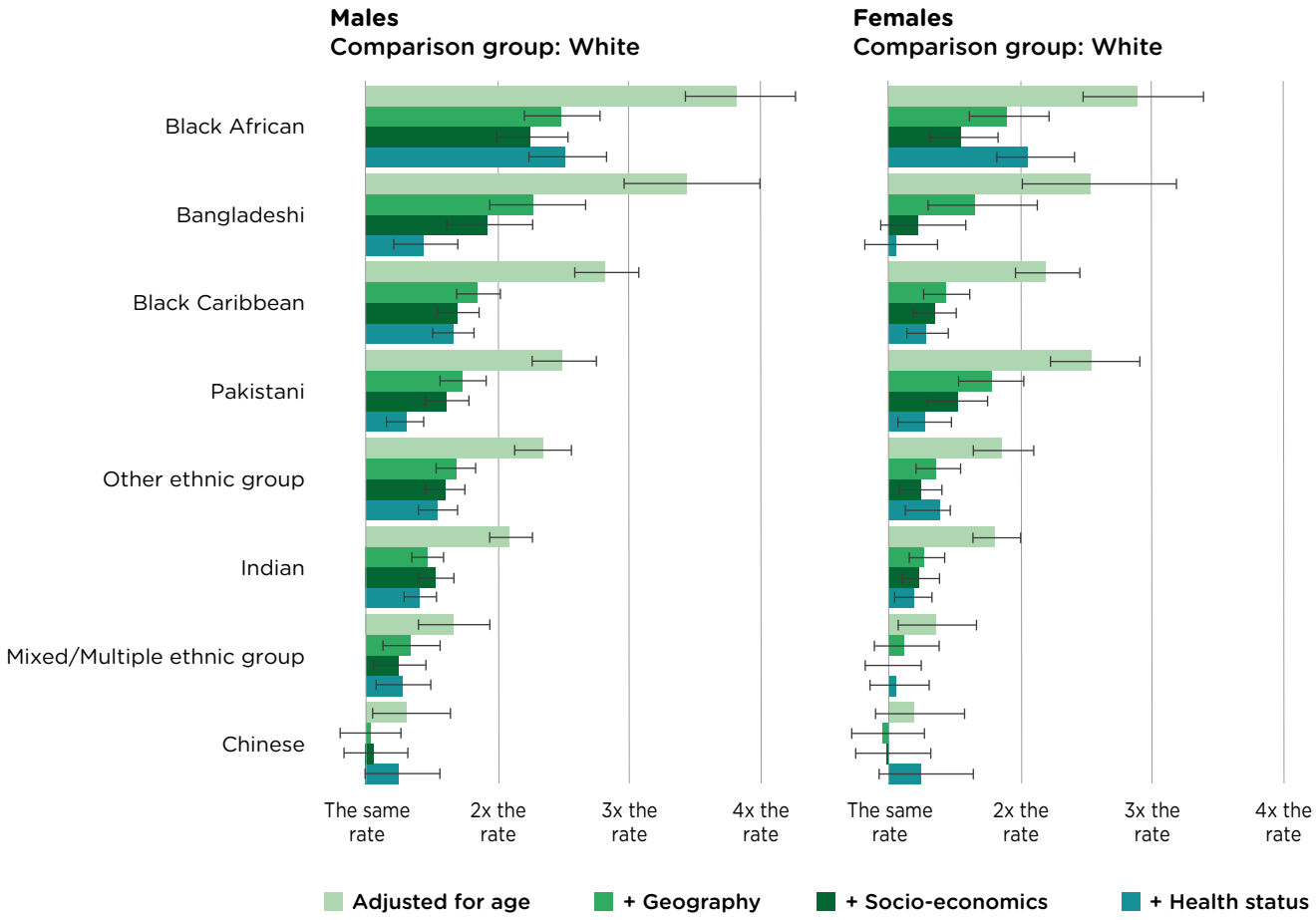
While different occupations have markedly different rates of mortality, there are additional differences within occupation groups related to age, underlying health conditions and area of residence. Those working as managers and in professional occupations have an above-average risk of mortality if they live in a deprived area, whereas those in elementary occupations have a much lower risk if they live in a wealthier area. This points to the significance of level of deprivation of area of residence for the risk of mortality for COVID-19 (15).

BAME GROUPS AND RISK OF MORTALITY

Mortality risks from COVID-19 are much higher among many BAME groups in England than they are for the White population. The reasons for this relate to these groups being disproportionately represented in high-risk occupations and more likely to be living in deprived areas and with more underlying health conditions that increase the risk from COVID-19, such as diabetes. All these conditions are the result of longstanding inequalities and structural racism. However, even these unequal conditions do not fully account for the higher mortality rates of non-White ethnic groups.

Figure 9 shows that even after accounting for age, geography, socioeconomic factors and health, mortality rates are highest for males and females with Black African ethnicity, and all ethnic groups described have higher rates than White people.

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



Notes:

1. *Cox proportional hazards models adjusting for age, geography (local authority and population density), socioeconomic factors (area deprivation, household composition, socioeconomic position, highest qualification held, household tenure, multigenerational household flags and occupation indicators – including keyworkers and exposure to others), and health (self-reported health and disability status in March 2011, and hospital-based co-morbidities since April 2017).*
2. *Figures relate to persons enumerated living in private households as indicated by the 2011 Census, for whom deaths that occurred between 2 March and 28 July could be linked to ethnic group data from the 2011 Census.*
3. *'Other ethnic group' encompasses Asian other, Black other, Arab, and other ethnic group categories in the classification.*
4. *Error bars not crossing the x axis at value 1.0 denote a statistically significant difference in relative rates of death.*

Source: *ONS, COVID-19 related deaths by ethnic group, England and Wales, 2020 (18).*

SUMMARY

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

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

The recommendations from *10 Years On* will be even more critical after the pandemic. Given all the evidence for the inequalities in risks of mortality from COVID-19, it is essential that all efforts at rebuilding have the goal of greater equity at their heart – so that we can Build Back Fairer and ensure that unfair and unnecessary health inequalities are reduced. We make recommendations throughout the report for how to reduce the longer-term health inequality impacts that will arise as a result of containment measures.

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

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

As COVID-19 treatments and vaccinations are rolled out, it is essential to take into account the differential risks facing people. The Government has signaled its intention to prioritise older people, care home residents and health and care staff for early receipt of the vaccine, but working age people in particular occupations could also be prioritised.

RECOMMENDATIONS

BOX 6. BUILD BACK FAIRER: REDUCING INEQUALITIES IN MORTALITY FROM COVID-19

- Consider **proportionate allocation of measures** to prevent COVID-19, including vaccinations and support to people in particularly high-risk occupations and geographical areas.
- Ensure that **personal protective equipment is available** and its use enforced.
- Provide **adequate financial support** for workers who cannot work because of COVID-19 risk and those who have to self-isolate.

CHAPTER 3

GIVE EVERY CHILD THE BEST START IN LIFE: COVID-19 CONTAINMENT AND INEQUALITIES

In the *10 Years On* report we showed that from 2010, in a number of critical drivers of children's early years development and education, trends were going in the wrong direction: in particular, regressive changes to taxes and benefits and a rise in child poverty. There was widespread closure of Children's Centres and early years services, with greatest impact in more deprived areas, where they are most needed. Inequalities in early childhood development and in attainment at school were persisting, closely related to deprivation and socioeconomic position of households. We also pointed to positive outcomes in places where there was a particular focus on improving equity in the early years, including London and Greater Manchester.

BOX 7. SUMMARY OF INEQUALITIES IN EARLY YEARS AND IN EDUCATION (FROM *10 YEARS ON* REPORT)

- Since 2010, progress has been made in early years development, as measured by children's readiness for school. However, clear socioeconomic inequalities persist, with a graded relationship between these measures and level of deprivation.
- For low-income children, levels of good development are higher in more deprived areas than in less deprived areas, providing encouragement that it is quite possible to break the link between deprivation and poor early child development.
- Funding for Sure Start and Children's Centres, and other children's services, has been cut significantly, particularly in more deprived areas.
- There are still low rates of pay and a low level of qualification required in the childcare workforce.
- Clear and persistent socioeconomic inequalities in educational attainment that were present in 2010 remain.
- Regionally, the North East, North West and East Midlands have the lowest levels of attainment at age 16 and London has the highest. The gap in achievement between poorer children and the average is less in London than in the rest of the country. This may result from higher levels of funding in London.
- School student numbers have risen while funding has decreased, by 8 percent per student, with particularly steep declines in funding for sixth form (post-16) and further education.
- Since 2010 the number of exclusions from school has significantly increased in both primary and secondary schools.

The persistent inequalities in attainment and severe cuts to school funding in England did not provide a sound footing to support early years development and educational attainment through the COVID-19 lockdowns in an equitable way. Furthermore, containment measures have led to widening inequalities in early years development and in educational attainment. Children with special needs and children with poor mental health have been especially vulnerable to damage from containment school closures.

Even prior to the pandemic and the first lockdown, the UK ranked poorly in child wellbeing. UNICEF Report Card 16 ranks children in 38 rich (OECD and EU) countries using three measures: mental wellbeing, physical health and academic and social skills. The UK ranks 27th out of 38. The five best-performing countries are the Netherlands, Denmark, Norway, Switzerland and Finland. Without even accounting for wide inequalities in the UK, it was doing poorly in child wellbeing. The COVID-19 lockdowns and school closures will have damaged children's wellbeing and it will be instructive to learn if the international rankings change as a result of the COVID-19 crisis.

BOX 8. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN THE EARLY YEARS AND DURING SCHOOL-AGE EDUCATION

EARLY YEARS

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

EDUCATION

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

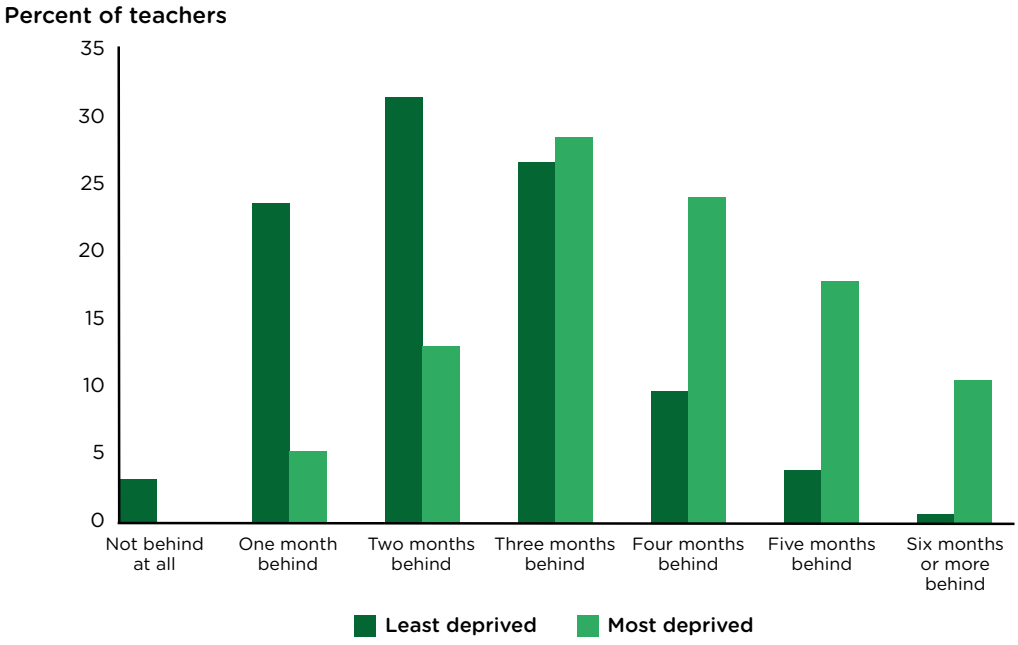
As abundant evidence over many years has shown, early years settings are particularly beneficial for more disadvantaged children, helping to close inequalities in development levels at this early and critical stage.

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

Despite the support measures introduced by the Government, a quarter of early childhood settings reported that it is unlikely they would be operating in spring 2021 (20). Early years settings in deprived areas are most concerned about their futures and most likely to have to close and make staff redundant; their financial security needs to be further supported. As we pointed out in *10 Years On*, the closures of early years settings in more deprived areas are leading to even greater inequality in early childhood development and for a range of outcomes, including educational attainment, later in life (1).

The closure of schools during the first lockdown has also harmed the educational attainment of more deprived students in particular. Teachers in more deprived schools were significantly more likely than teachers in schools in less deprived areas to report that their students were further behind compared to where they would normally expect them to be at the same time of year (Figure 10).

Figure 10. Percent of teachers reporting loss of learning in the least and most deprived schools, England, September 2020

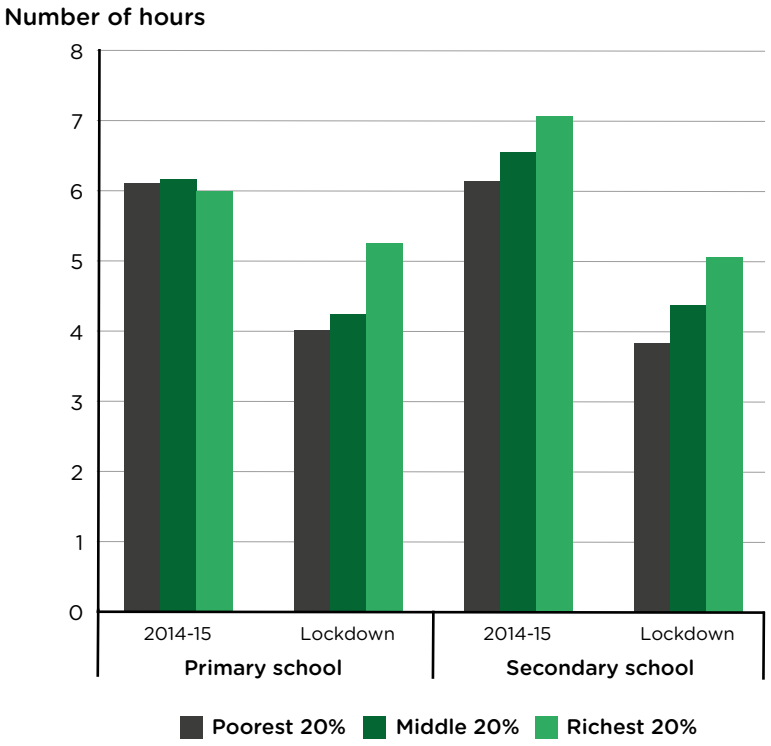


Source: *The National Foundation for Educational Research. The challenges facing schools and pupils in September 2020 (21).*

Among the reasons for widening inequalities in learning and attainment during lockdowns and social distancing are unequal access to laptops and technology, with schools in deprived areas less able to provide online learning and more deprived students having much less suitable space at home to study. Some schools, including most private schools, have the resources to provide a full timetable of online lessons and one-to-one support and wealthier parents can compensate for loss of learning through additional tutoring and educational resources, as well as through having more time to devote to supporting their children's education.

Inequalities in education are widening. Figure 11 shows changes in student learning time by three family earning groups. Learning time for primary school students had been equitable for all three groups before the pandemic, but COVID-19 containment measures have introduced new inequalities, and inequalities during secondary school have widened even as total learning time has reduced for everybody.

Figure 11. Number of hours spent learning during 2014/15 and lockdown in 2020, by family earnings



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

Source: *Institute for Fiscal Studies (IFS) calculations using data from the 2014–15 UK Time Use Survey and the IFS–IOE survey of time use during COVID (22).*

Containment measures clearly harm more deprived students the most, but the funding allocations for schools mean they have no opportunity to reduce these damaging inequalities. More deprived schools have received lower real-terms increases in funding per student since 2017–18 for each year up to 2021–22: funding per student will increase by 4 percent less among the most deprived primary schools when compared with the least deprived ones. More deprived secondary schools are similarly affected. Further, special needs provision in England was reduced by £1.2 billion between 2015 and 2019 and urgent additional support for students with SEND is now required.

Problems with the grading of public exams in summer 2020 have further exacerbated disadvantaged students' capacity to demonstrate their capabilities, even after grading was handed to teachers. On average, independent and selective school students benefitted more from changes to the grading systems, while students in state schools were more likely to lose grades, magnifying existing grade systems inequalities (23).

SUMMARY

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

Shortfalls in funding for early years settings and schools mean that the intensity and resources required to reduce widening inequalities are not available. The 2.2 percent increase in funding for schools announced in November 2020 is insufficient to meet the task and does not compensate for cuts to funding in the pre-pandemic decade, which harmed more disadvantaged areas the most. It is essential we learn the lessons from the pandemic and from the previous 10 years and invest proportionately more in early child development and education in more deprived areas in order to Build Back Fairer and for the long term. In the shorter term, investments in laptops and online infrastructure in more disadvantaged areas will help reverse some of the inequitable impacts arising from the pandemic.

RECOMMENDATIONS

BOX 9. BUILD BACK FAIRER: GIVE EVERY CHILD THE BEST START IN LIFE

LONG TERM

Government should prioritise reducing inequalities in early years development.

MEDIUM TERM

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

SHORT TERM

- Allocate additional government support to early years settings in more deprived areas, to prevent their closure and staff redundancies.
- Improve access to availability of parenting support programmes.
- Increase funding rates for free childcare places to support providers.

BOX 10. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EDUCATION

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

- Address inequalities in access to laptops and expand and adequately resource the programme designed to enable provision of laptops to more deprived students.
- Significantly increase the focus on achieving equity in assessments for exam grading.
- Urgently roll-out catch-up tuition for children in more deprived areas, in full.
- Provide additional support for families and students with SEND.
- Urgently give excluded students additional support and enrol those who need it into Pupil Referral Units.

CHAPTER 4

CHILDREN AND YOUNG PEOPLE: INEQUALITIES AND COVID-19 CONTAINMENT

Children and young people have a much lower risk than adults of experiencing adverse physical health impacts from contracting COVID-19. However, the containment measures and the resulting social and economic impacts are having significant negative impacts on children and young people's mental health and on the long-term prospects for young people. Factors include reductions in family income, increases in child poverty, food poverty and hunger, damage to employment and training prospects as well as educational attainment. In each of these areas there are widening inequalities, which will blight the lives of many more disadvantaged young people and in turn translate into widening health inequalities in the longer term.

In *10 Years On* we assessed how the previous decade had been particularly scarring for many children and young people and for those from more disadvantaged households and areas, as summarised in Box 11.

BOX 11. SUMMARY OF INEQUALITIES IN CHILDREN AND YOUNG PEOPLE'S DEVELOPMENT (FROM *10 YEARS ON*)

- Rates of child poverty increased in the decade from 2010, with over 4 million children affected.
- Rates of child poverty are highest for children living in workless families, at an excess of 70 percent.
- More deprived areas have lost more funding for children and youth services than less deprived areas, even as need has increased.
- Violent youth crime increased greatly over the period.

BOX 12. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN CHILDREN AND YOUNG PEOPLE

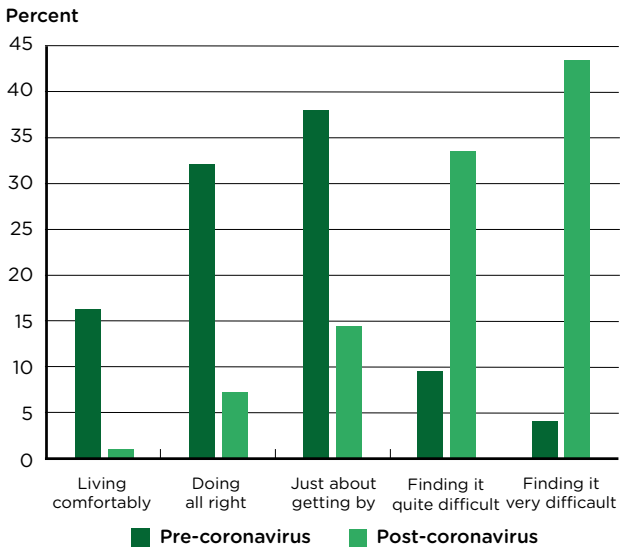
- Indications are that child poverty will increase further.
- Food poverty among children and young people has increased significantly over the pandemic.
- The mental health of young people, already hugely concerning before the pandemic, has deteriorated further and there is widespread lack of access to appropriate services.
- Exposure to abuse at home has risen through the pandemic, from already high levels beforehand.
- Unemployment among young people is rising more rapidly than among other age groups and availability of apprenticeships and training schemes has declined.

Child poverty is a critical determinant of early child development and educational attainment and has a negative impact on other outcomes throughout life, including employment, income and health. Rates of child poverty increased between 2010 and 2020, with greatest increases for families with an adult in work. Even before the pandemic, increasing numbers of children were living in temporary accommodation, and this is set to increase as poverty rises and housing costs remain high.

While poverty data will not be available until March 2021, there are likely to be significantly more families in poverty, including those with a working adult, compared with before the pandemic. Working parents made up the highest number of furloughed workers; the furlough scheme is paying only 80 percent of wages, pushing many families into poverty.

Eight in 10 respondents to on an online survey of 285 low-income families by the Child Poverty Action Group reported a significant deterioration in their living standards due to a combination of falling income and rising expenditure. As shown in Figure 12, in July to August 2020 low-income families were doing substantially worse than they were before the COVID-19 crisis and the financial situation of families who responded to the survey had worsened since an earlier survey carried out in May to June.

Figure 12. Low-income families' responses to how they were coping financially, July–August 2020, England

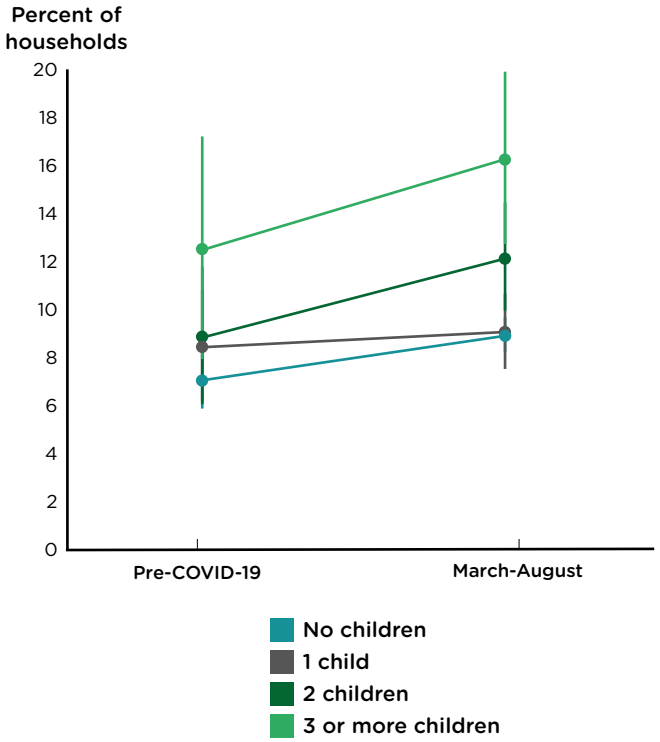


Note: *Online survey of 285 low-income families by the Child Poverty Action Group.*

Source: *Child Poverty Action Group. Poverty in the pandemic, 2020 (24).*

School closures led to greater strain on family finances as free school meals were taken away from 1.3 million children. The substituting food voucher scheme mitigated hunger, but did not eliminate it and there have been reported increases in hunger and food poverty among young people; for example, the Food Foundation found that food poverty rose from 12 pre-COVID-19 to 16 percent in March to August 2020 in homes with three or more children (25).

Figure 13. Food insecurity in homes by number of children, before lockdown and in March–August 2020

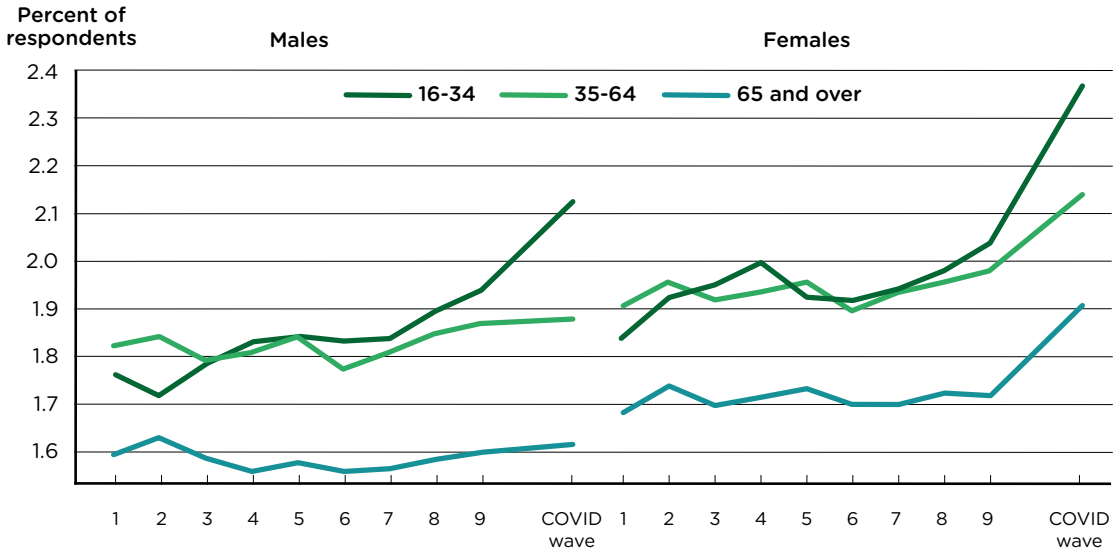


Notes: *Analysis by Loopstra R comparing 12 month food insecurity data for 2016 to 2018 to 6 month food insecurity data from YouPoll collected at the end of August, 2020. Analyses are adjusted for age, gender, ethnicity, marital status, region, and employment status.*

Source: *The Food Foundation (25).*

Another of the more immediate impacts of containment measures has been a deterioration in mental health, which is evident for all groups but particularly for young people. Traumatic experiences, social isolation, loss of education and routine, and a breakdown in formal and informal support and access to services and support from school have all been experienced during the COVID-19 crisis. Figure 14 shows that unhappiness and depression had been increasing slightly before the pandemic but then increased rapidly from the first lockdown, especially for women and all young people. Children and young people living in deprivation are likely to have experienced higher levels of mental distress than their better-off peers, given household conditions and pre-existing socioeconomic conditions (26).

Figure 14. Percent unhappy or depressed, UK household longitudinal survey waves 1-9 (January 2009 to May 2019) and April 2020 by gender and age group



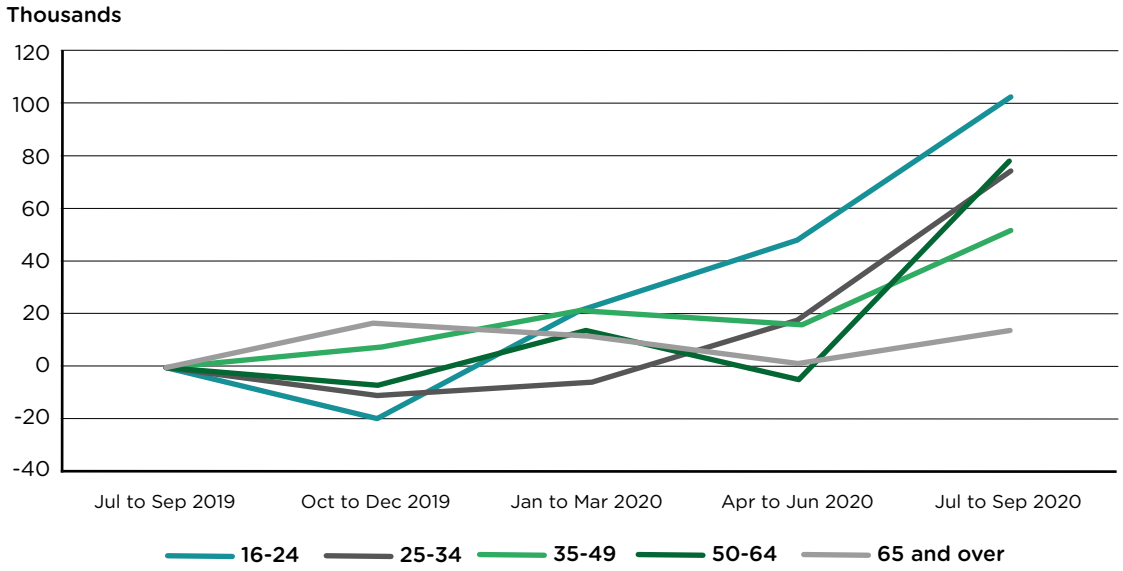
Note: *The waves ran as follows: wave 1 January 2009–March 2011, wave 2 January 2010–March 2012, wave 3 January 2011–July 2013, wave 4 January 2012–June 2013, wave 5 January 2013–June 2015, wave 6 January 2014–May 2016, wave 7 January 2015–May 2017, wave 8 January 2016–May 2018, wave 9 January 2017–May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

Source: *UKHLS waves 1–9 and April COVID-19 survey (27).*

Before the first lockdown, numbers of children exposed to violence in England were already high – with estimates that one in five children were exposed to domestic abuse (28). Children and young people who experience trauma and abuse at home are at high risk of immediate and long-term harm to their physical and mental harm. During the first lockdown it was estimated that there was at least a 25 percent increase in domestic abuse (29), with surveys indicating that the increases could be even higher. Women's Aid research on the impact of COVID-19 containment on domestic abuse showed that 53 percent of respondents stated that their children have witnessed more abuse towards them (30). Schools and a range of other services have a crucial role to play in identifying and supporting the young victims of abuse. Extra resources are required urgently to support them to do so.

While the increase in the unemployment rate has been relatively low so far (increasing by one percentage point for men and 0.5 percentage points for women between February - April 2020 and July to September 2020), it is projected to increase further. Young people are experiencing the greatest increases in unemployment compared with other age groups (Figure 15) because they tend to work in sectors that have been most affected by the containment measures, such as hospitality, leisure and tourism, and as students leave schools and colleges there are fewer jobs available to them than before the pandemic. As overall unemployment rises, youth unemployment will increase markedly. This is a scarring experience, reducing the future opportunities for young people and potentially leading to long-term loss of income and career progression, and adversely affecting mental and physical health.

Figure 15. UK unemployment by age group, seasonally adjusted, cumulative growth from July to September 2019, for each period up to July to September 2020



Source: *Based on ONS. Employment in the UK: November 2020 (31).*

The number of young people not in education, employment or training (NEET) had been stable before the pandemic. However, there was an increase of 1 percent in the NEET rate for young men between February/March 2020 and July/September 2020 and this rate will likely rise again as employment and training opportunities decline further.

Apprenticeships are particularly important for more disadvantaged groups and are important in reducing inequalities in work and income. They have been badly impacted by the crisis. The Sutton Trust shows that, by May 2020, fewer than 40 percent of apprenticeships were continuing as normal, more than a third of apprentices had been furloughed, one in 12 had been made redundant (32), and prospects for hiring apprentices in the future look bleak. Meanwhile youth services, which were cut severely in the decade to 2020, are struggling further as local government and charitable funding is reduced. It is likely that many of the remaining services that support young people and improve participation in schools and work, and reduce youth crime, will be forced to close.

SUMMARY

All children and young people have been affected by the pandemic and associated containment measures. Many young people are facing particularly bleak prospects as a result, and the impacts are being and will continue to be felt the most by the most disadvantaged (33). Reversing these impacts and reducing inequalities is a critical challenge; short-term interventions to reduce family poverty and food poverty and improve access to mental health services must be central to this. In the longer term, investments in employment and training for young people and more support for good mental health will be critical.

RECOMMENDATIONS

BOX 13. BUILD BACK FAIRER: IMPROVING OUTCOMES FOR CHILDREN AND YOUNG PEOPLE

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

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

CHAPTER 5

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

In countries that have had good control of COVID-19 infection and relatively low rates of mortality, the economic damage has been less severe than in countries, such as England, where the infection and mortality rates have been high. There has been much discussion of the trade-offs between protecting health and protecting the economy but less remarked on is that economic impacts are also health impacts. The UK economy is expected to have shrunk by 11.3 percent in 2020. There is a robust evidence base showing that unemployment, poor quality work and low wages are hugely damaging for health and health equity. The COVID-19 economic crisis is therefore going to lead to another health crisis, and the people and geographical areas that are most likely to suffer these poor health effects are those that already had poor quality work and high levels of unemployment before the pandemic.

As we showed in *10 Years On*, in the decade from 2010 there were increases in employment in low-paid, unskilled, self-employed, short-term and zero-hours contract jobs. Rates of pay did not increase and, notably, more people in poverty by the end of the period were in work than out of work. This labour market context is critical for understanding the broad impact of COVID-19 and measures to contain it – the impact both on mortality in some occupations and on longer-term economic and social inequalities, with their knock-on effects on health inequalities.

BOX 14. SUMMARY OF INEQUALITIES IN WORKING LIVES (FROM *10 YEARS ON* REPORT)

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

The COVID-19 containment measures are having hugely damaging impacts on the labour market in England, including declining employment rates and wages, despite the Coronavirus Job Retention Scheme (CJRS) (furlough) scheme. Unemployment is projected to rise to 7.5 percent in spring 2021, with 2.6 million people out of work. The impacts have not been experienced equally and wide inequalities are set to deepen when the furlough scheme ends. Young people are experiencing the greatest loss of employment but low-paid workers, BAME groups, disabled workers, women, part-time workers and the self-employed have all been disproportionately affected. Employment in hospitality, non-food retail, leisure, aviation, transport and tourism are all adversely affected.

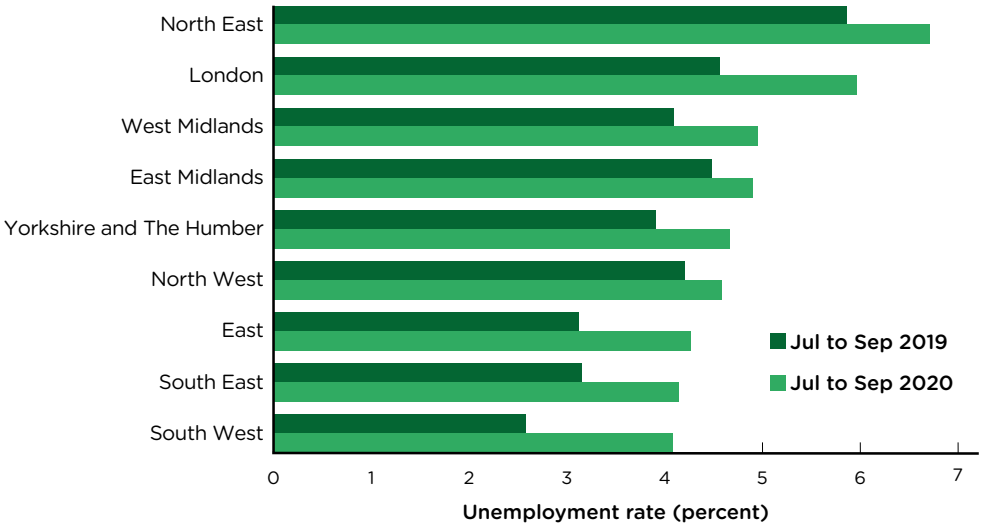
BOX 15. SUMMARY: BUILD BACK FAIRER: EMPLOYMENT AND GOOD WORK

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

IMPACTS OF COVID-19 CONTAINMENT ON UNEMPLOYMENT

One of the most immediate impacts of containment has been on unemployment, despite the Coronavirus Job Retention Scheme protecting many jobs. From March 2021, unemployment is projected to increase significantly, to over 11 percent, as furlough ends. Regional inequalities in unemployment were already wide before the pandemic, widened further to September 2020 and will increase again after March 2021. This will widen regional inequalities in health in the longer term. Figure 16 shows that the highest rates of unemployment in September 2020 were in North East England and the rates were lowest in areas in the South outside London. Although there have been increases everywhere over the year to July/September 2020, the largest increases were seen in the South West (1.5 percentage points), followed by London (1.4) and the East (1.2).

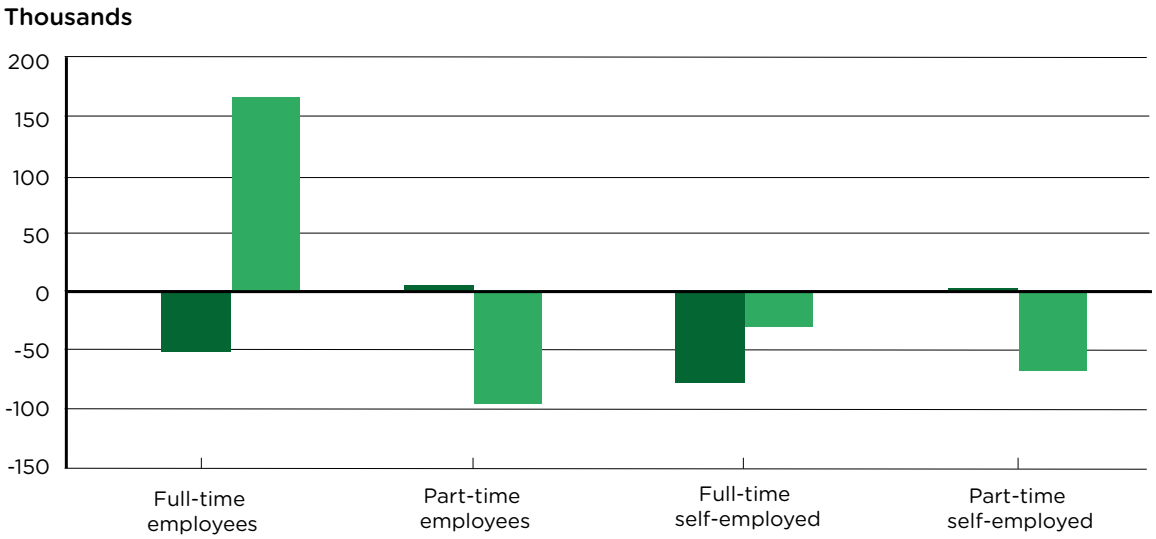
Figure 16. Unemployment rate estimates for people who are economically active, by English region, seasonally adjusted, between July–September 2019 and July–September 2020



Source: *Based on ONS. Employment in the UK: November 2020 (31).*

For the period until September 2020, part-time and self-employed workers were more likely than others to have lost their jobs, although much larger increases in unemployment for all workers are projected for the rest of 2020 and over the coming years.

Figure 17. UK quarterly changes for total in employment, full-time and part-time employees, and full-time and part-time self-employed by sex, seasonally adjusted, between April–June 2020 and July–September 2020

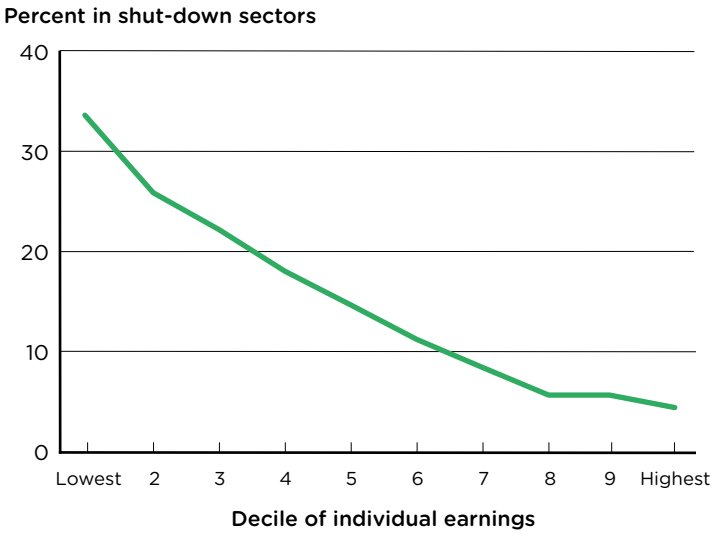


Source: *Based on ONS. Employment in the UK: November 2020 (31).*

SHUTDOWN AND FURLOUGHED SECTORS

Low-income workers are most likely than higher-paid people to have been furloughed, putting a further dent into their already low earnings as they take a 20 percent pay cut. This is likely to push many people into poverty as many do not have sufficient savings or other means to withstand the economic shock. One-third of people in the bottom decile for earnings were employed in shuttered sectors, compared with under 10 percent in the top three income deciles. Incomes in the bottom decile have been protected somewhat by increases in benefit payments, but for the second decile, the decrease in wages has not been compensated for and the loss of wages will be particularly acute. This shows the importance of benefit support that is proportionate across the income gradient.

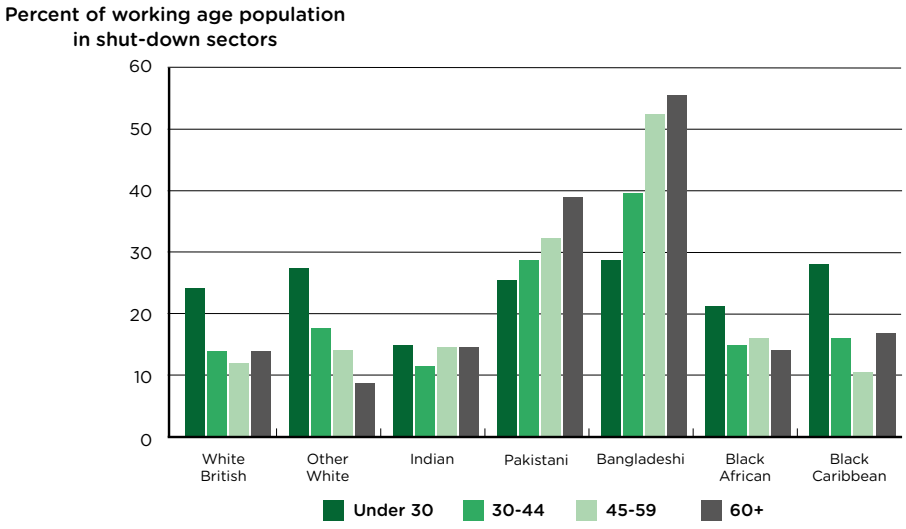
Figure 18. Percent of workers in shuttered sectors by earnings decile, (based on quarterly data for 2019), UK



Source: *IFS, analysis of Quarterly Labour Force Survey Q1-Q4 2019, Waves 1 and 5 only in: 'Sector shutdowns during the coronavirus crisis: which workers are most exposed?' 2020 (34).*

In terms of ethnic and age groups, older Pakistani and Bangladeshi workers have been the most likely to be in shutdown sectors and particularly affected by the reduction in wages. For other ethnicities it is largely younger people who have been most affected.

Figure 19. Percent of working-age population in each ethnic and age group in shutdown sectors in England and Wales, (based on quarterly data for 2016 - 2019)



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

Source: *Platt L, et al analysis of Quarterly Labour Force Survey Q1 2016 to Q4 2019 in: 'COVID-19 and Ethnic Inequalities in England and Wales,' 2020 (35).*

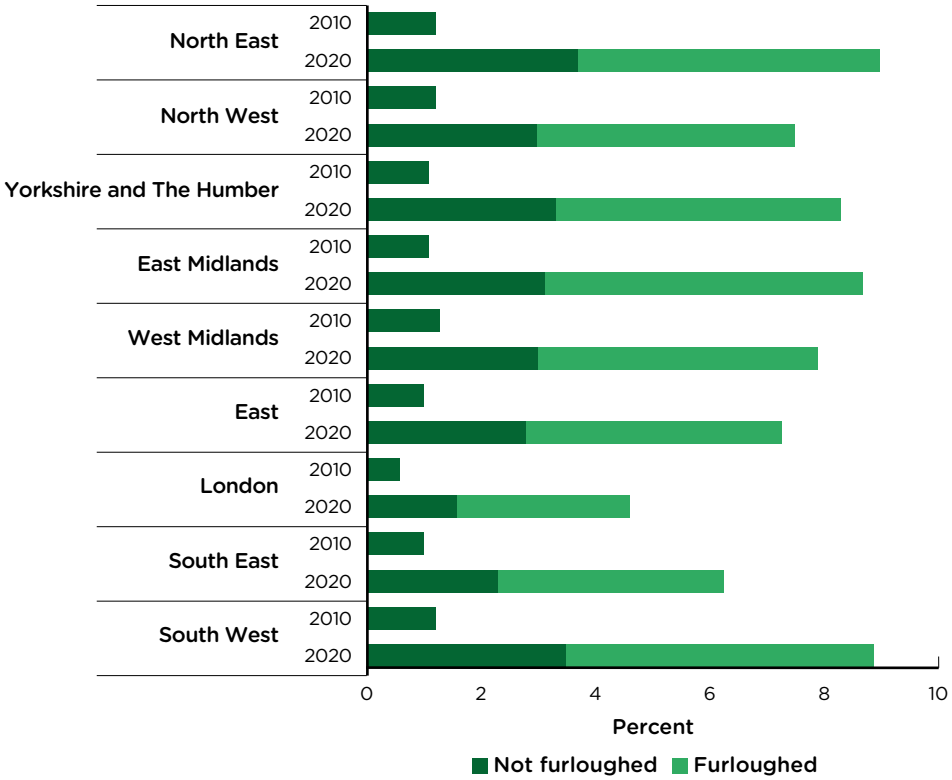
WAGES

While the furlough scheme and increases to benefit payments have helped mitigate the loss of wages for many, they do not do so sufficiently. Wages were already low before the pandemic and there had been substantial rises in in-work poverty over the preceding decade. There were 221,000 people in England earning below the national minimum wage in 2010. By 2019 this figure had risen to 354,000 people below either the national minimum wage (at ages under 25) or national living wage (at ages 25 and over) (36). However, in April 2020 the total number below these minimum wage rates rose to 1.7 million -comprising 649,000 who were not furloughed and just over one million who were furloughed. Some, but not all, of the increase due to furlough was a result of their pay being

frozen at rates that preceded the annual increase in the minimum wage level- indicating just how many people are on wages at or just above the minimum wage.

Figure 20 shows the large inequalities in the percentage of jobs paid below the national minimum wage between regions, with the North East having more than twice the rate in London for those who were not furloughed in 2020, and these inequalities increased between 2010 and 2020. The negative health impacts of low wages are clear, and the large increases in low-paid jobs will widen health inequalities, including regional inequalities, still further.

Figure 20. Percent of jobs paid below the national minimum wage/living wage by region in England, 2010 and 2020



Note: *Includes all furloughed employees.*

Source: *ONS Annual Survey of Hours and Earnings (ASHE), 2020 (37).*

Meanwhile, the highest paid have had faster hourly pay growth in 2020 than in 2019, which is further increasing wage inequality in England.

Self-employed workers have been particularly badly hit by the COVID-19 containment measures, with many having to stop working but being ineligible for the furlough scheme. This includes large numbers working in the gig economy on zero-hours contracts and low wages, who were already at risk of poverty and the associated health impacts. Many self-employed workers have reported considerable mental distress as well as reductions in wages. Prior to the introduction of the first lockdown measures in March 2020, workers on casual contracts were paid on average around £605 less per month than permanent employees. The difference has widened to £730 per month since the outbreak of the pandemic. In April 2020, 60 percent of self-employed workers were earning less than £1,000 per month, up from 30 percent a year earlier.

SOCIAL CARE WORKERS

As well as social care being one of the occupations with the highest rates of mortality from COVID-19, the crisis has exposed the pre-existing difficult conditions and low pay in this sector. In the UK there are more than 900,000 people working in frontline social care roles as their main job. A high proportion are women (83 percent) and 18 percent are BAME compared with 12 percent for all occupations. One in 10 care workers is on a zero-hours contract and 70 percent earn less than £10 an hour (38). The proportion of care workers on low wages is highest in the North of England, which is also the region whose care homes have been the most affected by COVID-19 (39). There are growing calls to reform social care pay to create parity with NHS pay (38) but the November 2020 spending review subjected care workers to a pay freeze.

SUMMARY

In practice there is no trade-off between protecting health and protecting the economy. Reducing the toll of the COVID-19 pandemic reduces the economic hit. It is critical that economic impacts are also understood as health impacts. Widening inequalities in wages and quality of work and growing unemployment will all widen economic inequalities in England, and health inequalities in turn. In many cases the geographical areas and groups of people who have experienced higher rates of infection and mortality from COVID-19 are now at risk from the health impacts of unemployment, poverty and low wages – the social care workforce being a case in point. Targeted support for wages and employment as part of a universal approach to fostering good quality and adequately paid employment will support health as well as livelihoods.

RECOMMENDATIONS

BOX 16. BUILD BACK FAIRER: CREATING FAIR EMPLOYMENT AND GOOD WORK FOR ALL

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

- Provide subsidies or tax relief for firms that recall previously dismissed workers.
- Extend the Coronavirus Job Retention Scheme to cover 100 percent of wages for low-income workers and self-employed workers who have lost work and wages.
- Enforce living wages so that the large number of workers who are currently exploited earn their entitlement.

CHAPTER 6

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

"Insufficient income is associated with poor long-term physical and mental health and low life expectancy" (1). The COVID-19 pandemic and associated containment measures have led to declining incomes and an increasingly precarious financial position for many, which has exacerbated already concerning levels of poverty, debt and financial insecurity in England. The last decade was marked by low and stagnating wage growth and increases in rates of poverty for people in work and for children. There were associated rapid increases in food poverty and homelessness. The introduction of the living wage did not prevent poverty among working people, while the new Universal Credit, limits to benefit entitlements and changes to the tax and benefit system were regressive and resulted in widening income and wealth inequalities. Incomes for wealthier people and regions increased markedly – buoyed by rising house prices and share values, and the relatively low levels of taxes.

BOX 17. SUMMARY OF INEQUALITIES IN STANDARDS OF LIVING AND INCOME (FROM 10 YEARS ON REPORT)

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

While the COVID-19 containment measures have had significant negative economic impacts for much of the population, the level of impact has varied considerably between households, according to prior socioeconomic position, region, occupation, age, ethnicity and disability (40). The impacts will lead to further widening of income inequalities in the UK. Pre-pandemic levels of income and poverty are directly related to the hardship experienced by increasing numbers of households during the pandemic. By the end of July 2020, around one in three people reported that they were unable to save for the year ahead (40) and there is evidence of increasing debt, poverty and risks of homelessness. Food poverty has been one of the most visible and immediate effects and reliance on food charity has increased from already high levels (41).

BOX 18. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN STANDARDS OF LIVING AND INCOME

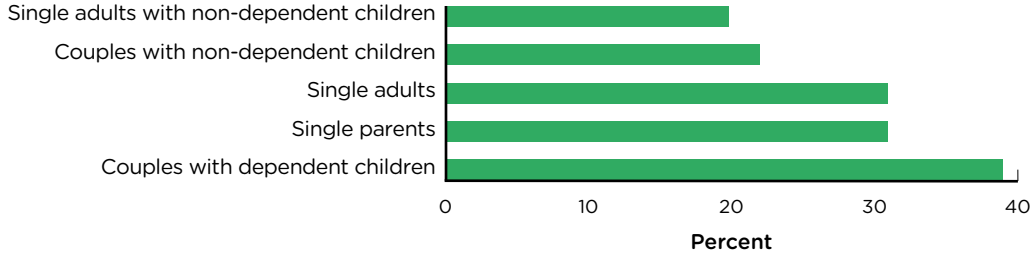
- Young people and BAME groups have been most affected by decreases in income.
- Poverty is increasing for children, young people and adults of working age.
- Increases to benefit payments have protected the lowest income quintile (the poorest) from the effect of decreases in wages, but have not benefitted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

INCOME

Household income (from all sources, including wages, benefits, assets and savings) fell in the UK in April 2020, following the outbreak of the pandemic. Changes to the benefits system, introduced to support households, did reduce the impact on the lowest-income groups, but when these changes are reversed in March 2021 there will be great financial and health harm to those groups. People on a low income but who are not reliant solely on benefits have experienced large declines in their income.

The declines in income since March 2020 have been unequal, and lower-income groups have lost a greater proportion of their income from earnings than better-off groups (40). A higher proportion of people earning less than £20,000 reported receiving a reduced income than those in the higher income brackets (40). Families with children have been particularly affected, figure 21. and this is leading to increases in child poverty and food poverty.

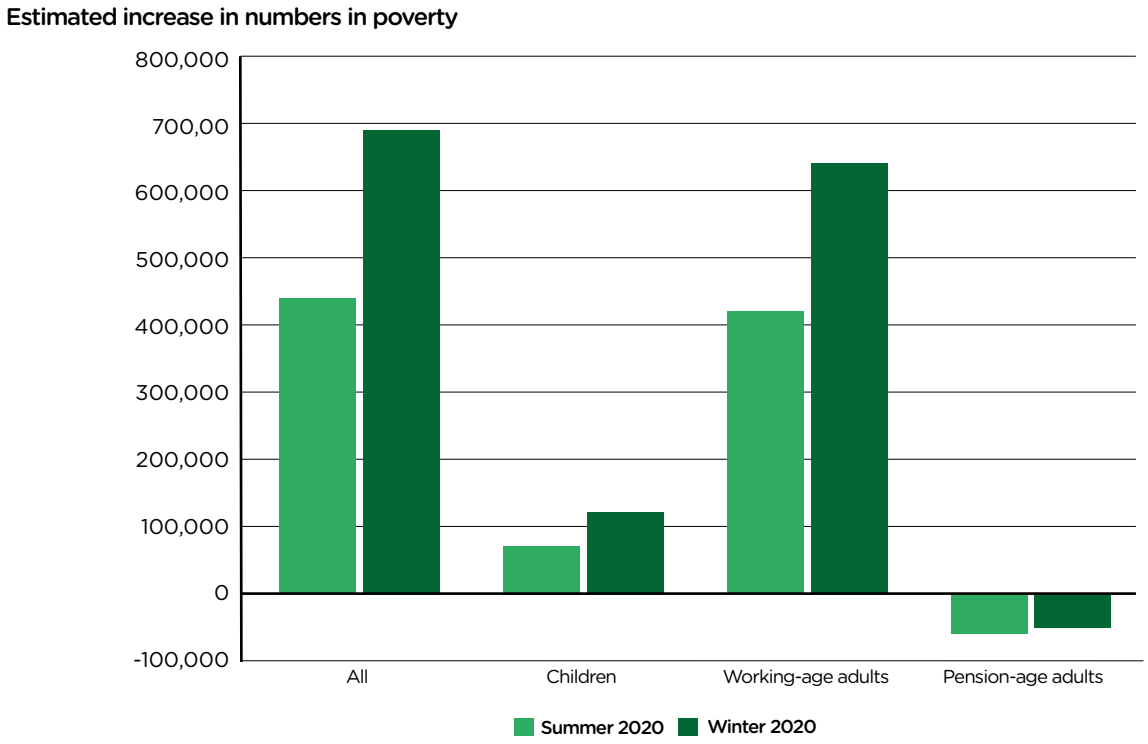
Figure 21. Proportion of those reporting their finances had been affected as a result of COVID-19 containment, by family household arrangement, Great Britain, May 2020



Note: *Finances that have been affected is defined as being furloughed, a fall in income, a reduction in hours worked, unemployment or redundancy.*
Source: *Based on data from StepChange poll (42).*

Data on poverty will not be published by the Department for Work and Pensions (DWP) until March 2021, but estimates show that there have been substantial increases in poverty rates this year. Estimates by the Legatum Institute indicate substantial increases from the start of the pandemic in the numbers of children and working households in poverty (43).

Figure 22. Changes in the number of people in poverty in summer and winter 2020, compared with 2018/19, UK



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

Source: *Legatum Institute, Family Resources Survey and HBAI dataset (1998/99 – 2018/19), IPPR tax and benefit model (43).*

The level – or depth – of poverty has also increased compared with before COVID-19 containment. In the UK, 270,000 more people are in the deepest form of poverty (50 percent-plus below the poverty line) and the number of people that are 25–50 percent below the poverty line has increased by 160,000. The highest increase has been for those that are 0–25 percent below the poverty line, at 370,000 more than before the pandemic (43). The Institute for Public Policy Research (IPPR) estimates that it is plausible that by the end of 2020 over 1 million more people, including 200,000 children, will be in poverty compared with a situation where the pandemic had not occurred, and that unemployment will stand at 9.8 percent. Increases in the numbers of people on low incomes and living in poverty will harm health and lead to widening health inequalities.

As described in *10 Years On* (1), there are wide variations in poverty rates by ethnic group and all minority ethnic groups had higher rates of poverty than White groups over the decade from 2010. BAME and migrant groups have been particularly badly impacted by loss of income and employment during the pandemic and are 1.3 times more likely to have experienced income loss (44) than the White UK-born population. Disabled people also have been disproportionately harmed by the economic impacts of containment and have been much more likely than non-disabled people to think that the crisis would result in them being in debt and that they were likely to run out of money.

COVID-19 AND INCOME PROTECTION FROM BENEFITS

Prior to the pandemic, reforms to social security over the decade had damaged the income of low-income families. The introduction of Universal Credit (UC), the two-child limit – the restriction of the child element in UC and tax credits to the first two children, the benefit cap and changes to tax credits, have significantly and negatively affected low- and middle-income households and children and widened income inequalities. This has penalised the poorest the most and caused increasing hardship (45) (1). The disproportionate impacts on more deprived families and regions of cuts to local government and reduced support for babies, children and families over the past 10 years were well documented in the *10 Years On* report (1).

Since March 2020, temporary Government support schemes have protected incomes and jobs for many including through the Coronavirus Job Retention Scheme (CJRS) (furlough) and increases to UC and to the Employment and Support Allowance. The lowest income quintile, which has experienced the largest decreases in earnings as a result of the pandemic at nearly 20 percent, have had the losses reduced by 16 percent through increased benefits, including a temporary increase of £20 a week in the standard allowance of UC. In the short term, this is a real achievement. If the increase to UC were to be made permanent, it would be hugely beneficial for the health of out-of-work families in England. Currently, 75 percent of recipients find that UC is too low to meet basic living costs (46).

UC claims were nine times higher than the usual number of claims made per week in the first two weeks of the first lockdown and 5.7 million people were receiving UC by 8 October 2020. Of these, 3.6 million were new claims since March (47). Figures from the DWP show that the numbers affected by the benefit cap, which limits the financial support available to £20,000 a year outside London and £23,000 a year in London, increased by 93 percent between February and May 2020 to 154,000 households (48); 62 percent of those whose benefits were capped in May 2020 were single-parent families. Capping benefits during the pandemic is leading to much higher levels of poverty, including food poverty and inability to pay rent. Many low-income households are having to borrow money to cover housing and other costs, including from family, on credit cards and from loan companies. Other coping strategies have included selling possessions and spending available savings.

WEALTH INEQUALITIES

As a result of COVID-19, inequalities in wealth will widen even beyond their high level pre-pandemic (1). One-third of families in the top income quintile saved more than usual in the first two months of the pandemic, whereas lower-income families were more likely to have taken on additional debt and 50 percent of people with savings under £1,000 had used them to cover everyday expenses (49). In *10 Years On* we assessed the wide and increasing regional inequalities in income and wealth. Between 2006 and 2018, and particularly from 2010 onwards, households in London and the South East rapidly increased their wealth (1). Average household wealth in South East England was 2.6 times the wealth of households in North East England by 2017/18. These regional inequalities have significant long-term impacts on inequalities in health between regions and will be exacerbated by the different extent of containment measures in different regions.

FOOD POVERTY

Among the most immediate impacts of containment and school closures have been rapid increases in food poverty and hunger. Prior to the pandemic, food insecurity was already of significant concern in the UK and the Trussell Trust found that an estimated 8–10 percent of households had experienced either moderate or severe food insecurity between 2016 and 2018. These levels have risen considerably during the pandemic as a result of loss of income, school closures and the additional costs of having children at home. During March to August 2020, four million people in households with children experienced food insecurity – 14 percent of households - up from 12 percent before the pandemic (50). In September 2020 the prevalence of food insecurity in Black and mixed ethnicity households with children was nearly 50 percent higher than in White ethnicity households with children (50). Households with either an adult or child with a long-term health problem or disability were also at much higher risk, over 40 percent of such households.

Campaigns by the footballer Marcus Rashford succeeded in persuading the Government to provide food vouchers to families with children currently in receipt of free school meals during school holidays. However, many families living with food insecurity do not receive free school meals or holiday vouchers, so to reduce hunger and food insecurity free school meals should be provided to all children in households on UC.

SUMMARY

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

RECOMMENDATIONS

BOX 19. BUILD BACK FAIRER: ENSURING A HEALTHY STANDARD OF LIVING FOR ALL

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

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

CHAPTER 7

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

The physical, economic and social characteristics of housing, places and communities have an important influence over people's physical and mental health and wellbeing, and inequalities in these are related to inequalities in health (1) (51). Pre-existing characteristics of communities shape their resilience to the social and economic impacts of COVID-19 containment measures. The levels and tiers of restriction will lead to further geographical variation. These differences will translate into wider inequalities in health between places.

Inequalities between places had been widening over the decade 2010–20. Cuts to local government over this period were regressive, with more deprived local authorities experiencing greater cuts than wealthier areas (1). From 2009 to 2020, net expenditure per person in local authorities in the 10 percent most deprived areas fell by 31 percent, compared with a 16 percent decrease in the least deprived areas. In North East England spending per person fell by 30 percent, compared with cuts of 15 percent in the South West. Cuts to public services were also regressive and negatively impacted more deprived areas the most. In some areas, which we call 'ignored places', by the start of 2020 deprivation was entrenched and deepening (1).

BOX 20. SUMMARY OF INEQUALITIES IN PLACES AND COMMUNITIES (FROM *10 YEARS ON* REPORT)

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

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

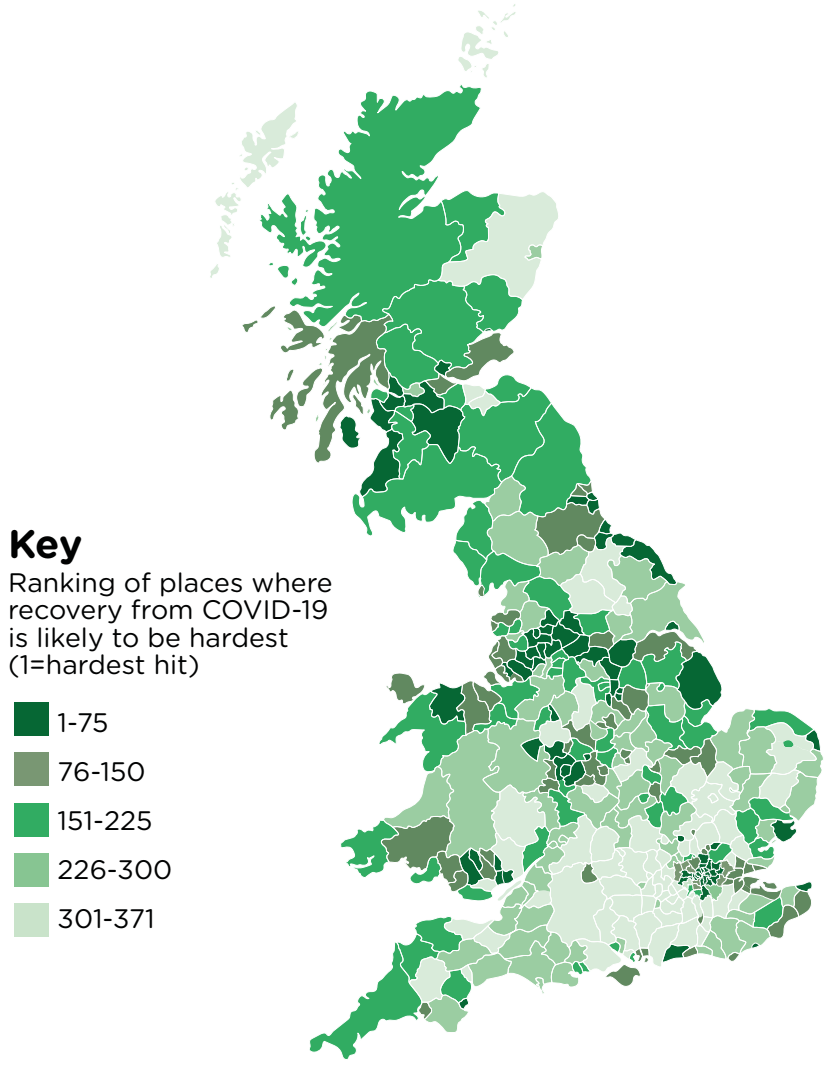
BOX 21. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PLACES AND COMMUNITIES

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

Places have been affected differently in terms of both infection and mortality rates from COVID-19, and the containment measures. Places that were already deprived and struggling before the pandemic are those that will have been most negatively impacted by the containment measures and will find recovery from the COVID-19 crisis more difficult and experience even greater deprivation and ill health after the pandemic.

The Joseph Rowntree Foundation (JRF) has ranked places in England, Scotland and Wales on how difficult job recovery from COVID-19 is likely to be (Figure 23). The analysis shows that it will be difficult in areas with pre-existing deprivation and low employment and in places with high employment in retail and travel and leisure, which have been hit hard by containment measures. Some areas, such as Greater Manchester, are experiencing both types of impact.

Figure 23. Ranking of Local Authorities in Great Britain where employment recovery from COVID-19 is likely to be hardest, July 2020



Note: *The ranking uses a combined score based on: the claimant count, the share of local jobs in shut sectors pre-COVID-19, and the share of people currently supported by CJRS. This is combined with almost real-time information on the number of jobs currently being created.*

Source: *JRF analysis of OBR Coronavirus analysis, Business Register and Employment Survey (via NOMIS), Institute for Employment Studies' Weekly vacancy analysis, and ONS claimant count and vacancies time series (52).*

LOCAL GOVERNMENT FINANCES

Local authorities are central to efforts to Build Back Fairer from the pandemic. However, their capacity to manage during the pandemic, and to support recovery afterwards, has been hampered by the cuts over the last 10 years. The regressive nature of those cuts had weakened the resilience of more deprived areas before the pandemic, contributing to conditions that have led to high rates of infection and mortality during it and will affect how areas are able to recover. Inequalities between places will widen.

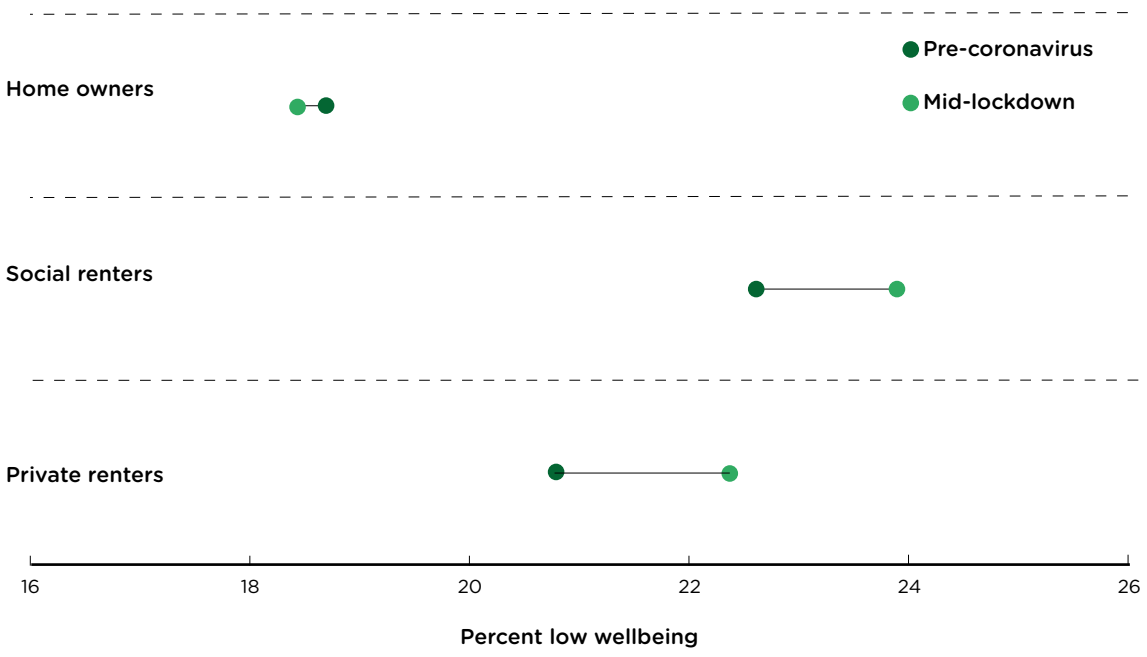
The Government has provided additional funding to local authorities to help them manage with additional pressures and funding shortfalls as a result of the pandemic. However, with reduced council and business tax revenue, the support from central government is insufficient and the outlook for local government revenues and spending in the coming years is bleak. Increased cost pressures and reduced revenues have left a shortfall of £2 billion in 2020–21. Without additional funding and/or flexibility over council tax rates, councils will have insufficient revenues to keep pace with rising spending needs. More deprived local authorities, which have a greater reliance on council tax revenues, and generate less revenue from business rates, are already underfunded and will experience even greater spending pressures in the coming years to deal with the impacts of COVID-19. Unless more funding is generated, local authorities in deprived areas will struggle to maintain basic services and meet statutory obligations, and inequalities in health and other outcomes will widen further still.

HOUSING

Housing is a critical determinant of health. Physical conditions of housing have direct and indirect impacts on health and poor conditions raise the risk of chronic diseases and infections and poor mental health. Overcrowded housing is associated with poor mental and physical health and is emerging as a high-risk factor for COVID-19 infection and mortality. Housing costs are also a key determinant of health as they push many households into poverty, causing both stress and mental health problems, while low incomes as a result of housing costs are associated with poor health.

During the COVID-19 pandemic, housing has become an even greater determinant of health and wellbeing. Over the lockdowns households have spent much of their time in their homes, and for some this has increased their exposure to unhealthy and overcrowded conditions and added to the stress of living in poor quality housing. Figure 24 shows that while all types of households have experienced declines in wellbeing during the lockdown, private renters experienced the largest declines in wellbeing. Inequalities in wellbeing related to housing have widened.

Figure 24. Percent of individuals reporting lower-than-usual levels of wellbeing on at least four of 12 General Health Questionnaire variables, controlling for personal characteristics, by tenure, UK, 2017–19 (pre-COVID-19) and April 2020 (mid-lockdown)

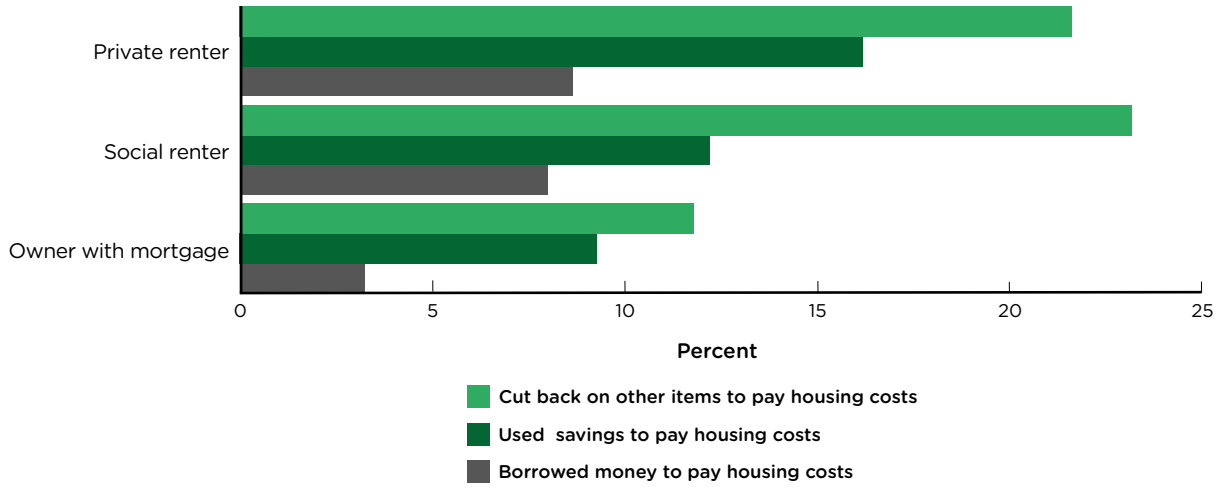


Source: *Judge L. Lockdown living: Housing quality across the generations, Resolution Foundation, 2020 (53).*

There are regional differences in housing quality, which will have impacted on experiences during lockdown. In the West and East Midlands, and Yorkshire and the Humber, more than one in five homes failed to meet the decent homes standard in 2017, dropping to 16 percent in the South East and 11 percent in the North East. Lockdowns have exacerbated health inequalities related to housing conditions. During lockdowns people with gardens, who tend to be more affluent and include relatively more White people than BAME people, were able to benefit from the significant positive impacts on health and wellbeing from being outside, and inequalities in access to outdoor spaces were exacerbated. Income and ethnic inequalities related to quality of indoor spaces became more pronounced.

As unemployment has risen and wages have fallen due to furlough, housing costs have become an even greater burden. Housing costs have remained high in England in 2020, as house prices have increased related to stamp duty reductions. In order to meet housing costs nearly one-fifth of private and social renters have cut back on other items and 16 percent of private renters and 12 percent of social renters have had to use their savings to pay the rent and some have borrowed money. Some people with mortgages have also cut back and used savings, although to a lesser extent.

Figure 25. Percent of working age adults taking action to meet housing costs since COVID-19 by housing tenure and type of action taken, September 2020, UK



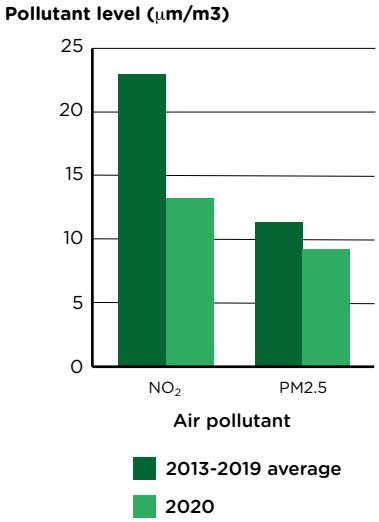
Source: *Resolution Foundation analysis of YouGov, UK adults aged 18–65 and COVID-19 – September wave (54).*

The economic impact from COVID-19 and associated difficulties in paying rent will lead to an escalation in homelessness. Between 2010 and 2017 in England, homelessness and rough sleeping rates increased by 165 percent. For a short while, the extraordinary circumstances of the pandemic led to decisive action by the Government on homelessness: in March 2020, the Government instructed and provided funding to local authorities across the UK to provide accommodation for people sleeping rough during the pandemic and almost 15,000 people in England were moved into safe emergency accommodation such as hotels early on (55). Help with benefits applications and medical prescriptions was also provided to homeless people. However, there have since been increases in rough sleeping and large rises in homelessness, including people living in temporary accommodation and sofa surfing and people who have lost their housing during lockdowns. Many support services have had to stop face-to-face work and move online, which has reduced access.

AIR POLLUTION AND GREENHOUSE GAS EMISSIONS

Among the more positive outcomes of the COVID-19 crisis have been reductions in the global rate of increase of emissions of greenhouse gases, and a reduction in local air pollution. Carbon Brief reported that global CO2 emissions declined by 17 percent in early April 2020, and cleaner air was reported across the UK – Figure 26.

Figure 26. Average levels of fine particulate matter (PM2.5) and nitrogen dioxide (NO_2) levels in the UK in the 100 days following the start of the first lockdown, compared with the 2013–19 average



Source: *Higham et al. (56).*

Reductions in air pollution, if they had been sustained, would have gone on to provide enormous health and health equity benefits. However, people are currently understandably reluctant to use public transport if they have an alternative and since the first lockdown road traffic and its associated pollution have bounced back. The cleaner air during lockdown did afford an opportunity to experience cities and towns with much reduced air pollution and quieter roads with more people walking and cycling. Building Back Fairer requires a sizeable reduction in private car use and greater active travel and use of public transport – which would also help to reduce greenhouse gas emissions and lead to a more sustainable environment, contributing to our stated goal of reaching net-zero by 2030, ahead of the UK's legislative goal of net-zero by 2050. Efforts to support these changes are required urgently.

SUMMARY

The COVID-19 pandemic and containment measures are creating widening inequalities in local environments and prospects for communities there. The pandemic has also caused an even more bleak financial outlook for local authorities, especially those which are more deprived. To avoid further cuts to services and quality of environments, additional funding will be needed, a greater share of which should be for more deprived local authorities. The unaffordability of much of England's housing for lower income groups are compounded by rising poverty and unemployment. Services for homeless people, including rough sleepers need greater support.

The clean air during lockdown did afford an opportunity to experience cities and towns with much reduced air pollution and quieter roads with more people walking and cycling. Building Back Fairer requires a sizeable reduction in private car use and greater active travel and use of public transport. Efforts to support this are required urgently and would help to reduce Greenhouse Gas Emissions and lead to a more sustainable environment.

RECOMMENDATIONS

BOX 22. BUILD BACK FAIRER: CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LONG TERM

- Invest in the development of economic, social and cultural resources in the most deprived communities.
- Ensure 100 percent of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
- Aim for net-zero greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.

MEDIUM TERM

- Increase deprivation weighting in the local government funding formula.
- Strengthen the resilience of areas that were damaged and weakened before and during the pandemic.
- Reduce sources of air pollution from road traffic in more deprived areas.
- Build more good-quality homes that are affordable and environmentally sustainable.

SHORT TERM

- Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls.
- Increase government allocations of funding to the voluntary and community sector.
- Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates.
- Remove the cap on council tax.
- Urgently reduce homelessness and extend and make watertight the protections against eviction.

CHAPTER 8

STRENGTHEN THE ROLE AND IMPACT OF ILL HEALTH PREVENTION: INEQUALITIES AND COVID-19 CONTAINMENT

In the *10 Years On* report, we did not focus specifically on health behaviours, but on the causes of these health behaviours – the social determinants of health. We assessed how best to implement action on the social determinants of health to reduce health inequalities. These principles for governance for health equity and principles for implementing action on health and their social determinants (summarised in Boxes 23 and 24) are highly relevant to managing public health through the pandemic and in the aftermath.

BOX 23. PRINCIPLES FOR GOVERNANCE FOR HEALTH EQUITY – FROM *10 YEARS ON*

1. Health equity is an indicator of societal wellbeing.
2. The whole of government is responsible for prioritising health equity in all policies.
3. Development of strategies and interventions must involve a wide range of stakeholders.
4. Accountability must be transparent with effective mechanisms.
5. Communities must be involved in decisions about programmes and policies for achieving health equity.

BOX 24. PRINCIPLES FOR IMPLEMENTING ACTION ON HEALTH INEQUALITIES AND THEIR SOCIAL DETERMINANTS – FROM *10 YEARS ON*

1. Develop a national strategy for action on the social determinants of health with the aim of reducing inequalities in health.
2. Ensure proportionate universal allocation of resources and implementation of policies.
3. Intervene early to prevent health inequalities.
4. Develop the social determinants of health workforce.
5. Engage the public.
6. Develop whole systems monitoring and strengthen accountability for health inequalities.

This report's remit is not to assess the Government's, the NHS's or Public Health organisations' efforts to manage and contain COVID-19 infections. We are, however, assessing how policies leading up to the pandemic laid the conditions for England's high, and geographically and socially unequal, mortality toll and set out how containment measures are leading to a deepening of health inequalities in England. We have made recommendations for immediate action to reduce widening inequities in the social determinants of health in order to mitigate the inequitable impacts of the pandemic.

In this section we assess how containment measures have affected the public's health and health inequalities and assess how Public Health organisations and their workforce need to be further focussed on reducing inequalities in the social determinants of health and strengthened in terms of capacity and funding. We make recommendations to refocus and strengthen public health in the wake of the pandemic to meet the challenge of reducing widening health inequalities and ensure that the new found prioritisation of public health is maintained.

The public's health and the public health workforce have been at the centre of the COVID-19 crisis in a number of ways, as summarised in Box 25.

BOX 25. SUMMARY OF COVID-19 CONTAINMENT IMPACTS ON INEQUALITIES IN PUBLIC HEALTH

- The priority and importance of public health has increased during the pandemic and public health is now a central concern of the public and Government, with a new focus on the importance of protecting and improving health in England.
- The longer-term health impacts of the containment measures are creating a new public health and health equity crisis.
- Inequalities in health behaviours and health have contributed to inequalities in COVID-19 mortality.
- There have been some significant changes in behaviours during lockdown – including potentially increased inequalities in smoking and obesity, increased consumption of alcohol, declines in mental health and increasing violence and abuse within households.
- We have set out the concept of the causes of the causes: health behaviours are causes of non-communicable diseases (NCDs); social determinants of health are causes of inequalities in these health behaviours. The causes of the causes of NCDs have to be addressed during the pandemic and as part of Build Back Fairer.
- Inequalities in health behaviours should also be a priority area for action.
- The Public Health system needs a strengthened focus on the social determinants of health. Deteriorations in these determinants as a result of containment measures make this focus even more critical.
- The Public Health system needs higher levels of investment and resourcing from central government – sustained cuts of 22% in real terms to the budget since 2015/16 have undermined action on health and health inequalities and will lead to worse health and higher inequality.
- Underfunding and planned reorganisation of Public Health organisations and workforce has undermined capacity to contain the pandemic and improve health through the containment measures.

The Marmot Review in 2010 looked at inequalities in health behaviours, which we related to conditions in the social determinants: smoking, obesity, alcohol harm and drug misuse are all higher in more deprived communities and areas. In that report and several other subsequent reports, we showed that many unhealthy behaviours are driven by the conditions in which people are born, grow, live, work and age – the social determinants of health. These social determinants are the causes of the causes of poor health. Stress associated with poverty, for instance, makes changing behaviours much harder and the cost and availability of healthy food is a major constraint among more disadvantaged communities.

PUBLIC HEALTH AND INEQUALITIES DURING THE PANDEMIC

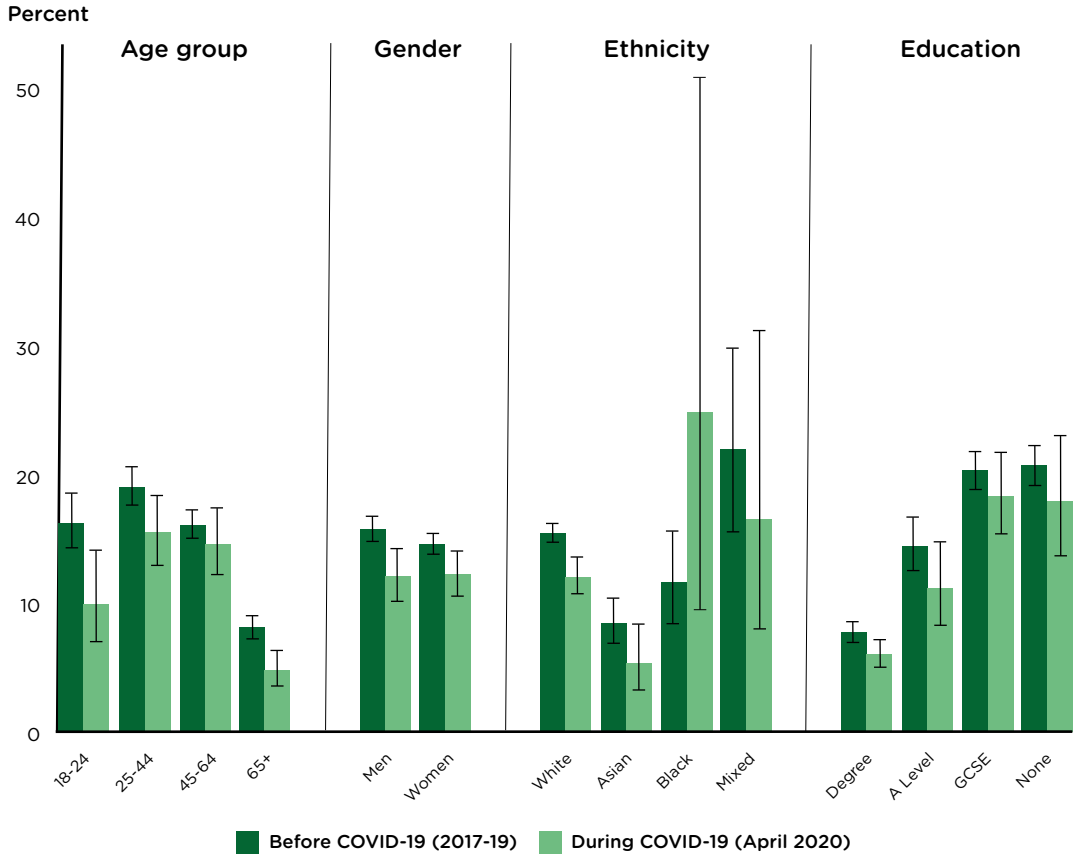
Public Health's overriding concerns during 2020 have been, quite rightly, about management and containment of the pandemic. While the challenges continue to be immense, there are also other concerns during this period and ongoing efforts by Public Health to improve health and reduce health inequalities.

Conditions in key social determinants of health have deteriorated and COVID-19 containment measures have resulted in some changes to health behaviours, increasing inequalities and concerning deteriorations in mental health.

SMOKING

Inequalities in smoking by social class have been well documented and reducing smoking rates in more disadvantaged communities continues to be a focus of Public Health efforts nationally and locally. Stress and anxiety have consistently been found to be risk factors associated with smoking (57; 58; 59), and stress and anxiety during the pandemic have been experienced disproportionately by more disadvantaged groups (60)(61). On the other hand, concerns about smoking and COVID-19 severity encouraged people to quit smoking. Although data is preliminary it suggests that cigarette smoking decreased during lockdown, except among those of Black ethnicity. The decrease in smoking was more apparent in younger age groups and men, shown in Figure 27 (62).

Figure 27. Percent smoking before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



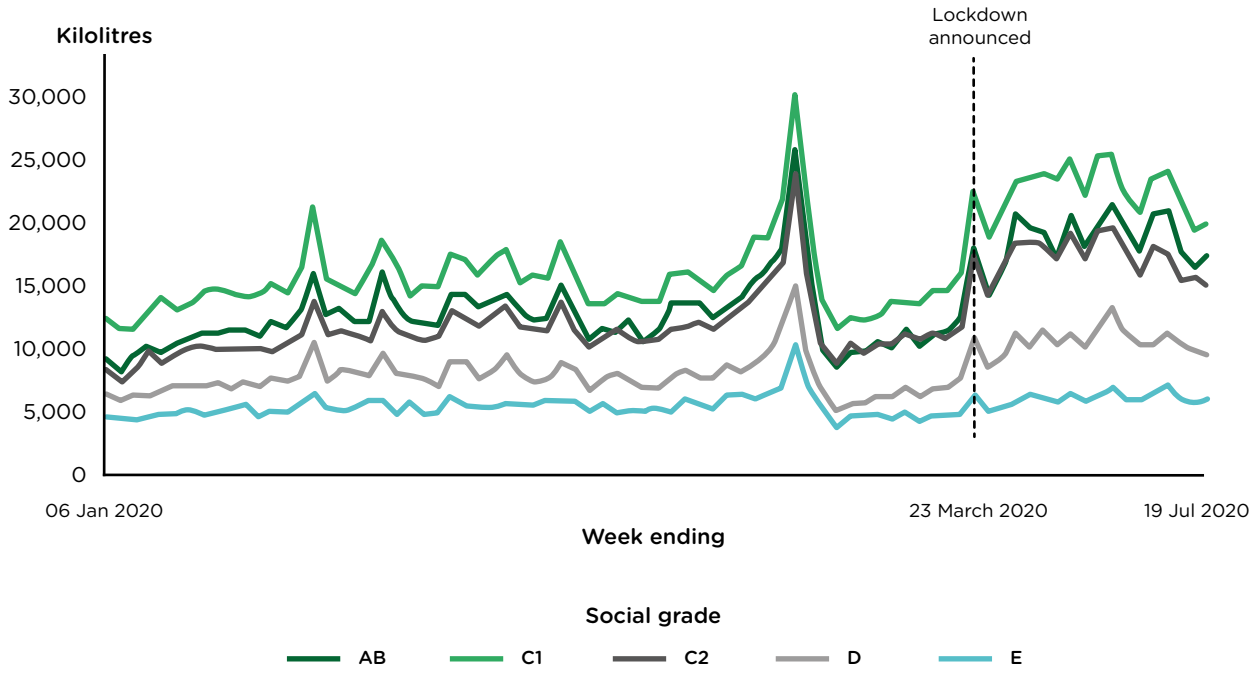
Source: *Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (62).*

When looking at smoking patterns across income groups, there was a decrease in the percent of respondents smoking in July 2020, when compared to the pre-COVID period for most income groups with the exception of those in the £10-20,000/year and £40,000-50,000/year income groups (63).

ALCOHOL

Alcohol consumption increased markedly in England during the lockdowns, particularly for those in social groups A, B and C1 (higher-income/-skilled). However, while alcohol consumption may be higher in those groups (Figure 8), harm from alcohol is disproportionately high among those in lower-income/-skilled groups – C2, D and E.

Figure 28. Trends in alcohol volume sales in Great Britain from 6 January to 19 July 2020, by occupational social grade

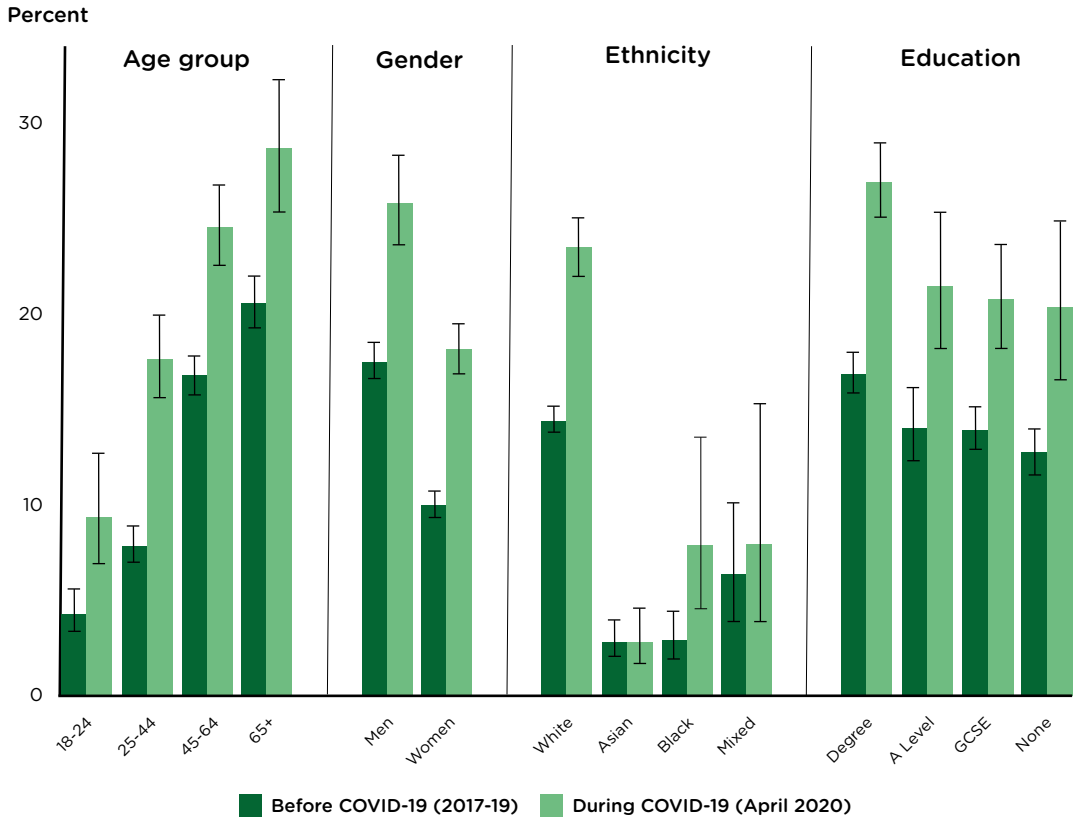


Notes: *AB = higher and intermediate managerial, administrative and professional workers, C1 = supervisory, clerical and junior managerial, administrative and professional workers, C2 = skilled manual workers, D = semi-skilled and unskilled manual workers, E = people on long-term state benefits, casual and lowest grade workers, unemployed with state benefits (including pensions) only.*

Source: *Institute of Alcohol Studies (2020) (64) based on PHE analysis of Kantar Worldpanel Data.*

Frequent drinking defined as the percent of people reporting drinking four or more times a week increased during lockdown. Differences by age group and gender were apparent and increased more among women, White ethnic groups and those with degree-level education, Figure 29 (65).

Figure 29. Percent with alcohol intake 4+ times/week before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



Source: *Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (62).*

OBESITY

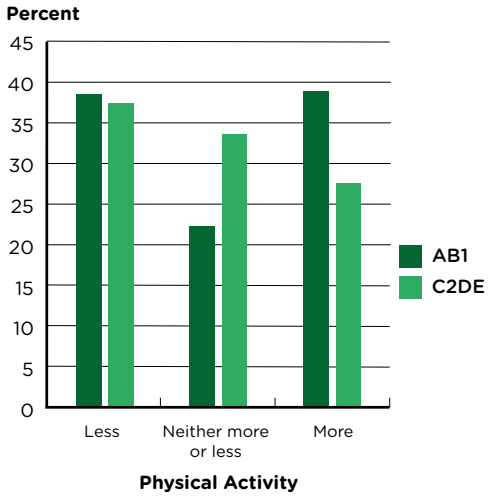
Obesity is a key health inequality issue and a risk factor for mortality from COVID-19. Obesity rates are higher among children and adults in more deprived groups compared with better-off groups, and analyses of 2018 data show that the prevalence of men and women who were obese increased with each level of deprivation (20).

While national data for levels of overweight and obesity during the period of COVID-19 containment are not yet available, there are studies and surveys showing inequalities may have risen and that those who are already obese gained relatively more weight (67). Data from a COVID-19 symptoms app show in every region users' weight had increased on average, but that increases in the South of England were lower than elsewhere (69).

A survey conducted during the first lockdown showed that being lower income, non-white, having a high-risk medical condition, a higher BMI and experiencing negative mental health symptoms were all associated with lower physical activity levels during lockdown (68).

Figure 30 shows differences in physical activity by social class during the first lockdown, showing adults in better-off social classes increasing their levels of physical exercise more than adults in lower-income classes.

Figure 30. Percent of adults doing more, less or the same amount of physical activity in England between 3 April and 11 May 2020, by social grade



Notes: *ABC1 (higher and intermediate managerial, administrative and professional workers, supervisory, clerical and junior managerial administrative and professional workers) C2DE (skilled manual workers, semi-skilled and unskilled manual workers, people on long term state benefits, casual and lowest grade workers, unemployed with state benefits (including pension) only) (63).*

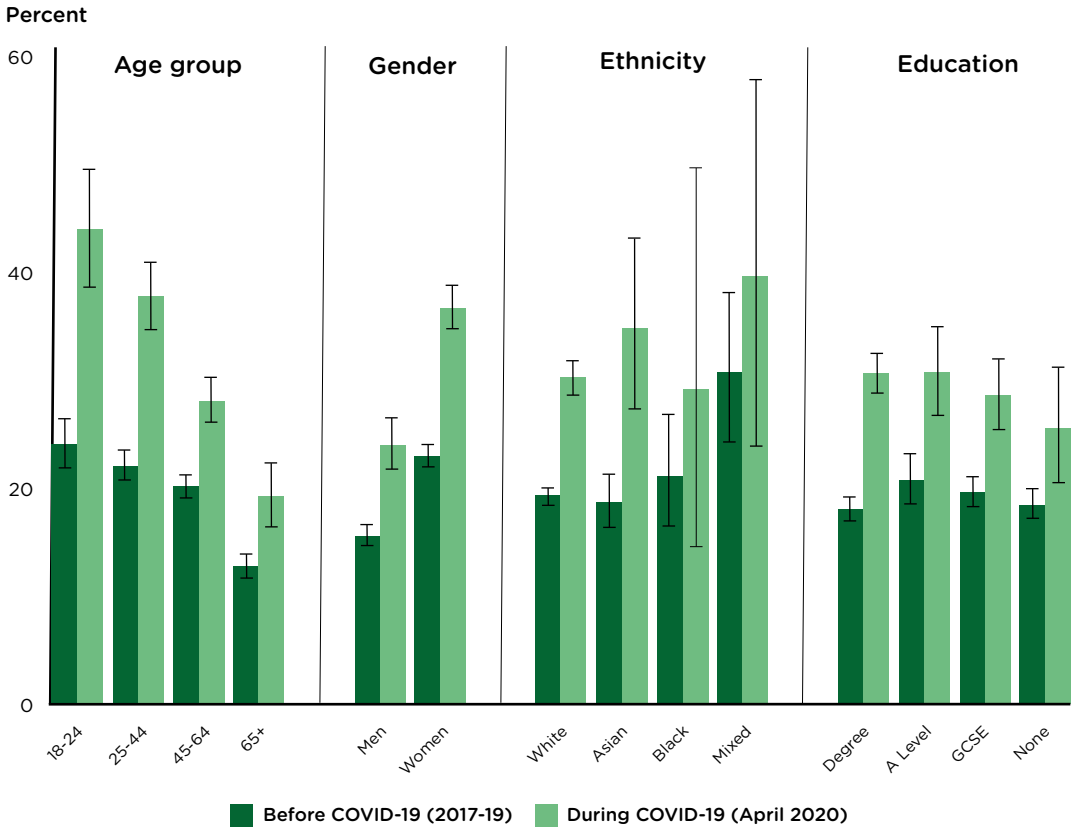
Source: *based on survey data from Sport England by Savanta ComRes as presented in PHE monitoring tool to look at the wider impacts of the COVID-19 pandemic on population health (63).*

MENTAL HEALTH

In the section on children and young people we outlined highly concerning increases in mental health problems and lack of access to appropriate services for young people since the start of the pandemic.

Levels of psychological distress worsened during the COVID-19 lockdown, according to the UK Household Longitudinal Study. Among the indicators measured, enjoyment of normal day-to-day activities showed the steepest decline. Worsening symptoms were also observed for concentration, sleep, feelings of unhappiness and loss of purpose (62). The overall increase in psychological distress was most pronounced among young people, as well as among those with higher educational attainment and among women. Among ethnic groups, those of Asian ethnic origin experienced the largest increase (Figure 31) (62).

Figure 31. Rates of psychological distress (GHQ-12) before (2017–2019) and during the COVID-19 lockdown (April 2020) by age, gender, ethnicity and education, longitudinal analyses of the UK Household Longitudinal Study



Source: *Niedzwiedz CL, et al Mental health and health behaviours before and during the initial phase of the COVID-19 lockdown, 2020 (62).*

Disabled people, many of whom have been self-isolating since the start of the pandemic and who are also experiencing increasing poverty and loss of employment, are reporting much higher levels of anxiety following the outbreak of the pandemic (70).

SOCIAL ISOLATION

The containment measures instigated in response to the virus exacerbated an existing problem to loneliness, 36 percent of survey respondents to wave 1 of Understanding Society COVID-19 Study stated feeling lonely (24-30 April 2020) (70).

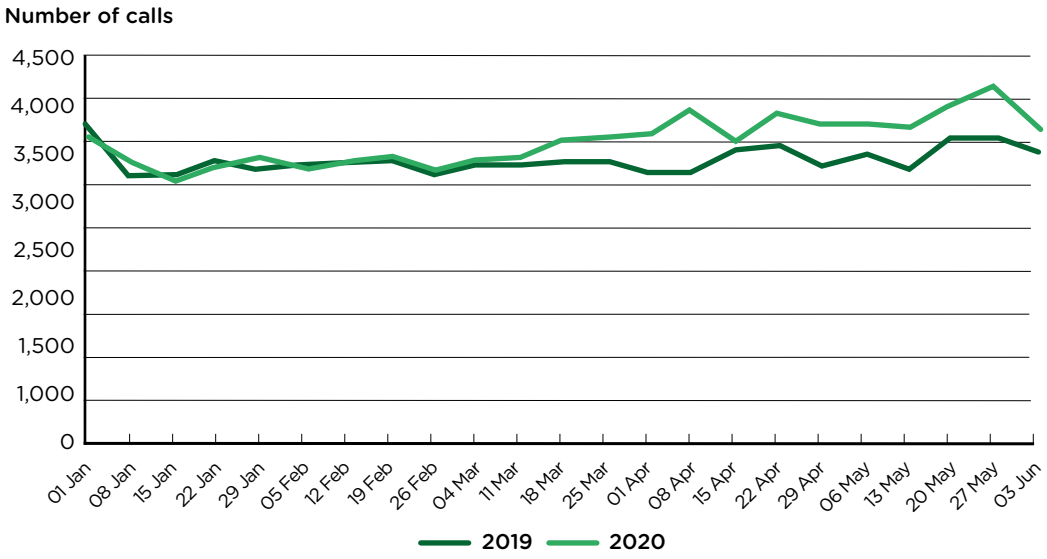
A study by Li et al investigated the prevalence of loneliness in the UK (in April 2020) by sociodemographic factors (70). Women had significantly higher odds of loneliness than men (Odds Ratio of 1.79), younger people had higher odds of loneliness compared to older people and those who do not live with a partner had higher odds of loneliness when compared to those who did live with a partner (Odds Ratio 3.22) (70). Fancourt et al. explored the risk factors for loneliness both before and during the pandemic and they found that the risk factors for loneliness were similar before and during the pandemic (71). Results showed similar groups at risk of loneliness to those in Li et al and their analyses found that those of lower education and on low income, were also at higher risks of being lonely (71). Students, who are usually not considered to be of high risk of loneliness, were identified as a new high risk group for loneliness during the pandemic (71).

VIOLENCE AND ABUSE

There have been many reports of increases in violence and abuse within households during lockdowns. Financial dependence and poverty are diminishing women's and children's resilience when experiencing domestic abuse and can prevent women from leaving an abusive partner (72).

Figure 33 shows that the London Metropolitan Police Service received a total of 41,158 calls-for-service for domestic incidents between 25 March (following the lockdown restrictions imposed on 23 March) and 10 June 2020 a 12% increase compared with calls over the same period in the previous year (73).

Figure 33. Weekly number of calls-for-service for domestic incidents, recorded by London Metropolitan Police Service, Greater London, 1 January to 10 June 2019 and 2020



Note: *Dates in the horizontal axis refer to date of when week commenced.*

Source: *Ivandic R. Changing patterns of domestic abuse during COVID-19 lockdown (73).*

COVID-19 containment measures such as lockdown and school closures increased the need for domestic violence support services. However, Women's Aid research showed that containment measures also restricted women's ability to access support services and support from friends, relatives and work colleagues (30).

PUBLIC HEALTH ORGANISATIONAL AND WORKFORCE CAPACITY AND FUNDING

Public health has been at the forefront of efforts to reduce infection and mortality from COVID-19 and trying to continue essential work to improve health and reduce inequalities in health in hugely difficult circumstances. In the decade before the pandemic, funding for public health declined and a series of major reorganisations took up organisational capacity, leaving public health systems and workforces without the necessary funding, resources and capacity.

The Public Health grant has been reduced substantially over the last decade, and despite an increase of £80 million in 2020/21, it is now 22 per cent lower in real terms compared with 2015/16. Restoring real-terms per capita spending to the same levels as 2015/16 would require the equivalent of an additional £0.9 billion a year (74). Meanwhile, the regressive cuts to public services and local authority grants over the last decade have undermined health and health equity and had a hugely negative impact on services that support health such as education, youth services, social care, housing, transport, leisure centres and green spaces (75). While spending on health care is projected to increase, public health funding is still woefully inadequate, with further cuts planned (3). As the president of the Association of Directors of Public Health stated in November 2020:

> "COVID-19 has shone a light on the knowledge, expertise, and skills of Directors of Public Health and their teams. In the current circumstances, and following years of cuts to local public health, it is completely incomprehensible that the Government is not increasing the public health grant. … During 2021–22, local public health teams will continue to have a key role in the management of COVID-19 – and being prepared for any future epidemics. In addition, if we are serious about learning the lessons of how existing health inequalities have driven and exacerbated the impact of COVID-19, we must address the socio-economic determinants of health and invest in local public health teams." (76)
>
> **President of the Association of Directors of Public Health**

The decision to reorganise public health at the national level in 2021 will undermine public health leadership focus and capacity at a time when it is needed more urgently than ever. Existing public health organisations need further support and a stronger focus on social determinants of health and health inequalities. As we said in *10 Years On*:

> "It is imperative that the Government, NHS England, PHE and other organisations charged with reducing health inequalities, work more effectively to improve the conditions in which people are living, and the structural drivers of these conditions, as well as positively influencing the choices that people make about health behaviours. The Government has the evidence about the overwhelming impacts of social determinants on health but it has largely not acted on it and certainly not at sufficient scale (1)."
>
> **10 Years On report**

These imperatives are even more critically important during, and following, the pandemic, as the country struggles with the health impacts of containment measures. Underfunding and undermining capacity of public health run completely counter to meeting these challenges.

SUMMARY

Public Health organisations and workforce must be at forefronts of efforts to contain the pandemic, while continuing efforts to improve health and reduce health inequalities. These efforts are undermined by insufficient government funding and planned reorganisations and weakening of public health leadership. As we have documented throughout the report, health in England was already in a poor state before the pandemic and the pandemic and associated containment measures are further damaging health and significantly increasing health inequalities. For these deteriorations to be reversed it is essential to have a better resourced, flourishing Public Health system. Without this it will be impossible for England to build back fairer.

Action on the social determinants of health is necessary to reduce health inequalities. Hence, we have set out the need for an Inequalities Strategy to be at the centre of recovery from the pandemic, which should involve the whole of Government, and be led by the Prime Minister. Public Health has a crucial role, centrally and locally in providing the expertise, helping shape policies, monitoring and evaluation. The pandemic has reemphasised the importance of Public Health experts' clear and effective communication with the public. While there has been a welcome focus on social determinants among Public Health systems in recent years, this still needs to be strengthened.

RECOMMENDATIONS

RECOMMENDATIONS – BOX 25. BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LONG TERM

- A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health.
- Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities

MEDIUM TERM

- Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities.
- Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.

SHORT TERM

- Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient
- Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

CHAPTER 9
CONCLUSIONS

In 2017, Hurricane Maria hit Puerto Rico. Two months afterwards, mortality had risen – but far from uniformly: it shot up sharply for the lowest socioeconomic group, increased somewhat for the middle group, but the highest socioeconomic group saw far less impact (77). A huge external shock had thrust the underlying inequalities in society into sharp relief. So it has been with COVID-19 – a central message of this report. Documenting the pandemic's impact on inequalities in the social determinants of health, and in health, is a first step to achieving a more important goal: to Build Back Fairer. To do this, it is necessary to have the evidence of what has gone wrong and how to put it right.

In February 2020 we published Health Equity in England: The Marmot Review 10 Years On, a review of what had happened to health and health inequalities in the decade since the publication of the 2010 Marmot Review, Fair Society, Healthy Lives (78). The picture was bleak: stalling life expectancy, rising health inequalities between socioeconomic groups and regions, and life expectancy declining for people in the most deprived areas. We made a series of recommendations, addressing the social determinants of health, for how things could and should improve.

Since then, with the COVID-19 pandemic, the world has changed dramatically. But in England the changes have been entirely consistent with its existing state when the pandemic hit in February. We set out at the beginning of this report the proposition that England's comparatively poor management of the pandemic was of a piece with England's health improvement falling behind that of other rich countries in the decade since 2010. We offered four likely reasons why: the quality of governance and political culture which did not give priority to the conditions for good health; continuing increases in inequalities in economic and social conditions, including a rise in poverty among families with children; a policy of austerity and consequent cuts to funding of public services; and a poor state of the nation's health that would increase the lethality of COVID-19.

Addressing all of these needs to be at the heart of what needs to change if we are to build a fairer, healthier society as we emerge from the pandemic.

One striking feature of health in the time of COVID-19 is the high mortality rate of members of Black, Asian and minority ethnic groups. Much of this excess mortality can be attributed to living in more deprived areas, working in high-risk occupations, living in overcrowded conditions and, in the case of Bangladeshi and Pakistani groups, a greater prevalence of relevant pre-existing conditions. Structural racism means that some ethnic groups are more likely to be exposed to adverse social and economic conditions, in addition to the everyday experiences of discrimination – causing a "robbery of resilience", as Marvin Rees, the Mayor of Bristol, put it. The spreading of the Black Lives Matter protests to the UK has raised the visibility of these issues. Building Back Fairer will entail addressing this fundamental cause of social injustice, in addition to the social and economic inequalities that are so pervasive.

With vaccines coming on stream there is talk of getting back to 'normal'. As our *10 Years On* report made clear, 'normal' is not acceptable, if that means where we were in February 2020. The pandemic must be taken as an opportunity to build a fairer society. In Building Back Fairer we must accept the growing recognition, worldwide, that economic growth is a limited measure of societal success. We note the example of the New Zealand Treasury which in its 2019 policy statement put wellbeing at the heart of its government's mission.

Building a society that puts fairness at the heart of policy-making, from birth – equity from the start – through every stage of the life course, to flourishing later life, means building a society that no longer fares poorly by comparison with other rich countries. Whether it is ranking only 27th out of 38 countries on child wellbeing or having the slowest improvement in life expectancy of any rich country bar Iceland and the USA, or having the highest excess mortality in Europe during the COVID-19 pandemic, or having unacceptably high social and ethnic inequalities in health, we can do better.

But the problems we lay out here are not unique to England. In the USA, for example, both the widening economic inequalities and the high mortality associated with race and ethnicity are much in evidence. It was estimated that, from March to September 2020, the wealth of the United States' 643 billionaires increased by 29 percent. Over the same period the hourly pay of the bottom 80 percent of the workforce declined by 4 percent. The inequalities in the UK may be less dramatic than that, but how is that gross level of inequality compatible with a fair and healthy society? The answer is: it is not. In the UK, with the NHS, inequities in access to health care are not compounding the race/ethnicity disadvantage on anything like the scale that they are in the USA and elsewhere.

Fortunately, England, and the other countries of the UK, are blessed with having a strong scientific tradition and excellent high-quality data. We have drawn on these in this report. The scientific approach taken here has benefited from evidence from around the world. The insights could flow the other way, too. The evidence we have compiled here for England will have relevance more broadly.

We suggest that to Build Back Fairer we need commitment at two levels. First is the commitment to social justice and putting equity of health and wellbeing at the heart of all policy-making, nationally, regionally and locally. The pandemic has shown that when the health of the public is severely threatened, other considerations become secondary. The enduring social and economic inequalities in society mean that the health of the public was threatened before and during the pandemic and will be after. Just as we needed better management of the nation's health during the pandemic, so we need national attention to the causes of the causes of health inequalities.

The second level is to take the specific actions needed, as we lay out in this report, to create healthier lives for all.

This report has not dealt with the climate crisis. But as we stated at the outset, there is a companion report from the Institute of Health Equity, commissioned by the Government's independent advisory body, the Committee on Climate Change: Sustainable Health Equity: Achieving a Sustainable UK (2). The recommendations in that report are consistent with those contained here. To build back fairer, society needs to deal both with inequalities and with the climate crisis.

It is worth, perhaps, dealing with two objections. The first is money. Reversing the cuts to Children's Centres, to per-student funding in schools, to local governments, to the health service will take public spending. So, too, will paying care workers a living wage and having more generous safety nets that do not consign people and their families to dire poverty. At a time of huge national debt, can the country afford it? Britain has tried the austerity experiment, in the decade from 2010. It did not work, if health and wellbeing are the markers of success. Phrases like "maxing out the nation's credit card" are neither helpful nor based on sound economics. At a time of zero interest rates, with a tax rate that is at the low end among European countries and with control of its own currency, a nation can borrow for the purpose of building a better society. We should not be asking if we can afford for our children's wellbeing to rank better than 27th out of 38 countries, or to pay for free school meals during holidays so that eligible children do not go to bed hungry. Social justice requires it.

A second objection is that people make their own choices. Much of the ill health of the poor, it is argued, can be traced back to the poor choices they make. We have refuted this elsewhere (78). The evidence suggests that poverty leads to poor choices; not poor choices to poverty. For example, we have cited data from the Food Foundation that households in England in the bottom 10 percent of household income would need to spend 74 percent of household income on food were they to follow official healthy eating advice. We repeat: the problem is not poor 'choices'; the problem is poverty. During the pandemic this has become even more clear. Frontline workers were at high risk because they were doing essential work. People did not feed their children well not because they were spending money on the wrong things, or because they hadn't taken cooking classes, but because they lost their jobs. The rhetoric of the "undeserving poor" as justification for harmful social policies should have no place in Building Back Fairer.

We end this report on a hopeful note. The evidence is clear. There is so much that can be done to improve the quality of people's lives through the life course. Inequalities in health is a tractable problem. It is in all our interests to Build Back Fairer.

BOX 2.3. IN SUMMARY:

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

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

LONG TERM

Reduce inequalities in early years development as a priority for government

MEDIUM TERM

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

SHORT TERM

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

BOX 3.4. BUILD BACK FAIRER: REDUCING INEQUALITIES IN EDUCATION

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

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

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

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

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

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

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

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

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

LONG TERM

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

MEDIUM TERM

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

SHORT TERM

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

BOX 7.3. BUILD BACK FAIRER: CREATING AND DEVELOPING HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

LONG TERM

- Invest in the development of economic, social and cultural resources in the most deprived communities.
- Ensure 100 percent of new housing is carbon-neutral by 2030, with an increased proportion being either affordable or in the social housing sector.
- Aim for net-zero greenhouse gas emissions by 2030, ensuring inequalities do not widen as a result.

MEDIUM TERM

- Increase deprivation weighting in the local government funding formula.
- Strengthen the resilience of areas that were damaged and weakened before and during the pandemic.
- Reduce sources of air pollution from road traffic in more deprived areas.
- Build more good-quality homes that are affordable and environmentally sustainable.

SHORT TERM

- Increase grants for local governments to deal with the COVID-19 crisis to cover immediate short term funding shortfalls.
- Increase government allocations of funding to the voluntary and community sector.
- Increase support for those who live in the private rented sector by increasing the local housing allowance to cover 50 percent of market rates.
- Remove the cap on council tax.
- Urgently reduce homelessness and extend and make watertight the protections against eviction.

BOX 8.4. BUILD BACK FAIRER: STRENGTHENING THE ROLE AND IMPACT OF ILL HEALTH PREVENTION

LONG TERM

- A National Strategy on Inequalities led by the Prime Minister, to reduce widening social, economic, environmental and health inequalities. This should be a high priority for government policies and public investments. A major benefit of this strategy will be to reduce inequalities in the social determinants of health to reduce inequalities in health.
- Build a Public Health system that is based on taking action on the social determinants of health and reducing health inequalities

MEDIUM TERM

- Develop social determinants of health interventions to improve healthy behaviours and reduce inequalities.
- Public Health to provide the expertise to inform development of a whole of government health inequalities strategy.

SHORT TERM

- Funding for Public Health to be at a level of 0.5% of GDP with spending focused proportionately across the social gradient
- Public Health needs to develop capacity and expand focus on social determinants of health. The pandemic highlights how poverty, deprivation, employment and housing are closely related to health, including mortality from COVID-19 and impacts from containment.

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