The pandemic divide: how COVID-19 has increased health inequalities

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Rather than being a greater leveller, the pandemic has exacerbated pre-existing inequalities, hitting people on lower incomes and those from ethnic minority backgrounds hardest

The coronavirus (COVID-19) pandemic has affected hospital care for millions of people across England. This has led to rising waiting lists for routine care and increasing concerns about the consequences of missed treatment. However, the full picture is far more complicated – and far from equitable. Our recent research shows people living in the nation's poorest areas and those from Black, Asian and Minority Ethnic (BAME) backgrounds have experienced the most disruption to hospital care from cancelled and delayed hospital appointments. Why is this?

It is essential we understand how the pandemic has compounded existing health inequalities – and, importantly, what we as a society must do to counter these issues.

Even before the pandemic hit, the UK was already falling behind comparable countries on life expectancy. In addition, *Health Equity in England: The Marmot Review 10 Years On* highlighted large and growing gaps in health between different communities. Before COVID-19, there was a gap of nearly 10 years between life expectancy in the most and least deprived communities. In 2017, then-Prime Minister Theresa May launched a grand challenge to increase healthy life expectancy (while closing the gap between the richest and the poorest). Yet, healthy life expectancy has continued to fall and the health inequalities gap continues to grow.

The COVID-19 pandemic has had profound effects on healthcare systems around the world, including the UK's National Health Service (NHS). As a result of a reorganisation of services and changes in the care needs and care-seeking behaviour of patients, the use of hospitals in England changed drastically during the height of the pandemic.

The unequal impact of hospital disruption

Our research found elective (planned) hospital admissions fell by a third (nearly three million) between March and December 2020, while outpatient appointments and non-COVID-19 emergency inpatient admissions dropped by a fifth (over 17 million and one million respectively).

But these declines in admissions were not shared equally. People living in areas with the largest share of people from BAME backgrounds experienced a 37 per cent larger reduction in non-COVID-19 emergency admissions than those with the smallest proportion of people from BAME backgrounds. In addition, people living in the most deprived areas of the UK (of any ethnicity) experienced a larger fall in elective admissions.

Unfortunately, we can't yet distinguish the factors driving these changes in demand for healthcare. One potential explanation is that areas with higher shares of ethnic minorities had higher rates of COVID-19 infections or hospitalisation rates. As a result, potential patients in these areas stayed away (or were told to stay away) from hospitals. However, our findings did not substantially change when controlling for different measures of local COVID-19 rates, suggesting differences in infections and hospitalisation were not the driving factor behind differences in care loss.

> People living in the most deprived areas of the UK (of any ethnicity) experienced a larger fall in elective admissions

Nevertheless, our results do suggest these differences were not just driven by changes made by hospitals, such as cancelling appointments or raising admission thresholds. Large reductions in the use of emergency care in BAME communities, but not elective admissions, suggests these differences were, at least in part, driven by changes in patient behaviour. We know decisions made by hospitals would be more likely to have affected planned admissions, since they are often less urgent, and consequently easier and safer for hospitals to postpone.

This is consistent with survey evidence that ethnic minorities have been more likely to avoid seeking care during the pandemic. Understanding what drove these changes remains an important area of future research.

Ultimately, however, our findings underscore the need to increase available resources to address care backlogs and to direct resources to the people, local areas and groups that have been most affected. This is perhaps one of the greatest public policy challenges facing the country.

Where should we go from here?

There is no quick fix to tackling health inequalities, but making progress is vital for post-pandemic recovery and for the government to deliver on its commitment to levelling up the poorest parts of the country.

While the government has committed to increasing funding for healthcare, our research suggests there also need to be changes in how this money is allocated across communities. One way to do this is to change the funding formulae used by the government and to allocate more resources for healthcare in areas with higher proportions of low income and ethnic minority patients. Existing formulae do adjust for need, but these formulae have not changed since the pandemic.

However, the NHS cannot reduce inequalities on its own. The last 10 years have seen major cuts to local authority funding, which provides services that are both important to tackling health inequality and in the fight against inequality. A wider focus is needed to address the root causes of ill health and inequality. This means

strengthening education and employment opportunities, ensuring the social security system allows individuals on a low income to have access to decent housing and to buy healthy foods, as well as improving the environment of many deprived communities.

> Ethnic minorities have been more likely to avoid seeking care during the pandemic

In response to the pandemic, the government stated it wanted to operate in a much more collaborative way to improve outcomes. We need to build on this approach by developing a cross-government health inequalities strategy.

Even before the pandemic, we knew too many people from the poorest areas and BAME backgrounds were falling through the gaps. We have an opportunity to focus on these groups who we know struggled before and during the pandemic, and work with them to build much more effective and inclusive systems. The government's plan to "build back better" must mean "build back better for all".

This article draws on findings from "Socioeconomic Deprivation and Ethnicity Inequalities in Disruption to NHS Hospital Admissions During the COVID-19 Pandemic: A National Observational Study" by Max Warner, Samantha Burn, George Stoye, Paul A. Aylin, Alex Bottle and Carol Propper (Imperial London).

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About Carol Propper

Chair in Economics
Professor Dame Carol Propper is Chair in Economics and a member of the Centre for Health Economics & Policy Innovation. In 2010, she was awarded a CBE for her services to social science. She was elected as a Fellow of the British Academy in 2014, and made an International Fellow of the US National Academy of Medicine in 2018. In 2019, she was elected President of the Royal Economic Society. She was made a dame in the 2021 New Year's Honours for her contribution to economics and public health.

Read Carol's Imperial Profile for more information and publications.

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