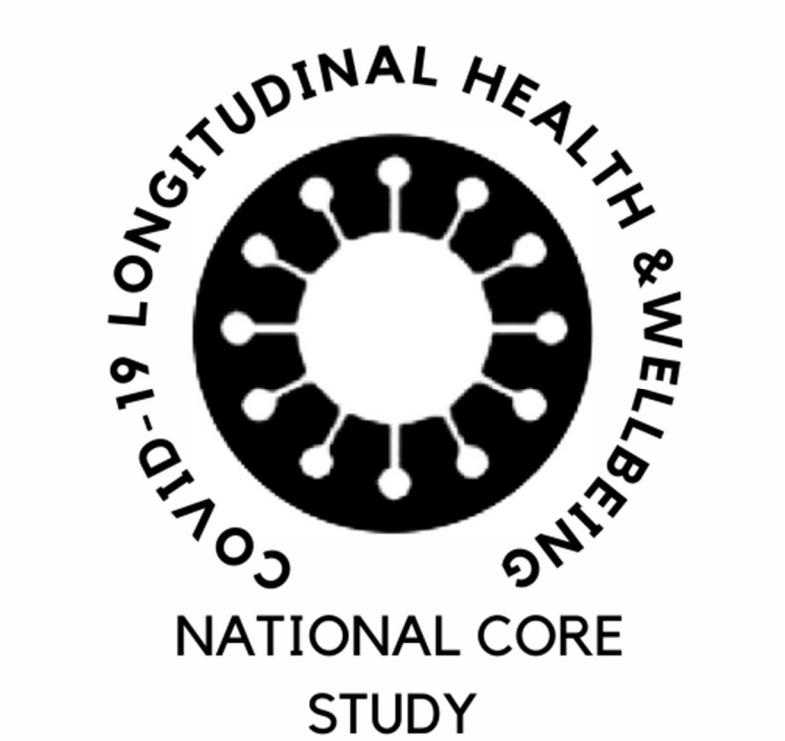
COVID-19 Longitudinal Health and Wellbeing National Core Study

Research Theme	**ARQ3 Healthcare Disruption**
Report Title	Inequalities in healthcare disruptions during the Covid-19 pandemic: Evidence from 12 UK population-based longitudinal studies



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Research Team	Jane Maddock, Sam Parsons, Giorgio Di Gessa, Michael J. Green, Ellen J. Thompson, Anna J. Stevenson, Alex S.F. Kwong, Eoin McElroy, Gillian Santorelli, Richard J. Silverwood, Gabriella Captur, Nish Chaturvedi, Claire J. Steves, Andrew Steptoe, Praveetha Patalay, George B. Ploubidis, Srinivasa Vittal Katikireddi
NCS Directors	Professor Nish Chaturvedi Professor Jonathan Sterne

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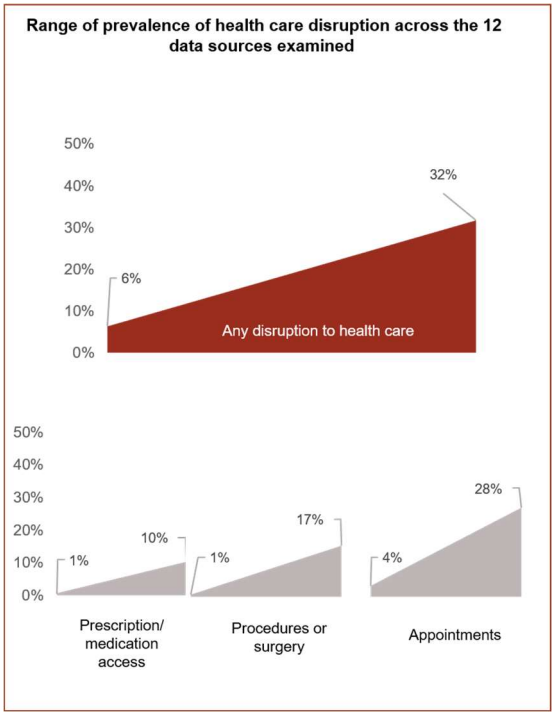
Summary

- Between 6% and 32% of the population reported some disruption to their healthcare since March 2020
- Disrupted access to medical appointments was most common, followed by disruptions to medication access and disruptions to planned procedures or treatments.
- Disruptions were more commonly reported by women, older adults, non-White ethnic minorities, and those in disadvantaged occupations; groups who already tended to experience worse health before the pandemic.
- These groups need to be prioritised as healthcare services resume and attempt to deal with the backlog of care that has been disrupted or postponed during the pandemic.

Key Findings

We examined inequalities in reported disruptions to healthcare across 12 UK population studies, covering over 68,000 adults. The proportion reporting any disruption ranged between 6% and 32% across the different surveys. Differences in reported proportions likely reflect differences in the ages of respondents sampled, sample non-response, and the questions asked. Disruptions to medical appointments (such as being able to see a GP) were most common (proportions ranged from 4-28%), followed by disrupted access to medications (1-10%) and disruptions to planned treatments or procedures (1-17%).



We examined inequalities in reported disruptions by age, gender, ethnicity, social class and education. Females were more likely to report healthcare disruptions than males, especially at younger ages (<55 years) and for all types of disruption. Older adults were especially likely to report disruptions to medical appointments and procedures and surgeries compared to their younger counterparts. Ethnic minority (excluding White minorities) groups were more likely to report healthcare disruption compared to White respondents, and this difference was higher among those who were shielding. Black ethnic minority groups had the most clearly increased odds of disruption compared to White ethnic groups. Among working age people (i.e. 25-64 years), occupational class was also found to be associated with healthcare

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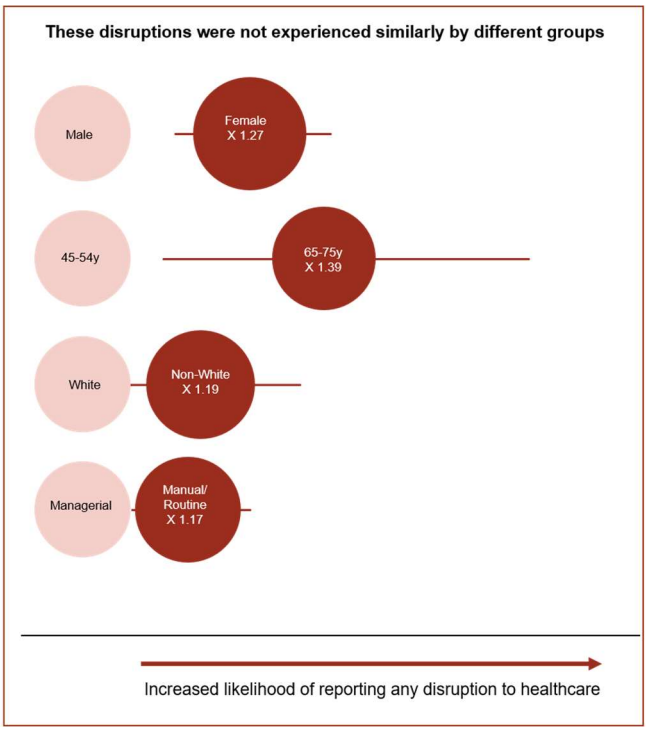
disruption with those in a routine/manual occupation experiencing more healthcare disruption than those in managerial/professional occupations. No clear association between education and healthcare disruption was found. Although the size of the differences differed, these inequalities were consistently observed across most datasets.



Policy implications

These groups were known to be disadvantaged in terms of healthcare access before the pandemic. Our findings show this has still been true during the pandemic, though the scale of disruption has likely increased. Delays and disruptions to treatment could have ongoing implications for patients' physical and mental health, so these disruptions have clear potential to maintain or even exacerbate existing health inequalities. Action is needed to remedy these inequalities, and efforts to ensure continuity of care during pandemic-related disruptions may need to be more clearly targeted to those who most need that care. As healthcare access resumes, given the forgone delays in treatments and the subsequent backlog of postponed surgeries, targeted support may be required for these groups to address unmet needs experienced during the pandemic.

Future Work

Future work which confidentially brings together information from these longitudinal studies with administrative health records will allow us to explore how people's experiences of disruption might be related to health outcomes.