Commission on Health and Prosperity

VACCI-NATION

A CASE STUDY IN HEALTH AND PROSPERITY

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ABOUT THIS PAPER

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SUMMARY

Vaccines have been integral to health and prosperity in the last three centuries. Alongside clean water, antibiotics and better sanitation (Greenwood 2014), vaccines have been among the most impactful interventions in the history of public health. They are recognised as one of the most effective and cost-efficient interventions ever created and are estimated to save millions of lives every year (De Pol 2022). Routine vaccinations have eliminated the deadly effects of viruses on a global scale, such as smallpox in 1980 (WHO 1980) and polio (in all continents except Asia, WHO 2020).

The Covid-19 vaccination has again demonstrated the value of vaccines – to lives, livelihoods, and national prosperity. The Covid-19 vaccination programme is the biggest and most complex vaccine programme in UK history. In December 2020, the UK became the first nation to approve and administer a Covid-19 vaccine. Vaccine targets for adults exceeded NHS England's expectations and, as of today, over 50 million people have received two doses of the Covid-19 vaccine across the UK (Gov 2022c). The vaccine programme also saw the UK mortality rate move from one of the world's worst to below the Western European average (ONS 2021a).

Despite that success, it is imperative that the UK isn't complacent: there is still huge room for improvement. New analysis presented in this report shows that:

- Almost one in four (23 per cent) adults in Britain say they are not likely to get a winter flu vaccine, should they be invited (IPPR/YouGov polling)
- In the context of Covid-19, almost one in five (18 per cent) adults in Britain still don't feel safe in public spaces, like restaurants or public transport (IPPR/YouGov polling)
- Every single national childhood immunisation (with comparable year-on-year data) has seen a decline in uptake in the last year. Uptake is below the World Health Organization's 95 per cent target on every indicator (IPPR analysis of NHS Digital 2022)

Doing better on vaccines could support population health, NHS system readiness and the economy. The NHS is under significant strain. As a preventative lever, vaccines could reduce that pressure – both this winter and beyond. In turn, this could also improve UK infectious disease outcomes. Following significant progress in the mid-90s and through the 2000s, improvements in both morbidity and mortality caused by infectious diseases has stalled (Global Burden of Disease 2020). Vaccines could even support the struggling UK labour market – where economic inactivity due to temporary and long-term illness is rising. New IPPR/YouGov polling finds that around one-third of British adults not in employment were less likely to agree that they felt safe in public spaces, compared to people in employment

The key lesson from the Covid-19 vaccination programme is that an overly individualised approach to vaccine uptake and inequality is fundamentally limited. The UK's approach to vaccination has been defined by an overly individualised approach: vaccines are made available, but access is then broadly left to individual choice. This paradigm is limited insofar as it does not sufficiently recognise the socio-economic, structural, and institutional dynamics of vaccine efficacy and take-up. Nor does it fully account for the important role government, employers, communities, civil society, and the NHS could play in addressing vaccine inequality. This report contends that vaccine uptake is everyone's responsibility, to everyone's

benefit – and that policy should reflect a greater role for employers, businesses, the state, civil society, and communities.

On that basis, our policy recommendations explore how we can move ahead on vaccines, by harnessing the role of innovation, a wider range of public institutions, government, and businesses to support equality in access, uptake, and outcomes.

Most immediately, and in the context of severe winter NHS pressures, we recommend government and employers work together to break down barriers to equal vaccine uptake.

- **Avoid coercive attempts to drive vaccine uptake.** In some cases, both public sector and private sector employers have used coercive means to try and increase vaccine uptake – whether mandates, or withdrawal of contractual sick pay. These policies take too little account of structural components of vaccine inequality and can have unintended negative consequences. Our polling shows that removal of benefits such as sick pay for unvaccinated staff could lead to up to 39 per cent of unvaccinated employees leaving their jobs (rather than taking the vaccine). We recommend the government bans the withdrawal of workplace protections from unvaccinated people, supports businesses to provide more empathetic spaces for discussion about the benefits of vaccines, and confirms it will not introduce vaccine mandates going forward.
- **Partner on a more positive role for businesses and employers in boosting uptake.** Employers and businesses do, however, have an important role in better vaccine uptake. The government currently encourages companies to give staff time off for work; however, evidence suggests that this is not implemented consistently. The government should legislate time off work for vaccines as part of employee rights and increase sick pay entitlement from day one, to reduce fears about missing work due to vaccine side-effects.

In the short term, we recommend that the government learns the lessons of the Covid-19 vaccination programmes, and takes a more active role in supporting better use of vaccines – by making more innovative vaccines available, using the NHS workforce strategically, and delivering locally-led vaccine champion programmes.

- **Strategically utilise community pharmacy skills and capacity.** Pharmacies across the UK have the capacity to take on the responsibility for administering more vaccines, more locally. Evidence shows that this has been successful in tackling the inequalities across vaccine coverage (King's Fund 2021). To deliver on this potential going forward, we recommend that the Department of Health and Social Care develop a long-term plan for community pharmacies which articulates their value, provides greater opportunities for training, empowers the workforce, and expands vaccination skills.
- **Build on the 'community champions' programme to deliver more locally-led vaccine uptake programmes.** The Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLUHC) created the 'community champions' programme which provided over £23 million to the 60 councils. The programme was successful but ended in July 2021. We recommend that government creates a new £400 million annual fund to support community vaccination programmes – expanded across all local authorities – and a broader range of vaccines.
- **Embed a rolling review process for all new and ongoing vaccine programmes.** The Covid-19 vaccine regulatory review and approval process was approximately three months, compared to an average approval timeframe of two years. This shows that it is possible for government to help make more innovative vaccines available, more quickly. We recommend a permanent rolling review process for vaccines, overseen by the Medicines and Healthcare products Regulatory Agency

(MHRA). To support this move, we recommend new public communications on the efficacy of vaccines, proper resourcing of the MHRA, and – ideally – funding for community pharmacies to provide appointments for people to come and discuss any concerns, fears, misconceptions or questions around vaccines.

In the medium to long term, we recommend a cross-society mission to build trust in vaccines and the institutions that administer them. This is good public health policy today – but also important to UK preparedness in the face of growing, global health insecurity:

- **A permanent health disinformation unit, jointly run between DCMS and DHSC to set up a national vaccine conversation.** The government should utilise new technologies to combat the spread of misinformation. While our polling suggests that authoritative sources such as the NHS are predominantly considered trustworthy, there remains a significant proportion of trust given to alternative sources of information such as Reddit and chatrooms. The rise in trust for these sources begins to increase across those who are not fully vaccinated (no more than one dose of the Covid-19 vaccine). This disinformation unit would be a permanent fixture in government to monitor the shift in how information is consumed for various health programmes and work with private technology firms to monitor disinformation.
- **Focus on earning, building and maintaining trust through the NHS' work as a provider, employer and anchor institution.** Institutional trust is influenced by patient and practitioner experience. IPPR analysis of experience data shows that, while many do have a good experience of healthcare, many do not – with ethnic minorities most likely to report experiencing poor communication, a lack of privacy or a lack of dignity when using the NHS. Building the trust that vaccines rely on means doing far better to tackle these inequalities. We recommend the experience of all patients is made a central part of the NHS' Core20PLUS5 programme, and that action on discrimination is made a fifth purpose of integrated care systems.

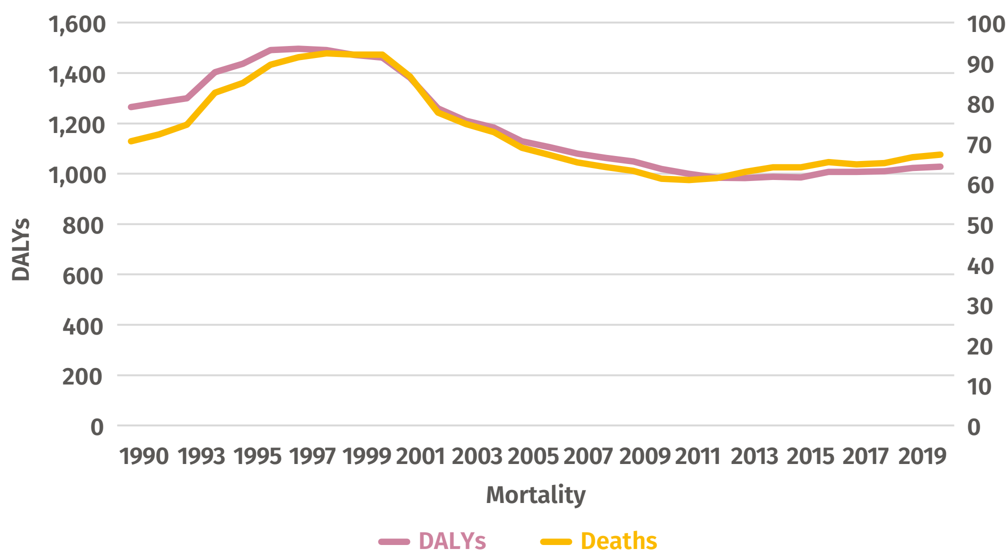
1. INTRODUCTION

Vaccines have supported significant health gains in the last hundred years. Today, it's estimated that immunisations prevent between 3.5 and 5 million deaths a year (WHO 2021). Moreover, as a preventative intervention, vaccines also provide benefit in the form of increased health system capacity (Brassel et al 2022). The literature shows that health systems function more efficiently when vaccine programmes for vaccine-preventable diseases are properly funded (ibid).

Despite this, our analysis shows that progress on reducing mortality and morbidity from infectious diseases has stalled in the last decade – after steady progress between 1995 and 2010 (Figure 1.1). This is despite prevalence of infectious diseases reducing during this period (Global Burden of Disease 2020).

FIGURE 1.1

Progress on mortality and morbidity from infectious diseases has stalled in the UK
DALYs (disability-adjusted life years) per 100,000 and mortality per 100,000 from select infectious diseases 1990–2019 (latest data)



Source: Authors' analysis of Global Burden of Disease (2020)
Note: Analysis includes HIV/AIDs, sexually transmitted infections, neglected tropical diseases, respiratory infections and other infectious diseases (including meningitis, diphtheria, whooping cough and acute hepatitis).

As well as their health benefit, vaccines can play an important role in prosperity too. Infectious diseases can have a devastating impact on the most vulnerable people in our society (Rodrigues and Plotkin 2020), and the long-term impacts of diseases can impact educational attainment, occupation and earning ability (Graff et al 2022). To that end, vaccines (distributed and accessed equitably) can contribute to social justice – by reducing the capacity for infectious diseases to pull people into poverty.

GOING FURTHER, FASTER

Covid-19 is a case study in both the health and prosperity benefits of vaccines. It is estimated that over 100,000 deaths were prevented by the Covid-19 vaccine in the UK, up to August 2021 (Public Health England 2021). For those aged over 65, the Covid-19 vaccine is estimated to have saved over 143,000 hospitalisations (ibid). Indeed, the UK's initially successful vaccination programme coincided with the UK transitioning from having among the highest excess mortality in Europe (2020) to an excess mortality below the Western European average (Wang 2022).

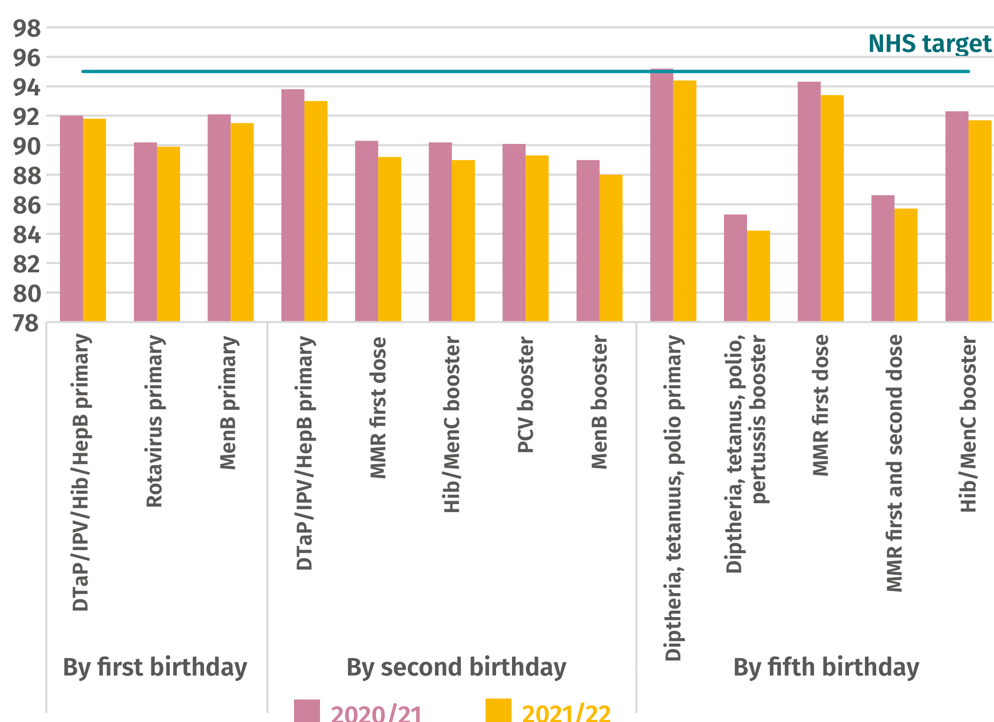
The economic benefits of this mortality shift are self-evident. In 2020, the period without a Covid-19 vaccine, the UK experienced the single biggest one-year drop in GDP in over 300 years (Harari et al 2021) and – as analysis from IPPR's Commission on Health and Prosperity has shown – significant problems around productivity, the UK labour market and economic inequality. The economic benefit of the vaccine has been estimated at $5 trillion in the US alone (Kirson et al 2022).

On that basis, it might be tempting to sit back and admire the benefits derived from the Covid-19 vaccine. This would be a mistake. While the initial Covid-19 vaccination programmes were broadly successful, there remain significant opportunities for improvement – particularly in addressing inequalities and in ensuring effective roll-out as part of our 'living with Covid-19' strategy.

There is also a pressing need to extend the lessons learned from Covid-19 vaccines to other national vaccine programmes. Indicatively, figure 1.2 shows worrying signs of declining uptake of childhood immunisations – with uptake of every vaccine (with comparable data) falling between 2020/21 and 2021/22, and the UK failing to meet its 95 per cent target across the board.

FIGURE 1.2

Childhood immunisation rates fell across the board this year
Childhood immunisation uptake (percentage)



Source: NHS Digital (2022)

VACCINES AND PROSPERITY

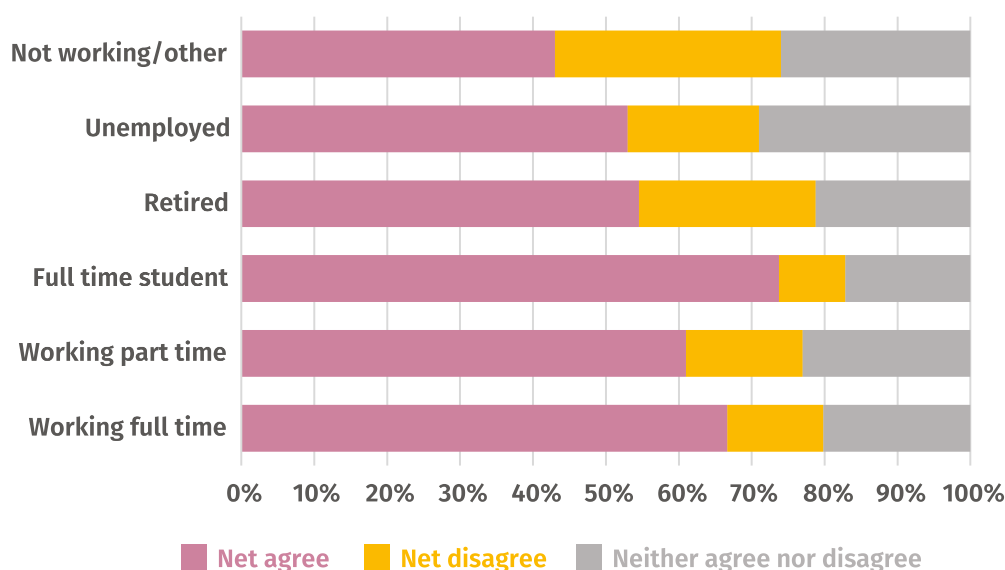
Beyond health benefits, continued equitable and effective Covid-19 vaccination could benefit the UK economy. Our polling finds that a sizable minority of 2,089 adults in Britain – 18 per cent, the equivalent to 9 million British adults – still do not feel safe using public spaces. Beyond the impact this will have on individuals' wellbeing, it is also likely to impact on people's economic lives – from their ability to engage with their community and to seek or take on work, to their confidence as consumers.

Topically, figure 1.3 shows the continued role Covid-19 could be playing in the UK's labour market problems. It shows that those who are not working, but are not classified as unemployed[1], are around a third less likely to say they feel 'safe in public spaces' compared to those in employment. This is highly likely to impact their confidence in seeking work – even though many who cite health as a reason for economic inactivity would like a job (ONS 2022). With 9 million people now economically inactive in the UK – a seven-year high – this is a worrying finding (ibid).

FIGURE 1.3

A sizable minority of people do not feel safe when they attend public venues like theatres, restaurants, pubs, sporting events or public transport

Responses to survey statement 'I feel safe to attend public venues'



Source: IPPR/YouGov polling of n = 2,096 British adults in June 2022

Covid-19, of course, is not the only infectious disease which is important to health system readiness and national prosperity. The UK lost nearly 25 million working days to minor illnesses, including flu, in 2021 (ONS 2022). Cold, cough and flu also explained nearly 14 per cent of staff absence among professionally qualified clinical staff in the NHS in January 2022 (NHS Digital 2022). And studies of vaccine value in the UK suggest that health protection interventions, including immunisation, have a return on investment of £34 for every £1 spent (ABPI 2022). In short, there is a clear health, justice, and prosperity case for doing better on vaccinations.

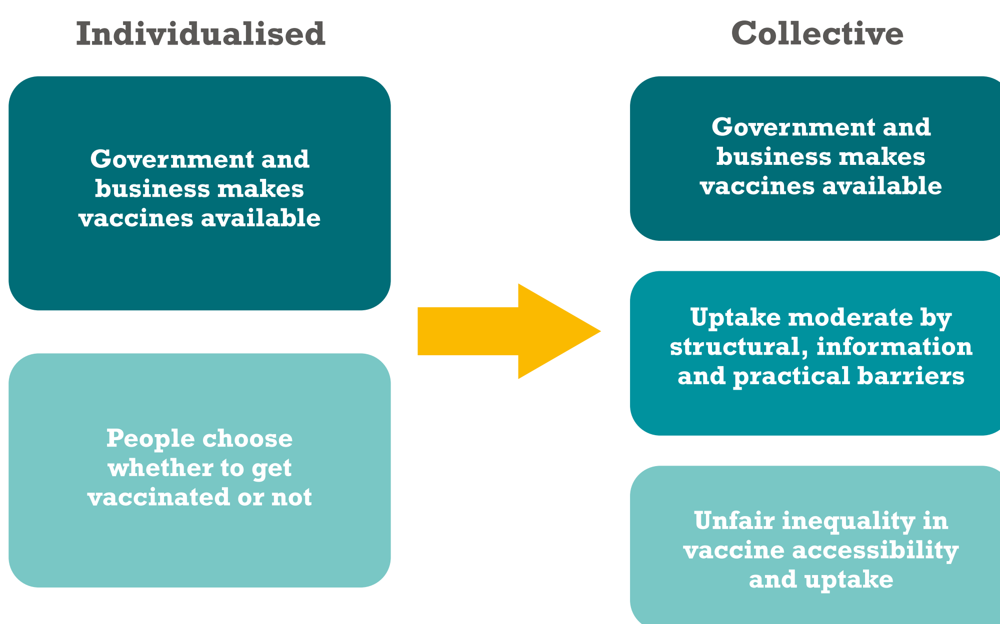
1 Broadly corresponding to economic inactivity figures rather than unemployment figures (the difference being the latter are actively seeking work).

BUILDING THE 'VACCI-NATION'

This report contends that the UK can and must improve equitable uptake of vaccines,[2] but that achieving better and fairer uptake will not be possible with an overly 'individualised' understanding of vaccine uptake and inequality. As it stands, the status quo approach is one in which the role of government is defined as making vaccines available, but where uptake is broadly left to individual choice. This takes too little account of the structural, information and practical factors at play in vaccine uptake (figure 1.4). And as a result, it suggests far too limited a role for wider institutions – public, private, and civil – to achieve better, fairer vaccine outcomes.

FIGURE 1.4

Individualised and collective understanding of vaccine inequality



Source: Authors' own analysis

This report explores the policy levers opened up by this more nuanced understanding – across three-time horizons. In **chapter 2**, we explore the government's focus on 'vaccine hesitancy' as indicative of a highly individualised conception of vaccine uptake and inequality. We explore the case for immediate improvements to vaccine programmes – both to support Covid-19 vaccine efforts this winter and to enhance ongoing vaccine programmes. We focus on the structural factors which, beyond individual choice, prevent full and equal uptake of vaccines. And we suggest ways to overcome these barriers, with a focus on a more positive role for businesses and employers – working with people and government.

In **chapter 3**, we explore where lessons from Covid-19 – on the opportunities for a greater role for government, the NHS and community – can be embedded into other vaccination programmes. We explore how more vaccines can be made available, more quickly, how communities can be empowered to tackle vaccine inequality, and how the NHS can be strategic in building a sustainable vaccine workforce.

2 Where clinically appropriate.

In **chapter 4**, we explore long-term trust in vaccines. Trust is a critical predictor of vaccine uptake – and mistrust would threaten both vaccine programmes today, and pandemic preparedness in the future. Given the sharp rise in global health insecurity, we argue far more needs to be done to build, earn and maintain trust in vaccines and the institutions that deliver them.

METHODOLOGY

This paper used a mixed method approach to explore attitudes towards vaccine uptake. The methodology encompassed quantitative, qualitative and literature review research.

- **Survey:** Our survey research explored attitudes among the British public towards vaccines. It explored disinformation, non-Covid-19 vaccines, trust, confidence, and mandates. All figures, unless otherwise stated, are from YouGov. The total sample size was 580 adults, and the fieldwork was undertaken between 6–7 June 2022. The survey was carried out online. The figures have been weighted and are representative of all British adults (aged 18+).
- **Interviews:** Throughout the research process, we undertook a series of interviews with experts who have researched changing attitudes, behaviours, and approaches towards vaccine uptake. These interviews were conducted with public health behavioural specialists, virologists, GPs, community pharmacists and historians from across academia. The questions in these interviews explored the lessons learned due to Covid-19, public health approaches that were effective or ineffective, and future policy programmes for improving vaccine programmes in the UK.
- **Literature review:** Finally, a thorough literature review was developed which combined literature from across clinical, public health, historical, social and economic research on the benefits of vaccines and the approaches taken to increase uptake while protecting and preventing an increase in social and health inequalities.

2.
A FAIRER APPROACH TO VACCINE UPTAKE, IMMEDIATELY

Any sort of transition to 'living with Covid-19' has relied – at least in great part – on vaccines (Gov 2022a). However, consistent with wider vaccine inequality, Covid-19 vaccine take-up has not been equal – meaning the transition to living with Covid-19 has not been equally safe across society. But this inequality does not have to become a fact of life: a more just transition is possible.

When it comes to vaccine inequality, a great deal of policy and political discussion has focused on the concept of vaccine 'hesitancy' – defined as a 'delay in acceptance or refusal of vaccination despite availability of vaccination services' (MacDonald 2015). Even before Covid-19, hesitancy was a key part of the vaccine discourse, both in the research literature and among health authorities (Bedford et al 2018; Dudley et al 2020).

The UK has had some success in reducing 'hesitancy' over the last two years – with particularly sharp declines observed in Wales, Yorkshire and the Humber and the North East (ONS 2021c). This may be attributed to the idea that an increasing disease burden such as Covid-19 may spike positive interest in vaccines (Pullan and Dey 2021). Indeed, over four in five people who were hesitant would now take the Covid-19 vaccine (ibid).

FIGURE 2.1

Vaccine hesitancy declined between Q1 and Q2 in 2021

Percentage of people expressing vaccine hesitancy between Q1 and Q2 2022 across regions'

Source: Authors' analysis of ONS (2021b)

IS HESITANCY THE RIGHT PROBLEM?

Few question whether greater vaccine uptake is a good thing. But there is increasing challenge to the idea that hesitancy is the right lens to apply to the core problem of unequal uptake. While these challenges don't suggest hesitancy has no role, they do point out that it is not the only factor in explaining why one might or might not get a vaccine – and as the figure above shows, willingness to vaccinate improved rapidly as the Covid-19 vaccine rollout progressed (for example, Patel and Bryne 2021).

WHAT IS THE PROBLEM REPRESENTED TO BE?

In 2016, Bacchi and Goodwin argued that policy needs to take more account of 'what the problem is represented to be' (Bacchi and Goodwin 2016). By this, they mean that the way a problem is understood and constructed has important political and policy consequences.

In the case of vaccines, the problem of variable uptake has been represented as one of hesitancy, an individual moral failure. This contrasts with the case of treatment and healthcare – where disparities in uptake are represented as a question of equality and fairness.

The former leads to policy solutions focused on the individual, while the latter leads to policy solutions focused on institutional support and supportive intervention. We argue that vaccines policy would benefit from this kind of support in line with how problems with equal uptake are conceptualised in most other parts of our healthcare system.

Understanding poor vaccine uptake or inequality solely through the frame of 'hesitancy' fits a highly individualised model and understanding of vaccine uptake – one where the role of government is to make vaccinations available, but where uptake is left to personal responsibility. In this model, failure to get vaccinated is seen as the individual showing a lack of something – whether that be knowledge, confidence or engagement rather than a systemic lack that requires further attention.

A dominant focus on hesitancy subordinates other, more structural explanations for low vaccine uptake. In other words, it does not fully take account of how precarious employment, low income, poor employment rights or other forms of social and economic injustice interact with vaccine uptake and inequality. This is even though these variables are well established in the research literature. For example, in addition to a 'lack of trust' of organisations in ethnic minority individuals, other factors such as a 'lack of culturally and linguistically appropriate information, and inconvenient locations and timings of vaccine appointments' were identified as barriers (Gov 2021b)

Other research has implicated barriers such as social isolation and lower access to travel as playing a part in ethnic disparities in vaccine uptake (Patel and Byrne 2021). Our polling provides new evidence on how certain dynamics of being on a low income, or in precarious work, might drive inequality in vaccine uptake. For example, British adults in lower income occupations[3] were: more likely to say they'd be unlikely to get a flu vaccine this winter if invited (27 per cent compared to 20 per cent); more likely to trust low quality information sources like chat rooms and forums (19 per cent to 12 per cent); less likely to feel safe in public spaces in the context of Covid-19 (55 per cent to 65 per cent); and – among those who said they were unlikely to get a winter flu vaccine – more likely to say the experience

3 Based on NRS social grade (ABC1C2DE).

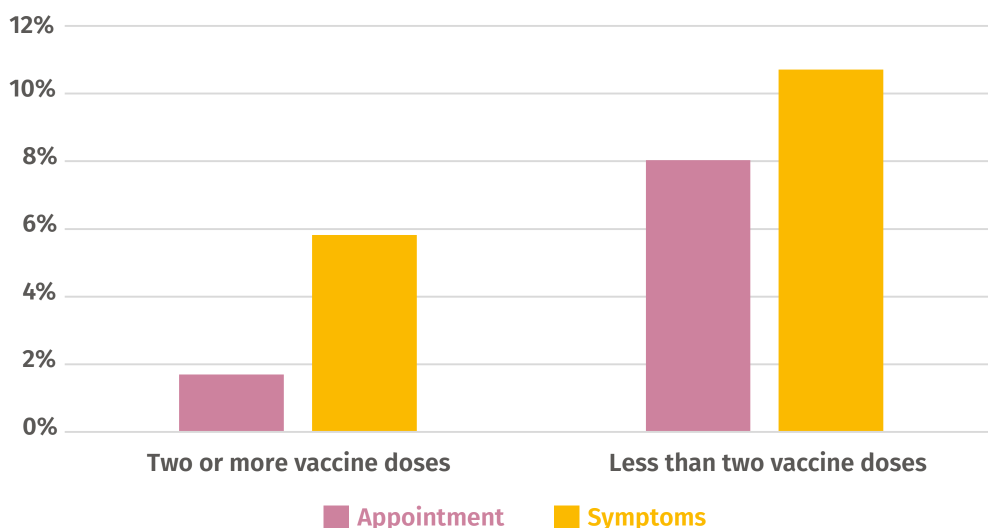
of Covid-19 was a key reason why they weren't likely to get vaccinated (25 per cent to 14 per cent). There is little scope with a hesitancy approach to see this as an injustice, rather than a moral failure, in our over-individualised approach to vaccines.

Looking across the whole population, our follow-up on why those who said they'd be unlikely to get a flu vaccine if invited showed a small but sizable minority for whom work was a prominent barrier. Figure 2.2 shows that, in this group, people with less than two Covid-19 vaccine doses were much more likely to be concerned about getting time off work – either for symptoms or appointments. Younger adults, aged 18–34, were also more likely to indicate that time off work for the appointment was a barrier.

FIGURE 2.2

People without at least two Covid-19 vaccine doses were more likely to be concerned about work

Proportion who stated time off work for a vaccine appointment, or to deal with symptoms, was a factor in low likelihood of getting a flu vaccine if invited by the NHS or government



Source: IPPR/YouGov polling of n = 2,089 British adults

POLICY RECOMMENDATIONS

The NHS in England faces one of its most difficult winters in history. The statistics from the summer have already been alarming with millions on elective waiting lists, 30,000 waiting longer than 12 hours in accident and emergency in July, and 1.2 million waiting for community mental health services (NHS England 2022). The NHS will only face more pressure this winter, in part because of the seasonal nature of Covid-19 and other, respiratory diseases like flu. As such, it is imperative that the government pulls all the levers available to it this winter to support the NHS – including action on more structural barriers to vaccination.

Recommendation 1: Avoid coercive mechanisms to drive vaccine uptake in future vaccine programmes

Coercive policies have been prominent in the Covid-19 vaccine policy discourse so far. Mandates such as vaccine passes are the obvious example. Having announced that full vaccination would be a precondition for deployment in the NHS and social care, the policy has been delayed subject to consultation. Even then, the government's

logic was not that mandates are a poor method to improve access and uptake of vaccines, but rather that neither the NHS nor adult social care systems could afford to lose workers. Formally, the measure remains under consultation.

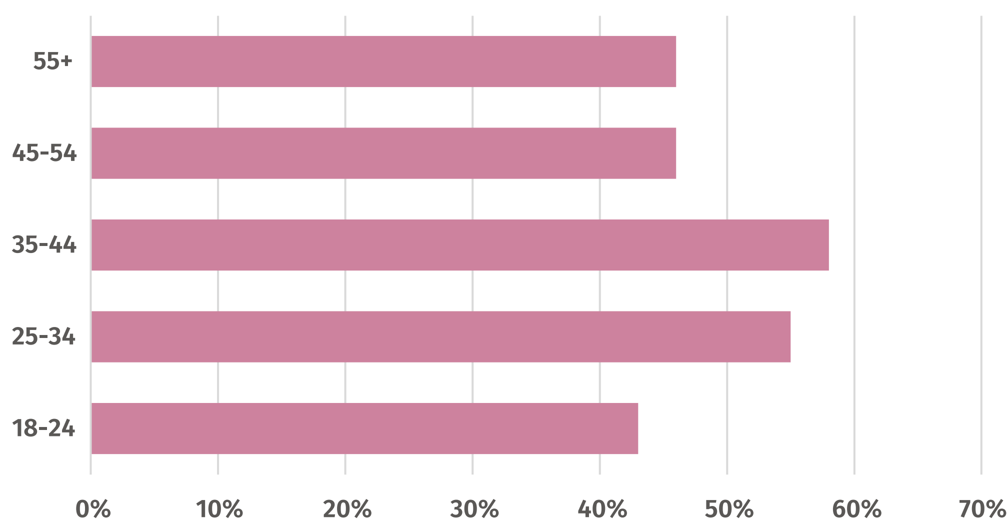
There have also been cases of employers using the withdrawal of workplace protections as a mechanism to push vaccination among their workforces. Most common has been the removal of contractual sick pay (CSP) for unvaccinated staff. While employers do not have the right to remove CSP (worth £96.53 per week), some companies chose to cut their CSP for unvaccinated staff. This decision posed a threat to unvaccinated employees' economic and health status by either forcing staff to return to work before it is deemed safe (10 days), or otherwise experiencing a large drop in wages.

Reactive and coercive policies – like mandates, or the removal of benefits and protections in the workplace – are unlikely to be effective interventions. For one, they misunderstand the drivers of vaccine hesitancy. Implicit in coercive mechanisms is the idea that people are not getting vaccinated due to a moral failure – and that these kinds of policies will encourage more people to become vaccinated. In fact, our polling shows that one of the key drivers of lower likelihood of vaccine uptake is people's confidence that their health is already good (particularly among younger to middle aged adults) (figure 2.3). Better, more empathetic policies would take into account that making decisions about one's health is hard – and would therefore better communicate the preventative nature of vaccines, and provide safe spaces for people to ask questions and interrogate health conditions further.

FIGURE 2.3

Confidence in health has a central role in low vaccine uptake

Proportion of those who report they are unlikely to get a flu vaccine if invited by the NHS/government, who say confidence in their health is a reason for that low likelihood, by age cohort



Source: IPPR/YouGov polling of 2,089 British adults

Elsewhere, evidence suggests coercive policies can be actively counter-intuitive. For example, in the case of vaccine passports, a 2021 study showed that half or more of unvaccinated people were less likely to take up their vaccine if they were made a requirement for international travel (Brogan 2021).

Our polling adds further context to the unintended consequences that coercive approaches can have. We asked respondents how they would react if their employer threatened to reduce pay, benefits, or workplace protections for unvaccinated workers. Overall, 6 per cent said they would leave the company, 23 per cent said they would seek union or legal advice and 37 per cent said they would get the vaccine (or encourage others to do so). Even more telling was the response of those who have not had any doses of the Covid-19 vaccine. In this group, only 2 per cent said they would get the vaccine or encourage others to do so, while 39 per cent said they would leave the company and 41 per cent said they would seek union or legal advice. This finding suggests such policies are ineffective as a tool to support vaccine uptake.

On this basis, we recommend new legislation to help ensure employers do not withdraw benefits and workplace protections based on vaccination status. This should be seen as adding consistency – this approach has not been universal among employers, and legislation would help embed better practice across the board. We further recommend that the government confirm that mandates will no longer be pursued as part of attempting to increase vaccine uptake for Covid-19, ongoing and future vaccine programmes. A further step to solidify this would be enshrining this in law – to ensure it does not become a temptation during future infectious disease spikes.

Recommendation 2: Partner on a more positive role for businesses and employers in boosting vaccine uptake

That does not mean employers shouldn't have a central, positive role in addressing inequalities in vaccine uptake. In fact, the workplace could serve as a place for encouraging or even administering vaccines. As an immediate priority, and based on our polling, we suggest government and business work together to break down barriers to equal vaccine uptake.

As it stands, government guidelines suggest employers do provide time off for vaccinations:

> *Consider allowing breaks in the day or time off to support getting vaccinated. Review your sick leave policies and procedures and consider if they disincentivise your employees from getting vaccinated.*
>
> (Gov 2022b)

But guidance alone has not led to consistent application. In addition to the survey evidence already outlined in this report, a 2021 poll by Acas and YouGov found that a quarter of British employers were not giving their staff time off to receive their Covid-19 vaccine (Acas 2021). Legislating for a formal and consistent right to time off for vaccination for adults, and for parents/carers for childhood vaccination, is a logical next step.

A second opportunity is sick pay. The risk of symptoms – and having to take time off work – was a bigger barrier than getting time off to attend a vaccine appointment. And the fact that this was more likely to be reported by younger adults and people in lower NRS social grades, might implicate particular difficulties around precarious work or lower paid jobs.

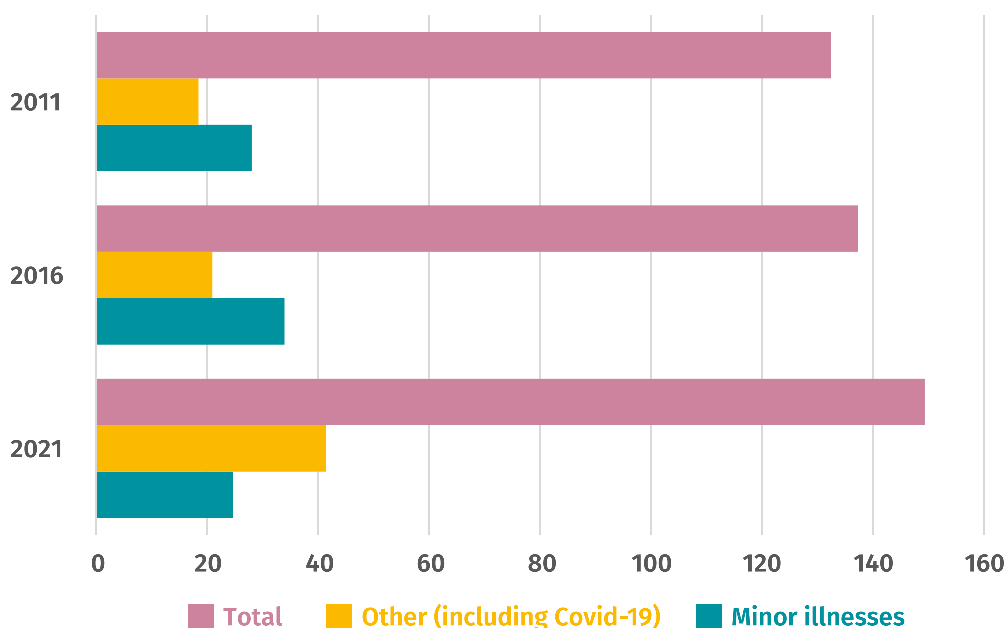
Better sick pay entitlements would be one way to get around this problem. Earlier this year, IPPR suggested increasing the statutory sick pay rate to 80 per cent of earnings, with a government rebate for small and medium sized employees (fewer than 250 employees). We also recommended that lower earning limits were abolished, and that sick pay was made available from day one of illness (abolishing the current three-day waiting period). This would cost the chancellor an estimated £7.5 billion per year.

A cost-benefit analysis is likely to conclude that these kinds of measures constitute enlightened self-interest for businesses. While time off for vaccination and symptoms will have a small rolling cost, it is likely to prevent significant sickness absence – and in some cases, full labour market exit. ONS data indicates that Covid-19 is driving a large amount of sickness absence – above and beyond the consistently large amounts caused by other infectious, respiratory diseases.

FIGURE 2.4

Covid-19 has driven a spike in sickness absence

Total days of sick leave by minor illnesses and other (including Covid-19), cumulative (millions of days)



Source: Authors' analysis of ONS (2022)

Compared to 2019, the cumulative total days lost to 'other' causes was 21.4 million days higher in 2021. It is not possible to attribute the higher number of sick days entirely to Covid-19 – there are other conditions in this category - but it is suggestive of the sheer number of additional sick leave days that are very likely down to the virus.

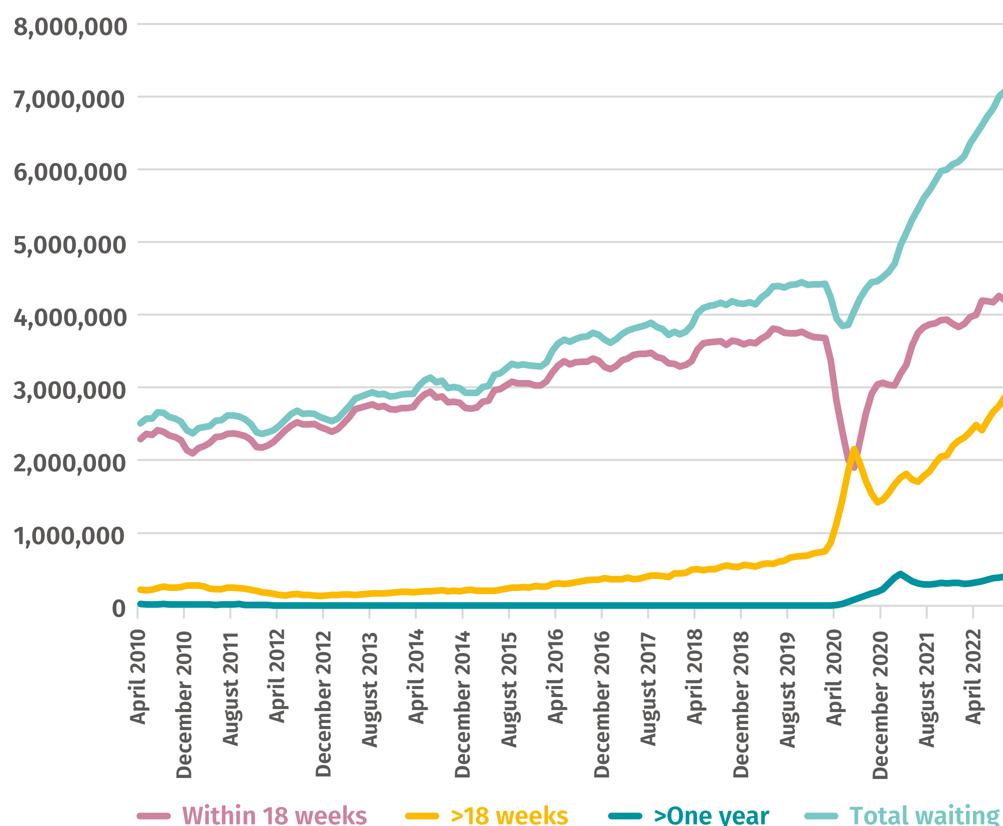
3. EMBEDDING COVID-19'S LESSONS FOR THE MEDIUM TERM

Immediate action to boost vaccination is important. But equally important is recognising that the NHS and the economy are in a long-term decline – not just short-term crisis. Figure 3.1 is indicative of this trend – showing that NHS elective waiting lists had hit record levels even before the Covid-19 pandemic.

FIGURE 3.1

Waiting lists were high and rising even before Covid-19

Referral to treatment waiting times 2010 – November 2022



Source: NHS Digital (2022)

Given this, it's not only important that we boost vaccination rates immediately – but also that we look for ways to harness the potential of vaccines beyond the winter. That means applying and adapting the lessons learnt from the Covid-19 vaccination programme to other vaccination programmes and wider vaccine policy. This chapter focuses on three key lessons.

1. Faster vaccine development and availability are possible.
2. There are opportunities to use the workforce strategically, to deliver higher vaccine accessibility and uptake.
3. Community-led vaccination schemes are vital to good, equal access across the country.

POLICY RECOMMENDATIONS

Recommendation 1: Embed an expedited rolling review process to facilitate faster vaccine development

The expedited rolling review process is an excellent example of good pandemic preparedness. The process speeds up vaccine approval by assessing data while simultaneously conducting ongoing clinical trials. This is an example of harnessing vaccines' preventative potential, as 'the faster a vaccine is deployed, the faster an outbreak can be controlled' (Excler et al 2021).

While there were several other successful, new approaches in the vaccine development and approval achieved during the development of the Covid-19 vaccines, the rapid rolling review was considered particularly successful (EMA 2022). The average vaccine approval process in the UK has typically been two years, yet the Covid-19 vaccine took only three months (Wellcome Trust 2021).

Given its success, a permanent rolling review process should be embedded across all vaccine development on an ongoing basis – to ensure that there is rolling availability of these updated vaccines, and to meet the growing and changing health needs, particularly during the winter. Respiratory vaccines in particular pose a specific threat to system preparedness as they tend to show high infection rates during the winter season in temperate regions such as the UK, and as such should be a priority within this scheme (Audi et al 2020).

Outside of the pandemic context, there is a need to ensure speed is balanced against safety – and that faster approvals do not generate public worry. This might not mean three months is a feasible target for all vaccine approval processes – but it does mean faster processes are possible.

It also means that the government should combine this expedited process with public-facing communication about the science behind vaccines, the fact they have tended to be relatively safe interventions, and about the data that sits behind vaccine approval decisions.

A lower level of ambition would see the government fund a public awareness campaign on the efficacy and safety of vaccines. At a higher level of ambition, the government could provide safe spaces for people to further interrogate and ask questions about vaccines. In the context of wider workforce pressures, the most appropriate setting for this is likely to be a community pharmacy – which could be funded to deliver vaccine information consultations with members of the public who would like to talk further.

Beyond being a precondition for faster approval processes, our polling suggests this could have a wider benefit for public perceptions. Of those who indicated that they would not be likely to get a winter flu vaccine if invited, one in five said a reason for this was that Covid-19 had made them question vaccines in general. Providing spaces for these questions to be voiced, explored and given assurance about is a sensible next step.

A permanent rolling review process should be overseen by Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA could adopt a similar review procedure to the European Medicines Agency (EMA) by utilising committees as part of the

review process. The MHRA could utilise the Joint Committee on Vaccination and Immunisation (JCVI) or create an alternative body dedicated to the rolling review of medicines. A rolling review process would be structured with one or more review cycles, using the current process, with each cycle lasting around two weeks.

This policy has already been implemented by the EMA for new variant Covid-19 vaccines – which allows the EMA to receive regular updates on the data on the immune response to the vaccine (European Medicines Agency 2022). Proper governance of the scheme would, naturally, require the right resourcing, staffing and competencies. Late last year, it was suggested that the MHRA could be asked to cut its headcount by as much as 20 per cent. Broadly, this seems incompatible with aspirations for the UK to lead on life sciences – and for the UK to lead on medicine approvals following Brexit. Specifically, it will make it harder for the UK to take new opportunities, like rolling review processes.

Recommendation 2: Better utilise the vaccination potential of community pharmacies and volunteers

The pandemic demonstrated the underutilised capacity and potential of community pharmacies, which were funded to support Covid-19 vaccination efforts. Evaluation has indicated these schemes were successful, particularly when increasing vaccination capacity in places with lower vaccine uptake (for example, Timmins and Baird 2022).

On the basis of the success of this expanded role for pharmacists, DHSC's new plan for patients (2022) outlined an expansion of community pharmacy powers, as part of efforts to reduce significant workload pressures faced by general practitioners.

Community pharmacies are one of the few healthcare professions with excess, untapped capacity. But if community pharmacists are to step up and take on additional responsibility, the infrastructure needs to be right. Reviews of the literature, informed by the experience of Covid-19, suggest community pharmacies would require:

- **Articulation**: A key enabler to greater use of community pharmacy is a greater understanding – within the NHS, general practice and among the public – of its role. The NHS should find opportunities to more consistently, and publicly, articulate the value and expanding role of community pharmacies – including as an integral pillar in future NHS sustainability.
- **Development**: A greater role in vaccinations requires greater time to develop skills and knowledge, yet pharmacists do not routinely receive protected time to learn new skills. Increasing flexibility in opening hours during Covid-19 facilitated greater capacity to allocate protected time for training and development – and we suggest this is maintained going forward. Pharmacists should also have access to multi-disciplinary team-based training, and we also recommend greater investment in developing vaccination skills among pharmacists and their teams, including through supported foundation training.
- **Involvement**: Community pharmacies need access to space and forums to collaborate and build networks, particularly in the context of the NHS' shift towards integrated working. This can be supported through digital infrastructure – for example, moves to share electronic discharge information with a community pharmacy of a patient's choice, and access to virtual consultation tools and equipment.
- **Permission**: Empowering community pharmacies means devolution of power and permission. The NHS has a tendency to demand a one-size-fits-all approach to innovation adoption and service delivery – which comes into friction with local context and variation in care pathways and relationships within places (see Thomas et al 2022). NHS England should explore options that give community pharmacists more power and greater ability to adapt

care provision – such as the power to adapt prescriptions even without a government-issued serious shortage protocol.

- **Resource**: Community pharmacists already deliver flu vaccines in England and Wales. We recommend this is expanded across the UK. We also recommend resourcing is expanded to better enable trained pharmacists to deliver a wider range of vaccinations (see RPS 2021; Maidment et al 2021).

Many of the pandemic responses showed that we are capable of making use of existing capacity, and we should look to carry those lessons forward. Even outside the exceptional circumstances of the first peaks of the pandemic, Covid-19 still remains a prevalent disease which burdens the health care system particularly in the winter. Local pharmacies have the potential to continue to address these impacts – while freeing up much-needed time for GPs and other clinicians to focus on other, pressing priorities.

Recommendation 3: Re-instate the 'community champions' programme as a permanent part of post-pandemic recovery and supporting vaccine uptake

In 2022, the British Academy undertook a study examining places with low vaccine uptake in the UK. They concluded that a 'top-down approach' was ineffective in supporting greater vaccine uptake (The British Academy 2022). Rather, it was local approaches and relationships that best supported better and more equal vaccine outcomes. This was particularly true in areas with high vaccine inequity, for example the London Borough of Ealing (see box below).

CASE STUDY: LOCAL VACCINE SCHEMES IN EALING

The London borough of Ealing is a diverse borough in north-west London which was disproportionately impacted by Covid-19 infections and deaths. Across the borough, people hail from all over the world, with over 170 languages spoken. While the borough overall had a high uptake of the Covid-19 vaccine, disparities were high across lower socio-economic and ethnic minority groups who had less engagement and trust towards healthcare providers.

A key part in the shift to increase vaccine uptake was a decentralised approach. This encompassed mobile pop-up sites and the use of community leaders and responders on-hand to answer questions and support the process. A key part of what made this approach successful was having the resources via local government to meet with local groups to actively listen and begin to address concerns. Evidence overwhelmingly supports the idea of 'going to' residents rather than only creating mechanisms whereby people must proactively seek a vaccine.

This government has made some attempts to replicate this success across the country. For example, the 'community champions' programme (DLUHC 2021), introduced at the end of 2021, allocated £22 million of funding to 60 local councils with the lowest vaccine uptake.

But there remain opportunities to go further. We recommend both continuation and expansion of funding for community-led vaccination schemes, which we estimate will cost up to £80 million a year to encourage people from across all local councils to take up the vaccine.

Continuing and increasing funding for community vaccination programmes would enable them to expand in three ways.

1. While Covid-19 will likely be a focus, it will allow schemes to focus on other areas of low uptake. For example, London has particularly low childhood immunisation rates (NHS Digital 2022).
2. It will allow schemes to emerge across the country. While there is a case for focusing a large amount of funding on areas with the lowest uptake (or the highest levels of health inequality and multiple deprivation), we shouldn't ignore vaccine inequality – which might affect neighbourhoods of smaller communities – even in places that report relatively high overall uptake.
3. It would allow the schemes to run throughout the year. This might enable a focus on respiratory vaccines in the lead up to winter, and on routine vaccines in spring and summer.

Overall, these schemes will help localise the health and prosperity benefits already outlined in this report

4.
A LONG-TERM PLAN FOR TRUST

A combination of climate change and globalisation have increased the average annual risk of major new infectious disease outbreaks – of which Covid-19, and more recently Monkeypox, are symptoms (Kenny 2021). One study has put the annual risk of a Covid-19 scale disease outbreak at 2 per cent – creating a high chance that we will each experience other, similar scale shocks in our lifetime (Marani et al 2021).

In reaction to growing global health insecurity, we should take steps to strengthen our national preparedness. This relies on trust in vaccines and the institutions that provide them.

In this context, it is worrying that our survey evidence indicates that a small but notable number of people have had their trust in vaccines undermined during the Covid-19 pandemic. Of the 23 per cent of adults in Britain who said they were unlikely to get an influenza vaccine if invited, 20 per cent explained this was because 'Covid-19 has made me question vaccines in general'.[4] Equivocated to the whole British population, this would equal an increased mistrust in vaccines among 3.1 million people.

Building trust is only possible with a shift away from a fundamentally individualised approach to vaccines – and towards one which harnesses the role of a range of actors and institutions in building, earning and maintaining societal trust in vaccines (and public health more broadly). The following policy explores how a range of different actors and public institutions can build, earn and maintain trust.

POLICY RECOMMENDATIONS

Recommendation 1: Set up a permanent disinformation unit, jointly run between DCMS and DHSC to set up a national vaccine conversation

The information age presents unique challenges and opportunities around regulating information – and disinformation – that can undermine trust in public health broadly, and vaccines specifically. On the latter, our polling shows most adults in Britain consider the genuinely authoritative health information sources trustworthy, such as the NHS website (90 per cent) and health charity websites (84 per cent). But on the former, a solid proportion trust far less reputable sources, like chatrooms, forums and Reddit (15 per cent, rising to 32 per cent among those with no Covid-19 vaccination doses).

In an ideal world, the government would simply ban the spread of harmful information. However, there are obvious limitations to such an approach. There are grave, democratic risks in making the government the sole arbiter of truth. More practically, the ability to regulate the internet at a domestic level is limited – doing so would require international consensus, huge resource and committed implementation. Current geopolitics make this increasingly unlikely.

4 This was higher in some demographics. Among lower income people it was 25 per cent, and among over-55s it was 29 per cent.

As such, the government would be better advised to invest in harnessing the internet and new technologies for good. In 2020, the government established a specialist unit to combat the spread of disinformation surrounding Covid-19. However, concerns have been raised about its transparency and permanency.

We recommend that the unit should be made both independent and permanent, within DCMS. The unit should be tasked with identifying areas where health disinformation in particular is present, and should work with tech firms, civil society, academics, and other government departments to curb its reach. During emergencies, it should provide a source of rapid response to both disseminate trustworthy information and tackle harmful disinformation. The unit should be transparent in its work and methods – including, through regular reporting on its methods, targets and assessment of the prevalence of disinformation.

Recommendation 2: Provide more opportunities to interrogate and discuss vaccines in schools

In England, every child will have the opportunity to have at least one vaccine in school as part of the NHS's immunisation programme[5]. For many students, this will be the first time they've thought about vaccines – and they're likely to have questions, concerns and received knowledge about their risks.

This makes vaccines administered by school immunisation teams – such as the first dose of the HPV vaccine – an ideal time to provide space to interrogate and understand vaccines further. That is, to build trust.

We recommend that as part of the government's healthy child pledge, greater effort is made to personalise each child's vaccination experience. This should centre on the offer of a one-to-one conversation between each child and healthcare professionals within the school immunisation service – involving parents if desired. Conversations should be student-led – offering an opportunity to discuss perceptions, misconceptions and fears, in support of both short-term and long-term uptake. School nurses have been found to have a positive impact on engagement with services, reducing stress and anxiety, and bringing about positive behaviour change (Turner and Mackay 2015).

This will require an uplift in healthcare capacity within schools. To support delivery, we recommend that school nurse numbers are expanded to meet a ratio of at least one nurse to 600 children. This would equal the mandatory level in Finland, where health professionals in a school environment have a closer relationship with the pupils.

Recommendation 3: Focus on earning, building and maintaining trust through the NHS' work as a provider, employer and anchor institution

Government institutions must build, earn and maintain trust. The high levels of societal inequality in the UK mean it is no surprise that some do not trust the NHS specifically, and government actors more broadly.

The Cancer Patient Experience Survey – one of the largest data sources on NHS experience available in England – is indicative of this point. Our analysis of 2021 data, looking at the difference in experience between black people and white people, reveals there is an inequality of experience across the two groups. Of the 58 questions asked, black people had experiences worse than the national average on 51 domains. Twenty-eight of these differences were statistically significant – including whether they got enough privacy in hospital, health information in a way they could understand, and sufficient follow-up support after treatment. By contrast, white people reported experiences better than the national average on 48 domains (although only five of these were statistically significant) (NCPES 2021).

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5 See https://www.nhs.uk/conditions/vaccinations/nhs-vaccinations-and-when-to-have-them

Staff experience is subject to similar inequality. The first ever pan-London survey of the primary care workforce by Health Education England showed that ethnicity was the most common characteristic associated with harassment; that one in three surveyed had experienced racial discrimination or harassment from patients in the past 12 months; and that 12 per cent had left or considered leaving their role due to racial discrimination (O'Dowd 2022).

This is indicative of the work still to do by the NHS to earn trust – in its capacity as a provider of patient care, but equally in its capacity as an employer and anchor institution.

As such, we recommend government adds action on discrimination as a fifth aim for integrated care systems. To some extent, schemes like Core20Plus5 are already supporting some tangible progress on healthcare inequality – but this purpose should go further and incorporate discrimination in experience – of both patients and employees. To support a fifth purpose on discrimination, we recommend clear targets are set on both patient experience and discrimination. In the first instance, this should cover ethnicity, sexuality, class and gender-based inequality.

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