The impact of financial and other targeted support on rates of self-isolation or quarantine [SPI-B: 13 September 2020]

Key points

1. *The effectiveness of NHS TT at reducing transmission of SARS-CoV-2 depends critically upon self-isolation of those testing positive and their contacts*
2. *Current rates of full self-isolation are likely very low (<20%) based on self-report. They are particularly low amongst the youngest and the poorest, thereby contributing to inequalities in the impact of COVID-19.*
3. *These low rates would likely increase with the addition of different forms of support and, in particular, financial support for those with the lowest household incomes. Ensuring that people who are self-isolating do not suffer as a result of a reduction in their income would remove important barriers to their ability to adhere.*
4. *These additional forms of support should be evaluated as a matter of urgency to realise the considerable investment already made in testing programmes and the potential of testing and self-isolation to hasten return of social and economic activities.*

Executive summary

If a return to normal life is to be achieved for most people in the short- to medium-term in the UK, members of the public must adhere to requirements for self-isolation. Although there are important methodological limitations to the data currently available, rates of full adherence among people in the community with cough, fever or anosmia may be somewhere in the region of 18% to 25%. The best available evidence suggests adherence would be increased by targeted support to those asked to self-isolate.

Four forms support seem most important:

- Financial support which ensures that people are not financially disadvantaged when self-isolating is likely to enable more people to adhere. Financial hardship and lower socioeconomic grade are currently associated with lower self-reported adherence. The roll-out of paid sick leave policies has previously been associated with reduced sickness absence in the USA and lower spread of influenza.
- Tangible non-financial support may be required by many people. At present, leaving the home to shop for food or groceries is the main self-reported reason given for non-adherence. Thirteen percent of people with symptoms report not adhering because of a need to "help or provide care to a vulnerable person" such as an elderly relative. Receiving support from outside the household is associated with greater likelihood of adherence. The type of support needed is likely to differ between households. Proactive outreach should identify the best way to help.
- Information about the principles underlying self-isolation should help people understand why and how to adhere. Multiple studies in the current pandemic and in previous outbreaks have shown that low levels of knowledge, not believing the illness to pose a serious risk and not perceiving a benefit to self-isolation are associated with lower adherence. The importance of making information clear should not be underestimated. A campaign similar to the current #HandsFaceSpace campaign may be helpful, in addition to targeted messages to those who are self-isolating.
- Support for psychological wellbeing can be delivered in large-part if financial, non-financial and information support is provided. Additional social and emotional support may also be required by some and can be provided by local schemes in addition to more formal mental health services. Reducing emotional distress is likely to further bolster adherence.

UKRI and DHSC should prioritise trials of these four forms of support, to identify the most effective support package, taking into account that a one-size-fits all approach is unlikely to be optimal. A validated measure of self-isolation, ideally using objective rather than self-report measures, should be developed as part of this.

Better quantification of adherence to self-isolation is also urgently required across the UK, ideally using objective, rather than self-report, measures. ONS and NHS TT should consider how best to provide regular data on this critical outcome.

significant association with non-adherence. Lower socioeconomic grade was also associated with non-adherence, although there was no association with index of multiple deprivation. Among symptomatic CORSAIR participants who had left their home (n=1,939), 11% reported that they had done so "to go to work."

Importantly, these findings do not indicate that willingness to adhere is lower among people with less financial resource. Instead, they suggest that ability to adhere is lower. A cross-sectional survey of 2,108 people conducted 17 to 18 March found that, while self-reported willingness to self-isolate for seven days was consistently high across all income and wealth groups, self-reported ability to self-isolate was three times lower in those with incomes less than £20,000 or savings less than £100 [11].

Recommendation

Currently, amongst those in the England entitled to statutory sick pay, this is frequently reported as insufficient both in amount and duration for many of the lowest paid to meet the basic expenses of daily living. Paid sick leave has been judged an effective intervention to reduce transmission of SARS-CoV-2 across OECD countries. However, it does not include all workers such as those on casual or zero-hour contracts or gig workers [12]. In addition, payment level and duration vary considerably across countries with the level most often below gross pay. When paid sick leave policies were mandated in Washington DC and Connecticut in 2008 and 2011, respectively, significant decreases in the rates of illness related leave taking were observed, as sick workers stayed at home and transmission of infection was reduced [13]. Sick pay policies also appear to mitigate the impact of flu epidemics [14].

Provision of financial support to safeguard incomes would likely have the single largest effect in achieving equitable self-isolation policies, in other words self-isolation that benefits the social groups with fewest material and other resources as well as those with the most. This is based on descriptive analyses of COVID-19 and other pandemics and epidemics which clearly highlight the difficulties for those who are poorest to support themselves and their families without leaving their homes [15-18]. It also includes a study conducted in the current pandemic in which intentions to self-isolate in a general population sample in Israel increased from 57% to 94% when lost wages were to be compensated [19].

To be most effective, existing evidence suggests financial assistance is more likely to be effective if it:

- ensures that those affected by self-isolation have no drop in weekly income;
- is provided rapidly;
- is easy to obtain.

Employment protection should also be offered for those needing to self-isolate, including parents who may need to stay at home with a child who is required to self-isolate. Scotland has issued a fair work statement to guide employers and employees including ensuring: No worker should be financially penalised for following medical advice [20].