# COVID-19: Protecting people and societies

In only a few weeks, COVID-19 has profoundly changed our lives, causing tremendous human suffering and challenging the most basic foundations of societal well-being. Beyond the immediate impacts on health, jobs and incomes, the epidemic is increasing people's anxiety and worry, affecting their social relations, their trust in other people and in institutions, their personal security and sense of belonging.

The short and medium-term impacts of COVID-19 will be particularly severe for the most disadvantaged and risk compounding existing socio-economic divides. This policy brief looks at the broad range of effects that COVID-19 will have on different aspects of people's lives, with a focus on specific population groups such as children, women and the elderly. It calls for rapid and decisive action by governments in order to support the most vulnerable people highlighting the importance of a broad and coordinated policy response that includes strengthened social protection, education, health care, housing support and specific interventions to enhance personal security of women and children, as well as actions supporting vulnerable workers, small businesses, communities and regions left behind.

## Context

With close to 900 000 cases[1] confirmed worldwide and the scale of contagion still rising in most affected countries, COVID-19 is causing tremendous human suffering with serious and long-term implications for people's health, well-being and quality of life. Beyond the very obvious risks to physical health and to the economy, the epidemic is also affecting people's social connectedness, their trust in people and institutions, their jobs and incomes, as well as imposing a huge toll in terms of anxiety and worry. COVID-19 is hitting at a time where inequality and social pressures in OECD countries are high; and many people and communities continue to be left behind despite the improvement of average living conditions in the past ten years or so.

While governments need to act swiftly and decisively to contain the spread of the virus, countries also need to assess the impacts of the disease and the counter-measures on all aspects of people's lives, especially those most vulnerable, and integrate these distributional impacts in the response. While racing against the clock in a complex and uncertain environment, countries' response to the COVID-19 crisis also needs to address the well-being perspective in a holistic and integrated manner, as opposed to a sectorial approach. Failing to do so risks deepening inequalities, possibly creating new divides and undermining the resilience of societies.

This policy brief looks at how the evolving COVID-19 crisis is affecting vulnerable people and communities, and specific population groups (children, women and the elderly) and places, across a broad range of dimensions. As other OECD policy briefs have addressed the effects on well-being dimensions such as health (OECD, 2020[1]; OECD, 2020[2]), employment (OECD, 2020[3]) and knowledge and skills (OECD, 2020[4]), as well as for selected population groups such as women (OECD, 2020[5]), the present note focuses on less explored dimensions, notably social connections, subjective well-being and mental health, personal security, financial vulnerability, stress and others. The policy brief also looks at policy responses for coordinated governance, protecting people and places left behind, and supporting small businesses and vulnerable workers; as well as identifying data gaps for an informed and evidence-based policy response in an evolving crisis.[2]

## Anticipated impacts on people's lives and well-being outcomes

The novel coronavirus that causes COVID-19, and the social, economic, and political fallout of the pandemic, will touch every aspect of people's lives. Vulnerable and disadvantaged groups will be impacted more severely and therefore require particular attention in the policy response. For example, home schooling will have different long-term impacts on children and youth, depending on their socio-economic background and the support that communities and decision-makers are able to provide.

Vulnerable groups are not limited to those in poor physical health: those in precarious employment or financial conditions, those living in poor quality housing, the socially isolated and those already struggling with low subjective well-being or mental health conditions are at particular risk. Temporary measures taken to limit and delay COVID-19 infection rates through confinement and social distancing could – in addition to their immediate effects on health – have other unintended consequences; some of which are positive – such as reduced air pollution, greater time spent with immediate family, and (perhaps) greater social solidarity; others of which are not – such as job and income loss. The economic consequences of the novel

[1] On April 1, 2020.

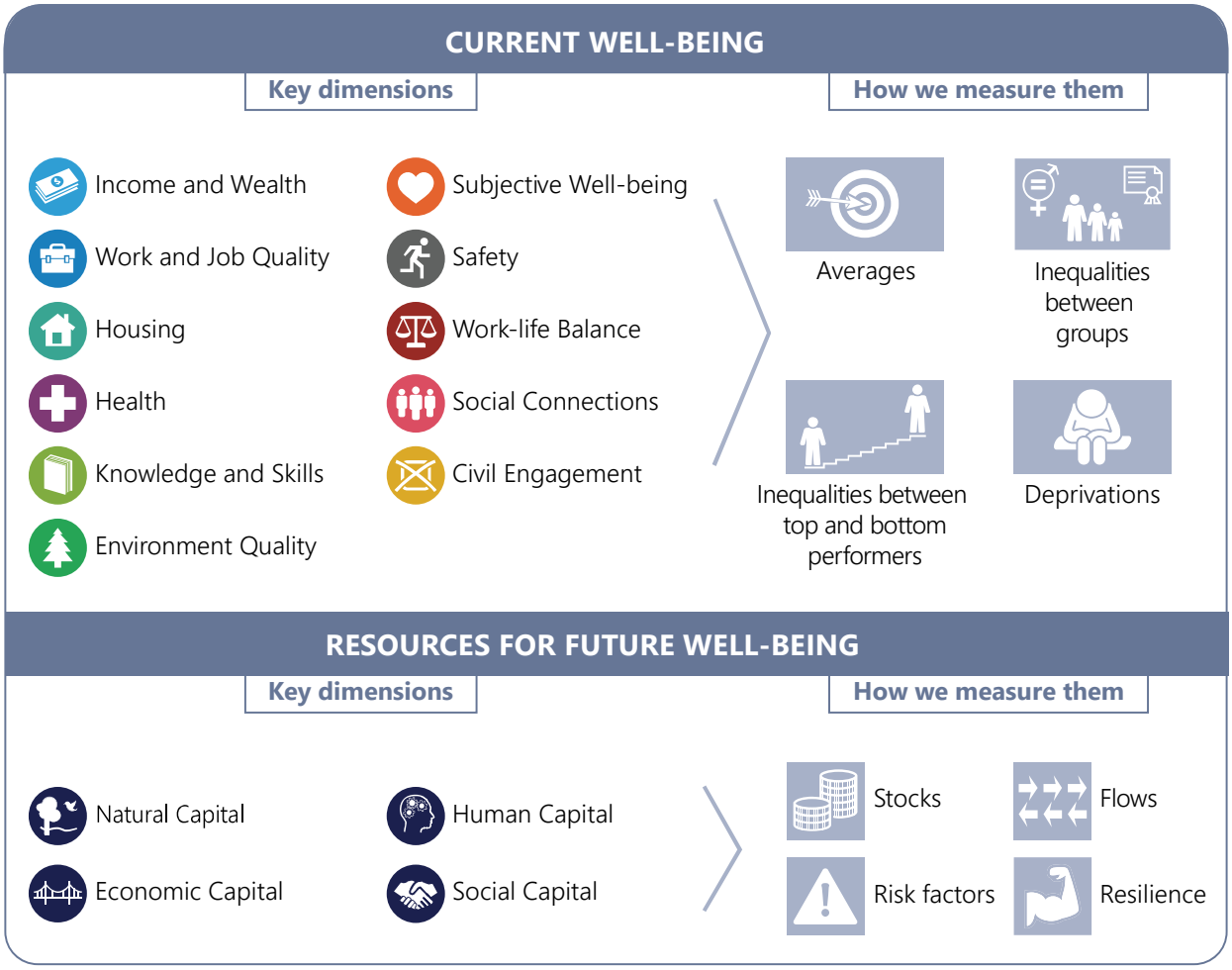
[2] This policy brief has been produced by the OECD Statistics and Data Directorate and the Inclusive Growth Initiative with inputs from the Directorate for Employment, Labour and Social Affairs, the Directorate for Education and Skills, and the Centre for Entrepreneurship, SMEs, Regions and Cities, under the leadership of Gabriela Ramos, OECD Chief of Staff, G20 Sherpa and Leader of the Inclusive Growth Initiative.

coronavirus could be long-lasting, acting on well-established fragilities in the system. This in turn will pose another set of indirect risks to people's health and well-being that will play out over a longer period of time, and have widespread impacts across the population, as already witnessed during the Great Recession (OECD, 2013[6]; OECD, 2015[7]; OECD, 2017[8]).

Immediate short-term government responses are needed to save lives and livelihoods today. Yet the crisis could provide useful lessons for longer-term change to build greater resilience in the systems that support well-being over time. This includes building social connections and social capital; opening up new ways of working and living; and reinforcing the capacity of public services and social safety nets to react in times of crisis. It also builds a case for redoubling efforts to reduce or mitigate sources of vulnerability associated with job insecurity, poor quality housing, poor environmental quality, mental and other health challenges and social isolation.

This note further looks at the different dimensions which are and will continue to be impacted by the COVID-19 crisis and its aftermath, by drawing on the OECD's Well-Being Framework (Figure 1). In particular, it explores the impact of COVID-19 on income and wealth, work and job quality, housing, subjective well-being, social connections, work life balance, environmental quality and safety.

## Figure 1. The OECD Well-Being Framework




Source: (OECD, 2020[9]), *How's Life? 2020: Measuring Well-being*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9870c393-en.

### *Income and Wealth: Financial insecurity was widespread, even before the current crisis*

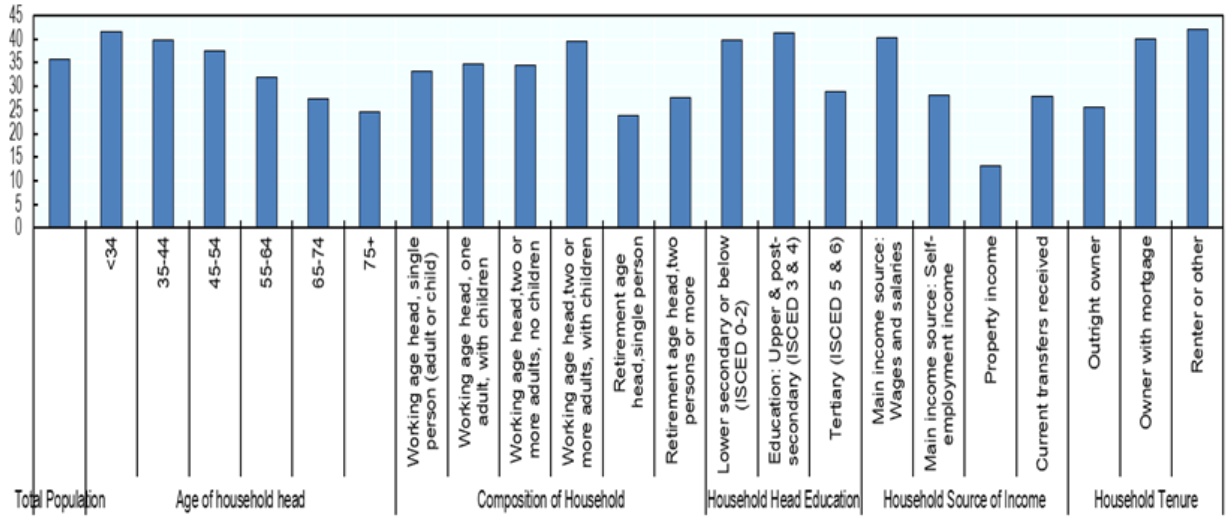
The coronavirus threatens to spread financial contagion in a world economy that was still healing from the scars of the Great Recession. While, since 2010, average household adjusted disposable income per capita has increased by 6% cumulatively across the OECD area, it was still below 2010 levels in Spain and Italy, two of the countries hit the hardest by the virus outbreak (OECD, 2020[9]). The transmission of lower GDP into lower household income may be faster in the current setting than was the case in 2008, as entire sectors of the economy come to a halt and large parts of the population are confined to their homes.

While governments are taking action to strengthen social safety nets (OECD, 2020[3]), it will take time to implement the complementary welfare policies addressed to non-standard workers and workers not covered by social safety nets. This is taking place in the context of increasing numbers of non-standard jobs in many OECD countries. Meanwhile, a large number of households have to deal with the prospect of falling into poverty due to a drop in their income linked to the health crisis, and limited financial buffers. In the OECD, more than one in three individuals are financially insecure – i.e., while they are not poor based on conventional income thresholds, they do not have enough financial assets to keep their family above the poverty line for more than 3 months, should their income suddenly stop. This risk is especially high for young people, people educated below tertiary level, and for couples with children (Figure 2), who are also among those who have to deal with school closures and new care responsibilities. Single parent families (especially those headed by women), may also face compounding challenges from a loss of income, difficulties with childcare, and a lack of family support.

While those with adequate financial resources will use them to support their consumption when confronted by an income shock, others will have to cut their household spending. Expenditures that are essential to daily life, such as food consumption at home, or those realised within the framework of contracts that are difficult to renegotiate in the short-term – e.g. rents, utilities, etc. – represent, on average, almost 75% of the disposable income of the poorest 20% of households (OECD-Eurostat, 2020[10]). Middle-income households will also struggle to make ends meet as one in five middle-income households spends more than it earns across the OECD. In most OECD countries, over-indebtedness is more widespread among middle-income households than among low and high-income households, and concerns around 11% of middle-income households on average (OECD, 2019[11]). This leaves a range of households at various levels of income with very few resources to cope with shocks. In these conditions, any loss of income or increased expenditure is likely to put these households under serious financial strain. Measures taken by a number of countries, such as rent deferrals or tax payment freezes, are welcome steps to alleviate the sudden loss of income.

## Figure 2. Younger people, couples with children and people educated below tertiary level are at greater risk of falling into poverty following a 3-month loss of income

Share of individuals who are financially insecure, by population group, latest available year, OECD average




Note: Financially insecure people are those who are not income poor, but have insufficient liquid financial wealth to support them at the level of the income poverty line for more than three months. Liquid financial wealth is defined as cash, quoted shares, mutual funds and bonds net of liabilities of own unincorporated enterprises. The OECD average excludes Colombia, the Czech Republic, Iceland, Israel, Lithuania, Mexico, Sweden, Switzerland and Turkey, as comparable data are not available. Country-specific data are available on request.
Source: (Balestra and Tonkin, 2018[12]), "Inequalities in household wealth across OECD countries: Evidence from the OECD Wealth Distribution Database", *OECD Statistics Working Papers*, No. 2018/01, OECD Publishing, Paris, http://dx.doi.org/10.1787/7e1bf673-en.

### *Work and job quality: The crisis will hit low-paid, insecure jobs hard but the middle class may also be severely affected*

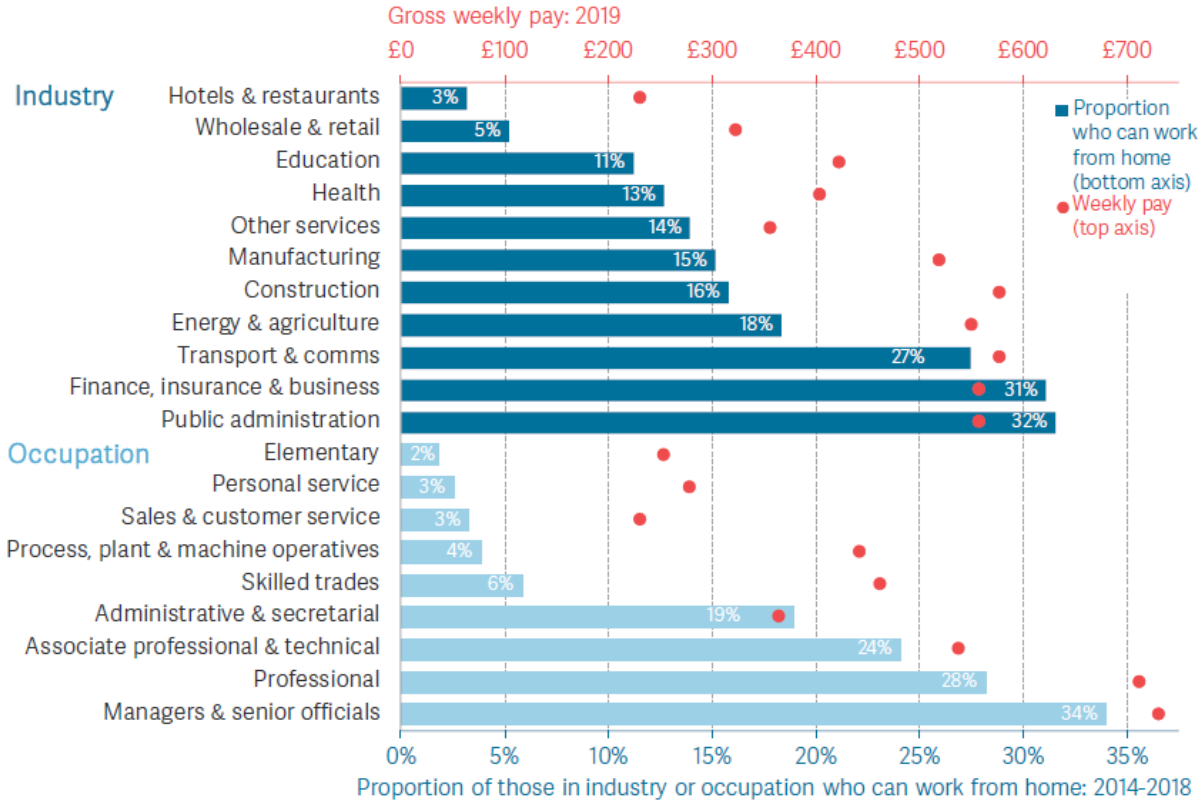
Measures taken to mitigate the health crisis, such as social distancing and closures in retail, transport, restaurants, hotels, and other service industries will hit low-paid and insecure workers particularly hard. Low-paid workers (full-time workers earning less than two-thirds of the national median) represent around 15% of all full-time employees across OECD countries on average. This ranges from 25% in Latvia and the United States, to fewer than 5% in Belgium and Turkey (OECD, 2020[9]). In some OECD countries, annual gross earnings have not yet recovered from the Great Recession. Between 2010 and 2018, average real earnings fell by 15% in Greece, by 6% in Spain and Portugal, and by 3% in Italy (OECD, 2020[9]). Lower-paid workers are likely to have fewer savings to fall back on in the event of income loss (see above).

Teleworking may reduce some of the immediate economic impacts of social distancing measures, but in practice it is restricted to a small share of workers, some of whom will be juggling additional care responsibilities in the event of school closures, as well as the need to support vulnerable or self-isolating friends and family both inside and outside the household. UK data indicates that, before the COVID-19 crisis, teleworking was largely limited to higher-paid workers (Figure 3). Even among this group, in 2014-18, only around one-third of managers, professionals, public administration employees and those working in finance, insurance and business roles could work from home if needed (Resolution Foundation, 2020[13]). A similar pattern was also observed in the 2015 European Working Conditions Survey (OECD, 2016[14]). Under the current circumstances, actual figures may be lower, since full workplace closures (from factories through to court houses) will limit how much even managers and professionals can get done whilst working remotely. At the same time, the COVID-19 crisis is prompting employers to extend teleworking opportunities where possible, leading to greater investment in teleworking infrastructures that could bring

some long-term benefits (see Work-Life Balance section, below). Yet this will be of little solace to those unable to telework, either because they are working on the front line and exposed to infection, or because their workplaces have closed and their jobs may be at risk.

### Figure 3. Lower paid workers are less likely to be able to work from home

Proportion of employees who can work from home if needed, by gross weekly pay, industry and occupation: UK, 2014-2018/ 2019




NOTES: Work from home data is from waves 6 and 8 of Understanding Society. Pay data is from the 2019 quarters of the Labour Force Survey.
SOURCE: RF analysis of ISER, Understanding Society; ONS, Labour Force Survey.

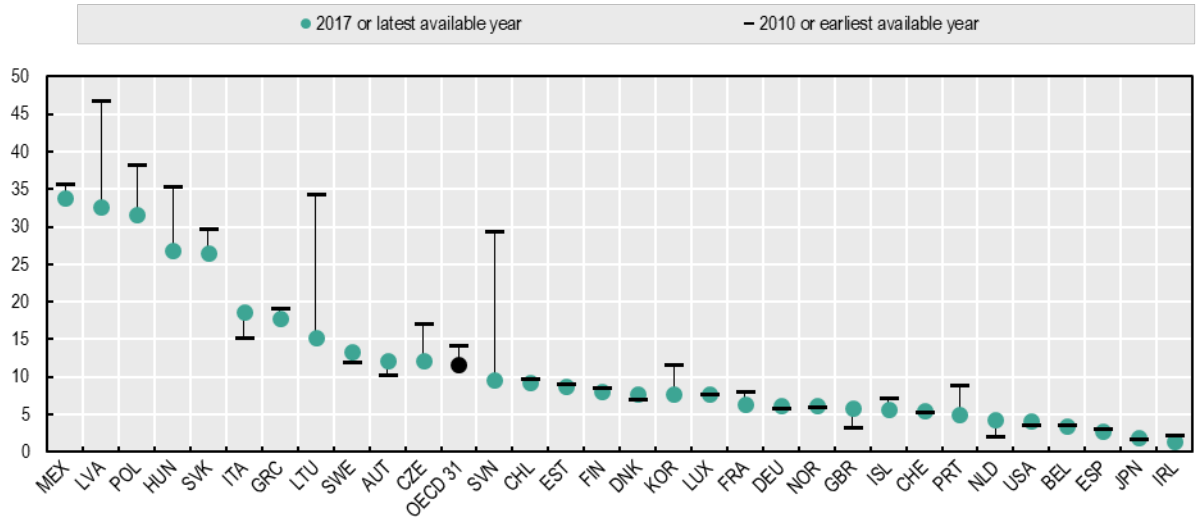
Source: (Resolution Foundation, 2020[13]), *Doing what it takes: Protecting firms and families from the economic impact of coronavirus,* https://www.resolutionfoundation.org/publications/doing-what-it-takes/.

### *Housing: Poor conditions put people at greater risk*

Nearly 12% of OECD households, on average, live in crowded conditions (Figure 4). This is likely to add to the psychosocial strains of confinement and social distancing measures, whilst also making it very difficult to isolate symptomatic individuals from other household members. Access to basic sanitation (i.e. an indoor flushing toilet for the sole use of the household) is still a challenge among poorer households in some OECD countries, and will be important for limiting the spread of the virus between households living in close proximity. In 2017, 6.8% of poor households lacked basic sanitation in the OECD on average, rising to over 25% in Mexico, Lithuania and Latvia (OECD, 2020[9]).

## Figure 4. More than 25% of households in Mexico, Latvia, Poland, Hungary and the Slovak Republic live in overcrowded conditions

Share of households living in overcrowded conditions, percentage




Note: A house is considered overcrowded if less than one room is available in each household: for each couple in the household; for each single person aged 18 or more; for each pair of people of the same gender between 12 and 17; for each single person between 12 and 17 not included in the previous category; and for each pair of children aged under 12 years (Eurostat, 2019[2]). The latest available year is 2016 for Iceland, Japan, Mexico, Switzerland, the United Kingdom and the United States, 2014 for Germany and 2013 for Chile. The earliest available year is 2011 for Chile and Estonia. The OECD average excludes Australia, Canada, Colombia, Israel, New Zealand and Turkey due to a lack of data
Source: (OECD, 2020[9]), *How's Life? 2020: Measuring Well-being*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9870c393-en.

Up to a quarter of households in ten OECD countries lack a personal computer; in Turkey and Mexico, fewer than half of households have access to a computer at home (OECD, 2020[3]). Reliable, high-speed internet access at home is also essential for large-scale teleworking and home schooling. It provides an important source of public information, and acts as a critical lifeline to connect people who are socially isolated or vulnerable or may need remote medical assistance or community support (e.g. delivery of groceries and medicines). In 2018, 85% of households in 29 OECD countries had access to broadband internet services. Yet coverage is below 60% in Mexico, below 70% in Japan, and below 80% in New Zealand, Greece, Portugal, Australia, the United States, Lithuania, Latvia, the Slovak Republic and Poland (OECD, 2020[9]).

Homeless populations represent another cut off and vulnerable group. They have no means of self-isolating, and where they do have shelter available it is typically in hostels with limited means of isolation or protection for at-risk individuals (such as those with existing health conditions). While country comparisons are challenging due to different definitions and methods of data collection, it is estimated that around 1.9 million people across OECD countries are homeless (OECD, 2020[15]).

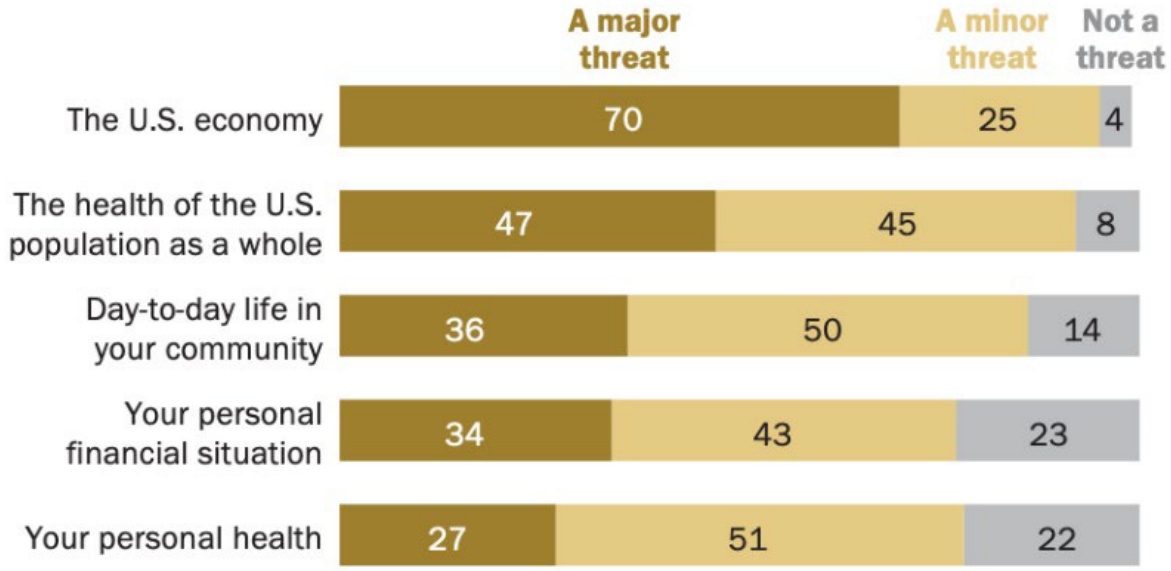
Governments can provide immediate support for lost employment and income, extend sick pay to excluded workers, and provide immediate shelter for homeless populations (OECD, 2020[3]). Nevertheless, it is much harder to address overcrowded household conditions, access to basic sanitation and digital exclusion on a short-term basis. In that sense, poor housing conditions represent a systemic risk for the impacts of health crises, requiring a longer-term government response to build resilience. In the shorter term, people living in overcrowded and/or unsanitary conditions may need to be prioritised for hospitalisation or other forms of out-of-home care, in order to protect other vulnerable household members. Similarly, those living alone in very isolated circumstances are likely to need additional forms of community support and care during periods when staying at home is advised.

### *Subjective well-being: Anxiety, stress and risks to mental health*

The COVID-19 pandemic is having immediate effects on people's anxiety and stress. An early Gallup Social Series Poll (conducted 2-13 March 2020) indicated that 60% of Americans were "very" (26%) or "somewhat" (34%) worried that they or someone in their family will be exposed to the novel coronavirus (up from 36% on 3-16 February) (McCarthy, 2020[16]). Levels of fear are higher among non-whites compared to whites, and among lower-income groups compared to higher income groups. Fears also extend to the state of the economy: the same poll found that 86% of Americans believe the virus will have a "very" or "somewhat" negative impact on the global economy (up from 65% in the February poll). Other surveys from the Pew Resarch Center in early March (Figure 5) also indicated widespread concerns (Pew Research Center, 2020[17]), and this before confirmed coronavirus cases in the United States began sharply escalating. Fears about health and personal finances are notably higher among Hispanics than for the overall US population (Pew Research Center, 2020[18]).[3]

**Figure 5. More Americans view coronavirus outbreak as a major threat to the nation than to their own health and finances**

How much of a threat is the coronavirus outbreak for_____? (%)




Note: No answer responses not shown. Survey of United States adults conducted March 10-16, 2020.
Source: (Pew Research Center, 2020[17]), U.S. Public Sees Multiple Threats From the Coronavirus – and Concerns Are Growing, https://www.people-press.org/2020/03/18/u-s-public-sees-multiple-threats-from-the-coronavirus-and-concerns-are-growing/pp_2020-03-18_coronavirus_0-01/.

The psychological impacts of short-term social distancing and quarantining measures will be shaped by other household and individual circumstances outlined in this note (e.g. prospects of job and income losses; housing quality; the presence of existing medical conditions and vulnerable persons in the household; personal safety; family separations and the illness or loss of loved ones, the degree of social isolation, etc.). Research on previous epidemics and outbreaks of contagious disease have tended to focus

[3] These surveys were conducted in relatively early days of the pandemic, and it is likely that the level of concern among the population groups and across the various dimensions (e.g. economy, personal health and financial situation) is evolving rapidly.

on individuals quarantined on a mandatory basis, often in government facilities, during outbreaks with a higher mortality rate than COVID-19 (Brooks et al., 2020[19]). Nevertheless, some wider lessons for policy-makers responding to the COVID-19 crisis can be drawn, as detailed in Box 1.

Research on previous epidemics has also pointed to some long-lasting psychological impacts among those who fall ill. For example, a cohort study of SARS survivors receiving hospital treatment in Hong Kong found that the cumulative incidence of psychiatric disorders was 59%. At 30 months post-SARS, one-third of the cohort were suffering psychiatric disorder. One-fourth experienced post-traumatic stress disorder, and 16% experienced depressive symptoms (Mak et al., 2009[20]). During the 2003 SARS outbreak, a range of psychiatric morbidities, including persistent depression, anxiety, panic attacks, psychomotor excitement, psychotic symptoms, delirium, and even suicidality, were reported. Healthcare workers were among those affected, for example experiencing depression, anxiety, fear, and frustration, and post-traumatic stress disorder (Xiang et al., 2020[21]). Access to digital communication technology, especially video-based technologies, has however vastly increased since 2003, and this could help to lessen some of the negative impacts of confinement or social isolation, both for the general population (staying in touch with friends and family) and for those accessing some mental health services (e.g. online psychological therapy).

More broadly, health conditions, social connectedness, trust in others, employment, and income are all important drivers of subjective well-being – and all are potentially at risk in the current crisis. In 2018, around 7% of people suffered from very low life satisfaction[4] on average in OECD countries, and 1 in 8 people experienced more negative than positive feelings on a typical day (OECD, 2020[9]).

### Box 1 Potential psychological impacts of social distancing and confinement policies

In the absence of a vaccine or cure for COVID-19, non-medical interventions such as social distancing and confinement are playing an important role in slowing the spread of the disease and therefore reducing extent to which healthcare services are overwhelmed, causing preventable loss of life (OECD, 2020[1]; OECD, 2020[2]). According to UNESCO monitoring (as of 27 March 2020), more than 160 countries have now implemented nationwide school closures, impacting over 87% of the world's student population (UNESCO, 2020[22]). Several OECD countries or regions (e.g. the Czech Republic, Italy, France, Spain and Bavaria [Germany]) have implemented highly restrictive lock-down policies that involve mandatory confinement at home for the full population, other than for essential travel such as food shopping, or for key workers such as medical staff (OECD, 2020[2]).

Social distancing or mandatory confinement are likely to have psychosocial, as well as physical and mental health impacts, although these will prove very difficult to assess in the short-term. An unsettled time of anxiety, panic, and fear, coupled with disruption to positive health habits and other routines, the threat of job and income losses, and increased pressure on healthcare systems making it difficult to access support could each contribute to increased risk (OECD, 2020[2]). These risks also extend to children: even when out of school for much more benign reasons (such as weekends and summer holidays), evidence suggests that children are less physically active, spend much longer on screen time, experience more irregular sleep patterns, and follow less healthy diets (Wang et al., 2020[23]). Being confined indoors, without the opportunity to meet with friends, could deepen these challenges for children and adults alike.

(Brooks et al., 2020[19]) review of research from previous epidemics and outbreaks of contagious disease suggests that, to limit the psychological impacts of quarantines, authorities should:

- Keep the quarantine period as short as possible

[4] Defined as reporting 4 or below on a scale from 0 (not at all satisfied) to 10 (completely satisfied).

- Give people as much information as possible
- Provide adequate supplies of medical material
- Pay special attention to health-care workers
- Rely on altruism rather than compulsion when possible

The European Centre for Disease Prevention and Control (2020[24]) also highlights a number of considerations for governments implementing social distancing or confinement measures, including:

- Social and political factors
- Human rights and the proportionality of response
- Risk communication
- Countering stigma
- Support for people and communities subjected to social distancing
- Special support for vulnerable groups
- Promoting solidarity and mutual community support
- Financial compensation for lost income and employment
- Ensuring business continuity
- Process and impact evaluation

Positive mental health can also be supported by governments in a number of ways, both during and after the peak of the pandemic (OECD, 2020[2]). These include: providing online resources; advice to general practitioners and other frontline care workers about identifying individuals at risk of mental health problems or loneliness, as well as options for treatment and referrals; allowing pharmacists to renew prescriptions where appropriate; offering telemedicine consultations and allowing for the continuity of psychological and psychiatric treatment where possible; and reinforcing resources for mental health services in the aftermath of the pandemic.

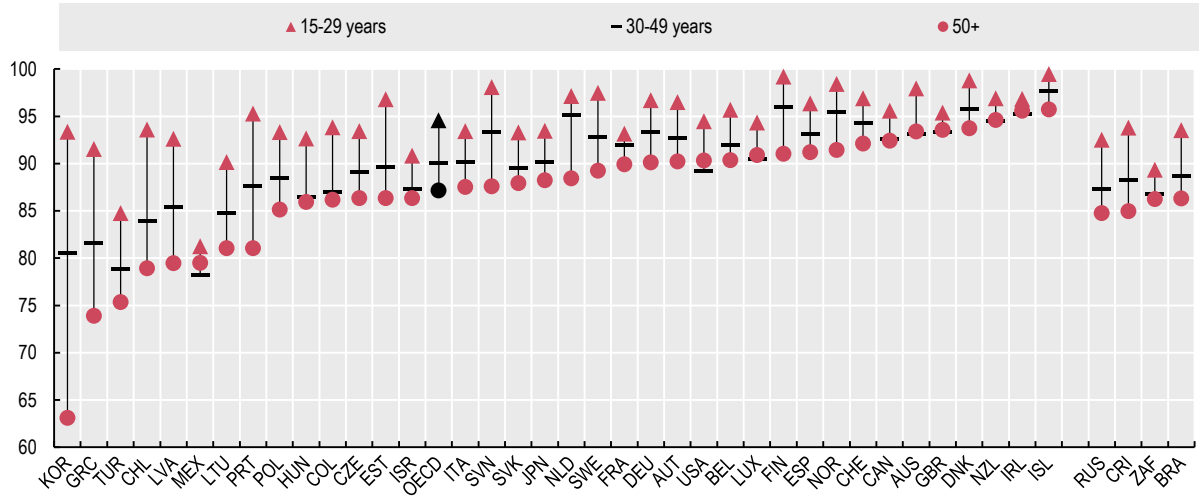
[1]: i.e. advising or legally compelling the population to remain at home, other than for a limited number of essential activities (e.g. food shopping, medical care, care for vulnerable people, limited exercise for people and dogs, and going to work for people in key services and care roles).
Source: (Brooks et al., 2020[19]; European Centre for Disease Prevention and Control, 2020[24]).

### *Social Connections: A vital lifeline*

Both voluntary social distancing and mandatory confinement policies have obvious implications for people's ability to maintain social relationships beyond immediate household members – whether for instrumental or emotional support, or simply for companionship. Around 31% of people in OECD countries live alone (OECD, 2016[25]), and will thus most likely be confining alone – bringing an additional set of risks in the case of illness, including for those being discharged from hospital early to make way for COVID-19 patients. On average across OECD countries, 1 in 11 people report having no-one to count on for support in times of need – and feelings of social support are generally lower among older people (Figure 6) (OECD, 2020[9]). Thus, in addition to being more physically vulnerable to the impacts of COVID-19, older people are more socially vulnerable as well (see below), including when it comes to getting access to food and other products and services.

## Figure 6. Older people have less social support

Share of people reporting that they have relatives or friends that they can count on to help them in times of need, by age, percentage, 2010-18 pooled data




Note: Countries are ranked in ascending order of social support among those aged 50 and above.
Source: (OECD, 2020[9]), *How's Life? 2020: Measuring Well-being, OECD Publishing*, Paris, https://dx.doi.org/10.1787/9870c393-en.

On average, people in OECD countries typically spend just 6 hours per week on social interactions with friends and family.[5] Although trend data in this field are scarce, studies in 7 OECD countries point to a worrying reduction of nearly 30 minutes on average over the past decade or so (OECD, 2020[9]). Under confinement measures or social distancing, the time for face-to-face interactions with household members will likely increase significantly, which could bring positive benefits to family connectedness. However, since it is not occurring through choice alone, it could also aggravate any underlying household tensions – particularly if extended over a prolonged time period, if livelihoods are under threat, or if teleworking is being combined with the need to home-school and care for young children or older family members.

At the same time, face-to-face interactions with friends and family outside the household will reduce to near-zero if social distancing measures are effective. This could cause considerable distress for those unable to visit elderly and vulnerable family and friends outside the home for a period that could last several months[6] – and these are also the social groups least likely to be able to make use of technological solutions for connecting remotely. Overcoming such digital divides will be critical to reduce the isolation and loneliness that many people in vulnerable groups already suffer, and which could be badly exacerbated by COVID-19. The risks of social isolation and loneliness for both physical and mental health are considerable (Klinenberg E., 2016[26]; Pantell et al., 2013[27]; House, Landis and Umberson, 1988[28]; Holt-Lunstad, Smith and Layton, 2010[29]) and need to be addressed by policy measures, for instance through regular check-ins by social services, civil society and volunteers.[7]

[5] This statistic refers to social interactions with friends and family as a primary activity, i.e. it excludes interactions that occur alongside other focal activities such as work, caring or studying.

[6] For example, starting on 23rd March 2020, the United Kingdom Government urged 1.5 million people in England with health conditions that make them particularly vulnerable to COVID-19 to stay at home for 12 weeks (Pickard, 2020[83]).

[7] Some countries are making use of traditional services to provide non-traditional tasks. For example, postal services in Ireland are checking-in on the elderly and delivering essential supplies to those in need.

Anecdotal reporting suggests that the pandemic may be prompting wider acts of solidarity (World Economic Forum, 2020[30]). Increases in social support were also documented in a random sample of the general Hong Kong population following the 2003 SARS outbreak (Lau et al., 2006[31]). A large psychological literature has documented the important direct and buffering roles that social support plays during times of stress (Cohen and Wills, 1985[32]; Bowen, Uchino and Birmingham, 2014[33]; Cohen, 2005[34]; Cohen et al., 2014[35]). In the face of extended social distancing measures, it will be important to sustain social connectedness and solidarity beyond the initial novelty-value of being stuck at home, particularly in the face of prolonged and strict confinement measures.

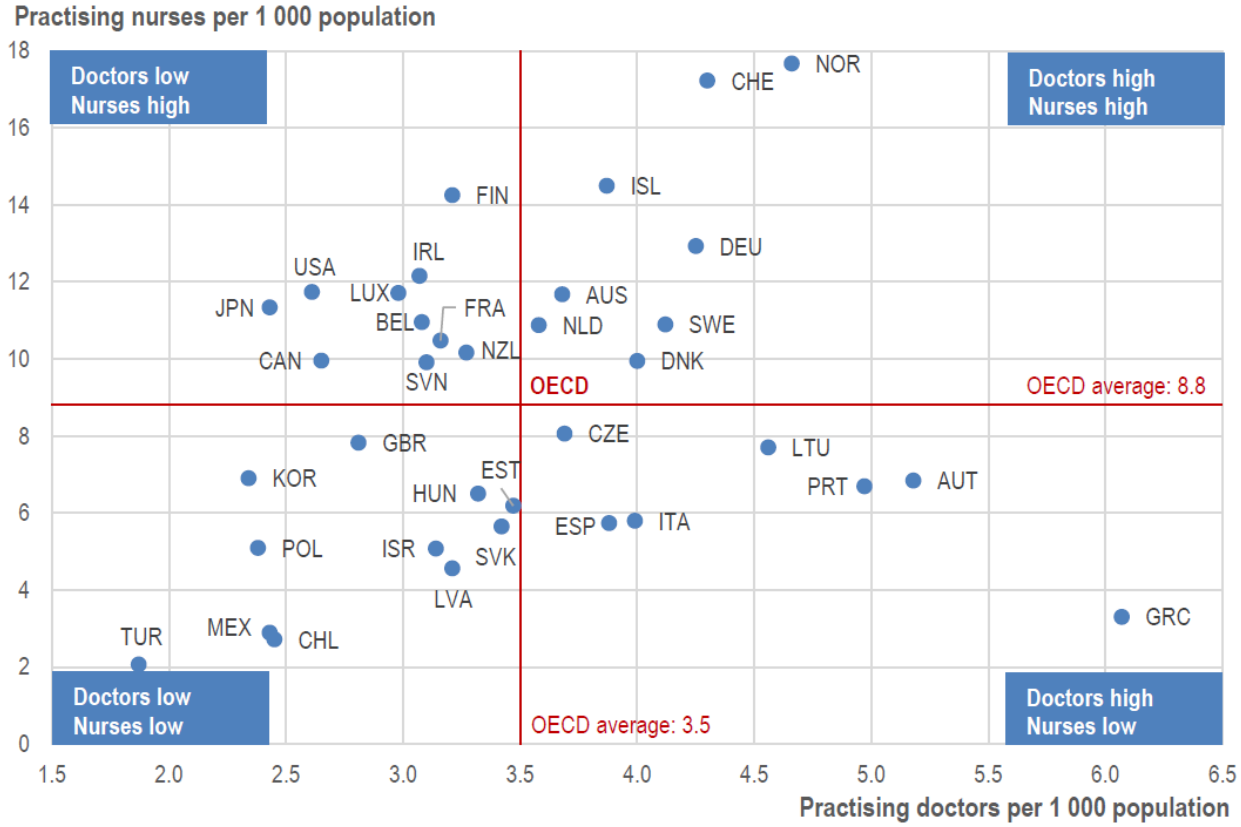
## Work-Life Balance: Pressure on the front line; a mass teleworking experiment for the lucky few

Key workers (e.g. in healthcare, homecare and care homes) are at particular risk of stress and burnout in the face of the pandemic. Even in "business as usual" circumstances, work-related stress, depression or anxiety are more prevalent in public service occupations, such as health and social care (Health and Safety Executive, 2019[36]; European Agency for Safety and Health at Work, 2009[37]). In the current crisis, direct exposure to greater risks of infection, long working hours, equipment, bed, and information shortages, and high mortality rates among patients (who are unable to have friends or family visit them) are taking a heavy toll on frontline staff, some of whom will be facing daily "life or death" decisions. Those same frontline staff may also face additional pressures at home as a result of caring responsibilities, the need to home-school children whose schools have closed, or the need to physically distance themselves from vulnerable people living in their own households. Data from the United Kingdom indicate that 42% of key workers have at least one child aged 16 years of below, that 28% of key workers with dependent children have a partner who is also a key worker, and that a further 16% of key workers with children under 16 years are single-parents (as compared to 11% for other workers) (Institute for Fiscal Studies, 2020[38]). This underscores the work-life conflicts likely to be faced by individuals in life-saving roles on whom the whole population now depend more than ever.

Measures are being implemented to arrange childcare for key workers and boost healthcare staff capacity in OECD countries, and this is a welcome step (OECD, 2020[1]). Those countries that have low numbers of doctors and nurses per head of population (e.g. Turkey, Mexico, Chile, Poland, Israel, Latvia, the Slovak Republic, Estonia, Hungary, Korea and the United Kingdom) may face particular challenges in coping with the pandemic (Figure 6). Equipment shortages, such as protective clothing, beds, and most notably ventilators, add considerably to the strain that healthcare professionals are experiencing.

## Figure 7. Countries with fewer doctors and nurses per head of population will be even more stretched in the face of additional demand from COVID-19

Number of doctors and nurses in OECD countries, 2017 (or nearest year)




Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: (OECD, 2020[1]), "Beyond Containment: Health systems responses to COVID-19 in the OECD", OECD briefs on the policy response to the COVID-19 crisis, OECD, Paris, https://oecd.dam-broadcast.com/pm_7379_119_119689-ud5comtf84.pdf.

Many workers, and particularly low-paid, self-employed and other precarious workers (e.g. gig workers), could find themselves out of work (or even out of a job) in the coming months – although the unprecedented nature of the current situation makes difficult to predict the extent to which different categories of workers will be affected. For a relatively small share of mostly office-based professionals and managers, meanwhile, teleworking has become the new normal in the face of workplace closures. This is happening alongside large-scale restrictions on international travel and increased use of digital tools for video- and phone-conferencing. A shift of this nature was very unlikely to have happened under "business as usual" circumstances, and could lay the foundations for more enduring changes in ways of working. This could offer employees greater flexibility to improve their work-life balance, reduce the climate impacts of business travel, and make access to high-quality education possible for a wider range of people – whilst at the same time making it harder for the digitally excluded. Several factors could hamper the success of the great teleworking experiment currently underway, such as the implementation of measures at extremely short notice; the need of many workers to juggle work and caring responsibilities; and the absence of connectivity for many households. Online learning meanwhile requires strong investment in pedagogical skills, and content related work to make it effective. At a minimum, the current circumstances will make both employers and employees, as well as school children and university students, more aware of the critical success factors for mass teleworking, enabling greater resilience to be built into systems for the future.

### *Environmental Quality: A helping hand from falling pollution and access to green space*

Nearly two-thirds of the OECD's population is exposed to a level of small particulate matter air pollution that puts health at risk (OECD, 2020[9]). Outdoor air pollution caused more than 3 million premature deaths in 2010, with elderly people and children the most affected. OECD projections imply a doubling, or even tripling, of premature deaths from dirty air by 2060 (OECD, 2016[39]). The actions taken to address the COVID-19 epidemic in China led to a decrease in fine particulate matter in February 2020 compared to the previous three years, with reductions of around 20-30% over large parts of China (European Space Agency, 2020[40]). Since the country went into lockdown on 9 March, nitrogen dioxide levels in Milan and other parts of northern Italy have also fallen (European Space Agency, 2020[41]). These reductions in air pollution will prove beneficial to people with respiratory problems or asthma, considered more susceptible to COVID-19, as well as reducing negative side-effects of pollution such as increased inflammation and lowered immunity (Glencross et al., 2020[42]).

Under confinement conditions, movement may be restricted, and public spaces and parks may be closed (e.g. at the time of writing in France, only one period of daily outdoor exercise is permitted per person, limited to within 1 km from their home). Many urban families are confined to small apartments. Access to green space provides numerous health and well-being benefits, including psychological relaxation, stress reduction, enhanced physical activity, the mitigation of exposure to air pollution, excessive heat and noise, improved social capital and pro-environmental behaviours (WHO Regional Office for Europe, 2016[43]; Engemann et al., 2019[44]). On average in European urban areas, 93% of people have access to public parks, forests or other recreational green spaces within 10 minutes' walking distance from their home. However, fewer than 90% do in Iceland, Portugal, Italy and Denmark (OECD, 2020[9]) (and comparable data are not available for non-European OECD countries). People living under confinement need ways to access green space safely, while respecting social distancing requirements.

### *Safety: Threats from near and far*

Mandatory confinement poses particular problems for people at risk of domestic abuse, with support groups already sounding the alarm about the potential for abuse cases to rise during the pandemic (Mahdawi, 2020[45]; Selvaratnam, 2020[46]). Intimate partner violence (IPV) is a common form of abuse: one in three women have experienced physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime (OECD, 2019[47]; WHO, 2013[48]). Male intimate partners carry out most of this violence: globally 30% of all women who have been in a relationship have experienced physical and/or sexual violence by their intimate partner, and intimate partners commit 38% of all murders of women (WHO, 2013[48]). The WHO Regional Office for Europe estimates that, across the WHO Europe Region, the lifetime prevalence of childhood sexual abuse is almost 10% (5.7% of boys, 13.4% of girls), physical abuse almost 23%, and emotional abuse 30%. In addition, almost 15% of children witness intimate partner violence in the home (Sethi et al., 2013[49]; OECD, 2019[50]).

Cybercrime also poses heightened risks in the present circumstances.[8] With many shops, services and offices shut, and a significant number of people isolating themselves, an increased number of people will be relying on goods and services purchased online. Cybersecurity concerns are paramount for the many businesses that are reliant on the internet to continue functioning during the pandemic, including with workers connecting through home networks with fewer safety features. Cybersecurity incidents are already widely experienced in OECD countries (Figure 8). In 2017, around one in five people in OECD countries reported to have experienced a cyber-security incident, with higher shares in France, Luxembourg and

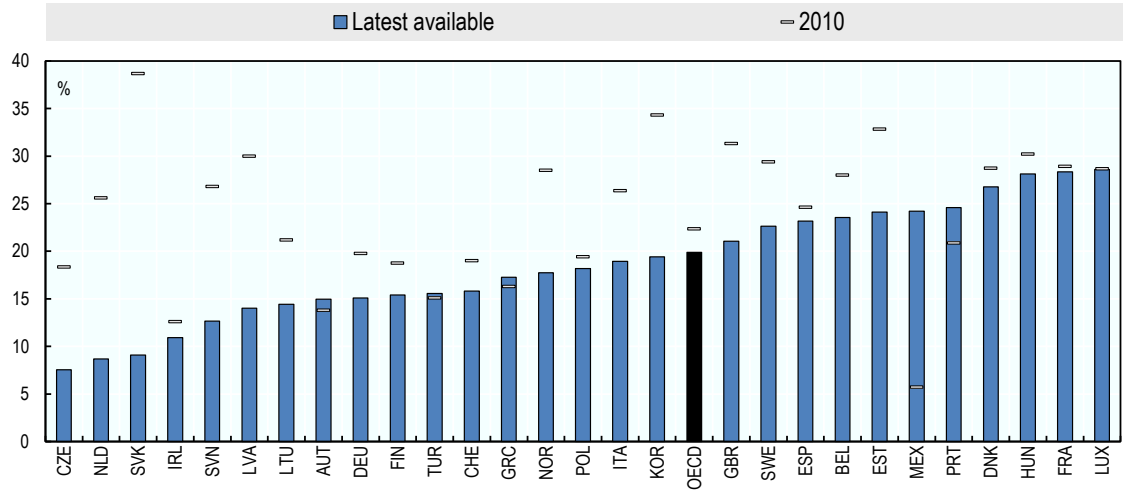
[8] For detailed advice on cybersecurity through the Covid-19 crisis, see the forthcoming OECD policy brief on digital security during COVID-19.

Hungary. The share has fallen, on average, since 2010, but changes in internet use and behaviours during the pandemic could bring additional risks (see the forthcoming OECD Brief on Digital Security Policy).

Panic and desperation also leave people vulnerable to online and doorstep fraud, as they try to source essential items now in short supply. The United Kingdom's national fraud and cyber-crime reporting centre, Action Fraud, has recorded nearly 970 000 GBP's worth of fraud associated with coronavirus scams between 1 February and mid-March – mostly associated with ordering online goods (facemasks, hand sanitiser) that never arrived (Action Fraud, 2020[51]). Bogus door-to-door home testing kit scams (Action Fraud, 2020[52]) as well as cons targeted towards vulnerable people needing help with shopping for groceries and collecting medicines whilst self-isolating have also been highlighted. Consumer groups are also reporting fake medicines and cures offered online (Studman, 2020[53]) and profiteering on the part of companies supplying scarce goods (hand sanitiser, thermometers, baby formula and tampons) at exorbitant prices (Walsh, 2020[54]).

### Figure 8. In 2017, around one in five people in OECD countries reported experiencing a recent cyber-security incident

Share of individuals who report having experienced online security incidents in the last 3 months, 2017




Note: Latest available data is from 2015 for all countries, except for Korea and Mexico, where latest data is from 2017; and Chile and Switzerland, for which latest data is from 2014. For Korea, results include both private and business purposes, and the reference period is 12 months. For Mexico, in 2017, the following categories are considered: "virus infection", "excess of unwanted information", "fraud with information (financial, personal, etc.)" and "violation of privacy". For Switzerland the reference period is 12 months. Data is available for Canada and New Zealand for 2012, but is methodologically too different to include here. The OECD average is population-weighted.
Source: (OECD, 2019[55]), *How's Life in the Digital Age?: Opportunities and Risks of the Digital Transformation for People's Well-being*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264311800-en.

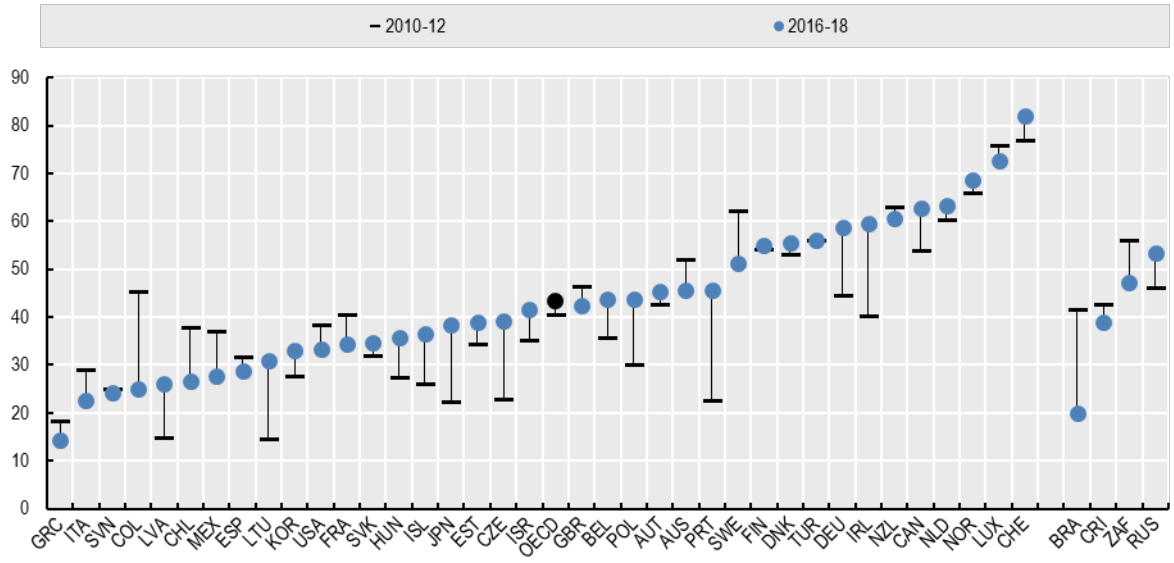
### *Social capital: Trust more important than ever, but starting from a fragile position*

Prior to the coronavirus outbreak, societal trust was already in a fragile position. When people are asked whether they trust other people (0 meaning no trust and 10 meaning complete trust), the average score in OECD countries is 6.1. After a general deterioration in the aftermath of the 2007-08 financial crisis, trust in public institutions improved by 3 percentage points across OECD countries between 2010 and 2018, although still less than half of the population (43%) trusts their national government. In addition, trust in government has fallen in some of the countries where it was already low. This could weigh on countries' capacity to put in place collective responses to the challenges that loom ahead.

More recent evidence suggests that trust in government may be particularly volatile at present. A recent Gallup Social Series Poll the United States (conducted on 2-13 March 2020) indicated that people's confidence in the Government's ability to handle the outbreak dropped by 16 percentage points, relative to a poll conducted one month earlier (from more than 75% in February, to 61% in March) (McCarthy, 2020[16]).

### Figure 9. Trust in government has been unstable since the global financial crisis

Share of the population responding "yes" to a question about confidence in the national government, percentage




Source: (OECD, 2020[9]), *How's Life? 2020: Measuring Well-being*, OECD Publishing, Paris, https://dx.doi.org/10.1787/9870c393-en.

## Focus on vulnerable groups and places

### *Elderly*

The COVID-19 outbreak poses significant challenges for older people. First, older people (and men in particular) have higher risks for developing serious complications in case of infection. Second, the development of illness in old age has the potential to significantly deteriorate their functioning and health status. Third, stronger confinement measures are directed at older people, changing significantly their day-to-day lives and restricting their independence. These challenges will be heightened for those in poor health, living alone or in long-term care, or caring for a family member. To put this in context, the share of the population aged 65 years or older in OECD countries has nearly doubled in recent decades, rising from less than 9% in 1960 to more than 17% in 2017.

COVID-19 will have significant impacts on older people's social connections. Limiting exposure to COVID-19 requires older people to self-isolate and rely on support networks, and local health and social care services for necessities, such as grocery shopping and cooked meals. The latest edition of *How's Life?* (OECD, 2020[9]) highlights the problem of social isolation among older people; in times of need older people are three-times more likely than younger people to report not having a family member or friend that they can rely on (the average number in the population is one in 11 people). Furthermore, many older people live alone, particularly women. For instance, across many G20 countries around one in three adults aged 65 years and older live alone; the share of women in this situation is almost twice that of men. Education

is also a factor, as across eight G20 countries older adults with lower educational attainment are more than 40% more likely to live alone than those with high educational attainment.

Taking care of the elderly who become sick will fall on the many older people who are carers for spouses or other family members. OECD research shows that family and friends are the most important source of care for people with long-term care needs in OECD countries. In European countries, around 13% of people aged 50 and over report providing informal care at least weekly for either a parent or spouse. The likelihood of caring for a spouse increases with age until plateauing at older ages (OECD, 2019[56]). This is particularly problematic given the transmission risks of COVID-19. Moreover, COVID-19 is causing the disruption of routine health care for the many older people with chronic health conditions – although in many countries taking care of elderly and sick relatives is still allowed under confinement.

COVID-19 poses particular risks for older people resident in long-term care facilities, in terms of increased mortality and low subjective well-being. A sizeable proportion of older people across OECD countries receive long-term care, an average of 10.8% of people aged 65 in 2017 (OECD, 2019[56]).

The communal living environment of long-term care facilities and the vulnerability of residents are conducive to the rapid spread of influenza virus and other respiratory pathogens (Lansbury, Brown and Nguyen-Van-Tam, 2017[57]; OECD, 2019[56]). To protect residents, some long-term care facilities have been shut off from visitors. The absence of contact with family members has, however, negative effects on psychological well-being, especially in the case of a prolonged outbreak. COVID-19 has caused a strong fall in share prices which may reduce considerably the material well-being and financial security of the elderly. At present, it is unclear whether stock market falls are a one-time correction or the beginning of a longer downward fall. In the latter case, there is a direct negative wealth impact on asset holders, which may affect funded pension programmes in particular. Further easing of monetary policies by central banks (especially by the ECB where deposit rates are already negative) has the potential to reinforce the negative income effect for pensioners and/or push savers towards higher risk investments. The financial effect will be smaller in countries where pensions rely less on private funds.

### *Women*

The OECD has published a policy brief entitled *Women at the Core of the Fight against COVID-19*, which provides a more detailed analysis of the impact of COVID-19 on women.[9] In summary, women are potentially more exposed to material hardships associated with the economic fallout from COVID-19. In the very short-term, it is likely that some sectors of the economy will be more affected than others. Most immediately, industries that rely on travel and on physical interaction with customers will inevitably be hit hard. This includes air travel, tourism, accommodation services (e.g. hotels), and food and beverage service activities (e.g. cafés, restaurants, and catering) and retail activities where women are overrepresented (OECD, 2020[58]). In general, women are likely to be more vulnerable than men to any crisis-driven loss of income, as women's levels of incomes are, on average, lower than men's and their poverty rates are higher. They also often hold less wealth than men, for a variety of reasons. Women may find it more difficult to secure alternative employment and income streams (such as piecemeal work) following lay-off, due to greater caring obligations.

Single parents, many of which are women, are likely to find themselves in a vulnerable position. Reliance on a single income means that jobs loss can be critical for single parent families, especially where public income support is weak or slow to react. Evidence from the 2008 financial crisis suggests that, in many countries, children in single-parent families were hit much harder by the recession than children in two-parent families, not only in terms of income and poverty, but also in terms of access to essential material goods and activities such as adequate nutrition and an adequately warm home (Chzhen, 2014[59]).

[9] For detailed advice on supporting women through the Covid-19 crisis, see (OECD, 2020[5]), Women at the core of the fight against COVID-19.

COVID-19 will increase the levels of women's unpaid work; and may also increase long hours in paid work. First, evidence from some OECD countries suggests that health and social care workers are likely to be carers for dependent children, and in cases more so than workers in other sectors (Cauchmez, 2019[60]). Women constitute an estimated two-thirds of the health workforce. In particular, women make up around 85% of nurses and midwives in the 104 countries for which data are available (Boniol, 2019[61]). In addition, 90% of the long-term care (LTC) workforce across the OECD are women. Second, much of women's unpaid work time is spent on child care. School closure and home confinement are likely to increase unpaid work time (OECD, 2020[58]).

COVID-19 will affect women's personal safety as it is likely to escalate the problem of violence against women. Evidence from past crises and natural disasters suggests that confinement measures often lead to increased violence against women and children. Indeed, early reports from social service providers in China and some OECD countries have shown an increase in domestic violence (DV) against women during the pandemic, as many women and children are trapped at home with their abusers (OECD, 2020[58]).

The COVID-19 crisis puts women and children at further risk of violence as it restricts women's ability to deploy their usual safety strategies; for example, not being able to stay with relatives or send children out to play when the level of abuse is escalating. COVID-19 is also disrupting the operation of formal support mechanisms, such as shelters and medical services, and access to legal remedies, such as court granted safety orders. The potential downstream consequences of COVID-19 – including higher unemployment (for women and men), lost wages, and job insecurity – are particularly dangerous for women in abusive relationships, as economic control is a key tool of abusers. Financial insecurity may force victims to remain with their abusers.

### *Children*

The COVID-19 outbreak has the potential to have significant impacts on child well-being, with the effects unlikely to be evenly distributed. The outbreak is increasing the day-to-day stress associated with caring for children and adding to parents' long-term worries around ensuring good quality care and home life for children. For children in some families, pre-existing stressors such as poverty, housing instability, social isolation, and limited access to good quality health care will increase. High levels of family stress increase the likelihood of intimate partner violence and parental health problems, including substance abuse and untreated mental health problems (Shonkoff, 2020[62]). Some of the impacts on well-being are likely be more intense during the suppression or containment phrases, while others will follow children into the long-term.

Evidence suggest that home confinement during health pandemics has enduring effects on child and adolescent psychological well-being (Wang et al., 2020[23]). A study by (Sprang and Silman, 2013[63]) found that the mean score for post-traumatic stress disorder was four times higher for children quarantined during health pandemics compared to those who were not. As parents are the closest and most important source of support for children during the COVID-19 crisis, the level of stress which they are under and their ability to cope is paramount for child well-being. Stressors during confinement include fear of infection and prolonged confinement, boredom and frustration, lack of personal space, loss of contact with peers and other adults, and financial worries. The burden of such stressors will weigh more heavily on some families, for instance those living in overcrowded or homeless accommodation, and low-income and single parent households. On average in OECD countries, almost one in three children in low-income families live in overcrowded housing, with the rate among children in single-parent families. Moreover, confinement will have an unfavourable effect on children's health behaviours, for example reduced physical activity, increased screen time and irregular sleep patterns, resulting in weight gain and loss of cardiorespiratory fitness (Wang et al., 2020[23]).

The success of interim educational measures implemented during school closures, for example remote learning, depends on the quality of children's home learning environment. Important factors include home

educational resources, availability of space, parental level education, parents' fluency in language of school instruction, and parents' digital competencies, but also parents' engagement with schools. In general, children from low socio-economic households are at a disadvantage for continuing their study and learning at home (http://www.oecd.org/social/family/child-well-being/).

OECD data underlines the differences in children's home learning environments, some of which during school closures will have even more pronounced effects on children's educational progress. First, PISA 2015 data shows that around one in four 15-year olds from low socio-economic households do not have a quiet space to study at home, and one in five do not have access to computer for school work nor an internet connection. PISA 2018 highlights large gaps between countries on these fronts; around one in four children in Mexico do not have access to a quiet space to study, whereas as few as one in twenty children in Austria, Finland, Germany, the Netherlands and Portugal face this problem. Second, parents' level of fluency in the language of school instruction will influence help available for children in following remote learning. This is particularly relevant for children with an immigrant background. PISA 2015 data highlights that the greater the linguistic distance between the language spoken at home and the language of instruction, the less likely a student will attain baseline academic proficiency in PISA tests (OECD, 2018[64]). Third, the OECD's Programme for the International Assessment of Adult Competencies (PIACC) data shows a strong relationship between socio-economic background and adult digital skills; in OECD countries a large share of low-educated lack very basic proficiency in ICT while basic ICT skills are nearly universal among tertiary- educated adults (OECD, 2019[65]). Fourth, PISA 2018 data shows that parents in socio-economically advantaged schools are more likely to initiate discussion with teachers on children's progress while in low socio-economically disadvantaged schools teachers are more likely to take the lead (OECD, 2018[66]).

Prolonged school closures will have a stronger impact on the well-being of vulnerable children. Research strongly underlines that the gap in educational performance between children by background widens during the school breaks and may account for two-thirds of the attainment gap by age 14 (Alexander, Entwisle and Olson, 2007[67]). Unequal access to educational and developmental activities are factors accounting for such gaps (Stewart, Watson and Campbell, 2018[68]). More than likely, children who receive limited parental support for completing homework will receive limited parental support for remote learning.

Vulnerable children rely on schools for other essential supports, such as hot meals, and access to recreational activities. Food poverty is a real issue for some children; one in five children in low-income families in European OCED countries do not have access to fresh fruits and vegetables and/or one meal including meat, chicken, fish or vegetarian equivalent at least once a day (OECD, 2019[50]). Schools also provide the opportunity for vulnerable children to be in consistent contact with supportive adults who can monitor their well-being and respond quickly to concerns. School closures may also mean an increase in time spent by vulnerable children in self-care (i.e. time spent unsupervised), if parents cannot make alternative childcare arrangements or work from home.

The COVID-19 outbreak severely compromises the effectiveness of child protection systems and safeguards for vulnerable children at a time of increasing risk. First, fewer supportive adults will be in regular contact with vulnerable children to monitor their well-being and report concerns. Second, child protection services, like other public services, are adopting measures to reduce contagion risk to the general public and these may include reductions in home visiting and prioritising the most serious cases only for intervention. Third, vulnerable children's access to protective factors such as mentoring and therapeutic interventions will be disrupted. In particular, the alternative care system will be under immense strain to provide and maintain care placements. Stressors include the higher average age of foster carers to birth parents, especially kinship carers (McDermid et al., 2012[69]); increased levels of anxiety and distress in the caring environment, and increased behavioural problems among children; and disruptions in school placements and family contact.

The COVID-19 outbreak presents specific challenges for the well-being of children with disabilities, in particular across education, health, and social and family life dimensions. It has introduced significant stress and disruption to the lives of children who under normal circumstances are used to and need structure and routine. During school closures, children with disabilities are more likely to miss out on their education. For instance, the suitability of remote learning depends on children's individual needs and schools' ability to provide tailored tuition. They also face considerable disruptions to therapeutic services that are critical for supporting the development of communication and social-emotional skills and helping children cope better at school and at home. In particular to children with higher needs, disruption to schooling and respite care placements have the potential to push some families into crisis. Moreover, the presence of a sibling with a disability in the home will compromise parents' abilities to meet the new demands of home schooling for other children and managing heighten levels of family stress.

### *Youth*

COVID-19 exposes vulnerable youth to higher risks of disengagement and drop-out from education and training and may increase the overall number not in education, employment or training (NEET). Although the reasons for disengagement and drop-out are complex and develop over time (Aarkrog et al., 2018[70]), COVID-19 may act as a potent multiplier through a number of pathways. These include declines in performance and loss of motivation due to break in education or training; loss of connections with supportive adults and positive peer interactions: and increases in household poverty and higher household stress. Furthermore, the larger practical or workplace learning components of vocational education and training, compared to other forms of educational instruction, make it less adaptable to remote learning.

Young people who are NEET is a longstanding issue for OECD countries; 2018 data indicate that 1 in 10 youth aged 15-24 years are NEET, on average (OECD, 2020[9]). Up to 40% of all youth experience a period of inactivity or unemployment over a four year period, but for half of them this period will last a year or more and may lead to discouragement and exclusion. The high number of NEETs also represents a major economic cost, estimated at between USD 360 billion and USD 605 billion, equivalent to between 0.9% and 1.5% of OECD GDP. In general, NEET is higher among young women, mainly due to caring obligations (OECD, 2019[71]).

COVID-19 has the potential for long-term effects on youth unemployment, based on previous large economic shocks. During the Great Recession, almost 1 in 10 jobs held by workers under 30 were destroyed. In the countries most affected by the crisis, for example Spain, Greece and Ireland, the number of employed youth halved between 2007 and 2014. Up until now, despite the recovery, the youth employment rate across OECD countries has stagnated since 2010 and is still below pre-crisis levels. Young people with low levels of educational attainment (below upper-secondary) were most vulnerable during the economic crisis and have continued to be so during the slow recovery. (OECD, 2019[71]). Periods of inactivity and unemployment in early adulthood have also been shown to have lasting negative effects on future employment prospects and earnings (OECD, 2015[72]).

### *Places and communities left behind*

In today's increasingly urban world, more than half of the global population live in cities. Cities may be better equipped than the rest of a country to respond to the COVID-19 crisis due to their well-developed health care facilities. However, close proximity, transport corridors and challenges with implementing social distancing also increase the risk of spreading the virus through increased human contact (OECD, 2020[73]).

Cities marked with high inequalities and a high concentration of urban poor are potentially more vulnerable than those that are better resourced, less crowded and more equal. The World Economic Forum (WEF) recently reported that pandemics often emerged from the edge of cities. Viral outbreaks are frequently incubated and transmitted via peri-urban communities and transportation corridors at the outskirts of cities

before they spread into the downtown core. Pollution levels, which are higher in cities, also cause lung and heart damage that are responsible for at least 7 million early deaths a year. Residents with existing respiratory conditions, such as asthma or chronic bronchitis, can be more susceptible to COVID-19 (OECD, 2020[73]).[10]

Serious presentations of COVID-19 may be more prevalent in poorer neighbourhoods, as neighbourhood socio-economic status is negatively correlated with influenza-associated hospital admissions among all age groups. US data shows that influenza-associated hospital admissions are higher in high-poverty neighbourhoods. For instance, one US study found that the mean incidences of hospitalisations among children are three times higher in high-poverty and high-crowded neighbourhoods than in low-poverty and low-crowded neighbours. Health factors, such as higher prevalence of underlying conditions and lower uptake of influenza vaccinations, only explain some of this correlation (Yousey-Hindes and Hadler, 2011[74]). Similar conclusions are made across other age-groups, including the over-65s. This is significant as the over-65s account for the large majority of influenza-associated hospital admissions (Hadler et al., 2016[75]).

In rural regions, the rapid ageing of the population in some regions over the past decade and more will challenge the provision of services during the COVID-19 outbreak. On average, from 2000 to 2017, elderly dependency rates have increased by 6 percentage points in the OECD. The highest growth has been observed in predominantly rural regions (7 percentage points), while the lowest is reported in predominantly urban regions (5 percentage points) (OECD, 2018[76]). Rurality provides however some protection to the spread of COVID-19, such as remoteness and greater social distancing. Rurality may, in the context of rising distress, offer residents some reassurance.

The provision of a high-speed broadband can be a key factor in the provision of health and social services in remote areas. It also facilitates teleworking. In general, lower income countries often have larger regional disparities in broadband access. Regional differences in the percentage of households with broadband access are strongly pronounced both in countries with a high ICT penetration, such as France, Israel, the United States and New Zealand, and countries with low average ICT access such as Mexico or Turkey. In these last two countries, broadband access in the region with the highest proportion of households with broadband connection is more than three times higher than in the region with the lowest access (OECD, 2018[76]).

## Can we assess the "net" impact on people's well-being? Highlights based on the Multi-Dimensional Living Standard metric

The COVID-19 virus will have a negative impact on most dimensions of people's lives, as well as on inequalities. While no single metric allows capturing the cumulative effects of these impacts, the OECD Multi-Dimensional Living Standards (MDLS) metric, developed in the context of the OECD Inclusive Growth Initiative and building on (Fleurbaey and Blanchet, 2013[77]; Murtin et al., 2017[78]), provides a money-metric measure reflecting changes in household income, unemployment status, life expectancy as well as income inequality (Boarini et al., 2020[79]). An application of this approach in the aftermath of the 2008 financial crisis found that the economic recession triggered a fall in living standards of poor people of more than 10% per year in Portugal, Italy and Ireland, of 25% per year in Spain and of 40% per year in Greece over the 2008-13 period. The dramatic human cost of the crisis was largely explained by soaring unemployment and income inequality in these hard-hit countries, which more than offset the continuous improvement in health conditions.

[10] For detailed advice on supporting cities and regions through the Covid-19 crisis, see note developed by the OECD Centre for Entrepreneurship, SMEs, Regions and Cities (CFE) in collaboration with the Working Party for Urban Policy.

The COVID-19 epidemic has the potential of generating even deeper effects, as all four components of the MDLS metric could be negatively affected by the ongoing crisis. The scale of some of these effects is illustrated by (Eichenbaum, Rebelo and Trabandt, 2020[80]), who combine the classical epidemiological model to a simple macro-economic model and find a 10% decline in GDP under plausible calibration. This fall is much larger than the one observed between 2008 and 2013 in the 'hard-hit' countries mentioned above (with GDP falls -1.3% in Ireland and Portugal, -2% in Spain and Italy and -6% in Greece). In the simulation by Eichenbaum et al., income, hours worked and consumption fall dramatically over a period of more than 3 years if the strictest confinement measures are adopted, triggering soaring unemployment. Together with the increase in mortality directly due to the COVID-19 epidemic, an economic recession of this size would further deteriorate the health status of the population. According to (Lorenzoni et al., 2018[81]), in a BAU scenario, i.e. when no compensatory actions are taken, a 10% decline in GDP has the potential of lowering life expectancy at birth by half a year.

What could the cumulative impacts of these changes be? Overall, with GDP and average household income falling by 10%, unemployment rising by 5 percentage points and life expectancy falling by half a year, Material Living Standards could decline by 23%, well in excess of the fall experienced after the 2008 financial crisis in most OECD countries, and not far from the fall experienced by the "hardest hit" countries. These estimates consider neither the possible adverse impact of rising income inequality; nor the adoption of any possible measure to counter the crisis. More broadly speaking the estimates need to be interpreted with caution due to the uncertain size of the economic and health impacts. The OECD will update these estimates as more information on the economic and health scenarios become available.

## Policy responses

To deal with the evolving crisis, governments need to act swiftly and forcefully, with priority given to those who are most vulnerable. Three key pillars, aligned with the OECD's Framework for Policy Action on Inclusive Growth, can be useful in considering a comprehensive, well-coordinated response: (1) protecting people and places left behind; (2) supporting small businesses and vulnerable workers; and (3) responsive and coordinated governance.

### *Protecting people and places left behind*

#### *Social protection*

- Automatically extend social protection entitlements (e.g. for disability, child support, poor families) that cannot be renewed in person or online due to, for example, quarantine, illness, excessive number of requests, technical difficulties or lack of access to digital platforms.
- Use digital tools to deliver social services, provide screening, advice, reaching remote and vulnerable constituencies.
- Increase capacity to effectively register and process the rising number of unemployment cases, if needed prioritising financially vulnerable groups, such as single parents, young people, people educated below tertiary level, and for couples with children, who are also among those who have to deal with school closures and new care responsibilities.
- Workers with low job security will be hit hardest and should receive unemployment coverage, even if not meeting the criteria (e.g. uninterrupted employment for six months or more in some countries).
- Introduce temporary support for non-standard workers and persons in the informal economy who are not covered or entitled to social protection.
- Organise delivery of essential supplies to socially isolated groups (e.g. the elderly) and persons in quarantine and treatment (for cases not requiring hospitalisation).

- Co-ordinate regular check-ins with people at risk of isolation and loneliness for the benefit of psychological and physical well-being. As needed, extend the role of public services during the crisis (e.g. postal workers could check-in on the elderly and other people living alone) and coordinate with civil society and volunteers.

*Health care (see also OECD 2020)*

- Alleviate pressures on the health system by implementing measures to contain and mitigate the spread of the disease, including public health services to prevent infection and contagion, and stepping up public information campaigns for practicing personal hygiene and social distancing.
- Implement well-targeted policies to support health care systems and workers. Provide additional funding for health care to help rapid deployment of resources and higher capacity. Ensure adequate spaces to diagnose people safely and efficiently, to isolate suspected and confirmed cases.
- Mobilise inactive health professionals, adapt the roles and responsibilities of health providers and protect the health of health worker, including by providing special childcare for healthcare workers.
- Recognise and reward overtime work in health care and emergency response sectors.
- Boost the provision of required supplies and equipment to diagnose and treat patients safely; work with partners along the supply chain/transport routes to ensure that provision of essential supplies is not restricted by containment measures (e.g. border closures) and trade restrictions.
- The “hard to reach” deserve special attention – make health care and testing services both affordable and accessible to vulnerable groups, and public health information clear and easy to comprehend.
- Take steps to promote positive mental health during the pandemic, including during social distancing and confinement measures. For example, provide online resources and advice on how to get help for the general public; provide advice to general practitioners and other frontline care workers about identifying those at risk of mental health problems or loneliness, as well as options for support, treatment and referrals; monitor work stress and burnout in health and other key workers; allow pharmacists to renew prescriptions where appropriate; offer telemedicine consultations and allow for the continuity of psychological and psychiatric treatment through phone or video calls where possible; reinforce resources for mental health services in the aftermath of the pandemic (OECD, 2020[2]).

*Housing*

- Implement measures to ensure that individuals and families can remain in home dwellings, throughout the crisis and into the recovery period. Options include temporary deferment of mortgage repayments and utility bills, and suspension of foreclosures and evictions.
- Increase bed capacity in homeless accommodation and reduce overcrowding. Options include acquisition of hotel rooms and conversion of publically owned buildings. In case of re/accommodation of the most vulnerable outside of homeless services, ensure continuity of support services.
- Step up support to the rough-sleeping homeless population, who may be more reliant on informal support from restaurant or shop owners, and members of the local community.

*Education services*

- Support affected students through effective remote learning opportunities. Public institutions and the private sector can be called upon to donate the equipment needed for remote learning

(computers, tablets, smartphones, fees for the instalment and subscription to internet) to those whose relatives are particularly vulnerable.

- Provide remote training facilities for teachers, as well as students and their parents, to navigate any technical difficulties (e.g. provide directions for prioritisation in case of overload of servers and internet capacity) in the transition to remote learning.
- Depending on the success of remote learning, consider extending classes beyond the regular school year/after the lifting of the school and university closures to minimise impacts on students' future education performance and job prospects, especially for those graduating from middle school, high school or university.
- Pay particular attention to supporting vulnerable children (and their families), who are less likely to have a suitable learning environment, parental support and technical facilities for remote learning, as these are also children more vulnerable to dropping out of school and experiencing a more severe drop in academic achievement after prolonged school breaks. Consider inclusion of the most vulnerable children in emergency childcare provisions for children of essential workers in countries where such arrangements exist.
- Provide support to children who rely on schools for meals and contacts with supportive adults e.g. food vouchers, food parcels, and regular check-ins by teachers.
- Support working parents, and especially women, with unforeseen care needs when schools are closing and when elderly relatives require special assistance. Offer public childcare options to working parents in essential services, such as health care, public utilities and emergency services.

### *Safety*[11]

- Strengthen capacity of the police, health services, voluntary sectors and the courts to responds to cases of family and intimate partner violence. Maintain in operation telephone help-lines, webchat and emergency sittings of family courts, and increase capacity of domestic violence refuges.
- Ensure that victims' needs and safety are considered when moving towards more electronically-delivered services.
- Decisively address violence against women and children, in part by highlighting how home confinement during COVID-19 will increase the problem. Push back on social acceptance of violence.
- Consider exceptions to breaching home confinement for victims of violence.
- Strengthen capacity of child protection services, schools and the police to respond to needs of the most vulnerable children and to reports of child maltreatment. Put in place procedures for sharing of information, and create child protection plans if necessary.
- Maintain front door child protection services in operation and as far as it is possible ensure that home visiting and safety checks on children and families most-at-risk are not disrupted.

### *Environment*

- Monitor air pollution levels and warn vulnerable population groups.
- Improve people's well-being (e.g. psychological relaxation, stress reduction, enhanced physical activity, the mitigation of exposure to air pollution, excessive heat and noise) through regulated access to green spaces, while respecting requirements for social distancing. Include provisions

[11] For policies response addressing cybersecurity risks, see OECD STI Policy Brief Digital Security Policy and COVID-19 at http://www.oecd.org/coronavirus/en/.

for transition corridors for persons who live further away from green spaces than current movement restrictions (e.g. 1 km in France currently).

- Systematically evaluate the environmental implications of support and recovery measures to businesses and industries and their alignment with longer-term decarbonisation plans and environmental objectives (OECD, 2020[82]).
- Enhance the contribution of sector-specific financial measures to environmental and climate objectives, where possible (OECD, 2020[82]). For example, consider asking for improvements in environmental performance when approving bailout packages in the aviation sector.
- The window of opportunity to take strong action on climate is closing fast and short term economic measures will have a significant impact on the ability to meet global goals (OECD, 2020[82]).
- Ensure that the measures to contain the spread of COVID-19 and to address the impacts on health, well-being and economy do not roll back on environmental standards (OECD, 2020[82]).
- Low oil prices could represent a good opportunity to reform subsidies for fossil fuels.

*Local response*[12]

- Map the geographical distribution of the impacts of the disease both on health, as well as on the economy of communities and tailor responses accordingly.
- Ensure multi-level coordination of response through active engagement with local authorities.
- Ensure the continuation of basic services, such as water provision and collection of waste, including for the residents who cannot pay bills due to sudden loss of income. Check-in regularly with persons in vulnerable situations who may need support (e.g. the elderly, especially those living alone) and families with previous (or suspected) episodes of family and intimate partner violence and child maltreatment.

### *Supporting small businesses and vulnerable workers*

- Implement short-term support measures for SMEs and severely affected sectors (e.g. tourism) including temporarily reducing or eliminating property/business taxes.
- Provide liquidity support through creation of temporary loan-repayment amnesties or provision of grants to bridge liquidity gaps.[13]
- Help firms adjust working time to remain operational and preserve jobs. Encourage teleworking and other types of remote work, where possible. Encourage training and upskilling.
- Work with technology companies to provide SMEs and the self-employed with free and rapid access to communication and sharing tools to allow for more flexible and remote working arrangements and for shifting to remote/online provision of goods and services.
- Reduce exposure to COVID-19 in the workplace, for example, by limiting interpersonal interaction, encouraging flexible timing for commute (off-peak hours on public transport); and, where possible, encourage remote work. Also, introduce measures such as delimitations and barriers between bus drivers and commuters, or between shop assistants and customers. Involve social partners.

[12] For detailed advice on supporting cities and regions through the Covid-19 crisis, see developed by the OECD Centre for Entrepreneurship, SMEs, Regions and Cities (CFE) in collaboration with the Working Party for Urban Policy.

[13] For detailed advice on supporting workers and businesses see OECD ELS Policy Brief, "Supporting people and companies to deal with the Covid-19 virus: Options for an immediate employment and social-policy response", https://oecd.dam-broadcast.com/pm_7379_119_119686-962r78x4do.pdf.

- Provide income support of vulnerable groups, such as sick workers and their families; quarantined workers, who cannot work remotely; workers losing their jobs and the self-employed and others in non-standard forms of work who are experiencing a drop in activity.
- Extending paid sick leave coverage to non-standard workers, including the self-employed. Ensure that it is possible to obtain and extend sick leave in line with medical and other emergency recommendations and procedures. Support SMEs in covering the financial compensation during sick leave thus encouraging workers to remain isolated as long as needed.
- Strengthen in particular income support to financially vulnerable groups, who risk falling into poverty if they forgo income for three months (single parents, young people, people educated below tertiary level, and for couples with children, who are also among those who have to deal with school closures and new care responsibilities).
- Introduce more flexibility in short-term work schemes, allowing to recruit and train job seekers to step in for ill and quarantined workers.
- Consider the specific needs of women, who are likely to take on a greater share of the caring responsibilities for children and the elderly, as a consequence of more often being "second earners", e.g. address possible consequences on their social security contributions and pensions.

### *Responsive and coordinated governance*

- Provide comprehensive and coordinated information on:
  - the spread and consequences of the epidemics;
  - the conditions that will trigger an upgrade or downgrade of the security conditions;
  - the readiness of health infrastructure to respond to emergency conditions; and
  - prevention and containment measures.
- Establish a clear structure of crisis response responsibilities at all levels of government and across the central level; as well as a clear and flexible operational plan for decision-making, monitoring and updating of the population.
- Monitor and prevent attempts to increase prices on essential supplies.
- Invest in research, including for a vaccine. Prompt businesses, entrepreneurs and civil society to work together to develop new technologies, production methods and other ideas that can provide helpful solutions in the crisis.
- Ensure coordination with neighbouring, regional and other partner countries on cross-border containment measures and planned activities.
- Use international fora, such as the G7, G20, as well as the advice of international organisations, including the OECD, for a comprehensive and coordinated crisis and recovery action.

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