

Public attitudes to a Covid-19 vaccine, and their variations across ethnic and socioeconomic groups

Findings from RSPH-commissioned national polling conducted by Yonder between 4th-6th December 2020



Introduction

The success of the Covid-19 vaccine roll-out depends in no small part on the public's confidence in the safety and effectiveness of the vaccine. We believe the results from a series of polls conducted over the course of the year are reasonably promising in this regard with between two thirds and three quarters of respondents saying they were likely to have the vaccine, depending on when the public polls were undertaken¹. However, when RSPH conducted a survey into whether people would get the vaccine and, if they would not, what policies may be effective at changing their mind, we identified some troubling disparities which if not acted upon may exacerbate pre-existing health inequalities.

We found three in four (76%) of the UK public would take a Covid-19 vaccine if advised to do so by their GP or health professional, with just 8% stating they would be very unlikely to do so. However, willingness to be vaccinated was statistically significantly lower amongst people from lower socioeconomic grades or of Black, Asian or minority ethnic (BAME) backgrounds. For instance, 84% of those classified as ABs said they would get the vaccine, while only 70% of DEs said the same. The difference between BAME and White respondents was also significant: 79% of White respondents said they would get the Covid-19 vaccine compared to 57% of BAME respondents. As would be expected, there was some variation within "BAME", with the lowest willingness to be vaccinated in Asian respondents (55%).²

These findings support those of a poll recently conducted by Queen Mary University, which found that 39% of BME Londoners, compared to 70% of White Londoners would accept a Covid-19 vaccine³, and

research done by a survey of 1,252 parents in May, published in Vaccine, which found that parents of Black, Asian, Chinese, Mixed or Other ethnicities were almost 3 times more likely to reject a Covid-19 vaccine for themselves and their children than White parents.⁴ It is notable that, like organ donation and blood donation⁵, BAME volunteering rates for medical trials in the UK are low.⁶ Around 7% of those on the NHS Vaccine registry are from a minority ethnic background; with only 0.5% from a Black ethnic background,⁷ although it should be noted that 41% of participants in the internationally conducted trials of the current approved Covid-19 vaccine were Black, Asian or Latinx/Hispanic.⁸

This must be of particular concern given the disproportionate impacts of Covid-19 on certain ethnic groups, both with respect to the infection and mortality rates⁹ of the virus itself and the impact on mental and financial health. Both the infection and the mortality rates of Covid-19 have been higher amongst BAME communities than the White population.¹⁰ The ONS

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has also shown that a greater proportion of people of BAME backgrounds have reported struggling to be able to cope financially because of the pandemic and that self-reported mental health has deteriorated across most ethnic groups, especially amongst those of Indian origin.¹¹ Indeed, the disproportionate risk that Covid-19 poses to people of Black, Asian and minority ethnic backgrounds accounts for some groups calling for them to be listed as a priority group in the vaccine roll-out.¹² Socioeconomically disadvantaged groups also face an elevated risk of being infected by Covid-19 given their increased probability of working in public-facing

roles and living in extended households.¹³ Sir Michael Marmot's report with the Health Foundation, *Build Back Fairer*, has shown how Covid-19 has both exposed and exacerbated inequalities across socioeconomic, regional, and ethnic lines, and between those with health conditions, mental or physical disabilities and those in good health.¹⁴ The increased vulnerability which Covid-19 poses to both BAME and socioeconomically deprived communities unfortunately goes alongside a historically lower vaccination uptake.¹⁵ It is vital, therefore, that the Covid-19 vaccine roll-out bucks this trend.

About the survey

Polling was conducted by Yonder between 4th and 6th December 2020, on a representative sample of 2,076 UK adults, including participants from England, Scotland, Wales and Northern Ireland.

We first asked respondents if they would be willing to take a Covid-19 vaccine in three different contexts: if advised to by their GP or another health professional; if it was mandatory; or if it was recommended but optional. To those who answered that they were quite or very unlikely to get the vaccine if advised to do so, or unsure, (477 respondents) we presented various scenarios and asked how likely each would be to make them change their mind and ultimately receive the vaccine. These included soft-mandatory policies as well as options

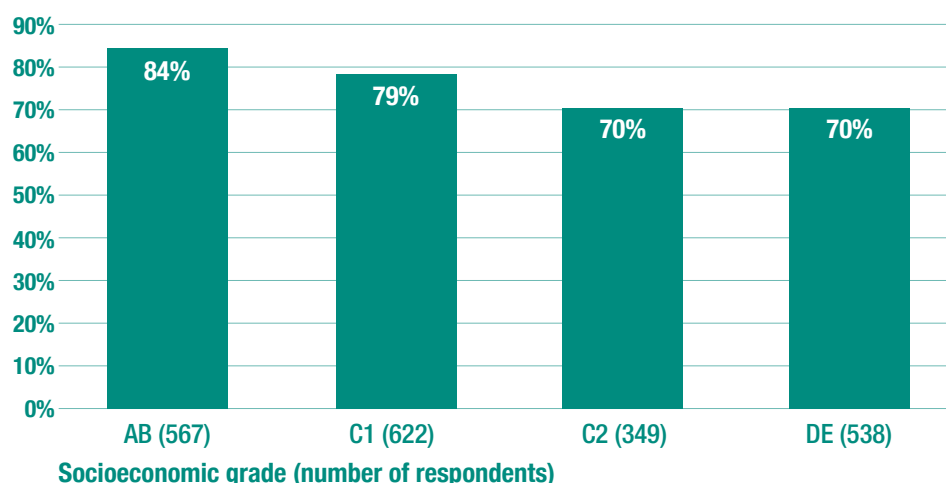
around receiving more information about the vaccine including its effectiveness, its ingredients, how it was tested or how vaccines work. Finally, we asked all respondents which figures they would trust to provide them information about the vaccine, including health professionals, the media, politicians, peers, and people posting on social media.

In each case a 5-point Likert scale was used, including the options Very Likely, Quite Likely, Quite Unlikely, Very Unlikely and Don't Know. For the purposes of analysis, we have grouped together the Quite and Very Likely/Unlikely options and reported on them as 'Likely' or 'Unlikely'. Where findings are reported as statistically significant, it is at the level of 5%.

Lower vaccine confidence amongst lower socioeconomic grades

We found a clear correlation between socioeconomic grade (based on the NRS grade system) and willingness to accept a Covid-19 vaccine if advised to take one by a GP or healthcare professional. The proportion of ABs and C1s willing to accept a vaccine (84% and 79% respectively) was significantly higher than that among respondents classified as C2 and DE (both 70%).

“How likely or unlikely would you be to take a Covid-19 vaccine if you were advised by your GP or another health professional to take it?” (Net likely)



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There was remarkably little difference between those who were more likely to get the vaccine if mandatory compared to if it was only recommended. For instance, 68% of the C2s said they would get the vaccine when presented with both scenarios. There was also only a single percentage point difference in the proportion of DEs who said they would be get the vaccine if mandatory compared to those who would get it if recommended but optional (65% compared to 66%). A slightly greater percentage point difference was found amongst the higher social grades, though again this was marginal: 83% of ABs and 79% of C1s said they would be likely to get a Covid-19 vaccine if it was mandatory, compared to 79% and 76% respectively who would get it if it was optional.

Respondents who said they would be either unlikely to get, or unsure about getting, a Covid-19 vaccine if recommended to by a healthcare professional were then asked if various soft-mandatory policies would change their mind. These options included it being necessary to have been vaccinated to go to pubs and restaurants, sports venues, entertainment venues, to go to work, and to travel abroad. For each scenario, the effectiveness was low across the groups but ABC1s were more likely to indicate they would change their mind than were C2DEs. For example, if a vaccine was required to go to a pub or restaurant, 25% of ABs and 28% of C1s indicated they would change their mind but only 11% of C2s and 14% of DEs would do so. These findings suggest that soft-mandatory policies may not be best suited to addressing socioeconomic inequalities in the uptake of a Covid-19 vaccine, given the lower effectiveness of these types of policies at persuading those in lower socioeconomic grades.

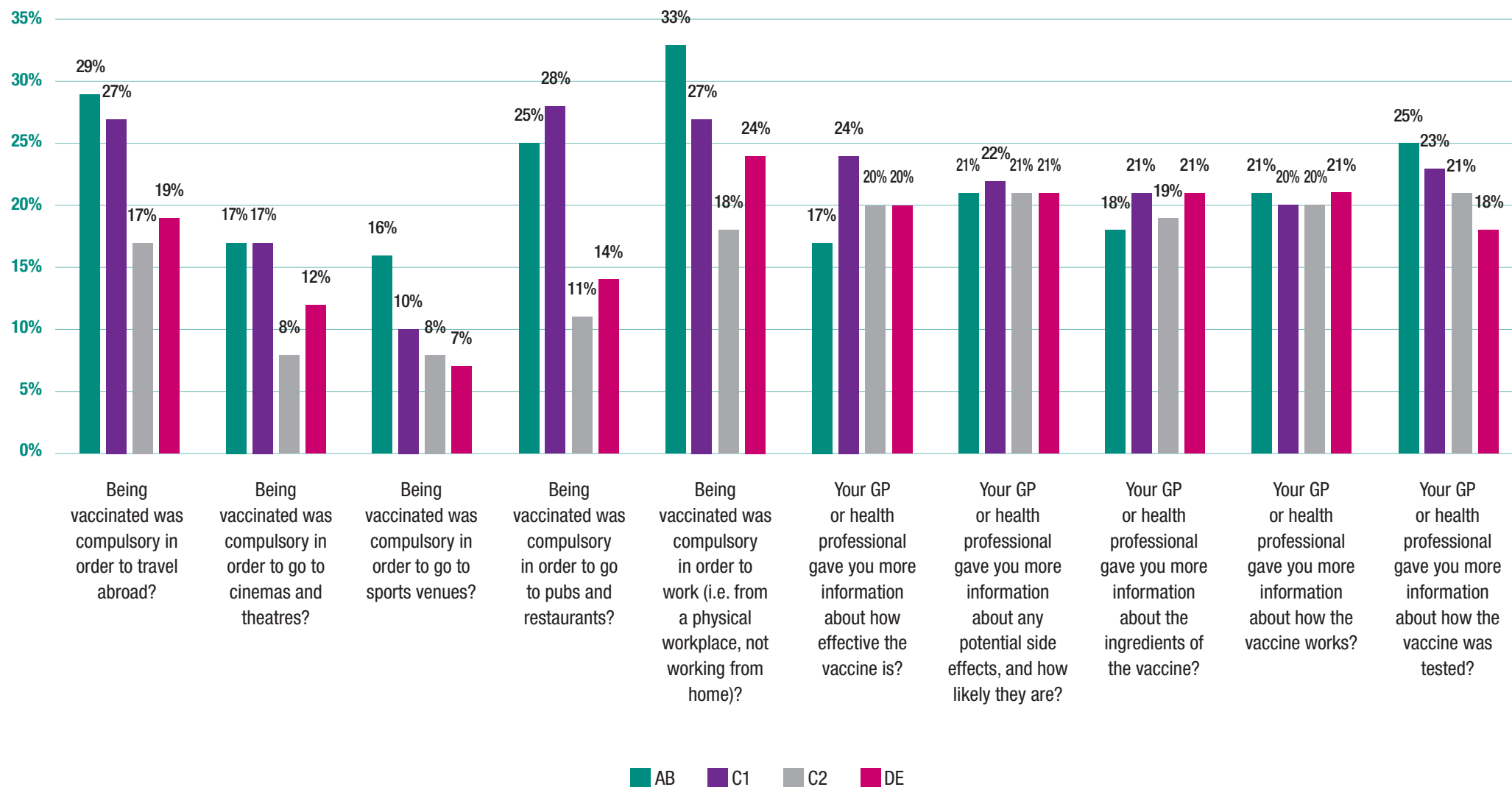
By contrast, and more reassuringly, receptiveness to advice from health professionals appeared to be fairly consistent across the socioeconomic spectrum. When those unwilling to have a Covid-19 vaccine were asked if they would change their mind if given more information about the vaccine by their GP, there was less variation by social grade. For example, if given more information about the side effects of the vaccine, and their likelihood, just over one in five of respondents from all social grades who had originally said they were unlikely to get the vaccine thought they would change their mind (21% of ABs, 22% of C1s, 21% of C2s and 21% of DEs). Likewise, if given more information about how the vaccine works, 21% of both ABs and DEs said they were likely to get the vaccine, as did 20% of C1s and C2s. Although this strategy appeared to be the most widely effective, and one who could boost

understanding of, and confidence in, medical research for the longer-term, it is concerning that there appears a significant proportion of the vaccine-hesitant who would be unpersuaded by this approach.

Given the resources involved in implementing and enforcing soft-mandatory policies, a more cost-effective strategy, at least in the first instance, would be to ensure clear, accurate and easy-to-understand information about the vaccine is easily and widely accessible, and to support health professionals to address patients' concerns.

“How likely or unlikely would you be to change your mind and take the Covid-19 vaccine if...” (477 respondents)

% Net likely (very likely and quite likely)



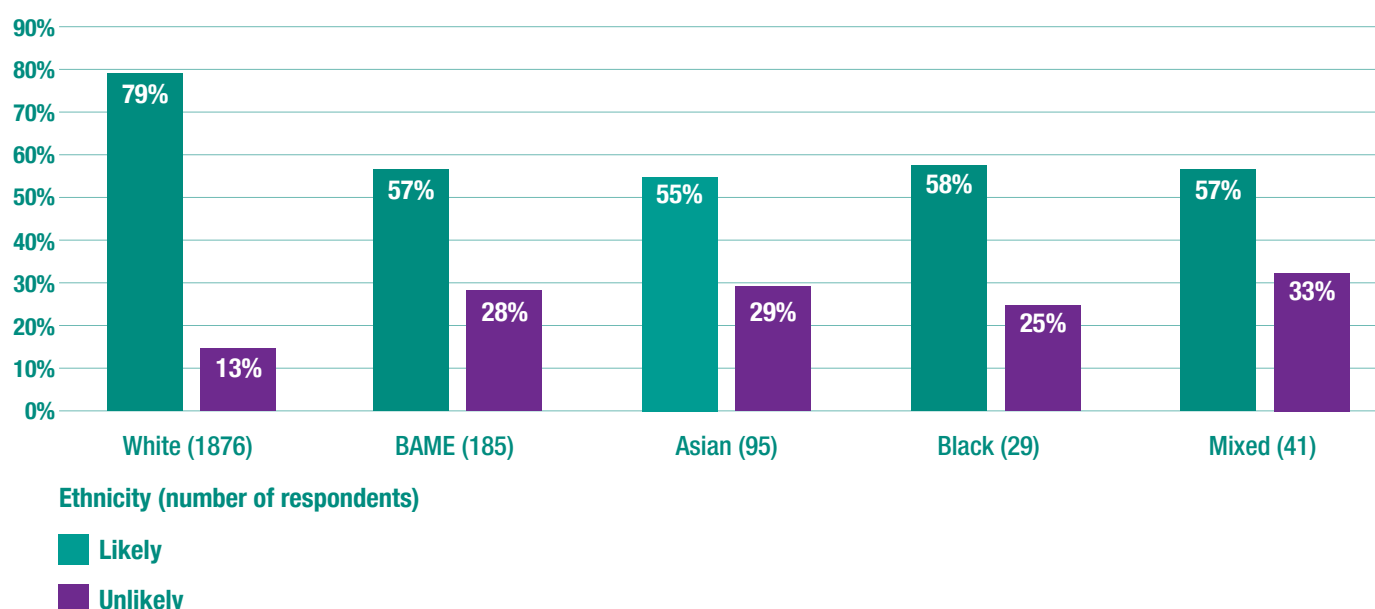
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Lower vaccine confidence amongst BAME communities

The starkest difference in willingness to accept a vaccine against Covid-19 if recommended by a GP was along ethnic lines, with a statistically significant divide between White and BAME respondents, of 79% versus 57%. There were also significant differences between White respondents and those of Mixed heritage (79% vs 57%), and between White respondents and Asian respondents (79% vs 55%). Between groups other than White and BAME and White and Asian, the sample sizes were

too small to draw any substantive conclusions, but the levels of confidence in the vaccine appear to be broadly similar across the BAME groups.¹⁶ It is a limitation of this poll that sample sizes do not allow us to investigate differences beyond the headline ONS categories of “Black”, “Asian”, “Mixed Heritage” and “White” and it is possible, indeed likely, that there is substantial variation within these categories.¹⁷

“How likely or unlikely would you be to take a Covid-19 vaccine if you were advised by your GP or another health professional to take it?” (Net likely and net unlikely)



In both other scenarios (the vaccine being mandatory, and it being optional but recommended), the willingness to vaccinate among White respondents remained statistically significantly higher than among BAME respondents.



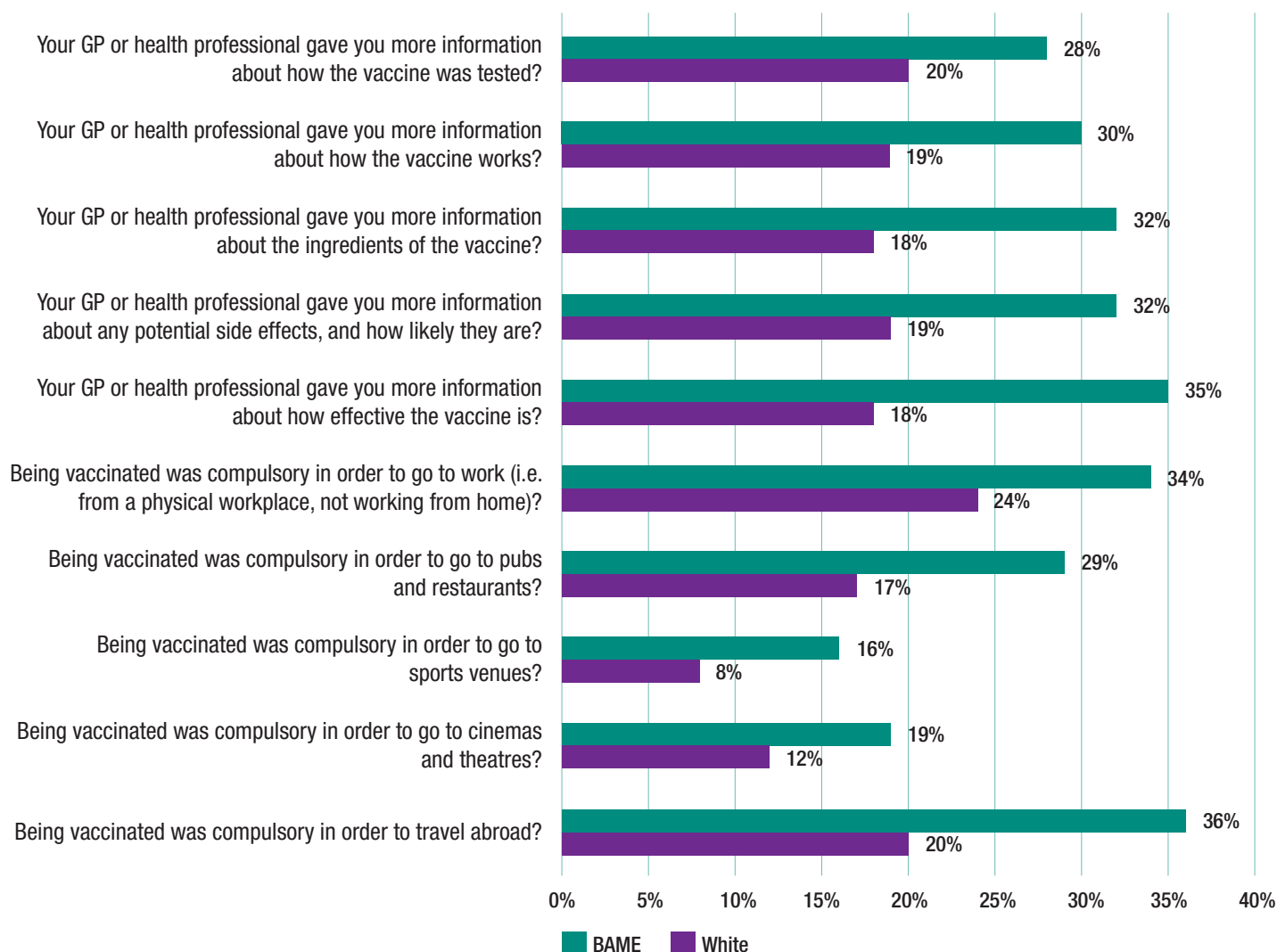
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Encouragingly, respondents from BAME backgrounds who were unsure or did not want the vaccine indicated they were especially receptive to further information about the vaccine from their GP or another health professional. For instance, there was a statistically significant difference between the proportion of BAME respondents and White respondents who would change their mind about getting the vaccine if given more information about:

- its effectiveness (35% of BAME respondents compared to 18% of White respondents)
- its side effects (32% of BAME respondents compared to 19% of White respondents)
- its ingredients (32% of BAME respondents compared to 18% of White respondents)

On the whole, BAME respondents were more susceptible than White respondents to changing their mind if it was compulsory to be vaccinated for certain activities, though the overall levels remained low. For example, if being vaccinated was compulsory to attend sports events, 16% of BAME respondents said they were likely to change their mind and get the vaccine, twice the rate of White respondents (8%). The two soft-mandatory policies which would have the greatest impact on uptake amongst BAME respondents were: if the vaccine were required in order to go to work – over a third of BAME respondents would change their mind and get the vaccine in this situation (34% of BAME respondents compared to 24% of White respondents); and if it was required in order to travel abroad (36% of BAME respondents compared to 20% of White respondents).

“How likely or unlikely would you be to change your mind and take the Covid-19 vaccine if...” (477 respondents) % Net likely (very likely and quite likely)



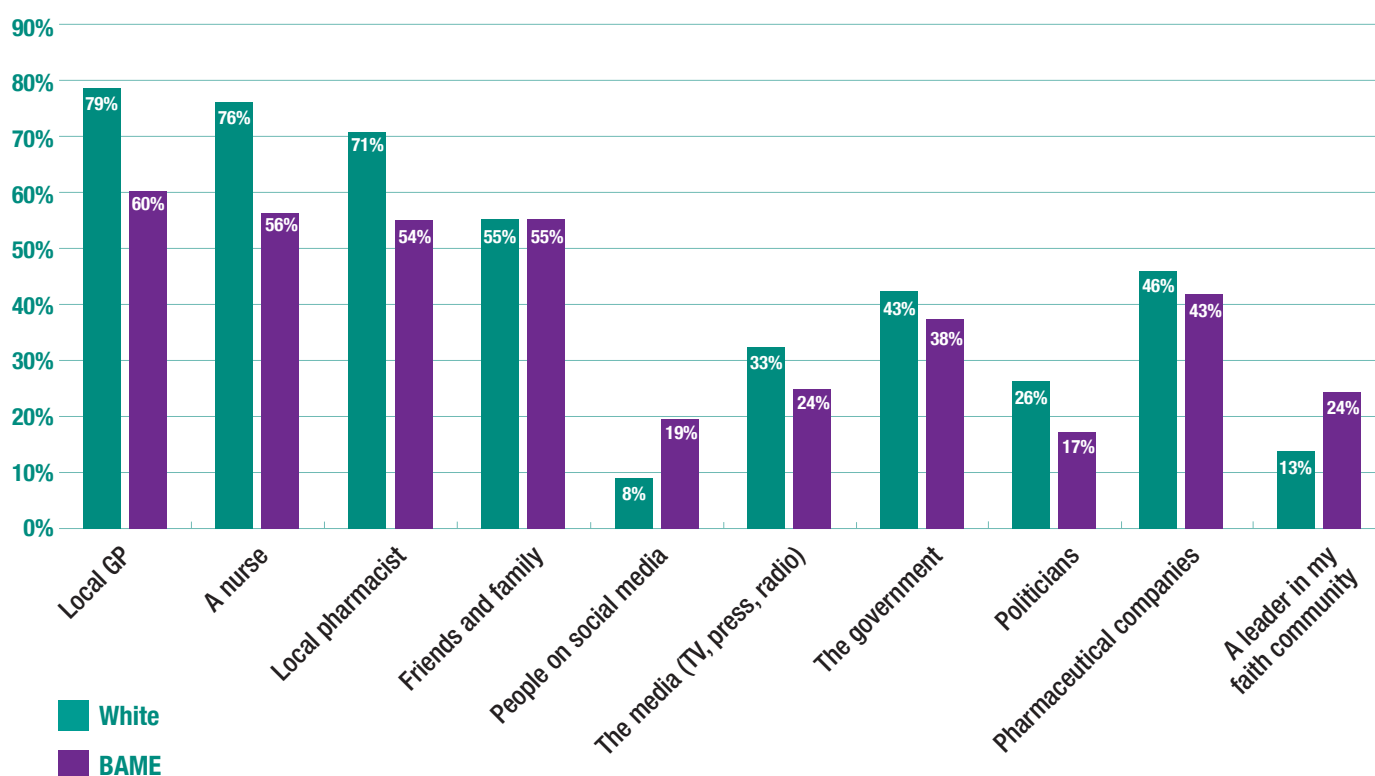
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There is clearly an urgent need to do further research to understand why vaccine confidence is lower amongst people of BAME backgrounds in the UK. But one possible reason indicated by our poll findings was lower trust, on average, in healthcare professionals than found among White respondents. For instance, there was statistically significantly higher trust amongst White respondents in one's GP (79%), nurses (76%), local pharmacists (71%) and the Government (43%) than amongst BAME respondents (60%, 56%, 54%, and 38% respectively).

By contrast, there was statistically significantly higher trust in the opinions of people on social media when it came to the vaccine's safety and effectiveness amongst BAME respondents than amongst White respondents. That level of trust was still reasonably low, with 19% of BAME respondents (compared to 8% of White) saying they would trust social media users as a source for information about the vaccine. It nevertheless suggests there may be higher susceptibility to disinformation and misinformation about the vaccine spreading online. Indeed, more BAME respondents said they would trust the view of someone on social media (19%) than they would trust politicians delivering information about the Covid-19 vaccine (17%).

“How much would you trust, if at all, the opinion of the following people regarding a Covid-19 vaccine (regarding its effectiveness, its safety, and whether you should take it)?”

% Net trust (strongly trust or somewhat trust)



Notably, amongst Asian respondents, the opinions of friends and family were more widely trusted (63%) than those of a nurse (59%) and local pharmacist (55%), and were ranked equally with that of a GP. This suggests an opportunity for supporting people in the Asian community to have productive conversations with their

peers and relatives about common concerns surrounding the vaccine. Ultimately, to build confidence in the vaccine whenever and wherever possible, we need to equip people of all walks of life, including faith leaders, community figures, and ‘ordinary’ citizens, to be able to champion the value of vaccines.

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Lower vaccine confidence amongst women

Our poll found a statistically significant difference between genders in the proportion of respondents willing to have a Covid-19 vaccine (on GP recommendation) based on gender: 73% of women compared to 80% of men said they were likely to have the vaccine in that situation. However, that divide appeared more concentrated amongst White respondents: 82% of White men compared to 75% of White women said they were likely to get the vaccine, while the difference between BAME men and women was just three percentage points (58% of men vs 55% of women).

Conclusions

The findings from our poll provide cause for concern: it is precisely the groups hardest hit by Covid-19 and facing the highest infection risks who are also least likely to accept a vaccine. It is estimated that we need a coverage rate of between 75% and 90% to achieve herd immunity from Covid-19, depending on the efficacy of each vaccine and the duration of immunity.¹⁸ From a national perspective, our findings are encouraging: three in four people say they are likely to have a vaccine against Covid-19 if offered one, with no further measures needed. However, herd-immunity is community-specific, and we must ensure there are no pockets of the country where coverage rates are allowed to fall below what is required.

There is, therefore, an urgent need to undertake more research into why confidence is lower among BAME communities and how it can be built up, both for the present roll-out and for future immunisation programmes. This research needs to build understanding of the barriers to healthcare for, and the concerns of, individual ethnic communities, so that the Government, public health and the NHS can reduce vaccine hesitancy. More than a mere communications strategy, there needs to be concerted engagement from Government, the NHS, and local public health with these communities, seeking to understand the concerns of those from BAME backgrounds, working in partnership with the voluntary sector and supporting champions whom people from those communities can readily trust.

We know that certain anti-vaccine groups target particular ethnic and religious groups on social media¹⁹ so, coupled with our finding that respondents from BAME backgrounds tend to put greater trust in opinions encountered on social media, tackling misinformation and disinformation on these platforms must be treated as imperative.

In the meantime, healthcare professionals need to be equipped with both the resources and the time to address the concerns of individual patients about the Covid-19 vaccine, as for the majority of groups – whether broken down by class, gender, or ethnicity – they remain the most trusted information source. Public health is everybody's health; for all of us to be protected, there must be a strategy undergirding the vaccine roll-out which leaves no group behind.

Access to data

For further information about the findings in this report, please contact Florence Gildea on fgildea@rsph.org.uk. Full data may be made available to researchers and public health practitioners on request.

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Endnotes

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2. It should be noted that this sample is too small to report at the level of individual ethnicities, for example Black African, Black Caribbean, Indian, Pakistani etc. although variations would be expected within the categories of "Black" and "Asian". Likewise, minority White communities have not been drawn out of the White category and this is also a significant limitation, given the health inequalities faced by, for example, the Gypsy, Roma and Traveller communities. We believe further investigating the levels of confidence among these groups, at the level of community and ethnicity, should be a priority for the Government.
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16. The other options for identifying one's ethnicity included in the polling were Chinese, Other, and Prefer not to answer. Sample sizes are too small to draw conclusions from, and so they have not been presented here.
17. We accept this limitation applies to the results below which groups respondents under the category of 'BAME'; we appreciate that this category will hide differences between, and within, the different ethnic groups. RSPH would be very keen to see further research with a greater number of people of all ethnic backgrounds so that more robust conclusions can be drawn about the concerns and barriers facing each.
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