



# Digital exclusion & health inequalities

Briefing paper  
Dr. Emma Stone

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## Executive summary

To support the Health Foundation's COVID-19 impact inquiry ([Health Foundation 2021](#)), Good Things Foundation, the Health Foundation and the King's Fund joined to convene a diverse group of people with a shared interest in tackling digital exclusion and health inequalities. Meeting almost a year after the start of the first national lockdown, there was no doubt about the importance of the issue or the challenges to overcome.

But the workshop was also an opportunity to make and strengthen connections, and share experience on promising approaches, opportunities and how to achieve sustained and inclusive change.

### These are our top ten takeaways from the breakout sessions:

1. Address the knowledge gap around digital inclusion and health inequalities – increasing the quantity and quality of data, especially with poorly served groups.
2. Improve what you know by evaluating with early adopters, sharing what works and doesn't work in practice.
3. Support those who are already innovating and implementing change – enabling them to hear directly from one another through peer learning and practice sharing.
4. Reach out to other practice managers and a wider workforce audience, with guidance on practical steps to increase digital inclusion for health and care.
5. Grow the number of local, welcoming spaces which support digital inclusion. Use existing assets – GPs, community centres, libraries, even disused retail outlets.
6. Call on strategic commissioners in health and local government to drive action on digital inclusion projects that help address health inequalities.
7. Support community organisations to build people's digital skills, confidence and trust in using digital health tools – including on disinformation and data sharing.
8. Build better bridges between local health, care, voluntary and community sectors. Shared values – such as rights of access to health care – enable collaboration.
9. Drive continuous improvement of digital tools through patient voice and user experience feedback, and promote more inclusive design of digital services.
10. Build on learning and innovation from Covid-19, and develop a call to action across government departments to address digital and health inequalities.

This paper gives an overview of digital exclusion and its relationship to health, social and economic aspects of people's lives; who is affected; how the pandemic has impacted on this; and what responses we have seen. Workshop breakout slides are shared in the Annex to support further reflection.

## What is digital exclusion and who is affected by it?

Digital exclusion is about not having the access, skills and confidence to use the internet and benefit fully from digital technology in everyday life.

- **Access** – lack of connectivity remains a challenge in some rural and also urban areas; an even bigger challenge is affordability of devices and connectivity. Costs of assistive technology present additional barriers to access for disabled people.
- **Skills** – not having the ability – the basic digital skills – to use the internet in everyday life or work – including to use the internet safely.
- **Confidence** – not having the confidence in oneself, or trust in technology, often alongside fears of things going wrong or online harms and risks (such as scams).
- **Motivation** – not seeing why using the internet could be relevant and helpful.

Over recent years, available data from Ofcom, the Office for National Statistics, Oxford Internet Institute and the Lloyds Banking Group Consumer Digital Index has consistently revealed clear correlations between digital exclusion and social exclusion. While older age remains the strongest single predictor of internet access and use among adults, poverty (and related disadvantages such as low literacy and low educational attainment) are the most reliable predictors across all age groups. Among working-age adults, those in the lowest socio-economic groups are more than three times as likely as those in the highest socio-economic groups to not use the internet or to be 'limited users' who use the internet for only a few tasks ([Ofcom 2020](#)).

The most recent reports from Ofcom's Adults Media Use and Literacy Survey ([Ofcom 2021](#)) and Lloyds Consumer Digital Index ([Lloyds 2021](#)) point to the continued links between economic, social, health and digital inequalities – as well as signalling how Covid-19 has shaped digital access and use.

According to Ofcom, an estimated 6% of the UK population did not have home internet access in March 2021 – around 1.5 million households. This is down from 11% in 2020, which Ofcom caveats referencing a change in methodology. Equivalent data from ONS ([ONS August 2020](#)) puts the number of households without internet access at 4% down from 7%; while the latest Lloyds CDI report shows a 3% increase in internet use (95% of households compared to 92% in 2020). Ofcom 2021 data finds that those more at risk of digital exclusion were those aged 65+ (18%), those in DE households (11%) and those most financially vulnerable (10%). Lloyds CDI found that 55% of those who were 'offline' had an income below £20,000. Concerns around affordability of data connectivity and devices, and worries about data privacy had increased among those who were 'offline' – including about how to stop organisations from using their data ([Lloyds 2021](#)).

In terms of use: both the [Lloyds 2021](#) report and analysis by Age UK of the English Longitudinal Survey of Ageing ([Age UK 2021](#)) find that digital engagement increased most in lockdown among those who were already digitally engaged. In some groups – older, less affluent groups,

including people with impairments or health conditions – engagement levels declined during lockdown. Ofcom’s analysis also reveals that more people are accessing the internet through ‘proxy’ users rather than independently – most likely family and friends, but this might also be carers or others providing support.

Unsurprisingly, both Lloyds and Ofcom reports find changing patterns of use during lockdown – with more people using the internet for social connectivity, shopping, keeping entertained, online learning, remote working, and to maintain physical health. As the Lloyds CDI analysis on digital and financial behaviours notes, some of this comes with increased risks, such as the rise in use of ‘Buy Now Pay Later’ online services.

The latest progress tracking against the UK Government’s Essential Digital Skills framework was published in 2020 ([Lloyds 2020](#); next data release expected September 2021). This found that 9 million people are unable to use the internet independently and a further 2.7 million can use the internet but lack all the essential digital skills for life; while 13.6 million working adults have the essential digital skills for life – but not the essential digital skills for work. Disabled people and those with long-term conditions are 23% less likely to have the essential digital skills for life ([Lloyds 2020](#)). Data from this year’s Lloyds report suggests that older people with impairments or conditions might be particularly missing out on the benefits of screen readers, dexterity tools and other assistive technologies ([Lloyds 2021](#)).

Of particular relevance to this report, the Lloyds CDI report found a significant rise in the number of people who want more local support to get online and build their digital skills and confidence: a seven-fold increase from 5% in 2020 to 35% in 2021; and a four-fold increase in the numbers who would turn to online information sources for support from 21% in 2020 to 80% in 2021.

Insights from all these reports resonate powerfully with experience on the ground – whether from community organisations supporting people to use the internet, or health and care providers and patient representatives. Recent reports by National Voices on ‘How can we dismantle health inequity together?’ ([National Voices 2021a](#)) and ‘Unlocking the digital front door’ ([National Voices 2021b](#)) powerfully bring the issues of equality, access and inclusion to the fore – highlighting both the benefits and the risks of digital tools for health and care – and a clear call to action for more inclusive health.

This is echoed in ‘Locked out: Digitally excluded people’s experiences of remote GP appointments’ ([Healthwatch England 2021](#)), which identifies five principles for post-COVID digital healthcare, including a commitment to digital inclusion.



## What is the relationship between digital exclusion and the health, social and economic aspects of people's lives?

We know that digital exclusion impacts on people's health – individual health outcomes, healthy lives, and healthy communities – in three main ways.

First, digital exclusion impacts directly on health outcomes with regard to healthcare access. People experiencing digital exclusion are locked out of using digital health tools and services. This reflects access barriers (not having a suitable device or connectivity); and skills and confidence barriers (lack of digital literacy which may overlap with lack of health literacy) ([Good Things 2020a](#)). Evidence shows a clear social gradient to health literacy, and also to digital literacy; and an overlap between these ([Rowlands 2020](#)).

Secondly, digital exclusion impacts on the broad range of factors which shape people's chances of a healthy life and good health outcomes

– the wider determinants of health. Internet access and use has become essential across all five domains: economy and employment; education and lifelong learning; social participation and community life; housing and the built environment; and access to health and healthcare. We have argued that digital – access, skills and confidence – should be recognised as a wider determinant of health ([Good Things 2020a](#)); and internet access should now be viewed as an essential utility ([Good Things 2020b](#)).

### Economy and employment

Even before the pandemic, at least 82 percent of jobs required digital skills (DCMS 2019) yet 13.6 million workers do not yet have the essential digital skills for work ([Lloyds 2020](#))

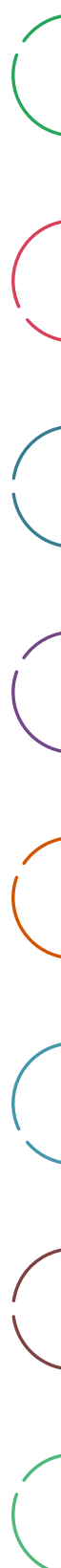
Manual workers with high digital skills earn around £2,160 more a year than those in the same jobs but with low digital skills ([Lloyds 2020](#))

4 in 10 people claiming benefits lack the essential digital life skills ([Lloyds 2020](#))

([Lloyds 2020](#) data on essential skills for life and work will be updated in September 2021)

76% of people supported by Good Things Foundation and our partners in 2019/20 said they improved their job prospects as a result of building their digital skills

<p><b>Education and lifelong learning</b></p>	<p>Online learning as a new activity is more likely to have been attempted by 18-29 year olds and those with High or Very High Digital Engagement (Appendix 4a and 4b) than others - some of whom may have the greatest need for online learning (<a href="#">Lloyds 2021</a>).</p> <p>Research into school responses to COVID-19 found 28% of pupils had little to no IT access in the home, rising to 43% in schools with the highest levels of deprivation (<a href="#">NFER 2020</a>)</p> <p>23% of 5-15 year olds in the poorest households (social grades D and E) do not have home access to broadband and a laptop, desktop or tablet (Yates 2020)</p> <p>For working adults, 10% of UK total economic output has been linked to the effects of online learning for work (<a href="#">Demos 2020</a>)</p> <p>When asked if they would download a COVID-19 contact tracing app, 71% of people with a degree compared to only 38% without formal qualifications said they would (<a href="#">Health Foundation 2020</a>)</p>
<p><b>Social participation and community life</b></p>	<p>80% felt digital was a vital support in the first months of national lockdown (<a href="#">Lloyds 2020</a>)</p> <p>71% of older and disabled people supported to use Learn My Way 2019/20 felt more independent as a result (Good Things 2020a)</p> <p>People facing digital exclusion (including low skills, even if they have internet access) experienced more loneliness and isolation during lockdown (<a href="#">British Red Cross 2021</a>)</p> <p>87% of internet users said the internet helped them connect better with friends and family, and 55% said it made them feel more part of a community (<a href="#">Lloyds 2020</a>)</p>
<p><b>Housing and the built environment</b></p>	<p>6% of people lack home internet access - equating to around 1.5 million households (<a href="#">Ofcom 2021</a>)</p> <p>There are still rural and some urban areas without any or adequate mobile coverage and broadband connectivity</p> <p>Not all housing associations and residential care providers have addressed availability and affordability of connectivity</p> <p>Many environments provide neither the safety nor privacy to access or disclose needs to health or other services; this is compounded where people lack a personal device and data.</p>



### Access to health and healthcare

Before the pandemic, 66% of all adults had never used the internet or apps to manage their health, rising to 79% among those with low digital engagement ([Lloyds 2020](#)).

Lloyds Consumer Digital Index 2021 reports that 37% of adults use digital tools to manage their physical health, and 25% for their mental health ([Lloyds 2021](#))

Awareness and use of online bookings for GP appointments increased to 48% and 19% respectively in 2020 (compared to 44% and 15% in 2019) ([GP Patient Survey 2020](#))

83% of GPs expressed concern about patients whose access to remote services may be impacted by digital literacy, disability, language, location or internet connection (GPonline 2020)

When asked if they would download a COVID-19 contact tracing app, 17% of over 65 years old said they lacked a suitable device ([Health Foundation 2020](#))

Thirdly, and less understood, digital exclusion raises questions for equalities in a data-driven health system. The [Ada Lovelace Institute](#) is exploring the relationship with health and social inequalities. Digital exclusion is a risk factor where certain groups have a very low digital and data footprint, compounding the risks of algorithmic bias with impacts on targeting and allocation of resources, for example.

The relationship between internet access, use, health outcomes and inequalities is complex. We still don't have enough good quality data – quantitative or qualitative – to understand and track whether (and how) digital exclusion contributes to poor health outcomes, and whether (and how) digital inclusion promotes better health outcomes and healthier lives. The [ONS Health Index \(beta\)](#) is the latest reminder of the paucity of data on digital inclusion and exclusion: there is not a single digital inclusion indicator, because existing datasets are not good enough.

This means we are equally failing to capture the ways in which digitally-enabled health tools can improve health outcomes of those who are

currently poorly served. Healthtech innovations – from wearables to making NHS content available on smart speaker devices – can be life-enhancing for those who can and want to use them. The shift in the pandemic to use of remote consultations – a shift that is likely to stay, and many health and care leaders want to keep ([IPPR 2021](#)) – has brought a range of benefits.

Insights gathered last year by the Leeds People's Voices Group ([Leeds Healthwatch 2020a](#)) found that people valued digital and telephone access when it made their lives easier, reducing money or time spent travelling, and fitting around work and caring roles: "I hope they continue to offer this after the lockdown as it is hard for me to get out due to mental health problems." Digital channels don't suit everyone: "it's not been as good as face to face, especially when it's for mental health appointments and building up a therapeutic relationship ... a level of your communication is taken away by being online or over the phone" ([Leeds Healthwatch 2020b](#)). These findings echo national research on GP remote consultations which found that many people (including those previously



sceptical) reported benefits, while the shift to remote delivery created barriers for some ([Healthwatch England 2021](#), [Healthwatch England and National Voices 2020](#)). Provision of digital mental health has also been found to have improved access to services, including online self-help, and reduce barriers such as stigma (NHS Confederation 2020).

Digital health tools can improve access for some; give people more choice and control over their own health; enable better sharing of information; and enable good use of time and money – for clinicians and for patients and carers. But overwhelmingly, this comes with a message about understanding and respecting choice and patient preferences, keeping multi-channels open, and the need for practical action to avoid the emergence of a two-tier, twin-track system which entrenches the digital divide and health inequalities. Without action on digital exclusion and an inclusive digital transformation approach ([Davies 2021](#)), use of digital health tools will fail to achieve better health outcomes.

### Five principles for post-COVID digital healthcare (Healthwatch England 2021)

- Maintain traditional models of care alongside remote methods and support people to choose the most appropriate appointment type to meet their needs.
- Invest in support programmes to give as many people as possible the skills to access remote care.
- Clarify patients' rights regarding remote care, ensuring people with support or access needs are not disadvantaged when accessing care remotely.
- Enable practices to be proactive about inclusion by recording people's support needs.
- Commit to digital inclusion by treating the internet as a universal right.



## How has the pandemic impacted digital exclusion?

Digital exclusion is not new. Organisations like Good Things Foundation have been delivering digital inclusion programmes and advocating to close the digital divide for over a decade. Covid-19 has shone a spotlight on digital exclusion – and exacerbated the nature, scale and significance of digital exclusion across the country.

The pandemic has likely resulted in a widening of inequalities between those who are digitally included, and those who are digitally excluded. The global response to the pandemic has been characterised by both the power of communities in responding and supporting each other, and the power of digital technology. Internet access has enabled children and adults to cope and survive through the pandemic. People who are digitally included have been able to use the internet for health, mental health and wellbeing support; to seek advice and support more generally – such as with money and debt worries; stay in touch with loved ones; learn at home; work remotely; stay entertained and informed; pursue interests; join in online exercise, faith, cultural or social activities.

There has also been an acceleration of digitalisation in public, voluntary and commercial goods and services. We have since this from accessing state welfare and benefits, to the rise in online shopping and use of online financial services. In healthcare, we have seen rising use of digital health tools, including remote monitoring, remote consultations and the provision of online patient and health information. The lack of digital access and skills among the population has made it harder for the NHS, government, health, social care and other service providers to reach, engage and support people – including groups and communities already poorly served or facing greater barriers in their lives. And the lack of digital skills and

confidence within the workforce – including in the health, care and voluntary sectors – has presented an additional challenge.

Face to face support – going where people are and feel comfortable – has long been recognised as a vital element of supporting people to get online and build their digital skills and confidence. Covid-19 restrictions have made this very challenging. The goalposts for what it means to be digitally included have moved again during the pandemic. Online activities such as banking have become more essential; and online harms – such as fraud, mis/disinformation, abuse and harassment – have heightened awareness of online safety as a vital part of digital inclusion ([Good Things 2020c](#)).

The pandemic has made digital inclusion more important than ever. And it has reframed the challenge away from simply ‘getting online’ to how we can ensure that everyone has the essential access, skills and confidence they need to participate, and live well and safely in a digital world. Hence growing interest in the development of a robust baseline: a Minimum Digital Living Standard to create a deeper, more comprehensive, universally recognised baseline for what it means to be digitally included in the UK; informed by in-depth consultation with the public (see [Carnegie UK Trust 2020](#); a new collaboration led by Prof. Simeon Yates will be taking this forward from September 2021).

## Which groups have been most affected?

The absence of a clear baseline, consistently applied definitions and robust local and national data currently make it impossible to build a detailed picture on internet access, and use, including the intersection with health inequalities.

While existing data provides a valuable national picture, sample sizes are too small to support detailed analysis at a local level and to allow for intersectional analysis. This restricts understanding of the links between digital exclusion and area deprivation, and in particular the digital exclusion of communities experiencing racial inequalities. Recent analysis of data collected in the pandemic by Ofcom and Lloyds Banking Group gives valuable insight into how the pandemic has affected national trends around home internet access and behaviours (discussed above). Importantly, analysis of data collected for the English Longitudinal Study of Ageing indicates the pandemic has had less impact on internet use among older people than might have been assumed – with increases largely among those who were already regular users ([Age UK 2021](#)).

Demand for improved quantitative data on digital exclusion has risen among strategic stakeholders who want to understand the extent of the challenge in their locality so they can target support. Some local authorities are making use of proxy indicators (risk factors) to inform their digital inclusion strategies (e.g. Salford, Westminster, Stockport). There has also been a welcome rise in research led by, with or about those groups which face greater risks – locally (e.g. Leeds Healthwatch) and nationally (e.g. National Voices).

Available quantitative and qualitative evidence shows a range of factors that separately – and more often together – create or compound barriers to digital access and inclusion: poverty, older age, low literacy, low digital skills and confidence, communication needs and preferences, complex or precarious lives, disability and some health conditions, lack of privacy, and fears and mistrust of technology and/or of institutions.

Below, we briefly list some of the groups most affected by digital exclusion during the pandemic – and whose opportunities for healthy lives and flourishing are also most likely to be limited during the recovery, without coordinated and concerted action.

### People on low incomes

There is a well-evidenced social gradient in health outcomes ([Marmot 2020](#)). People in the bottom 40% of the population by household income are almost twice as likely to report their health as ‘bad’ or ‘very bad’ compared to those in the top 20% ([Tinson 2020](#)). Low income is also a key factor for digital exclusion across all age groups. People in the poorest households are at least four times more likely to be digitally excluded: 13% of working-age adults in social grade DE households compared to 3% in social grade ABC1/C2 households; 27% of all adults in DE households compared to 4% in AB households ([Ofcom 2020](#)).

Not being able to afford an appropriate device – a tablet or laptop – is a barrier especially for education and work. A more widespread barrier is data poverty: ‘those individuals, households or communities who cannot afford sufficient, private and secure mobile or broadband data to meet their essential needs’ (Nesta 2020). Covid-19 has increased our reliance on data, and removed previously available ‘workarounds’ – such as accessing free wifi in libraries, community centres, supermarkets, food outlets or on buses.

*“I haven’t got a computer, I haven’t got a laptop, I can’t job search. Since I am in security work, it’s part-time at public stadiums when there’s work on. There has not been any work for ages. So right now, with the second lockdown incoming, I am going to have more months with no work which is obviously very, very stressful.”*

**Member of the Grassroots Poverty Action Group, JRF 200/21**

People on low incomes are less likely to be on monthly contracts and data plans, while lack of address and credit history can also make qualifying for internet contracts harder. Around 53% of the ‘offline population’ may not have the disposable income to afford an average monthly broadband bill of £30-35 (Lloyds 2020). Ofcom estimates that 4.7 million UK homes (almost 1 in 5) struggled to afford their telecoms bills in 2019 (Ofcom 2020). Many have cut back on spending on food and clothes to stay connected (APLE Collective 2021). Recent research has underlined just how little is known about the costs and affordability of mobile data and home broadband (Nesta 2020).

### **Low income families with dependent children**

Families on low incomes – especially single parent families – have faced additional challenges during the pandemic around being able to afford suitable and also sufficient devices, and to cover the costs of home connectivity, as well as other challenges around reduced earnings, extra costs, childcare, housing and social security (JRF 2021).

Children, parents, teachers and community supporters have talked about the challenges families have faced in doing home learning on small screens; needing to share devices; and needing to prioritise what lessons are accessed due to limited data. Some had to rely on phones, being posted work, or having to go elsewhere to access decent internet (JRF 2021). Some of these barriers have been removed for some families through national or local initiatives – but the general picture is still a patchwork of provision, with families falling through the cracks.

*“The family are struggling with home tutoring for their four children, and are not able to do the work the school is setting, due to lack of IT equipment. The oldest two children are getting very stressed at not being able to do their work, and one of the younger children is also showing signs of distress”*

**(Application for support with devices and data, Yorkshire)**

*“This young family is facing destitution. The breadwinner is in and out of zero-hour, short-term employment; they last worked about a year ago. There is depression and anxiety in the family from dealing with poverty over a long period of time. They have no spare finances or internet access, and rely on community internet access, but this has been stopped due to COVID-19.”*

**(Application for support with devices and data, Fife)**

Even before the pandemic – child poverty was rising, especially among lone parent (often female-headed) households, and with especially high levels in some ethnic minority communities, especially Bangladeshi and Pakistani communities. Digital exclusion and also low literacy and low English proficiency have also made it harder for families to find out about and then to access available support, including food vouchers.

## Black and minority ethnic communities

Many Black and minority ethnic communities have been significantly affected by the pandemic – across a range of domains – and in ways that highlight the depth of racial inequalities and marginalisation in the country. As already noted, the sample sizes of most national surveys about internet use and behaviours are too small to enable robust analysis. At a high level, the main differences in access between ethnic groups seem related to age and income ([Public Health Wales 2020](#)). But this masks everyday realities, barriers and cultural differences in internet use.

In addition to digital exclusion barriers related to low incomes, there can be barriers for some people (such as vulnerable migrants) around: lack of trust in technology; lack of trust in the NHS and Government; not understanding or being able to navigate the NHS and other public services – online or offline; and English language barriers.

*“British health system very difficult... Having to explain health issues to multiple professionals. The doctors call me. I don't have the language. All I say is 'o.k, o.k, thank you.' I don't understand”*

**(Mother of six from Iraq, supported by an online centre / community health hub)**

Insights from community digital health hubs supporting refugee and migrant groups show low awareness about how the health service works in general and patient rights; the impact that experience of the immigration system can have on people's health, and on their relationship with the NHS and public services; and the importance of cultural awareness and clear communication between patients and clinicians.

The pandemic has highlighted again the extent of racial inequalities in health outcomes, health access, and the wider determinants of health. The latest JRF annual report on poverty ([JRF 2021](#)) underlines the increased risks of poverty – especially in-work poverty – among Black, Asian

and minority ethnic households; 14% more likely to be made unemployed, 13% less likely to be furloughed during the pandemic. Reports (see [Runnymede Trust 2020](#), [Public Health England 2020](#)) have pointed to the causes of higher Covid-19 death rates among Black, Asian and minority ethnic communities: over-exposure (through work, reliance on public transport, overcrowded housing) and under-protection (linked to historic racism). While the Runnymede Trust report reveals an area where digital exclusion alongside literacy, health literacy and language barriers likely played a key part: differences in awareness of health information and state support. While overall awareness of state financial support was high, with 93% of white British and 92% of Chinese people saying that they had heard of the economic measures available to help them through COVID-19 – the proportion of Black African, Pakistani and Bangladeshi groups' awareness of these measures was much lower: only 61% of Bangladeshi people were aware of these.

Vaccine equity is now also highlighting the interplay of racial inequalities experienced by some Black and minority ethnic communities. Factors identified as contributing to low take-up within some communities include: transport, digital, literacy and language barriers, but also a lack of trust and confidence in institutions such as the NHS, in how personal information will be used, and the intentions behind the vaccine programme. This also reminds of the societal and health risks of internet-enabled disinformation and misinformation – and the importance of supporting people to develop digital and health literacy together ([Healthwatch England 2021](#)).

## Disabled people and people with limiting health conditions

Up to 5.7 million people in England with an impairment or condition which limits their activities face digital exclusion (Ofcom 2020 data). Of this number, 3.3 million people are non-users of the internet; 1.1 million only use the

internet in a very limited way (not even social media), and a further 1.3 million have some access but very low digital skills ([Ofcom 2020 data](#)). An Ofcom Access and Inclusion report in 2018 identified that only 67% of disabled people under 65 years old and in social grade C2DE households use an internet-enabled device, compared to 93% of non-disabled consumers in the same cohort. The implications of digital exclusion for disabled people are considerable, and sit alongside higher levels of poverty, extra costs of disability, increased risks of loneliness.

The pandemic has disproportionately affected disabled people ([House of Commons 2020](#)). Disabled people made up almost 6 in 10 of all deaths involving Covid-19 in the period from March to July 2020 ([ONS 2020a](#)). Disabled people were almost twice as likely as non-disabled people (36.7% to 16.8%) to report that their access to groceries, essentials and medication had been affected. People with learning disabilities have been particularly affected – medically, economically and socially; 74.6% of people with a learning disability reported their wellbeing had been affected compared to 57.9% of disabled people generally, and 37.1% of non-disabled people ([ONS 2020b](#)). Qualitative research identified loneliness, loss and anxiety among people with learning disabilities, and concerns about people living independently who – without digital access or skills – were unable to stay in touch with self-advocacy and support networks (Seale 2020). The pandemic has also led to a significant rise in mental health difficulties across all age groups. Online self-help and access to mental health services and peer support has been a lifeline – for those who have been able to benefit ([NHS Confederation 2020](#)).

The essential digital skills gap between people with and without impairments is narrower for those already active in the workforce ([Lloyds 2020](#)). However, this needs to be put in the context of continued barriers faced by disabled people in accessing work. In the UK, 71% of disabled people who were employed in March

2020 said their work has been impacted by the pandemic ([Leonard Cheshire Foundation 2020](#)).

Accessibility remains a challenge even though digital technology can enable a range of adjustments for people with sensory, learning, dexterity and communication needs. Too many disabled people on low incomes and with limited access to support are unaware of the assistive technology and advice that is available – such as from [AbilityNet](#) – or lack the means to benefit.

### Older age groups

Older age remains the single strongest predictor of not using the internet – especially among those over 75 years old, those living alone and with support needs. The reasons for this are varied: fear, mistrust, lack of confidence, concerns about online safety or things going wrong, a sense of ‘the internet is not for people like me’ ([Good Things 2018](#)). Older people may step back from using the internet for a number of reasons – including changes to dexterity, cognition, and finding it harder to keep up – or want to keep up – with changes in technology. More than half a million people aged over 65 years old in the UK are ‘lapsed’ internet users ([Age UK 2020](#)).

New analysis by Age UK sheds light on how the pandemic has shaped internet access and use among older people in the first few months. Overall, 39% of people aged 52 plus in England said they used the internet more since the start of the pandemic but the rise has mostly been among those already using the internet regularly. Data showed little sign that non-users had been prompted to get online. In fact, only 24% of those aged 75+ were using the internet more; 9% were using it less ([Age UK 2021](#)). The most common barrier for adults who said they’d like to use the internet more was lack of digital skills, especially among the 75+ group where 79% mentioned this. Lack of trust, and lack of devices and connectivity, were other factors.

This is a timely reminder that some people will never get online, or may only want to use the

internet in a limited way. Using the internet for health-related issues and government services were the least common activities, especially among older age groups (Age UK 2021). Balanced with this are inspiring stories from older people such as Mable, who started using the internet aged 91 years old to connect with her family during the pandemic, reducing her feelings of loneliness. What [Mable](#) also had access to was on the doorstep, friendly help from her community online centre, Starting Point.

### Rurality and area deprivation

People living in rural areas have less access to internet infrastructure such as a fixed broadband connection at home; they are also more likely to experience slower internet speeds with implications for use ([Public Health Wales 2020](#)). Some deprived areas are also more likely to lack access. Poor quality internet access in health and care settings was a barrier for several pathfinders in the Widening Digital Participation programme. For example, a GP surgery in a rural area had built trust with a local traveller community, and was keen to host digital health sessions – but these had to be cancelled due to the poor WiFi in the GP surgery ([Good Things 2020a](#)).

Regional variations – both in terms of physical connectivity infrastructure and everyday access and use – is not a new story, particularly in Wales and Scotland. In England, it has become more prominent during the pandemic alongside renewed concern about left behind communities and a call for ‘levelling up’. The digital divide in England maps clearly onto the North/South divide that has long been evident when analysing economic and health inequalities ([Tinson 2020](#), [Bambra et al 2018](#)). All the factors known to correlate with lower healthy life expectancy – not having qualifications, unemployment and long-term unemployment, low incomes, disability – also correlate with digital exclusion. Secondary analysis of Ofcom data last year revealed that around 49% of people in the South East use the internet fully compared to just 18% in the North East, and 31%

in the North West; and that 53% of adults in the North East region are non-users or limited users of the internet compared to ([Yates 2020](#)).

### Working age adults

Workers in certain sectors and roles already faced greater risk of job insecurity and redundancy due to increased automation and digitalisation of work. The pandemic has accelerated these changes – increasing the need for basic digital skills development among workers who might previously have felt unaffected or unconcerned about digital change ([Good Things 2020d](#)). Evidence shows that women, young people and workers in Black and minority ethnic communities are over-represented in sectors hit hardest by the pandemic – raising serious questions for economic and social recovery (JRF 2021).

Even before the pandemic, a worrying gap was emerging between the level of essential digital skills assessed as necessary for most jobs and workplaces, and the skill level of the working population. Around 13.6 million workers were estimated to lack the essential digital skills for work (Lloyds CDI 2020). Furthermore, and as successive reports from the Social Mobility Commission have highlighted, those with the least skills are the least likely to benefit from employer-provided training and development: 49% of the poorest adults have received no training since leaving school, compared to 20% of the richest ([SMC 2019](#)). Major investment in adult learning – targeted at those already facing the greatest disadvantage – is needed to prevent the disproportionate impact of automation on low skilled workers and their households.

### Complex lives and wider injustices

People who face severe and multiple disadvantages (homelessness, substance misuse, mental ill health) are more likely to experience poor health outcomes and barriers to health services. Poverty, violence and racism can compound these disadvantages. Barriers to health are also affected by status (being

a refugee or seeking asylum), low English language ability, and low digital access and skills. With digital health services, as with any service, working with people to discover what matters most to them helps to find ways to mitigate barriers to access, and tap into opportunities.

In the Widening Digital participation programme, a recurring digital barrier was opening a patient account to access GP online services (Good Things 2020a). This usually requires an address, a photographic ID and in-person verification of ID. Each of these is a barrier for people with complex lives, limited English language and/or who lack trust in services. While more inclusive design can reduce these barriers, some of the issues (especially lack of trust) have deeper roots in people's experiences of services and in wider systems. These experiences can make even well-designed digital health services inaccessible.

*"E is a victim of domestic violence and is fleeing abuse. She is struggling because she does not have internet access at home to link up with us and other services that support her. She also suffers from anxiety and is finding the lockdown situation difficult because she can't follow her usual routines including the social support she gets from attending our centre."*

**(Application for support with devices and data)**

Leeds Healthwatch Communities of Interest network recently surveyed members to learn about barriers and what would help digital access (Leeds Healthwatch 2020b). Their report brings together the perspectives of groups and organisations supporting groups who face significant barriers to healthy lives, including domestic violence, homelessness, and mental illness. Alongside other barriers, the report highlights space, safety & privacy. Many people's home environments provide neither the safety nor privacy to access or disclose their needs to health or other services. This is compounded where people don't have access to

a personal device and sufficient data. This raises a call for public spaces and community centres to be equipped in a way that they can be used to access the internet with appropriate privacy (Leeds Healthwatch 2020). Where Widening Digital Participation pathfinders made this possible for people facing complex barriers, this was valued and used (Good Things 2020a).

### Vulnerability to online harms

Vulnerability – including situational vulnerability (reflecting life events like bereavement or redundancy, or increased stress and anxiety) – can make using the internet less safe. Covid-19 has increased the level of situational vulnerability among the UK population. Exposure to online harms and risks has increased for some groups during the pandemic, with damaging consequences for them and their families (Good Things 2020c).

Around 6 in 10 adults reported having had a least one potentially harmful experience online in the past year (Ofcom/ICO 2020). In research by Glitch, 46% of women and non-binary people reported experiencing online abuse since the pandemic started, and this number was even higher among Black and minoritised communities (Glitch 2020). Some common symptoms of mental health problems can also make managing money and using the internet safely harder (Money and Mental Health Policy Institute 2020).

*"(I) am forced to do some things online even though I do not feel happy about doing any banking online. It makes me feel incompetent and stupid and terrified of being scammed"*  
**(MMHPI 2020)**

The government, regulators and technology companies need to take more responsibility for internet safety and protecting citizens and consumers. Alongside this, enabling people to stay safe online, recognise risks, and recover when things go wrong is an essential part of what it means to be supported to be digitally included (Good Things 2020c).



## What policy responses have we seen, and what lies ahead?

The policy landscape relevant to digital inclusion is complicated (in a similar way to the policy landscape relevant to health inequalities more generally) – with certain policy areas held or best taken forward at a UK level (e.g. broadband and mobile infrastructure) as well as key areas which are devolved – especially adult education and basic digital skills. The Scottish and Welsh governments also each have national digital strategies.

There have been significant differences in national policy responses to digital exclusion during the pandemic. For children and young people in education, there have been national responses in place across the UK to support access to remote education – for example, the Department for Education’s Get Help with Technology programme.

With regard to the digital exclusion of adults, the strongest response has been the Scottish Government’s Connecting Scotland initiative – backed by significant public funding, implemented in consultation with local authorities and the voluntary sector, and integrated into Scotland’s wider digital strategy with a focus on widening digital access and participation of citizens. Connecting Scotland is a programme providing devices with data and digital skills support to adults who lack these. Decisive action on digital exclusion was much needed in Scotland. Even so, this stands out as a welcome response providing clear national leadership backed by new funding. In Wales, the Welsh Government prioritised distribution of data-enabled devices to care homes first, and then other registered care settings, where devices belong to the institution rather than the individual. In England, there has been no equivalent to ‘Connecting Scotland’. The government lent non-financial support to the UK emergency response (DevicesDotNow, now called Everyone Connected) which was set up

by FutureDotNow and delivered by Good Things Foundation. More recently, and positively, the UK government has provided funding for an England-wide collaborative programme to provide devices, data connectivity and digital skills support to adults with learning disabilities as part of a package of measures to mitigate the effects of Covid-19: the [Digital Lifeline Fund](#).

The last year has seen several developments relevant to digital inclusion – Data Strategy, Online Harms White Paper and subsequent Online Safety Bill, a new Digital Markets Unit, Digital Skills Bootcamps, continued emphasis on 5G mobile and gigabit-capable broadband, including incentives for businesses to take up gigabit broadband. Much less attention has been paid to tackling digital exclusion of adults and addressing data poverty. There is welcome, if brief, reference to ensuring every adult has basic digital skills as part of a ‘tech savvy nation’ as one of the [Top Ten Tech priorities](#) for the UK government. However there is no UK plan (and no national plan for England) for addressing digital exclusion and data poverty. A cross-Whitehall digital inclusion group is being established – which reflects the reality that every government department has a vested interest in digital inclusion. But it is not clear what its remit will be or what resources will follow. There is a risk that digital inclusion is seen as everyone’s problem and no-one’s responsibility.

Members of the House of Commons and House of Lords have been investigating the impacts of Covid-19 through the [Women and Equalities Committee](#), and also the [Covid-19 Committee](#) which explored the role of digital exclusion and inclusion.

Some combined authorities and local authorities have increased interest in digital exclusion in the pandemic – recognising the relationship between digital exclusion, and also economic and social recovery. Greater Manchester Combined Authority is using its convening power to build a Digital Inclusion Agenda for Change. West Midlands Combined Authority is developing a new digital inclusion strategy. Some Local Enterprise Partnerships are getting more engaged, for example the North East LEP. The Local Government Association, with MHCLG funding, has supported Leeds City Council and Croydon Council to develop a [digital inclusion toolkit](#) for local authorities, and the LGA has produced a guide on Digital Innovation in Adult Social Care ([LGA 2020](#)).

In many areas, local authorities, the voluntary and community sector, and businesses have taken emergency response measures. This has provided vital support but also opens up the questions of what now, what next, whose responsibility, and where will the funding come from to secure sustainable change.

With regard to the NHS and healthcare, existing ambitions for mainstreaming digital health have been accelerated in primary and secondary care. The recent White Paper is focused on structures and systems. Within this, there is reference to the value of digital technology and data – but no reference to digital inequalities and the risks this presents to equity of NHS access. The White Paper leaves unasked and unanswered important questions about the role of Integrated Care Systems (whether NHS body or a health and care partnership) in monitoring, overseeing and commissioning services to reduce digital exclusion and health inequalities in their area; including the role of communities and their organisations. Last year, NHS England and Improvement required all NHS organisations to ensure that ‘no matter how people choose to interact with services, they should receive the same levels of access, consistent advice and the same outcomes of care’ – starting by testing new digitally enabled care pathways for a positive impact on health inequalities; reviewing impact on different groups, and putting in place mitigations to address any issues ([NHS England 2020](#)). The reviews were due by the end of March 2021.

Government funding has also been provided to sixty councils and some voluntary organisations for ‘Community Champions’ to give Covid-19 vaccine advice and boost take up ([MHCLG / DHSC 2021](#)). This has raised some challenges from within the voluntary and community sector, with concern about lack of resources for community groups and organisations to help drive change within their communities.



## What practical responses have we seen, and what lies ahead?

Across sectors – organisations have had to change what they do, how they do it, and how they use digital technology. Service providers – big and small – have responded as best they can, especially where they have had to move from face-to-face to remote delivery. Many have encountered the scale and realities of digital exclusion among their customers or clients for the first time. They have realised what it takes to support people to get online, and feel confident about using the internet. They have had to revisit their assumptions about the ubiquity of digital devices, the affordability of connectivity, and the level of digital literacy in the population as a whole.

The practical emergency response – from communities, corporates and civil society – has been incredibly positive; and largely piecemeal. The challenge is how to move from spontaneity to sustainability, and how to build on what's been learned and achieved.

The inclusion of Good Things Foundation as a new member of the [Health and Wellbeing Alliance](#) in England is welcome and timely. The Alliance is jointly managed by the Department of Health and Social Care, Public Health England and NHS England and NHS Improvement. It is made up of members from the voluntary and community sector that represent communities that experience health inequalities.

### Devices

- Devices and data to schools, e.g. DfE's [Get help with technology](#) programme, [Digital Access for All alliance](#) led by Learning Foundation
- Donation and distribution of new devices, see [Everyone Connected](#) (formerly DevicesDotNow), [Connecting Scotland](#), [Digital Lifeline](#) (for people with learning disabilities in England), [Digital Communities Wales](#) (included provision of devices and data for care homes in Wales)
- Donation and distribution of refurbished devices, see [Reboot](#)

### Data poverty

- Zero-rating by some telecoms providers of some educational, health and voluntary sector emergency websites (e.g. Citizens Advice, Samaritans)
- Voluntary steps taken by some telecoms providers e.g. introducing or improving social tariffs, removing the data cap for those with contracts, donating sims or vouchers to contribute to digital exclusion initiatives
- Campaigning to end data poverty, e.g. [Operation Wifi](#) – an alliance of over 100 organisations led by Community Organisers
- [Data Poverty Lab](#) – a new initiative led by Good Things Foundation to support convening, collaboration and co-design of sustainable solutions

*"We're all learning together, and we'll get there"*  
**(Ann Hughes, Staffs & Stoke-on-Trent CCG, Digital Nurse Champion)**

## Digital and health literacy

- Recommendations from the Patient Information Forum on how to address gaps in health and digital literacy – following findings that 89% of PIF members recognised the impact of low health literacy on inequalities but only 13% said their organisation had a health literacy strategy, and only 50% had considered the equalities impact of digital tools ([PIF 2020](#)).
- Learning resources to support people to build both digital and health literacy together – e.g. online health modules on Learn My Way; 83% of people surveyed who used the health courses on Learn My Way health said they felt more confident about using online tools to manage their health (Good Things Foundation Learner Survey, 2019/20).
- Learning resources on how to [improve health literacy](#) and assess workforce [digital readiness](#) from Health Education England, including a [digital literacy framework and tool](#).
- [100% Digital Leeds](#) with strategic joint leadership by Leeds City Council and Leeds Hospitals NHS Foundation Trust together with strong collaboration of community networks and partners across the city.
- ‘Get Connected in Nottingham – building on the digital support hubs in libraries and pop-up shops (before the pandemic) to provide a Digital Support Helpline and Tablet Lending Scheme for local people facing digital exclusion during the pandemic ([Farrow 2020](#)).
- ‘[Community digital health hubs](#)’ – like Asha, Starting Point, [Cross Gates Good Neighbours in Leeds](#) – evolving the model developed through the Widening Digital Participation programme ([Good Things 2020a](#)) of trusted community places where people access holistic, person-centred support with digital inclusion, health, wellbeing and wider needs – such as ESOL.

## Supporting remote access to services in health (and more widely)

- Finding ways to give remote support to people who are new to using the internet or learning the basics – with communities and the voluntary sector often playing the biggest part at the frontline.
- Helplines and resources to guide people through using a service, such as remote access to GP or hospital consultations (e.g. a [local video](#) made by a medical student on placement at an online centre; a [slidedeck](#) for NHS England on video consulting; top tips from Healthwatch and National Voices on [Getting the most out of the virtual health and care experience](#)).
- Digital champion, volunteer or buddy schemes – locally, nationally – including several focused on supporting remote access to health services, for example Surrey Heartlands Health and Care partnership’s Tech to Community Connect programme, and digital champions networks as part of 100% Digital Leeds and Connected Nottinghamshire.
- Examples of social prescribing link workers who have developed a remit around addressing digital exclusion in communities they serve ([NALW](#)).
- Some service providers (government, commercial and voluntary sector) are supporting telephone helplines or community-based support with ‘assisted digital’, so people who can get support where a service has gone ‘digital by default’ or ‘digital first’ (e.g. DWP contract with Citizens Advice for assisted digital for Universal Credit claims).

## Inclusive design and resources

- [mHabitat](#)'s continued work in championing co-design and inclusive digital transformation in the NHS
- Signs of increased interest in how to design out inequalities from services, tools and systems when thinking about digital technologies – not only in the short term, but for the long term – across all sectors. For example: inclusive approaches in design of fintech, online safety tech.
- Innovations in using digital to address existing access barriers which have increased during the pandemic, such as [Signhealth's British Sign Language Health Access](#) to ensure Deaf people have remote access to all health settings nationwide, and Kettering Hospital NHS Foundation Trust's use of a live translation service for non-English speaking patients
- A new [Inclusion Health Audit Tool](#) to support GPs and other health services to support inclusive practice which also takes account of low digital access or skills in the population.
- A new toolkit to support [Digital inclusion in mental health](#) from the NHS Confederation, co-designed with experts by experience.

## Better data and understanding

- Rising demand for better quality data and indicators on digital inclusion and digital exclusion – especially to understand and track trends at a local level and with specific population groups known to face more risks. As noted above, the beta [ONS Health Index](#) lacks a digital inclusion indicator due to lack of available data in the UK. This leaves major gaps in understanding and ability to track changes, with particular gaps around ethnic minority groups and intersectionality.
- Growing interest among policy think tanks and academics in digital exclusion which should improve evidence and understanding, and press for better policy development – including The King's Fund, Health Foundation, JRF, Demos, IPPR, Social Market Foundation – alongside the decade-long work in this area by Carnegie UK Trust.



In our recent paper sharing lessons learned from the NHS Widening Digital Participation programme, [Digital Inclusion in Health and Social Care](#), we identified eight steps for addressing digital exclusion to improve health outcomes and equity:

1. Recognise digital access and skills as determinants of health and wellbeing. The ability to get online is essential for education, employment, income, participation, and access to information and services, all of which impact physical and mental health. Digital inclusion is now essential for healthier lives and economies. This means addressing data poverty – making internet access an essential utility – and ensuring every community has a place to get support with digital skills.
2. Embed digital inclusion into economic recovery strategies and into health, care and wellbeing strategies – joining the dots between these. Place-based and system approaches are essential to eradicate digital exclusion; this can't be achieved without communities and the community sector as a critical partner.
3. A digitally-enabled health and care system should aim to be inclusive by design – with services and tools co-designed with target groups, especially those who face greater barriers, and have low digital skills and access. We also need to enable people to use what works best for them – digital, physical or a blend.
4. As digitally-enabled health care and information becomes mainstream, this makes population digital health literacy a priority. The government and the NHS need to recognise their responsibility and role in population digital health literacy. This should include supporting people to navigate the health and wellbeing risks of the internet, and helping people understand how their health data is used.
5. Scale and spread the digital health hubs model. A digital health hub is trusted and embedded in the community; responds to people's needs; reaches people who are poorly served; builds digital and health literacy together; and supports wider wellbeing as well as access to digital healthcare. Digital health hubs can also build stronger bridges between the community sector and health systems. A national community of practice, and developing commissioning frameworks to support local digital inclusion and digital health literacy could be next steps.
6. Trust is essential for rebuilding the relationship of poorly-served groups with the health service. This is best achieved through resourcing and partnering with those who already have the reach, relationships and trust. Issues of vaccine inequity and lack of trust in Test and Trace, the NHS and Government have come to the fore and urgently need to be addressed.
7. Digital skills and confidence – also motivation to use digital – need to be improved in the health, care, community and wider workforce. Following the lead of Health Education England, more work is needed to train, support and build a network of digital health champions, and improve digital skills in the workforce.
8. Digital inclusion can bring practical, emotional, economic, social and wellbeing benefits – especially for older people and for disabled people. Health, care, housing and other providers can support people to try out devices, find out more about assistive technologies, and upskill digital champions on accessibility.

There is an urgent need to move action and evidence forward across all these areas.

## Collaborating for change

In March 2021, the Health Foundation, the King's Fund and Good Things Foundation jointly hosted a virtual workshop on digital exclusion and health inequalities – building out of the briefing notes provided in an earlier version of this paper.

The workshop brought together representatives from a diverse range of community and voluntary sector organisations (both hyperlocal and national representative bodies), the NHS, health and social care providers, academics and other experts in health data, digital health, patient voice and digital inclusion. Our aim was to support connections and share knowledge and understanding, creating the potential for new collaborations and insights.

The workshop followed an event hosted by National Voices – the national organisation championing patient voice – on digital exclusion and the implications for health. Patient representatives, clinicians and others at that event highlighted the breadth of barriers which people face, and which risk deepening inequalities and reducing health access ([National Voices 2021a](#)). These resonated powerfully with the evidence presented above and the experiences shared in the workshop by community and other stakeholders.

Through breakout sessions, participants shared their experiences and ideas around how to move forward: learning from 'bright spots' of practice, supporting them to spread and scale, telling better stories about the issues and what works, ensuring groups which are already marginalised or poorly served groups benefit and are included, and identifying where the best chance for change lies.

### These are the ten top takeaways from across the breakout sessions:

1. Address the knowledge gap around digital inclusion and health inequalities – increasing the quantity and quality of data, especially with poorly served groups.
2. Improve what you know by evaluating with early adopters, sharing what works and doesn't work in practice.
3. Support those who are already innovating and implementing change – enabling them to hear directly from one another through peer learning and practice sharing.
4. Reach out to other practice managers and a wider workforce audience, with guidance on practical steps to increase digital inclusion for health and care.
5. Grow the number of local, welcoming spaces which support digital inclusion. Use existing assets – GPs, community centres, libraries, even disused retail outlets.
6. Call on strategic commissioners in health and local government to drive action on digital inclusion projects that help address health inequalities.
7. Support community organisations to build people's digital skills, confidence and trust in using digital health tools – including disinformation and data sharing.
8. Build better bridges between local health, care, voluntary and community sectors. Shared values – such as rights of access to health care – enable collaboration.
9. Drive continuous improvement of digital tools through patient voice and user experience feedback, and promote more inclusive design of digital services.
10. Build on learning and innovation from Covid-19, and develop a call to action across government departments to address digital and health inequalities.

## Conclusion

Digital exclusion in a digital world is a health inequality challenge: it reflects, creates and compounds health and wider inequalities. There is no single or silver bullet solution.

Embedding digital inclusion into a digital-first health service is not something you can fix with a single programme or cash injection. We need a sustained, collaborative effort; with a national plan and coherent policy in place of the patchwork of emergency responses. Local initiatives are vital, but not enough. We can't see this as a problem for communities to address alone, or even for the NHS to address alone. There needs to be some level of responsibility by the UK government to coordinate and resource action. Addressing digital exclusion has to be part of the conversation about economic and social recovery, and tackling

health inequalities. There is a huge opportunity for digital technology to support healthier lives, choice and agency. But as it stands, the shift to digital has widened a divide that now threatens to create a two-tier health service further compounding existing inequalities in health equity and access.

Gaps in data need to be addressed but, even in their absence, we cannot let this stop us from taking action and working together to create better health for everyone.

**Dr Emma Stone**  
August 2021





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## Annex: Workshop breakout session slides

In March 2021, the Health Foundation, the King's Fund and Good Things Foundation jointly hosted a virtual workshop on digital exclusion and health inequalities. These are the main slides.



**Good Things Foundation**

**Digital health and inequalities**

**Workshop**

**March 2021**

### How might we tackle the challenges of digital **and** health inequalities? Ten recommendations from cross-sector workshop participants (March 2021)

1. Address the knowledge gap around digital inclusion and health inequalities - increasing the **quantity and quality of data**, especially with poorly served groups.
2. Improve what you know by **evaluating** with early adopters, sharing what works and doesn't work in practice.
3. Support those who are already innovating and implementing change - enabling them to hear directly from each other through **peer learning** and practice sharing.
4. Reach out to other practice managers and a wider workforce audience, with **guidance on practical steps** to increase digital inclusion for health and care.
5. Grow the number of **local, welcoming spaces which support digital inclusion**. Use existing community assets - GPs, community centres, libraries, even disused retail outlets.
6. Call on **strategic commissioners in health and local government** to drive action on digital inclusion projects that help address health inequalities.
7. **Support community organisations** to build people's digital skills, confidence and trust in using digital health tools - including disinformation and data sharing.
8. Build **better bridges** between local health, care, voluntary & community sectors. Shared values - such as rights of access to health care - enable collaboration.
9. Drive continuous improvement of digital tools through **patient voice and user experience** feedback, and promote more inclusive design of digital services.
10. Build on learning and innovation from Covid-19, and develop a **call to action across governments departments** to address digital and health inequalities.

From the workshop co-hosted by Good Things Foundation, the Health Foundation & the King's Fund. March 2021







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For more information  
about the project, contact  
Good Things Foundation on:

e: [research@goodthingsfoundation.org](mailto:research@goodthingsfoundation.org)  
t: 0114 3491619



The Health Foundation supported this project as part of the COVID-19 impact inquiry but the views expressed are not necessarily those of The Health Foundation.

