

CANADIAN COVID-19 SOCIAL IMPACTS SURVEY

Rapid Summary of Results #1: Risk Perceptions, Trust, Impacts, and Responses

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Disaster & Emergency Management | York University
Technical Report #004 | April 14, 2020

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Recommended citation:

Kennedy, E. B., Vikse, J., Chaufan, C., O'Doherty, K., Wu, C., Qian, Y., & Fafard, P. (2020). *Canadian COVID-19 Social Impacts Survey. Rapid Summary of Results #1: Risk Perceptions, Trust, Impacts, and Responses* (York University Disaster and Emergency Management Technical Report #004). <http://dx.doi.org/10.6084/m9.figshare.12121905>

Executive Summary

In addition to the biomedical aspects of the disease, the COVID-19 pandemic has already had profound social, psychological, and economic effects on Canadians.

This report draws on a national, probabilistic, bilingual survey with 2,029 respondents between March 20th and April 8th. The sampling methodology was representative of provincial populations, urban/rural populations, and city populations among the largest thirty urban centres in Canada.

Risk Perceptions

- 94% agreed or strongly agreed that “getting sick with the coronavirus can be serious,” a number comparable to previous influenza measures.
- Respondents expected COVID-19 to have a significant effect on the Canadian population (only 7% agreed/strongly agreed with the statement “the Coronavirus will not affect very many people in Canada”).
- Despite this, relatively few Canadians saw themselves as *individually* at risk of contracting the Coronavirus (only 23% agreed/strongly agreed that they would “probably get sick with the Coronavirus”), a lower percentage than with influenza measures.
- Respondents seem to support the Canadian government’s assessment of the Coronavirus, with only 9% believing that the government is exaggerating the health threat of the Coronavirus.

Confidence in Authorities

- Medical experts were accorded a large degree of confidence by Canadians (especially chief medical officers and the World Health Organization). By a small but consistent margin, provincial authorities experienced a higher level of confidence than federal.
- When asked to identify the top three influences on government responses, respondents thought there were many influences: economic considerations (56%), scientific evidence (53%), advice from medical doctors (53%), international influences (42%), and political considerations (34%).
- However, there was a dramatic consensus among respondents on what should be the primary influences on government decision-making: “scientific evidence” (82%) and “advice from medical doctors” (78%).
- There was overwhelming support for several mandates responses, including canceling public events, closing places of worship, encouraging people to stay home, mandatory home isolation if potential exposure is suspected, and closing schools.
- There was lower support for mandatory vaccination (should a vaccine become available) and for instructions to provide care for family members at home because of hospital capacity constraints.

Impacts on Canadians

- Among all respondents who had employment before the pandemic measures were implemented, 44% reported changes:
 - 8% were on paid leave from their work
 - 11% were on unpaid leave from their work
 - 13% had seen their hours reduced
 - 12% were laid off entirely
- Additional employment difficulties were noted in qualitative responses:
 - Some participants expressed that while their job had not yet been cut, they expected possible changes.
 - Some noted increases in work (e.g., grocery store workers and truck drivers).
 - Respondents who are employers or are self-employed (e.g., independent consultant, small business owner, freelancer) expressed the difficulties (e.g., having work agreements canceled or invoices going unpaid).
 - Some respondents were in the situation of being in a job transition as the pandemic emerged (e.g., had left one job and were scheduled to begin another), but had had their new job suspended temporarily or indefinitely without the support of the previous occupation.
- The ability of respondents to work from home was positively correlated with household income
- At the time of response, 38% of respondents reported one or more medical appointments canceled because of the crisis, while another 18% reported difficulty booking a medical appointment if it was needed.

Responses of Canadians

- In general, most respondents reported complying with protective measures recommended by government authorities, such as handwashing (98%), limiting social events (96%), and cooking at home more often (81%). Mask wearing levels were reported as comparatively quite low (only 14% of respondents).
- Most respondents either strongly agreed (32%) or agreed (42%) that they “would be comfortable caring for [someone with mild symptoms] at home rather than taking them to the hospital.” 79% expressed the ability to keep someone mildly sick in a separate room away from others.
- Given a scenario of being told by a physician to self-isolate at home because of exposure to a known case of COVID-19, 14% of respondents would worry about losing their job, 26% feared money problems (such as being unable to pay rent or afford groceries), 38% would lose income, and 85% would worry about exposing a family member to the virus.

Further results will be released in subsequent working reports (including on trusted sources of information and what information Canadians are seeking). To be notified of upcoming results, visit cemppr.lab.yorku.ca, follow @CEMPPR_Lab on Twitter, or contact Dr. Eric Kennedy (ebk@yorku.ca).

Background

The novel coronavirus pandemic (also referred to as COVID-19 in this report¹) is having a significant impact within Canada and around the world. While much of the research to this point has, understandably, been focused on biomedical aspects of the disease, the outbreak is also causing profound social, psychological, and economic effects on the health and well-being of Canadians.

In March 2020, we began a series of survey- and interview-based assessments to track the national impacts of the COVID-19 outbreak on Canadians. This report draws on research supported by the Social Sciences and Humanities Research Council. We are grateful for this rapid funding program to address emerging COVID-19 research priorities, which is supported by the three federal research funding agencies (SSHRC, as well as the Canadian Institutes of Health Research and the Natural Sciences and Engineering Research Council).

This report represents the first in a series of rapid dissemination efforts to share our findings with practitioners and decision-makers. Further analysis of the results – including assessing the influence of gender, ethnicity, and other demographic features – will be published through a variety of reports and peer-reviewed articles. To follow the updates, you can visit the Principal Investigator’s research group online at cemppr.lab.yorku.ca or via Twitter at [@CEMPPR_Lab](https://twitter.com/CEMPPR_Lab).

Note to Health Agencies, Emergency Managers, and other practitioners

We are committed to rapid dissemination of research findings in a way that supports your decision-making and response to COVID-19. If you would like to discuss more granular findings within your province, to arrange a telephone/video presentation of results at your convenience, or to request data that we can collect in future rounds of this investigation, please reach out to Dr. Eric Kennedy (ebk@yorku.ca).

¹ Note that SARS-CoV-2 is the novel coronavirus that causes COVID-19. However, to match colloquial language usage regarding the disease at the time of publication, we use the terms “coronavirus” and “COVID-19” interchangeably in this report.

Methods

This report draws on responses from a national survey of Canadian households which began on March 20th. In this report, we consider data collected between March 20th and April 12th, including some 2,029 responses (margin of error +/- 2.2%, 95% CI). Because of the mail-based sampling method used, the relatively long window allowed for varying delivery times across Canada and participation by those who may be collecting mail from community mailboxes less frequently due to COVID-19. Responses are timestamped to allow for analysis according to date of completion, which was explored in some of the questions below.

A stratified random sample of households in all provinces and territories were invited to participate through the use of postcard sampling. Bilingual postcards were sent to a random selection of mailing routes, stratified to be representative of provincial populations, rural/urban populations, and city populations among the thirty largest Canadian urban centres.

Prospective respondents were directed to a website (using both URLs and QR codes on the postcards) which provided completion options in both French and English. Prospective respondents were first provided with details of the ethics approval and prize draw. They were then invited to provide their email to participate in the prize draw and future rounds of surveys and telephone interviews. Participants had the option to withdraw participation at any time, and to opt-in to a reminder to return at a later date to finish the survey (if not completed initially).

The research protocol was approved by York University's Office of Research Ethics (certificate # 2020-065). Following initial analysis, data will be made available through an open access repository, the details of which will be posted to cemppr.lab.yorku.ca as available.

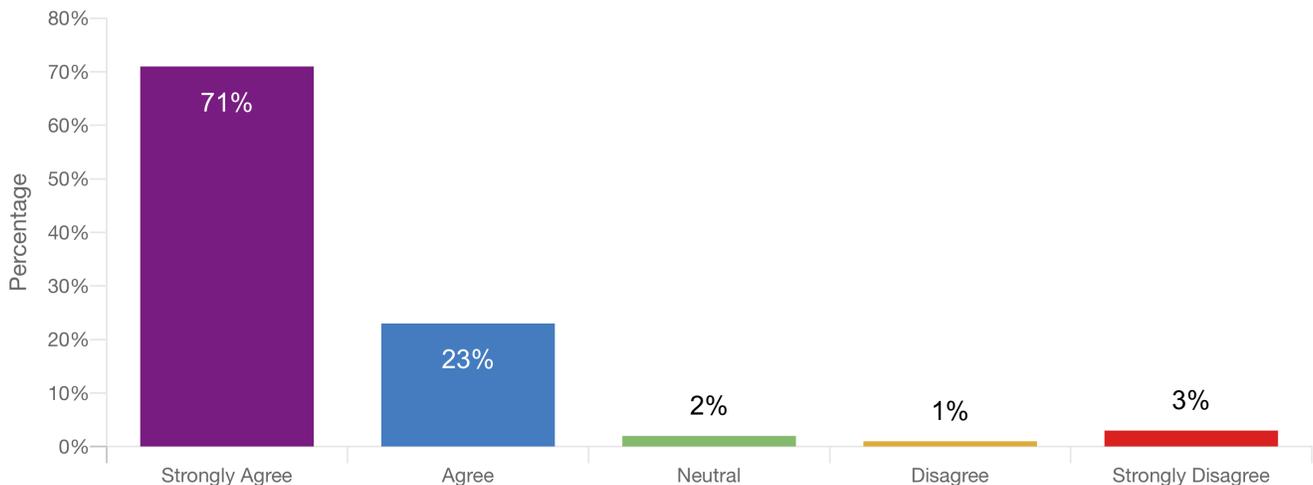
Risk Perceptions

To assess how Canadians perceive the risk of the Coronavirus, we adapted a scale used by the Public Health Agency of Canada (PHAC) that measure attitudes on influenza, including the perceived severity of getting sick, probability of getting sick, and likelihood of the infection affecting many people.² We added an additional measure to gauge perceptions of “overreaction” by the government to the outbreak. We also ran an additional set of questions directly comparing COVID-19 risks against other hazards (e.g., floods, assaults, influenza, etc), which will be presented in an upcoming report.

Severity of Sickness

As may be expected given the high degree of public attention on the novel coronavirus in Canada, Canadians expressed concern about the potential impact of COVID-19. A strong majority of respondents, for instance, believed that “getting sick with the coronavirus can be serious” (94% agree/strongly agree, see Figure 1).

Figure 1. Getting sick with the Coronavirus (COVID-19) can be serious



Despite a prolonged data collection period, there was little change over time in the perceived severity. Comparing responses in March and April, for instance, the mean level of agreement (on a scale of 1 to 5, with 5 representing “strongly agree”) had no notable change (4.57 vs. 4.63 respectively) when controlling for other variables.

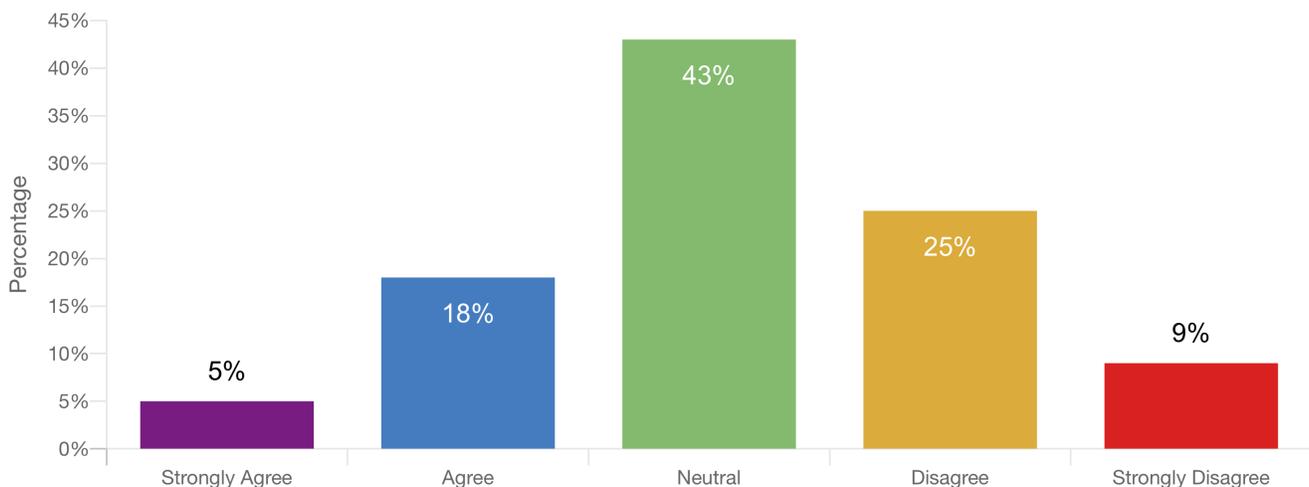
² For more on the PHAC report on influenza, see <https://www.canada.ca/en/public-health/services/publications/healthy-living/2018-2019-influenza-flu-vaccine-coverage-survey-results.html>

Interestingly, however, this level of concern is very similar to the general level of concerns with seasonal influenza in Canada. In the most recent year (2018-2019) of Public Health Agency of Canada’s (PHAC) annual survey on influenza, for instance, the same percentage of respondents (94%) either agreed or strongly agreed that “getting sick with the flu can be serious.”

Probability of Getting Sick

Although Canadians were concerned with the potential severity of the Coronavirus, far fewer believed (only 23% agreed or strongly agreed) that they would “probably get sick with the Coronavirus” (see Figure 2). These numbers are somewhat *lower* than the percent of Canadians who agreed that they would probably get sick with seasonal influenza (30% strongly agree or agree) based on the 2018-2019 PHAC survey. In other words, Canadians had equal levels of concern about the severity of COVID-19 and influenza, but saw themselves as less likely to become sick with COVID-19 than influenza.

Figure 2. I will probably get sick with the Coronavirus (COVID-19)



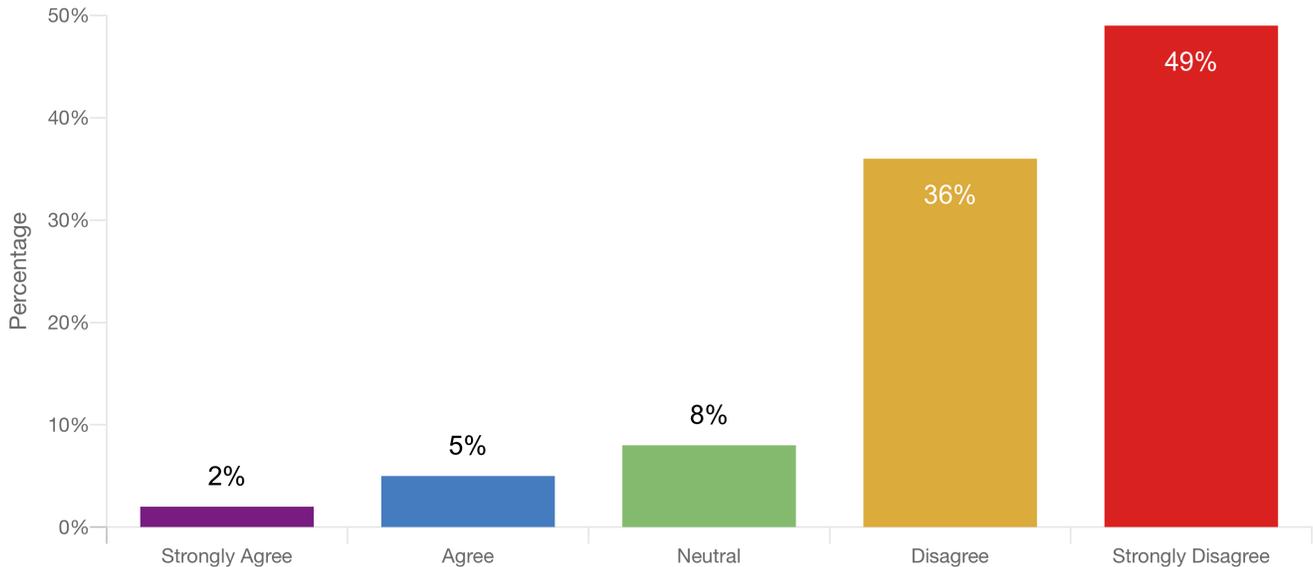
Effect on People in Canada

Respondents were also asked to rate their agreement with the statement “the Coronavirus will not affect very many people in Canada” (see Figure 3). Only 7% of respondents agreed (agree/strongly agree) with this statement. This percentage is much lower than the percentage that agreed with the same statement on the influenza survey: in 2019, a full 20% agreed that “the flu does not really affect that many people.”³

³ This is even more surprising given the more-narrow framing of the Coronavirus question (focused solely on people in Canada versus people in general). Strictly speaking, the broader

It's worth being careful in interpreting this item. Because it is asked with a negative phrasing, Canadians agree more strongly that the Coronavirus will affect many people in Canada than they believe influenza will affect many people.

Figure 3. The Coronavirus (COVID-19) will NOT affect very many people in Canada



This is a somewhat paradoxical finding: respondents said it was less likely that they would personally get sick with the Coronavirus than the flu, while simultaneously stating that more people in Canada were likely to be affected by the Coronavirus.

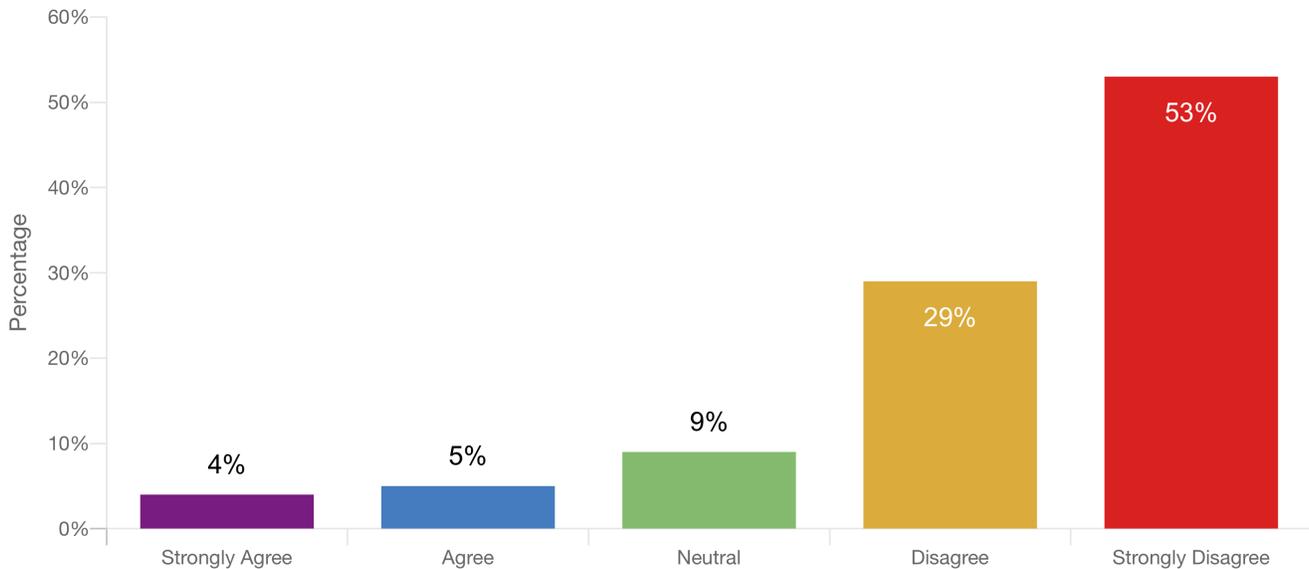
This raises an important question for public health agencies. Why were respondents less likely to imagine themselves getting sick with the Coronavirus, but more likely to imagine “very many” people being affected by the Coronavirus? Two hypotheses seem plausible. First, given the lower percentage that anticipated getting sick, it may be that Canadians envision the Coronavirus as being something more likely to affect *others* as compared with themselves, which raises a potential challenge for public messaging and behavioural change on the topic (i.e., if Canadians see themselves as being less vulnerable than others, more effort might be required to encourage the adoption of pro-social, disease-control behaviours). Alternatively, it may be that Canadians define being “affected by” the Coronavirus much more broadly than being affected by the flu (e.g., perhaps they see very many people being affected by economic or social consequences, but not the disease itself).

question should receive more support (i.e., something can affect more people globally than it can in Canada alone), and yet the effect was reversed.

Exaggeration of Threat?

Finally, it's important to note that an overwhelming majority of Canadians felt that the Canadian government was *not* exaggerating the threat of the Coronavirus. Only a small minority agree (5%) or strongly agree (4%) that the threat was exaggerated, while some 82% believed it was not exaggerated (29% disagreeing and 53% disagreeing strongly).

Figure 4. The health threat posed by the Coronavirus (COVID-19) is exaggerated by the Canadian federal government



It is also interesting to note that the risk perceptions shifted very little over the duration of our survey. On a scale from 1-5 (where 1 represents strongly disagree and 5 represents strongly agree), the mean response on the measures above varied only slightly during the duration of responses despite collecting responses for a period of three weeks during a very rapidly evolving public health event (see Table 1).

Table 1. COVID-19 perceptions in March and April

Question	Mean Response, March	Mean Response, April
Getting sick with the Coronavirus can be serious.	4.57 (Strongly agree)	4.61 (Strongly agree)
I will probably get sick with the Coronavirus.	2.85 (Neutral)	2.82 (Neutral)
The Coronavirus will probably NOT affect very many people in Canada.	1.76 (Disagree)	1.81 (Disagree)
The health threat posed by the Coronavirus is exaggerated by the Canadian Federal Government.	1.77 (Disagree)	1.83 (Disagree)

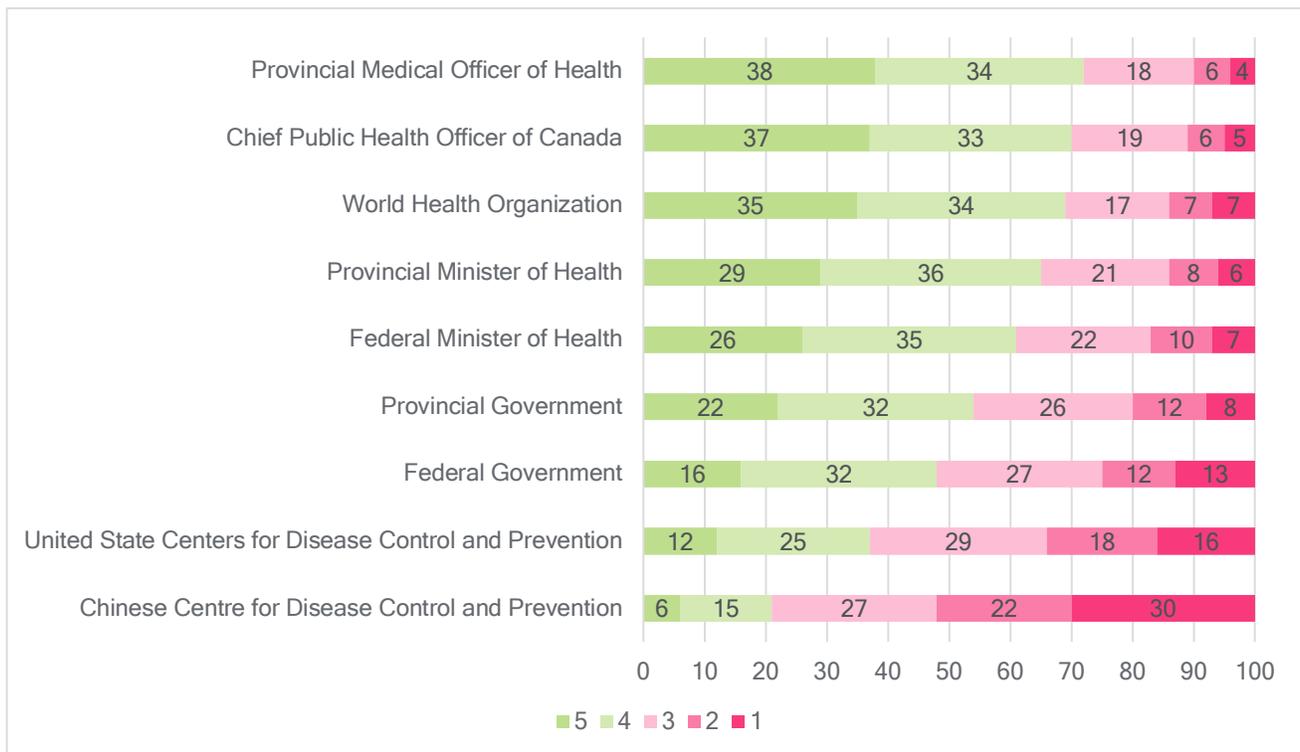
Governments: Confidence & Interventions

We asked Canadians a series of questions about their views on governments and their responses to the Coronavirus.

Confidence in Governments and Agencies

Respondents were asked “how much confidence do you have in the following groups?” and were presented with a random-ordered list of several health agencies and government officials. Respondents were then presented with a scale from 1-5, where 5 represented “can be trusted a lot” and 1 represents “cannot be trusted at all.” In Figure 5, agencies are ranked from highest to lowest with respect to mean confidence score.

Figure 5. Level of confidence in governments and agencies



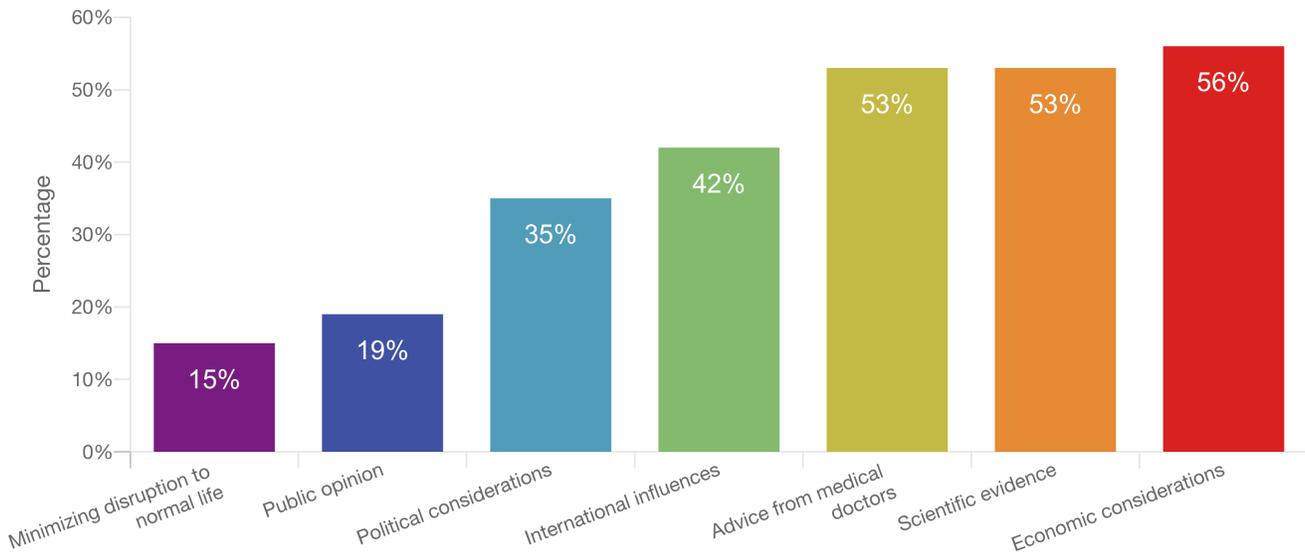
In general, the ranking resulted in a clearly sequenced order: chief medical officers (both provincial and federal) were accorded the highest confidence alongside the World Health Organization. Ministers of health experienced distinctly higher levels of confidence than their respective ‘governments’ in general. In every capacity (chief medical officers, ministers, and governments), provincial governments were *slightly* more trusted than federal. And, foreign *national* agencies – both the US and Chinese Centres for Disease Control – were seen with the lowest degree of confidence, dramatically different than the World Health Organization.

Current and Desired Influences on Government Decision-Making

Canadians were then asked to articulate which considerations they thought were – and which considerations should – affect government decision-making with respect to the Coronavirus. While the previous question indicated a relatively high degree of trust, here Canadians perceived a significant disparity.

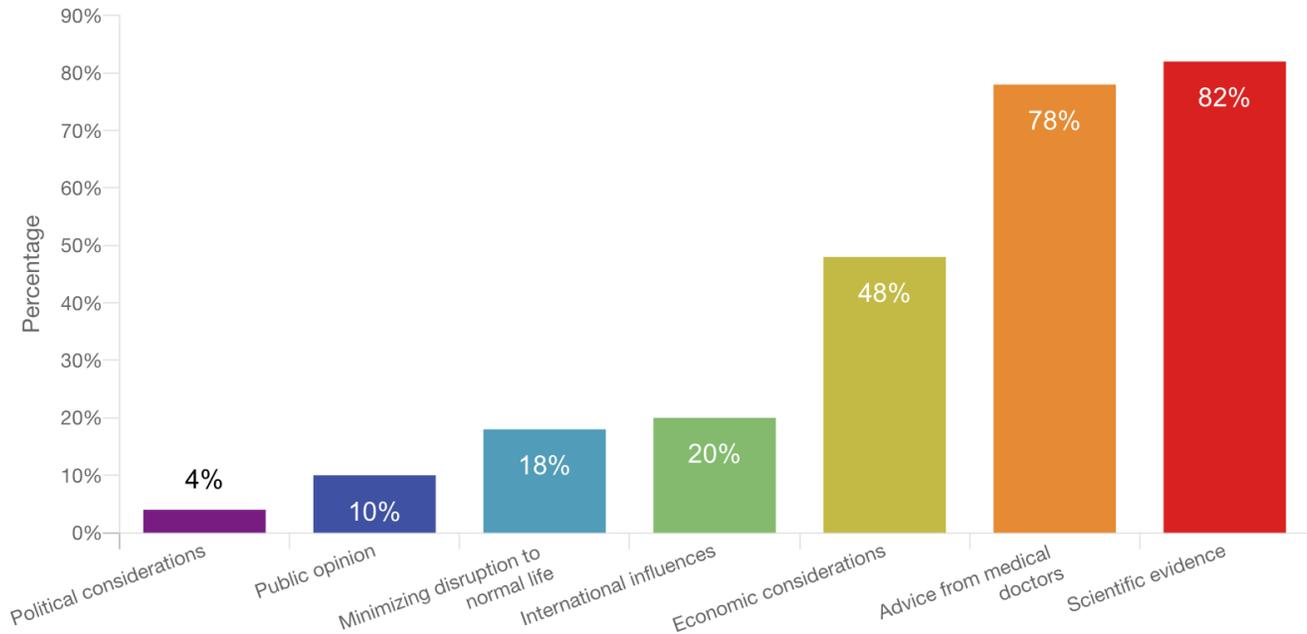
When asked to select up to three influences that they thought “...are most affecting government decision-making in Canada about the Coronavirus,” Canadians were relatively split. Over half of Canadians selected “economic considerations” (56%), scientific evidence (53%), and advice from medical doctors (53%), although “international influences” and “political considerations” attracted a relatively high number of respondents as well (42% and 34%, respectively). In other words, Canadians identified a wide range of influences as currently affecting government decision-making.

Figure 6. Which of these considerations ARE affecting government decision-making?



By contrast, Canadians were much more decisive on which influences should affect decision-making. A vast majority of Canadians (82% and 78%, respectively) thought that “scientific evidence” and “advice from medical doctors” should be the primary influences on government-decision making, whereas a significantly lower percent (48%) believed that economic considerations should be among the top three influences. Other influences (including international influences, minimizing disruption to normal life, public opinion, and political considerations) scored at roughly one fourth – or less – than scientific evidence and advice from medical doctors (see Figure 7).

Figure 7. Which of these considerations *SHOULD* affect government decision-making?



Put another way, while approximately half of Canadians believe scientific evidence is among the top three influences on government decision-making, roughly another 29% of respondents do not believe it is currently among the top three influences affecting government decision-making *but that it ought to be*. Similarly, while half believe that advice from medical doctors is among the top three influences, an additional 25% do not think that this is currently the case – but believe that it ought to be.

Political considerations (-30%), international influences (-22%), and public opinion (-9%) illustrate places where respondents viewed an imbalance between current and ideal influence: each of these were seen as more influential over government decision-making than respondents thought they should be.

It is important to remember that this question does not identify which factors are actually affecting decision-making. Self-reported surveys can only identify *perceptions* of influences, not the validity of those perceptions. The results show, however, a disparity in how decision-making is *perceived* versus *desired* to be. The results potentially indicate a place where governments might consider further refinements to their messaging if they wish to emphasize that they're relying on medical advice (rather than, say, political considerations or public opinion).

Support for Government Interventions

We also asked Canadians about their support of government interventions to help mitigate and respond to the Coronavirus outbreak. Respondents were asked to rate a series of interventions that could be, or had been, announced, presented in a randomized order and on a scale from 1-5 (5 representing “very favourably” and 1 representing “very unfavourably”).

In general, there was overwhelming support for five of the actions: canceling public events, closing places of worship, encouraging people to stay home, mandatory home isolation for those potentially exposed, and closing schools (from 84-80% scoring 5). By contrast, there was more than a 20-point gap between those actions and the next (mandatory vaccination), and relatively little support for instructions to provide care for family members at home because of hospital capacity constraints. In general, this seems to suggest a relatively high degree of support for collective, mitigation actions designed to help the hospitals maintain sufficient capacity.

Figure 8. Favourability of government actions

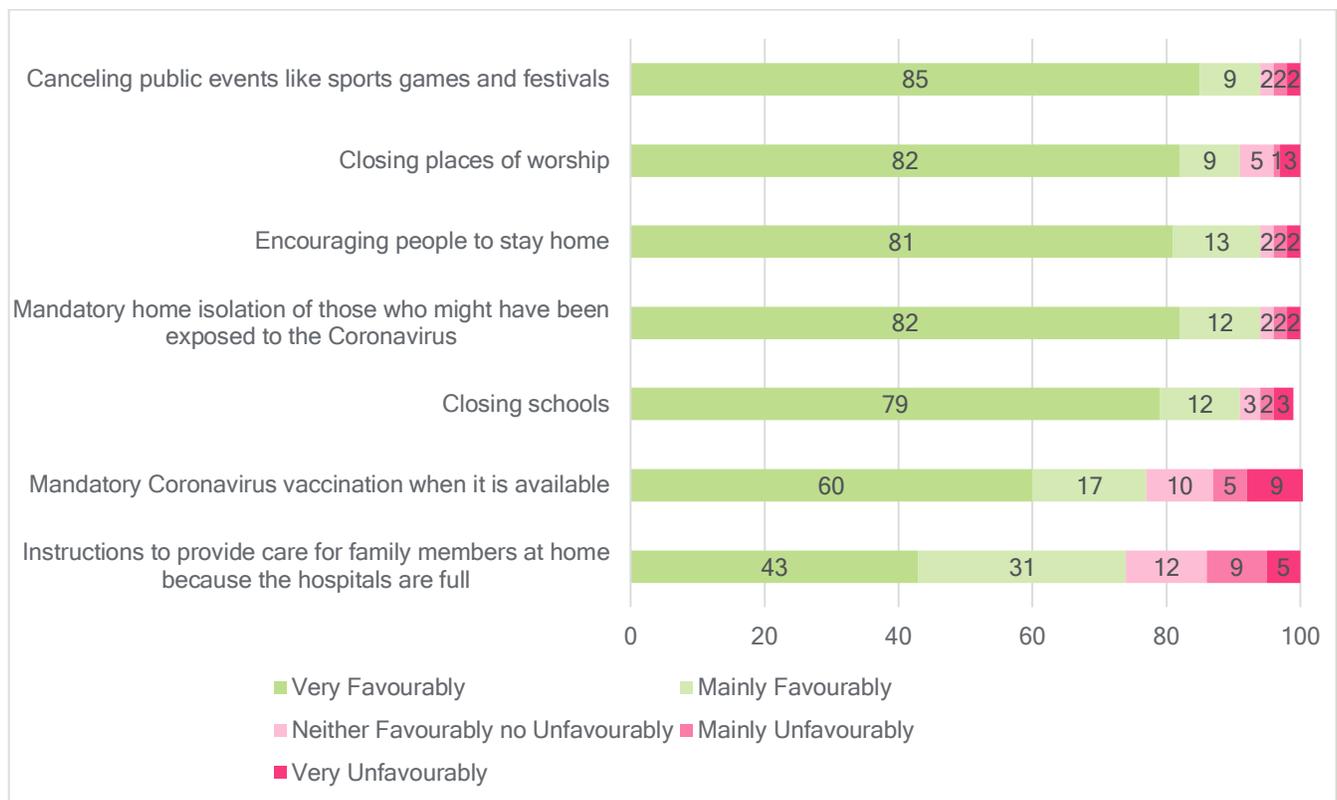


Table 2. Mean support of government actions

Government Action	Mean Support (5 = Very Favourable, 3 = Neutral)
Canceling public events like sports games and festivals	4.72
Closing places of worship	4.66
Encouraging people to stay home	4.70
Mandatory home isolation of those who might have been exposed to the Coronavirus	4.69
Closing schools	4.63
Mandatory Coronavirus vaccination when it is available	4.45
Instructions to provide care for family members at home because the hospitals are full	3.99

Impacts on Canadians

As might be expected, Canadians have experienced a wide variety of changes to their work, schooling, and day-to-day life as a result of the Coronavirus outbreak.

Employment Status

Among those who were employed in some sort of work before the outbreak began (including full-time, part-time, gig economy, and self-employed work, among others), 44% identified as having some sort of negative change in their ability to work, ranging from paid-leave to layoffs.

Of those respondents who were employed before the outbreak began, approximately:

- 8% were on paid leave from their work
- 11% were on unpaid leave from their work
- 13% had seen their hours reduced
- 12% were laid off entirely

As respondents were invited to provide additional qualitative detail about their situations, four notable clusters stood out in initial analysis.⁴

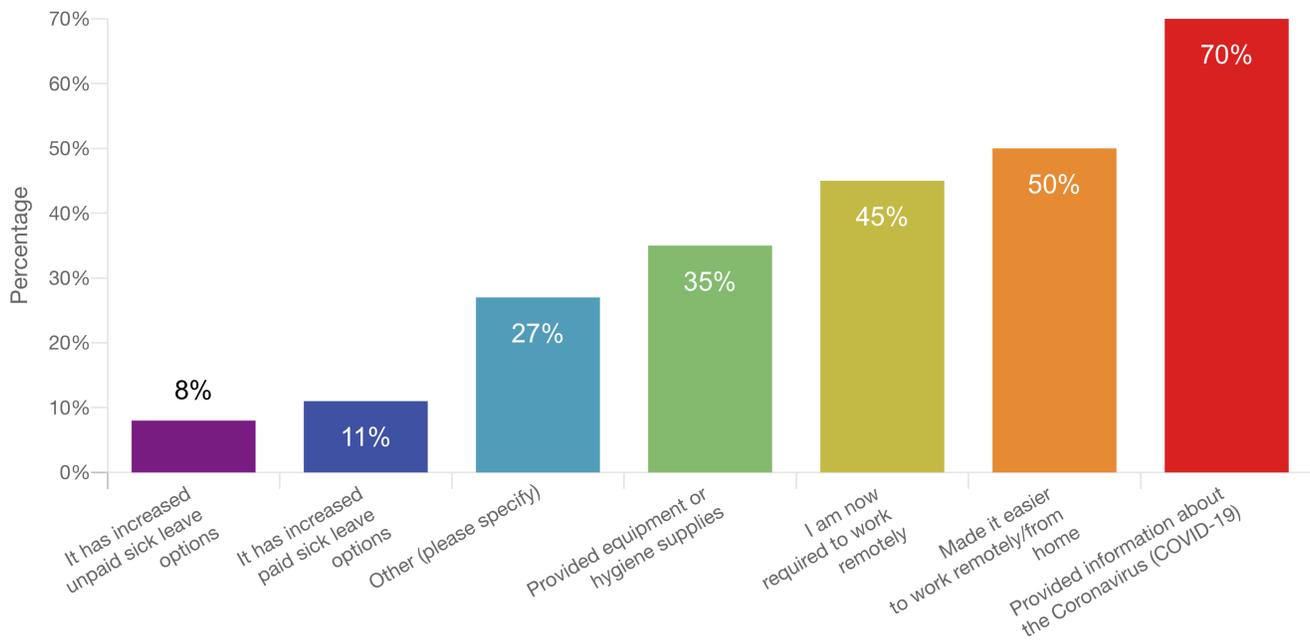
- First, a number of respondents expressed that – while their job had not yet been cut – they were unsure about whether that would change within a matter of days or weeks.
- Second, a group of respondents noted increases in work: multiple grocery store workers and truck drivers, for instance, commented that they were being called upon for more hours than normal.
- Third, other respondents expressed the difficulty of *being* the employer – whether as an independent consultant, small business owner, or freelancer – and not having a clear employment status (e.g., not being laid off, but also having work agreements canceled or invoices going unpaid).
- Fourth, some respondents were in the situation of being in a job transition as the pandemic emerged (e.g., had left one job and were scheduled to begin another), but have had their new job suspended temporarily or indefinitely without the support of the previous occupation.

⁴ Note that because we didn't prompt for these types of answers (e.g., didn't ask about fears or concerns of future layoffs or increases in work), we cannot speak to the true frequency or prevalence of these responses.

Changes in the Workplace

For those still working, the experience of work has changed tremendously over the past several weeks. For respondents who identified that their workplace had made changes, the most common *single* change reported is that workplaces are providing information about the Coronavirus. However, a very large number of respondents reported that their workplace has either made it easier (50%) or required (45%) them to now work from home.⁵ Indeed, in the qualitative descriptions of adjustments, work-from-home arrangements were among the most common discussed. However, comparatively few respondents reported that their workplaces had increased paid (10%) or unpaid (8%) sick leave options.

Figure 9. What changes has your school or workplace announced because of the Coronavirus (COVID-19)?



While a more details qualitative analysis will be presented in a future paper, there were a wide range of workplace adaptations that stood out. For instance, respondents mentioned their workplaces are now:

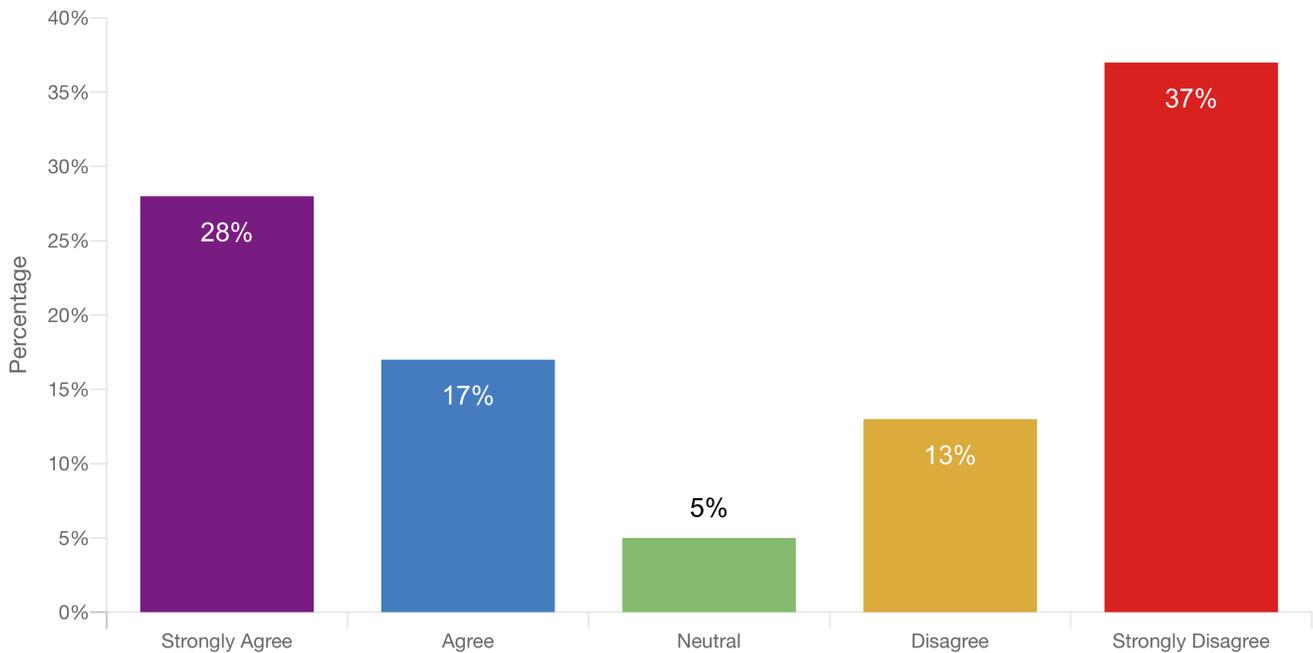
- “Monitor[ing] our body temperature four times a day, wearing masks, and washing hands a lot more often.”
- Screening employees or administering health questionnaires prior to entering the workplace.
- Selective work-from-home arrangements (e.g., 1/4 of staff work from office, 3/4 work from home to increase room for physical distancing).

⁵ Note that these percentages cannot be strictly added, as it was possible for respondents to select both “now required to work from home” (e.g., is a new policy) and “has made it easier” (e.g., has provided equipment or training). However, it is likely that

- Separating entrances for employees and customers.
- Creating policies against physical customer contact (e.g., changing how payment or ID verification occurs).
- Adopting new styles of shift schedules (e.g., more hours but fewer shifts; multiple days on then longer breaks off).

Indeed, this shift to work-from-home arrangements is striking, especially when considering the nature of work. When all respondents currently employed were asked about their arrangements, roughly 45% agreed that their current job allowed them to work from home (versus 50% who were unable).

Figure 10. Does your current job allow you to work from home?



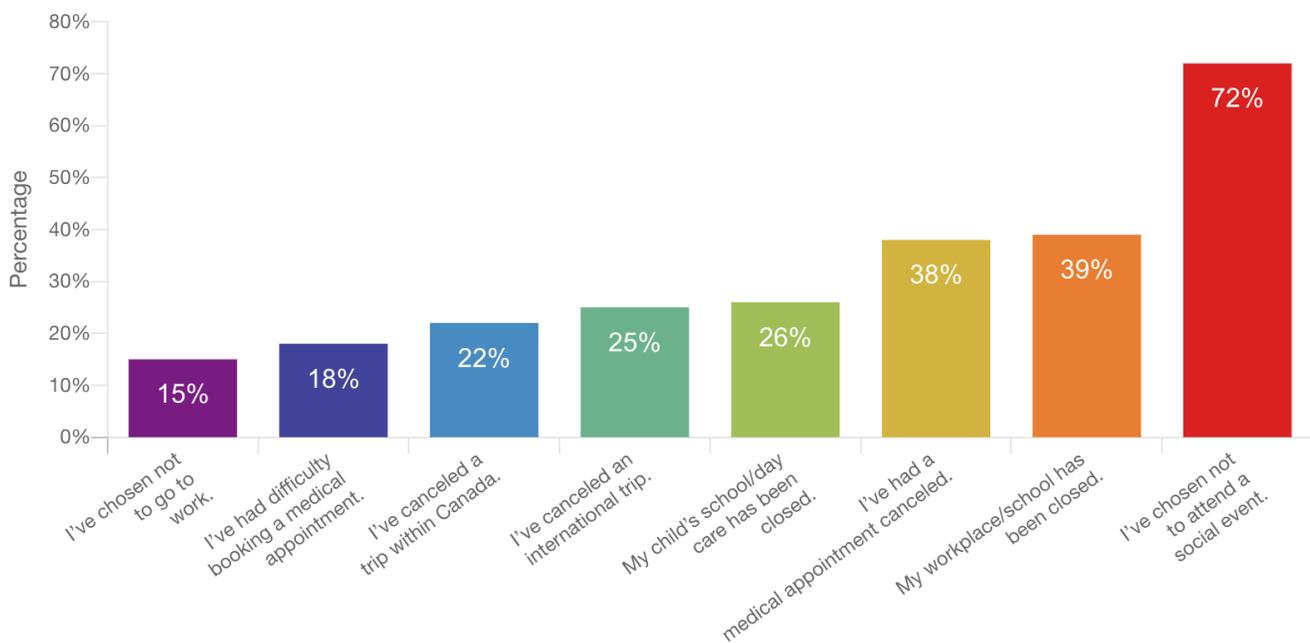
The ability to work from home was positively correlated with household income. For instance, those making between \$30,000 and \$39,000 scored a mean 1.84 (i.e., “disagree”), while those making \$150,000 or more scored a mean of 3.72 (i.e., “agree”). There was also a bi-modal distribution, with higher levels of flexibility in much lower income brackets (e.g., below \$10,000). Further analysis will be performed in future reports to identify explore these particular cases.

Difficult Situations

As might be expected, these changes also result in dramatic shifts for the public at large, especially as customers. We asked respondents about their experiences over the past three months in terms of *impacts* of the Coronavirus (see Figure 11). Among respondents, 73% suggested that they had chosen not to attend one or more social events. Twenty-six percent had canceled international trips, while 21% had canceled domestic trips.

Some of these impacts, however, might have more dramatic impacts. Some 38% of respondents reported one or more medical appointments canceled because of the crisis, while another 18% noted difficulty booking a medical appointment if it was needed. While this aligns with recent statistics about wait-times for telehealth services and the cancellations of elective procedures, this potentially represents a significant burden on health care delivery as routine needs go unmet.

Figure 11. In the past three months, have you...



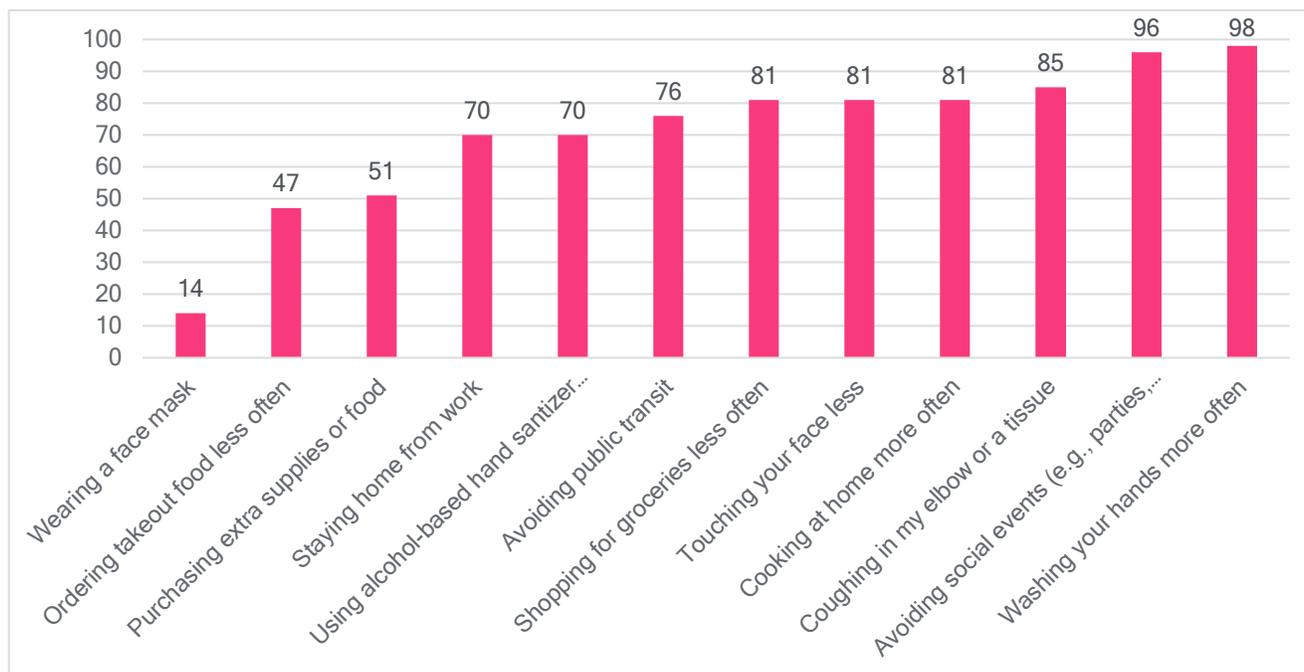
How Canadians are Responding

Personal Actions

While Canadians are dramatically affected by the Coronavirus outbreak, respondents also reported taking notable personal actions to try to protect themselves and others.

The most common self-reported actions were “washing your hands more often” (98%) and avoiding social events (96%). Several other actions, including covering coughs, cooking at home, touching one’s face less, shopping for groceries less often, avoiding public transit, eating out less frequently at restaurants, staying home from work, and using hand sanitizer were identified by 70% to 85% of respondents (see Figure 12).

Figure 12. Preparation Steps



Relatively fewer respondents reported purchasing extra supplies or food (51%) or eating takeout food less frequently (47%). Further, mask-wearing was very low (13%) – although the shift in advice regarding mask-wearing may well increase this number over time.

We also used an experimental design to test for potential stigmatization and bias in these actions. In particular, respondents were randomly presented with only one of three possible prompts as part of the larger list: “eating out less at restaurants,” “eating out less at Chinese restaurants,” or “eating out less at Italian restaurants.” While some 78% reported eating out less at restaurants, only 39% reported eating out less at Italian restaurants – and only 30% reported eating out less at Chinese restaurants.

There are obvious difficulties in evaluating these kinds of behavioural changes through self-reporting surveys. There are strong social desirability effects, for instance, that encourage respondents to *overreport* their compliance with broadly agreeable behaviours (e.g., handwashing). Moreover, even if certain behaviours (handwashing or mask-wearing, for instance) *are* occurring more frequently, it does not mean that they are being conducted effectively. More research is needed to assess the validity of these measures, and to provide empirical data about *actual* behavioural changes.

This self-reporting data, however, *can* speak to the perceived severity of the pandemic and the ways in which Canadians see themselves as responding. It is likely that encouragements and affirmations to *continue* these behaviours and to acknowledge hard-work may be more effective than assuming low compliance. In other words, the insight here is in understanding *how Canadians are perceiving themselves as responding* to the outbreak. Effective policy and public health messaging need to take this into account and seek to meet Canadians ‘where they are’ in these difficult times.

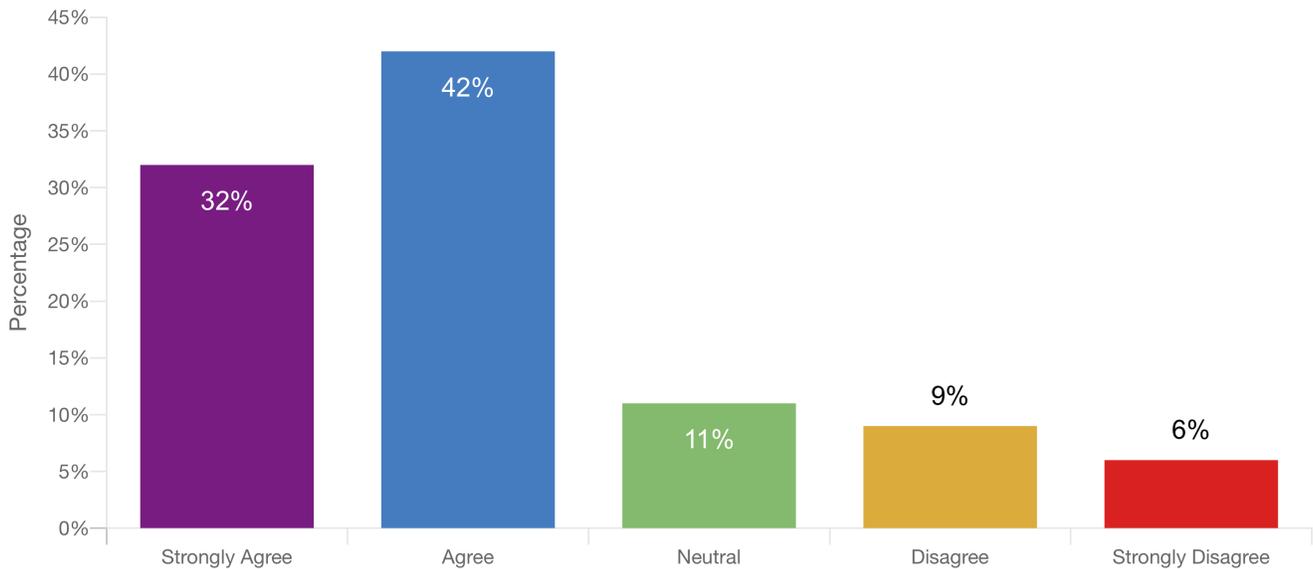
As a final note, we assessed these behaviours in two ways: a closed-ended question (Figure 12) that was presented to half the respondents, and an open-ended question (“Describe what steps, if any, you’ve taken to prepare for the possibility of many cases of the Coronavirus (COVID-19) in your community.”) for the other half. While the use of a closed-ended list helps to prevent memory failure (e.g., forgetting an action when put on the spot), it also leads to a systematic over-reporting of actions because of social desirability. In a future report, we will compare the results presented below (closed-ended responses) versus the open-ended responses to assess the reliability of the measure.

Caring for Others

For respondents who reported living with others – spouses, children, parents, housemates, or others - we also asked a series of questions about the abilities of Canadians to care for those in need. These questions help in measuring latent capacity within communities to respond to mild cases of the disease.

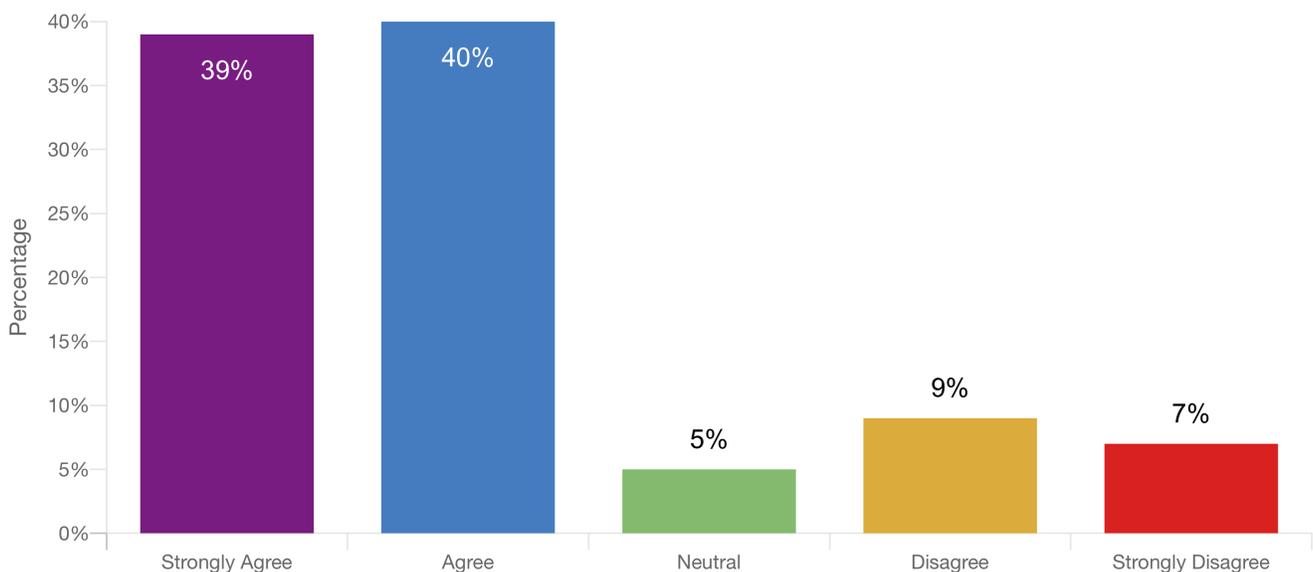
By and large, respondents either strongly agreed (32%) or agreed (42%) that they “would be comfortable caring for [someone with mild symptoms] at home rather than taking them to the hospital” (see Figure 13). However, some 15% of respondents disagreed with this statement, which identifies a gap for preparedness: if we wish to avoid sending mild cases to the hospital, how can these household members be made more comfortable in caring for mild cases?

Figure 13. If someone in my household experienced mild symptoms of the Coronavirus (COVID-19), I would be comfortable caring for them at home.



Part of this may line up with physical capacities at home. When asked if they could keep someone from their household sick with the Coronavirus in “a separate room where they could be kept away from others,” a similar percentage – 16% - disagreed. Some 78%, however, expressed that they had the capacity to conduct this kind of physical separation (see Figure 14). This was moderately associated with income, with those with no income agreeing much more weakly (3.25 on a scale from 1-5) than those making \$150,000 or more (4.19).

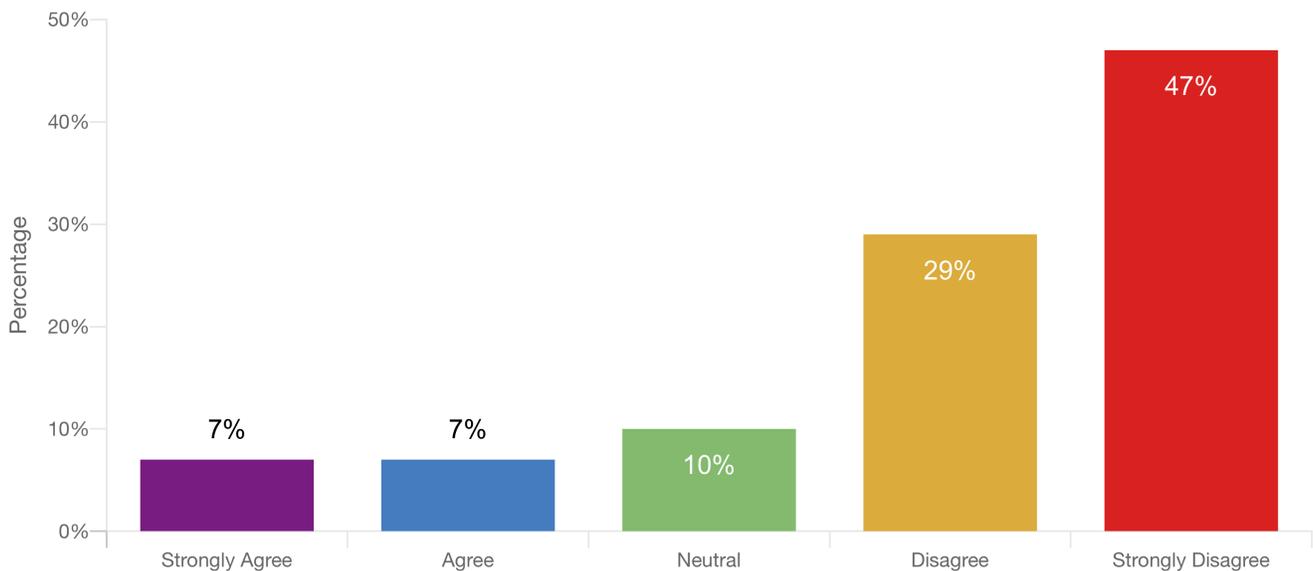
Figure 14. I have a separate room where they could be kept away from others



We then asked respondents to imagine a scenario where they had interacted with someone who had the Coronavirus and were subsequently told by a physician that they needed to isolate themselves for a period of 14 days at home. Respondents considered four potential outcomes: the loss of a job, loss of income, money problems, and worry about exposing family.

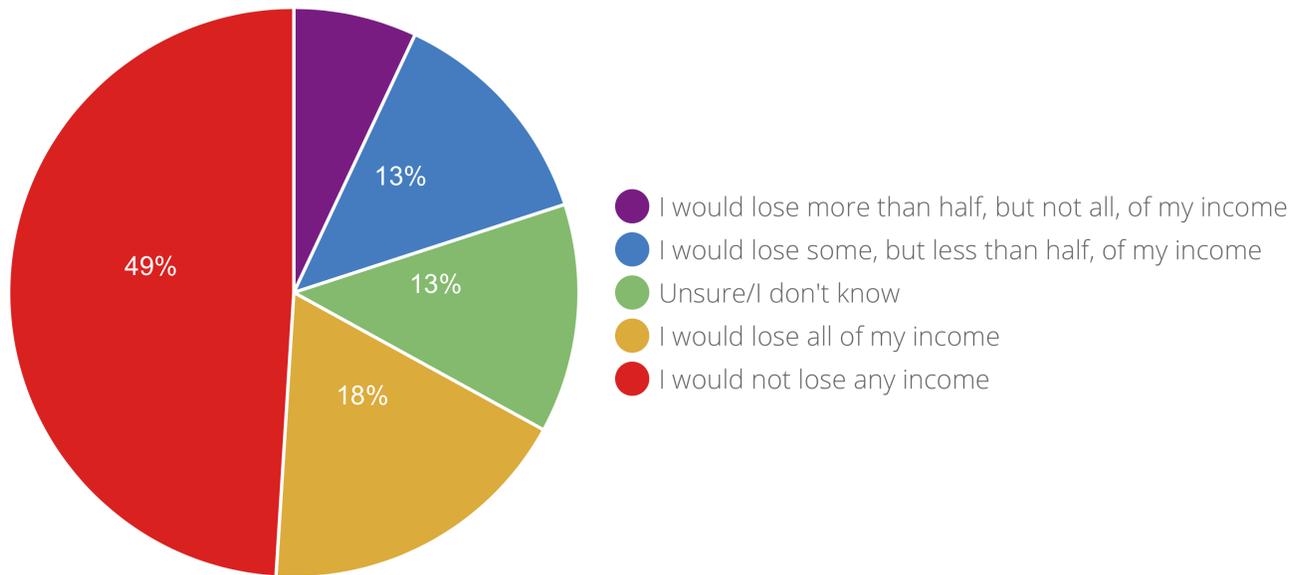
Approximately 14% of respondents expressed concerns that being required to take a 14-day self-isolation would cause them to worry about losing their job (see Figure 15). While this may seem to be a low percentage, it is striking considering the scenario asked specifically about a *physician-mandated* self-isolation period. It is possible that job concerns would be even higher for more judgement-based cases, such as having suspected exposure rather than specific public health instructions.

Figure 15. I would worry about losing my job



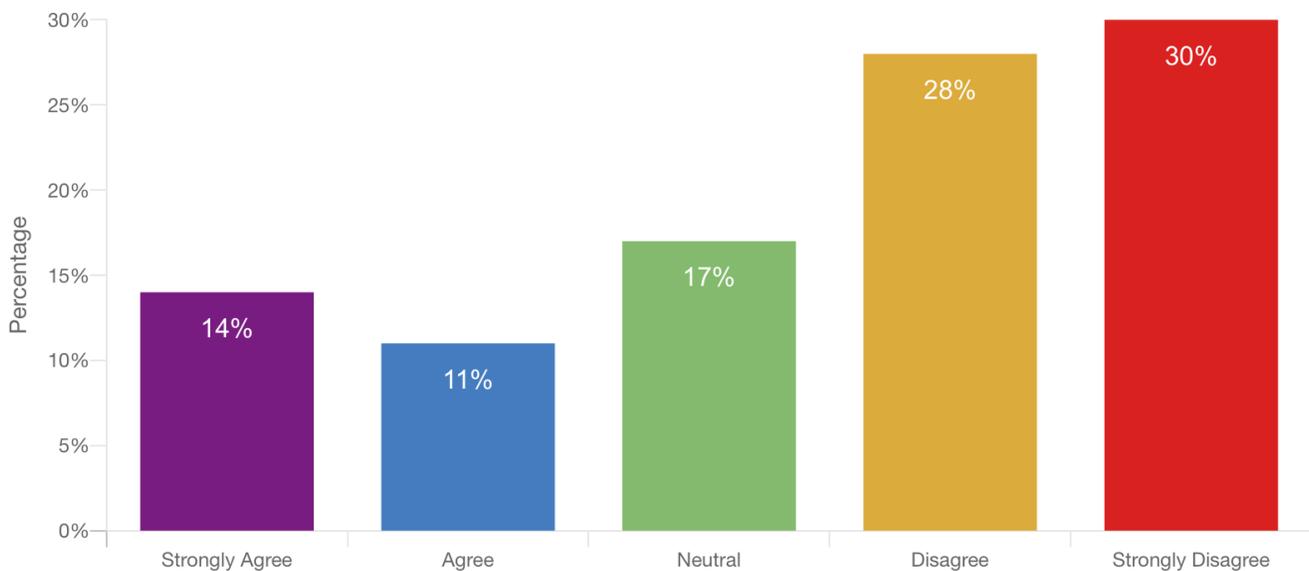
Though it may not result in job loss, a much larger percent of respondents were concerned that they would lose significant income during a 14-day isolation period (see Figure 16). Some 38% of respondents were concerned about losing at least part of their income if they were required to self-isolate, including 18% of respondents who would lose all their income. A further 13% were unsure about the potential for income loss if they were required to self-isolate.

Figure 16. How much income would you lose during a 14-day self-isolation?



Unsurprisingly, the potential for lost income translated into significant concerns about the ability to make basic expenses. Some 27% of respondents agreed that they would have 'money problems,' including things like the inability to pay rent, to meet basic bills (like electricity), or to afford groceries if they were required to self-isolate (see Figure 17). Indeed, only 56% disagreed with the idea of having money problems as the result of a 14-day isolation period.

Figure 17. I would have money problems, such as difficulty paying rent, bills, or for groceries



These results are worrisome. The scenario presented suggested a relatively clear-cut (i.e., physician ordered) and short term (i.e., single, 14-day) isolation. A situation where 38% of

respondents are worried about money problems, 27% about paying expenses, and even 14% about entirely losing a job is a situation where it could be difficult for individuals to make decisions in favour of public-health guidance. Extrapolating to a situation where individuals have less clear-cut situations (e.g., had close contact with an asymptomatic traveler, or worried – but were not sure – that they had been exposed to a potential carrier), it might be even more difficult to make the appropriate decision about self-isolation. If enabling Canadians to self-isolate is a priority, consideration should be given to how to make this decision more viable. It is worth noting, however, that because government support programs are being announced on a daily basis, public awareness of these programs may be a lagging indicator.

Finally, we also asked respondents about their worry – during that period of self-isolation – about exposing family members to the virus. These concerns were very high, with some 85% of respondents agreeing (29%) or agreeing strongly (56%) that they would fear exposing their family (see Figure 18). Although earlier data suggests that many Canadians have a room where those with mild illness could be kept separately, this does not appear to translate into confidence regarding containing possible exposures.

Figure 18. I would worry about exposing my family to the virus

