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COVID-19 casts light on respiratory health inequalities

COVID-19 has disproportionately affected people from disadvantaged populations and marginalised communities. People living in social deprivation, Black, Asian, and minority ethnic (BAME) groups, older people, and those with pre-existing health conditions, for example, have increased vulnerability to COVID-19 and its consequences. These imbalances will magnify the already pervasive inequalities associated with respiratory health across the lifespan, and the full effects might be apparent only in the decades to come.

Vulnerable populations experience uneven burden of disease, provision of and access to health-care services, quality of care, and health outcomes. Socioeconomic status, race, ethnicity, age, sex, disability status, geography, and environment can all place people at a health disadvantage. People living in social deprivation and those from BAME communities have disproportionately greater exposure to the major risk factors for respiratory diseases—tobacco smoke, air pollution, obesity, infections, and hazardous occupations—and a higher prevalence of several conditions, including COPD, asthma, lung cancer, and sleep apnoea. Inequalities are especially pronounced in children with respiratory disorders such as asthma and are evident in cystic fibrosis: children from disadvantaged backgrounds have worse growth and lung function than those from more affluent backgrounds.

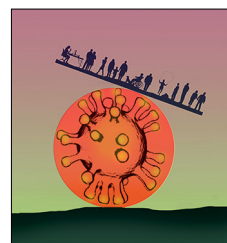
The COVID-19 pandemic is likely to deepen these inequities in respiratory health directly through effects of the disease and indirectly through lockdown measures exacerbating risk factors and social determinants for respiratory disease. The increased susceptibility of people living in deprivation to infection and worse health outcomes places them at greater risk of reduced income and unemployment, which in turn can affect access to health care and health insurance, leading to further deterioration in health. People from disadvantaged and minority groups are already more likely to live in densely populated areas and overcrowded housing, and income loss or reduction has consequences for housing security, all of which can lead to or exacerbate respiratory illness. Furthermore, food insecurity, which has dramatically increased during the pandemic, can impair development and cause lasting damage to respiratory health.

Many disadvantaged groups face further barriers to health care, affecting access to prevention services,

screening, and management. Such inequalities can be driven by discrimination or unconscious bias and assumptions about poor outcomes in some groups. Differences in patterns of seeking care, health literacy, language, and education might also affect health-care access. Moreover, the diversion of health care during the pandemic from cancer screening and treatment, paediatric and adult respiratory services for chronic conditions, and vaccination programmes will all affect long-term respiratory health.

We must make a concerted effort to improve understanding of the multitude of factors that underpin these inequities and their complex interactions with respiratory health. The imbalance in recruitment of people from diverse backgrounds into clinical research must also be addressed to ensure availability of appropriate interventions for minority groups. Improved education and understanding among health-care professionals of inequalities and campaigns to enhance awareness and health-care access for patients are paramount to reducing health disadvantages. Furthermore, practical measures in clinical practice are needed to reduce systemic inequities in care. Finally, the overarching social inequalities that underpin the imbalance in risk factors and determinants of respiratory health need to be targeted through carefully considered, long-sighted health and social policies. Strategies to reduce poverty by supporting people to secure appropriate employment, improve provision of income support, reduce the educational attainment gap, and promote better nutrition, in addition to increased provision of affordable housing and reduced overcrowding, are sorely needed. Moreover, measures to strengthen smoking cessation programmes, reduce air pollution, and improve conditions for those working in hazardous occupations are essential to tackle some of the key risk factors.

Respiratory health inequalities related to and exacerbated by COVID-19 must be viewed in light of social deprivation and discrimination. Research to better understand the intersecting factors that fuel these inequities and to identify innovative strategies to narrow the gaps in disease burden and outcomes should be prioritised. Public health goals and policies that promote social, economic, and health equity must be at the heart of pandemic recovery plans to eliminate these deep-rooted inequalities in respiratory health across the lifespan. ■ *The Lancet Respiratory Medicine*



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For more on **COVID-19 in vulnerable groups** see **Articles** *Lancet Infect Dis* 2020; published online May 15.

[https://doi.org/10.1016/S1473-3099\(20\)30371-6](https://doi.org/10.1016/S1473-3099(20)30371-6) and *Nature* 2020; published online July 8. <https://doi.org/10.1038/s41586-020-2521-4>

For more on **inequalities in respiratory health** see *Am J Respir Crit Care Med* 2013; **188**: 865–71

For more on **asthma prevalence in childhood** see *MMWR Morb Mortal Wkly Rep* 2018; **67**: 149–55

For more on the **effects of deprivation on clinical outcomes in cystic fibrosis** see **Articles** *Lancet Respir Med* 2013; **1**: 121–28

For more on **COVID-19 and the impact of social determinants of health** see **Comment** *Lancet Respir Med* 2020; **8**: 659–61

For more on **housing, socioeconomic status, and health** see *Cochrane Database Syst Rev* 2013; **2**: CD008657

For more on **child poverty, food insecurity, and respiratory health during the COVID-19 pandemic** see **Spotlight** page 762

For more on **health equity in clinical practice** see **Comment** page 758