Introduction

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Many forms of respiratory health inequalities exist, across different social groups, health conditions and countries. This *ERS Monograph* provides an accessible and engaging primer for health professionals and academics on all this and more. https://bit.ly/3kBm07h

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The COVID-19 pandemic brought respiratory health into the global spotlight. People with acute, life-threatening respiratory illness were the face of the pandemic, but the media also reported on health inequalities related to socioeconomic position and race, as well as the risks that come with having chronic respiratory illness. The very factors that influence respiratory health – cold and substandard housing, food poverty, air pollution, the tobacco industry, and access to care to name a few – are also front-page news and social media hot-topics that are debated and discussed by members of the public, the mainstream media, mass media, healthcare workers, healthcare leaders, policy-makers and politicians alike. It is, however, risky to consider such problems out of context. Health inequalities have been deeply engrained in our societies since long before the pandemic. We need to reflect on what has driven these inequalities, and critically review the approaches that do and do not work, if we are to begin to address them. And that is why we have produced this *Monograph*. We have brought together leading experts and up-and-coming researchers, in a collection of state-of-the-art articles discussing the drivers and consequences of respiratory inequality.

Respiratory disease is inextricably linked to poverty. In the first section of this *Monograph*, we aim to help the reader understand mechanisms of why this might be the case. It is clear that if people do not live in adequate housing [1], have access to a good diet [2], and breathe clean air [3], then their respiratory health is immediately under threat. For many millions of people around the world, however, this is their reality. Alongside these issues, the first section also considers respiratory inequalities related to sex [4], ethnicity [5] and occupation [6].

In section two we describe some examples of inequalities in respiratory disease. Some of the chapters in this section discuss specific conditions, such as cystic fibrosis [7], lung cancer [8] and asthma [9]; others discuss more broad and societal issues, such as antimicrobial resistance [10] and inclusion health [11]. What becomes clear from reading these chapters is that even though diseases have their own particular issues, there are themes common to all. It is here that

we need to strike the balance – it is important for clinicians to draw on their experience and expertise for their areas of interest; public health approaches will be broader. We need both. We must be careful that clinical approaches to health inequality aren't positioned so far downstream that some groups miss out on interventions that could benefit all people, but we also need to ensure that a population health approach does not pass certain people by because of the characteristics of their disease.

The final section, section three, focuses on certain aspects of global respiratory health and possible approaches to solving these. The global burden of illness and suffering from lung ill-health is immense, and in these chapters we touch on some of the key problems at the moment, including child health [12] and TB [13]. We also recognise that environmental health differs around the world, and this in itself will drive huge amounts of illness. We are excited to share a chapter relating to air pollution in this section [14].

We close with chapters that consider broader approaches to tackling problems of respiratory inequality – namely quality improvement [15], human rights [16] and a global strategy. The ethos of these chapters is to outline that alongside interventions discussed in other parts of the *Monograph*, we should think creatively, societally and critically about how to drive both upstream and downstream change. For example, if we wish to improve respiratory outcomes in women, we should be considering approaches through different lenses – those grounded in quality improvement at a local and national level; those which frame the issue as one of women's rights; and those which consider a global approach to the problem.

We are immensely grateful for all the hard work that has gone into the preparation of this *Monograph*. We are excited to share the chapters with you, and are sure you will find them as stimulating and informative as we did. The list of authors is geographically and professionally diverse, and the chapters are a reflection of how much expertise there is in the field of respiratory inequalities. The people who assisted with peer review have been incredibly helpful in honing these chapters, and we remain thankful for their input. The excellent team at the *ERS Monograph* have continuously offered support and advice, and we are grateful to Peter M.A. Calverley, John R. Hurst, Rachel Gozzard and Caroline Ashford-Bentley, not just for their expert guidance, but also for their persistence and organisational skills in keeping such a large project on track.

It has been a privilege to commission, read, review and edit the chapters in this *Monograph* – we hope you find them as useful and informative as we did.

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