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There is a real danger that covid-19 will become entrenched as a disease of poverty

We must act now to prevent a further widening in wellbeing between poor and rich

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Since reaching a height of around 70 000 confirmed covid-19 cases a day in England at the start of the year, the third lockdown has brought cases down to around 2500 a day (at the time of writing). Hospital admissions are back to levels last seen in September 2020, and over half of the adult population has received at least one dose of covid-19 vaccine. We've experienced almost six months of national lockdown in the past year and are just emerging from what has been promised to be the last one.

But while we have all experienced this pandemic together, we have not all had the same experience. Deprived and minority ethnic communities have borne the brunt of the pandemic so far and there is now a very real danger that covid-19 will become entrenched as a disease of poverty.

Those living in deprived communities have been more likely to contract covid-19, with weekly average case rates since September 50% higher than the least deprived communities (283 per week per 100 000 people compared with 184 per week per 100 000 people). Compared with the least deprived communities, people in the most deprived areas have had more than double the number of intensive care admissions and almost double the risk of dying, most likely because poverty often goes hand in hand with poorer health and covid-19 risk factors such as obesity, hypertension, and diabetes.[1-3] As the UK vaccination programme proceeds, we see differential uptake by deprivation there too: Open Safely data to the end of March shows, for instance, that among shielding adults 16-69 years old, 79% had had one vaccine dose in most deprived communities compared with 92% in least deprived communities.[4] The difference in vaccine uptake is most pronounced in minority ethnic communities.[5]

People in more deprived communities are more likely to catch covid-19 for several reasons. Firstly, they are much more likely to have to work outside the home and in roles, such as health and care workers, security guards, public transport workers, cab drivers, and retail. These jobs are all associated with higher exposure to catching covid-19.[6]

Secondly, those in more deprived communities are more likely to live in multioccupancy housing: those living in households with more than six people have twice the risk of infection compared with households with one or two people.[6] Those in deprived communities have worse access to high quality green spaces which, as we move out of lockdown, is likely to lead to more crowded meetings outdoors or more meetings in higher risk indoor spaces.[7]

Thirdly, many are financially unable to isolate. A recent paper in *The BMJ* reported that only about 20% of people with symptoms request a covid test and only about half of those with symptoms isolate.[8] It identified that being unable to isolate was a key factor in determining both testing and isolation behaviour. Dido Harding, head of test and trace, acknowledged that lack of support for isolation was lowering the effectiveness of contact tracing.[9] Poor housing further exacerbates the problem as even those who do isolate risk infecting others in their household because of cramped accommodation. Cevik and colleagues argued persuasively that enhancing comprehensive support for isolation is crucial as we exit the most recent wave of infection.[10]

The above three factors have two implications: firstly, that lockdowns are much less effective in deprived communities because more people work outside the home, cannot afford to isolate, and cannot lock down.[11] Also poorer and more crowded housing means covid-19 continues to propagate more easily. This means that there is significantly more covid circulating in deprived communities as we start coming out of lockdown—almost 2.5 times as many cases per head in the last two weeks of March as in the least deprived areas.[12] This makes outbreaks much more likely as people start to mix more—particularly with worse access to safer outdoor spaces. And differential vaccine uptake also means that these communities are less protected once outbreaks occur. Even as the rest of the country enjoys a more normal summer, more deprived areas will likely be subject to waves of infections, the burden of ill health (and potentially death) that follows, and local lockdowns restricting local economies—just where growth is needed most.[13]

Secondly, these differences will likely recreate the north-south divide in covid-19 cases and restrictions that we saw last summer and autumn in England as northern regions have substantially more deprived local authorities than the south.[14] Only one out of the 25 local authorities with the highest case rates is in the south of England.

This scenario is not inevitable. Improved support for self-isolation, as instituted now in Newham, is fundamental: increased population testing will do nothing to prevent infections in people who test positive but cannot isolate.[15] Work spaces and schools can be supported to improve ventilation to reduce transmission indoors—again, a policy that would disproportionately help those who cannot work from home. Thirdly, gaps in vaccine uptake must be dealt with by working with local communities to tackle vaccine concerns—particularly in the wake of

concerns about Oxford AstraZeneca vaccine—and to make getting a jab as easy as possible.[16] The government has touted a "levelling up" agenda for tackling regional inequality in England. They must act now to prevent a further widening in wellbeing between poor and rich, north and south.

CP is a member of Independent SAGE

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