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Task 1: Disability and Health Inequalities

Task 2: Chronic Obstructive Pulmonary Disease (COPD) among adults

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Task 1: Disability and Health Inequalities in the UK

Introduction

Disability is a long-term physical, mental, intellectual or sensory impairment, which interacts with environmental or social barriers to limit full participation in society (Sparkes et al., 2022). Identify first “disabled people” and person-first “disability” speech is used, but many disabled people in the UK prefer the latter as this involves recognising disability as a social identity rather than just part of the medical picture (Sharif et al., 2022). The 2021 Census indicates that nearly 24% of people in England and Wales have a disability, which is a significant public health and social policy issue (ONS, 2023). Whilst disabled people have some protections under the Equality Act 2010, there are continuing serious inequalities in health for disabled people, such as poorer mental and physical health; fewer opportunities to get a job; poorer healthcare services; and being poor. The social model of disability suggests that these inequalities are not caused by disability itself but by the barriers in society, institutions or the environment (Goodley, 2025). Hence, issues of disability differences must be tackled to make inroads into the broader social determinants of health.

Disability prevalence in the UK has risen fairly steadily since 2002/03

Percentage of people reporting a disability

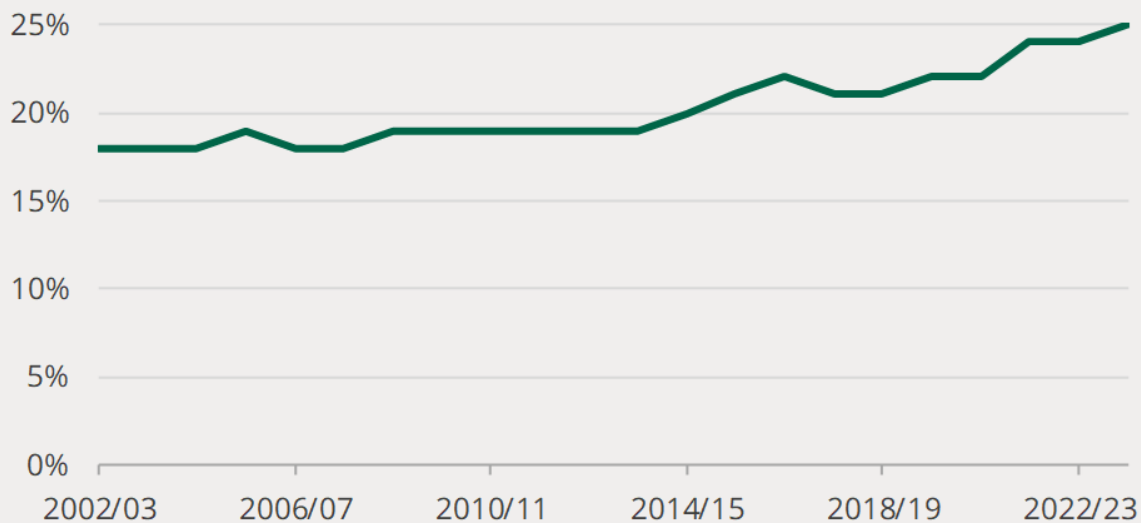


Figure 1: Disability prevalence

(Source: UK Parliament, 2025)

Context and underlying factors

Mental Health Inequalities

Higher rates of anxiety, depression, and psychological distress reported by people with disabilities than non-disabled people are caused by discrimination, lack of social participation, chronic stress, and difficulties in accessing the support that they need (Sang et al., 2022). Loneliness is shown to be associated with mental health outcomes using longitudinal studies and is a significant contributor to the poor mental health experienced by disabled adults, reinforcing the cycle of loneliness and poor health outcomes (Emerson et al., 2023). Ensuring mental health services are readily available, reducing stigma, and building community-based support will help to address these inequalities (Leahy and Ferri, 2024).

Early death and lack of access to health care

Disabled people are far more likely to be at higher risk of early death, as they are likely to be diagnosed late and to face inequities in access to health care services and barriers to accessing preventative care (Christiaens and Brittain, 2023). Research carried out in the UK has suggested that life expectancy of adults with autism is significantly shorter than for the general population, due to lack of access to health care and prevention (O'Nions et al., 2024). These deaths are preventable by earlier intervention, better training of professionals and health service provision that does not discriminate (Kuper et al., 2024). Providing reasonable adjustments in NHS services is therefore vital to governments in reducing preventable deaths.

Chronic Physical Conditions

Long-term conditions like cardiovascular disease, respiratory illness and diabetes are more common in disabled people, as well as asthma, cancer support services, and related issues. Asthma, other respiratory illnesses, diabetes, cancer support services, and other long-term conditions like cardiovascular disease impact disabled people disproportionately. While some health issues may be directly linked to the impairment, other inequalities emerge because of inaccessible health-care systems, difficulties in communication or lack of adequate professional understanding. Kuper et al. (2024) make mention that not offering reasonable adjustments speeds up the latent period of treatment as well as worsens disease management. Improvements to accessible primary health care and disability sensitivity education and disability-inclusive health policies can help to mitigate these unnecessary inequities.

Change in disability prevalence by age, 2012/13 to 2023/24

Percentage of people reporting a disability

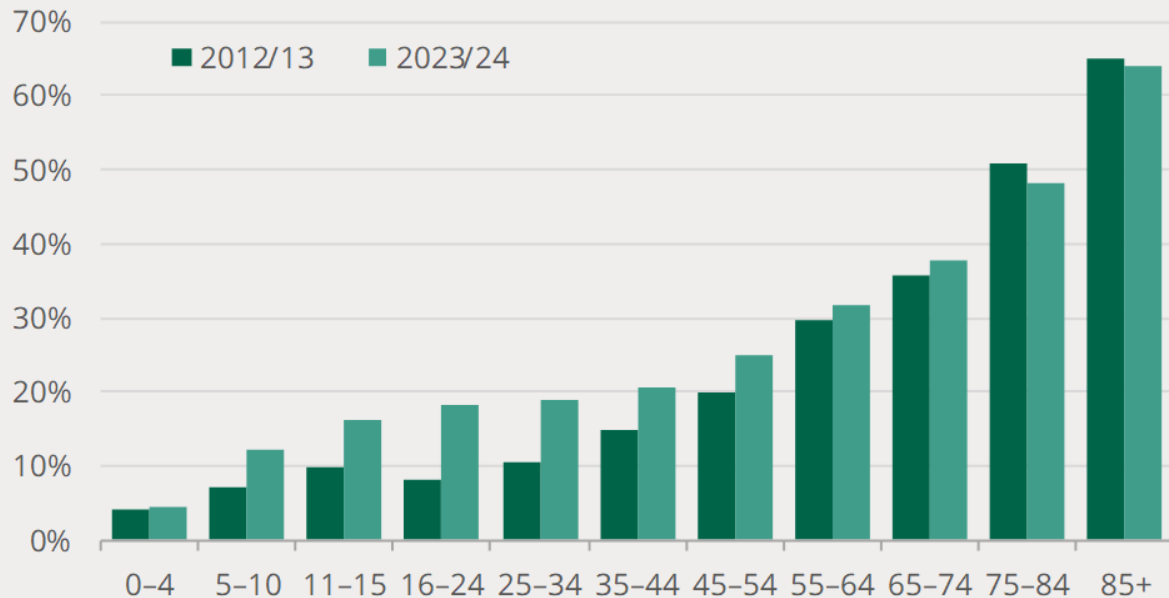


Figure 2: Change in disability prevalence

(Source: UK Parliament, 2025)

Socioeconomic Inequality

Disability-related health inequalities are strongly associated with socioeconomic disadvantage and lead to changes in disability prevalence. Governors and school leaders are aware of the higher poverty levels among disabled children, as they are less likely to be working or engaged in education or training and also face additional expenses relating to higher health care needs, transport, and providing specialist equipment.

Poverty

Unpaid carers in a family often also face financial difficulties as a result of their caring role and of the income lost or affected because of their caring role (Nicoricu and Elliot, 2023). Moreover, relations between gender issues and ethnicity can worsen the situation of employment inequity and economic insecurity (Berghs and Dyson, 2022).

Community practice for ensuring that persons with disabilities can enter the workforce and participate in their jobs is therefore a key point of ensuring health benefits.

Social isolation and exclusion

There is a significant connection between disability, social exclusion and ill-health. A variety of physical barriers, inaccessible contexts and negative attitudes from society can limit participation in education, employment, recreation and community life.

Emerson et al. (2023) found that this feeling of loneliness amongst disabled adults is much more likely than amongst the non-disabled and is linked to poorer physical and mental health. Greater access to and participation in transport, community facilities and social programmes can decrease isolation and improve participation (Hashemi et al., 2022).

National Response to Disability Inequalities

Policy in the UK to tackle disability inequalities has been developed. The Equality Act 2010 offers statutory rights to prevent discrimination and requires reasonable adjustments to be made to promote equality that should be implemented by organisations, such as healthcare providers. (UK Government, 2024). In addition, the Disability Action Plan concentrates on enhancing independent living, public participation, employment opportunities, and accessibility. The NHS will also publish guidance on delivering inclusive health services. Findings indicate that inconsistent implementation is taking place across services and regions, with the result that inequalities are not yet a thing of the past (Kuper et al., 2024). To make the improvements more meaningful, these accountabilities, monitoring and investment need to be increased.

Organisations that support disabled people

Scope is a leading UK disability charity that works to promote equality, independence and social inclusion for disabled people (Scope, 2026). The organisation fights against discrimination and offers help and guidance in employment practices, lobbies for better accessibility in services such as healthcare, housing and public services. Scope

responds to the immediate demand for support and also advocates for policy change over the longer term by combating structural inequalities that facilitate discrimination. It fulfills the mandate of the government of educating the population about disability rights and fostering an inclusive society alongside the various programs put in place by the government (Haller, 2024).

Conclusion

Health inequality that occurs around people who have disabilities in the UK is determined by the complex interaction between health conditions and inequalities of socioeconomic status and structural inequalities. Disabled individuals tend to suffer from worse mental health, have a higher incidence of chronic illness, lower life expectancy, and poverty, and have a higher rate of social exclusion. Legislation and national strategies have made progress towards recognising disability rights – but there are ongoing inequalities that reflect the need for more work to be done to make sure disability is better understood and mainstreamed within a more accessible and inclusive healthcare system and a more inclusive society. At the core of work on disability inequality is the need to go beyond disability and to concentrate on social determinants of health.

Task 2: Epidemiological Analysis

Chronic Obstructive Pulmonary Disease (COPD) among adults in England

Introduction

Chronic Obstructive Pulmonary Disease (COPD)

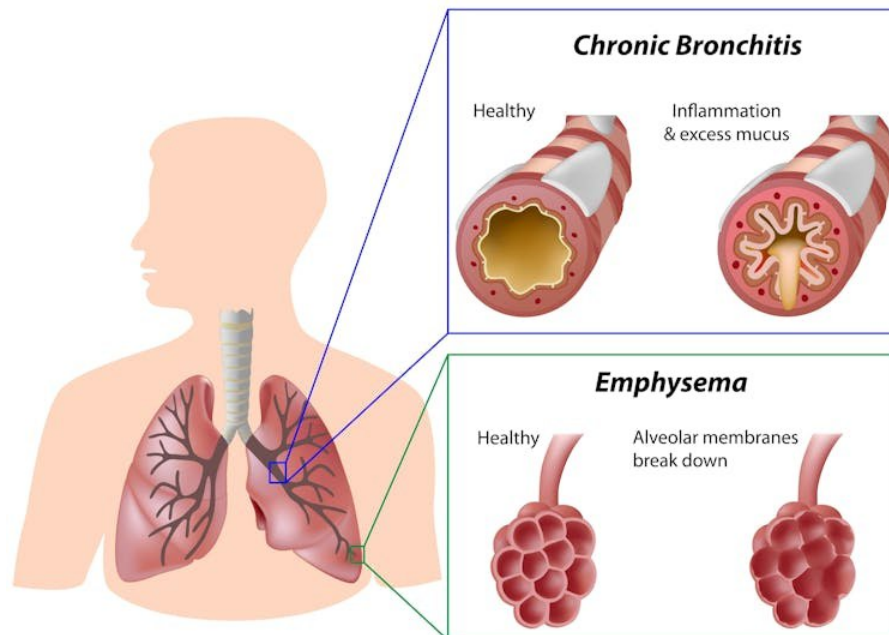


Figure 3: COPD

(Source: The conversion, 2026)

Chronic Obstructive Pulmonary Disease (COPD) is a progressive, chronic (long-term) lung condition in which normal breathing is impaired due to a persistent condition of limited airflow from the lungs (chronic bronchitis and emphysema), resulting in reduced quality of life. It is a serious non-communicable disease (NCD) problem as it causes disability, early death, loss of productivity, and high health expenditure. Worldwide, 392 million individuals and adults are living with COPD, and it is one of the top causes of death in the world (WHO, 2024). COPD is common, and prevalence has risen significantly in the past 20 years in England, despite improvements in healthcare management of healthcare (Stone et al., 2023). It invariably has serious social implications as the patients become less independent, anxious, depressed, and frustrated in their work and other activities. Thus, the distribution, cause, and effect of COPD need to be understood by the Regional Epidemiologist to guide the prevention and management for controlling it.

Efforts made to identify and assess COPD in England using an epidemiological

approach

England is the right population scale to assess epidemiological patterns and trends, as well as disease inequalities and NHS service outcomes, which are easily monitored through national health care databases. A recent population-based COPD prevalence study conducted in England from 2000 to 2019 showed that there was a persistent COPD burden of disease, with differences in prevalence according to age, sex and socio-economic factors (Stone et al., 2023). COPD is especially prevalent among elderly people as there is a greater chance of cumulative exposure to risk factors with age (Lewer et al., 2022). Sometimes, however, the younger groups are also in jeopardy as a result of early exposure to smoking, to the impact of environmental pollution and occupational hazards (Statista, 2026).

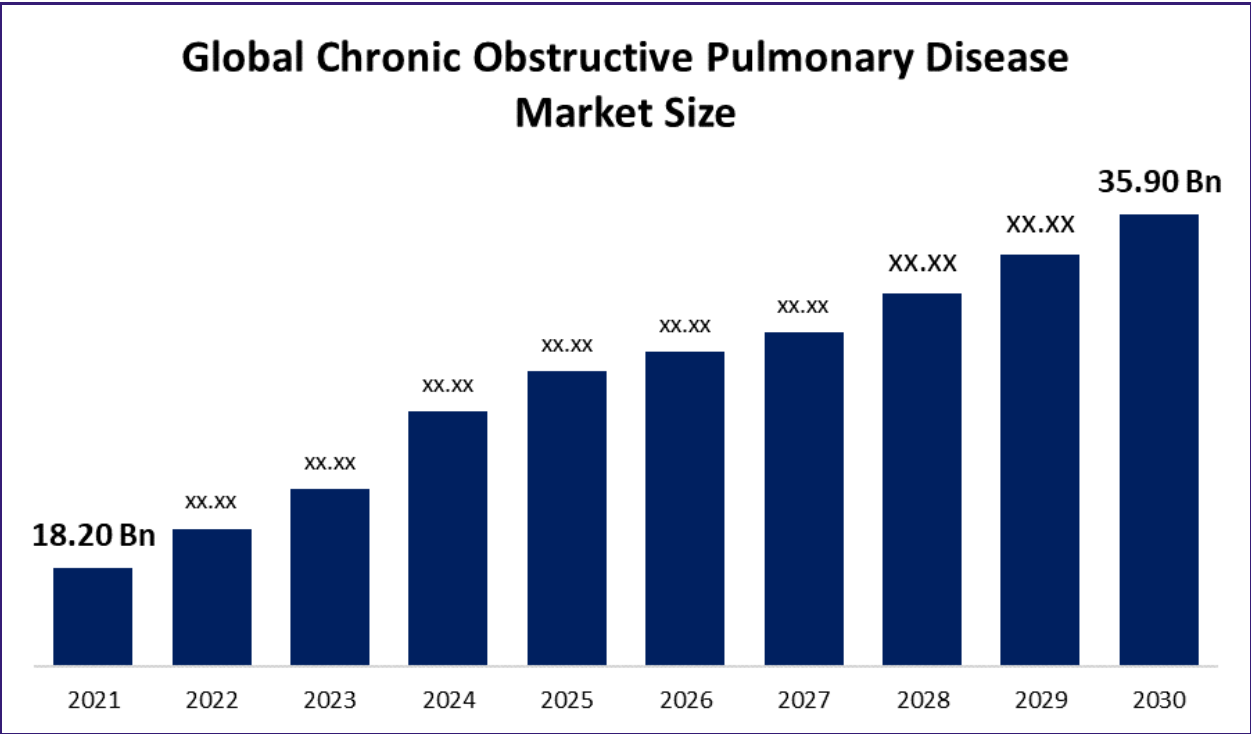


Figure 4: Global COPD conditions

(Source: Spherical Insights, 2023)

To conduct a health needs assessment for COPD, a comprehensive analysis of COPD occurrence, COPD health system consumption and the characteristics of the

population should be performed. In England, there is evidence that COPD places a significant burden on the healthcare system through emergency service admissions, medication use and frequent clinical consultations. Alternatively, the global Chronic Obstructive Pulmonary Disease Market Size is expected to grow from USD 18.20 Billion in 2021 to USD 35.90 Billion by 2030, at a Compound Annual Growth Rate (CAGR) of 8.2%. This was also reflected in a matched analysis performed in COPD patients, where it is found that there is high health service use, highlighting the importance of effective prevention measures and chronic disease management (Sansbury et al., 2022). The results suggest that the epidemiological evaluation isn't merely about quantifying the occurrence of a disease, but also about interpreting what it means for people and health services.

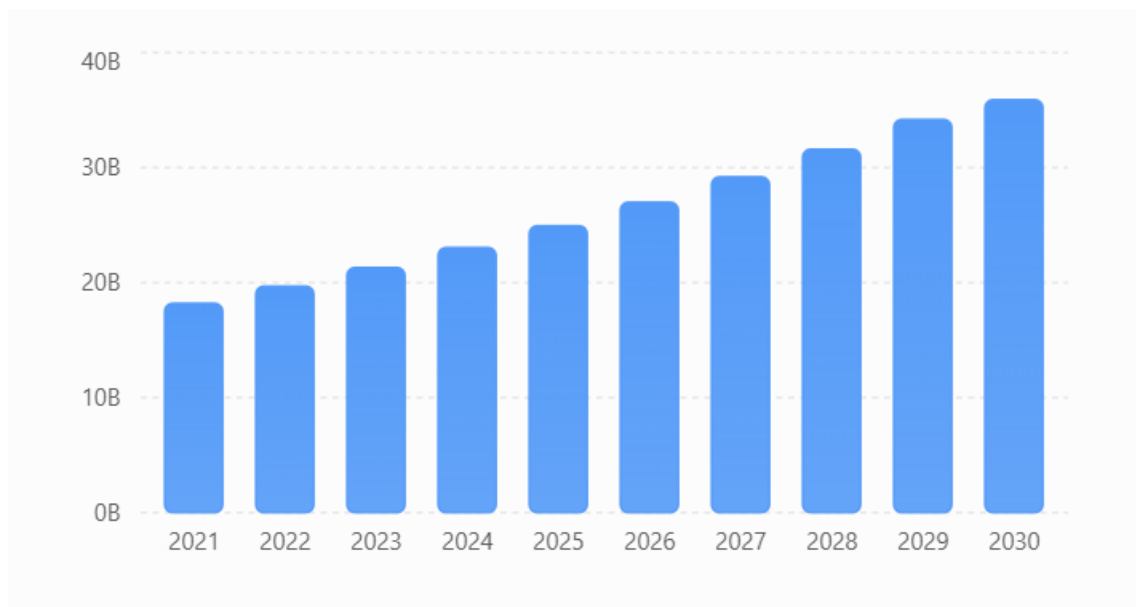


Figure 5: Global Chronic Obstructive Pulmonary Disease (COPD) Market Size Forecast (2021–2030)

(Source: Self-developed)

Assessment of COPD: Understand the determinants and risk factors of COPD

Smoking is an important preventable risk factor for COPD, responsible for chronic inflammation and progressive lung damage. In England, smoking prevalence has fallen, but the use of cigarettes in the past is the driver of the current prevalence of COPD,

given that this disease typically requires long-term smoking exposure. Smoking rates are regarded as the biggest risk factor for COPD in the NHS and will speed up lung function loss and exacerbate symptoms (NHS, 2024).

Another factor that is important to consider when assessing COPD is socioeconomic inequality. People in deprived communities face greater risks from disease because they are exposed to more risk factors such as smoking, work-related risk factors, poorer housing conditions, and less access to prevention and treatment services from their health providers. A correlation between unhealthy lifestyles and low socioeconomic status (SES) has been shown with respect to COPD development as factors of exposure and access to care (Liu et al., 2025). Thus, understanding COPD should be considered beyond just individual behaviours to wider social determinants of a disease.

Consequences of the disease on the specified population

Risk factors of COPD are also of environmental and occupational origin among adults. Chronic (long-term) exposure to air pollution and industrial chemicals and workplace dust can lead to greater respiratory damage, especially in workers exposed to these in high-risk occupations. Environmental and socioeconomic factors affecting respiratory diseases have been the subject of systematic review, which found urban pollution and urban deprivation to be significant factors in respiratory inequalities (Erraji and Zabadi, 2026). Therefore, a COPD prevention strategy should go beyond clinical treatment and focus on the environment that needs to be protected, as well as workplace regulation.

Utilising the 3P Public Health measures approach

Public health responses to COPD can be considered through prevention, protection and provision. Preventative measures are focused on decreasing the risk of occurrence of disease through modifiable risk factors. The major intervention is smoking cessation programmes, which help stop lung function from declining and disease from worsening. While the overall effects on smoking-related harm at the population level from tobacco control policies will take time to reach their full effect, examples of policy interventions reducing harm in England include policies to restrict tobacco product

display and promotion, taxes, and tobacco product availability/reduction support for hospital quitting services.

The goal of protection measures is to minimise exposure to the environment and to the workplace for adults (Halpin et al., 2026). Strengthen the regulations on air quality and add restrictions on workplace safety and monitoring hazardous exposures to protect vulnerable groups and avoid respiratory damage. These methods can be of particular importance as environmental conditions and personal behaviours affect COPD risk.

Provision is about a person living with COPD being diagnosed, treated and managed in the long-term effectively. The NHS offers pulmonary rehab, inhaled therapies and disease-specific management and organisational programmes to prevent exacerbations and enhance the quality of life. Inequalities in COPD outcomes in England have been highlighted as a driver for improvement in the national COPD outcomes strategy (UK Government, 2026), which focuses on early diagnosis, improved management and equality in outcomes. However, access to services in different ways is still a problem, and this can lead to constant monitoring for policy implementation.

Epidemiological Surveillance and Monitoring Systems

There is multiple surveillance approaches needed to monitor COPD and track trends and effectiveness of interventions (Browne et al., 2026). Papers by epidemiologists using primary care databases were able to estimate prevalence in populations, as well as other data such as diagnosed cases and patterns of treatment and disease progression. Another important resource is hospital admissions, where exacerbations are often treated in hospital; these reflect the disease burden (Mokdad et al., 2024).

A monitoring survey of the distribution of COPD and asthma in England and Wales in time and space from the same source also showed a trend in hospitalisations and prescriptions being filled over time and across different counties, indicating how useful routinely collected healthcare data can be to answer ecological research questions at the aggregated level (Alwafi et al., 2023). Primary reasons for the underestimation of COPD prevalence are that many people are undiagnosed, especially during the early stage of COPD.

Planning for Public Health Impact and Intervention

For the English population, there are profound short-term and long-term issues related to COPD. Short-term effects are acute exacerbations, emergency admissions to hospital, and limitations in the capacity to carry out activities of daily living. The long-term impact comprises progressive physical disability, lower life expectancy and greater reliance on health services. The effects of these impacts underscore the need for epidemiological evidence to inform allocation of resources and planning for interventions.

A COPD-specific intervention programme should be designed to include early detection, smoking cessation and a community programme of COPD management. The programme proposed will focus on deprived communities with higher smoking rates and older people, including by offering community screening, respiratory healthcare education, and better access to pulmonary rehabilitation.

Strengths and Limitations: Epidemiological Approach

Strengths	Limitations
Identifies disease patterns and trends within large populations.	Routine healthcare data may contain recording errors and inaccuracies.
Helps identify high-risk groups, enabling targeted prevention and intervention strategies.	Variations in diagnostic criteria and health system coverage can reduce data reliability and comparability.
Supports the prioritisation of public health interventions and resource allocation.	Observational studies can identify associations between risk factors and COPD but cannot establish direct causality.
Enables monitoring of disease burden and changes over time, allowing	Complex socio-economic, environmental, and behavioural factors make it difficult

evaluation of public health initiatives and policies.	to isolate individual causes of COPD.
Provides quantitative evidence for healthcare planning, policy development, and population-level decision-making.	Quantitative epidemiological data alone may not capture patients' live experiences, perceptions, or barriers to care.
Facilitates comparisons across different regions and populations to identify disparities in COPD prevalence and outcomes.	Effective understanding of COPD requires integration of epidemiological findings with qualitative evidence to inform comprehensive interventions.

Table 1: Strengths and limitations

(Source: Self-developed)

Conclusion

COPD continues to be a significant public health problem in England, due to its prevalence, the burden on healthcare services and its links to social inequalities. Epidemiological processes can help identify populations that are affected, to determine which factors pose a risk to them, and to identify and develop specific interventions. COPD impacts can be reduced with measures such as smoking reduction, environmental protection and enhancements in access to healthcare; however, ongoing monitoring and evaluation are necessary. In order to decrease inequalities and enhance population health outcomes associated with COPD, an all-encompassing epidemiological paradigm that integrates both medical and social factors needs to be adopted.

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