Chronic conditions

Chronic conditions such as cancer, chronic respiratory problems and diabetes are not only the leading causes of death across OECD countries. They also represent a major disability burden among the living. Many chronic conditions are preventable, by modifying major risk factors such as smoking, alcohol use, obesity and physical inactivity. The COVID-19 pandemic has also underscored the impact of chronic conditions on health outcomes from other diseases. Chronic conditions representing a high burden of morbidity across OECD countries – including diabetes, COPD, cardiovascular conditions and cancer – have also been associated with a higher risk of developing more serious COVID-19 illness, hospitalisation and death.

More than one-third of people aged 16 and over reported living with a longstanding illness or health problem on average across 26 OECD countries in 2019 (Figure 3.15). This figure rises to nearly one in two in Finland, while one in four or fewer adults reported having a longstanding illness or health problem in Luxembourg, Greece and Italy. As populations age, the prevalence of chronic conditions – including multimorbidity – rises. Health systems increasingly need to be prepared to deliver high-quality chronic care management to meet the needs of ageing populations.

Socio-economic disparities are also large: on average across OECD countries, 43% of people in the lowest income quintile report a longstanding illness or health problem compared with 26% of people in the highest income quintile (Figure 3.15). This income gradient is largest in Latvia, the Czech Republic and Ireland, where people in the lowest income quintile are more than two and a half times as likely to report having at least one longstanding illness or health problem compared with people in the highest income quintile. The income gradient is smallest in Iceland, Italy and France, where individuals in the lowest income quintile are only about 20% more likely to report living with a longstanding illness or health problem compared with individuals in the highest income quintile.

Diabetes is a chronic condition with a particularly large disability burden, causing cardiovascular disease, blindness, kidney failure and lower limb amputation. It occurs when the body is unable to regulate excessive glucose levels in the blood. In 2019, 6.7% of the adult population were living with diabetes across OECD countries (Figure 3.16). In addition, a further 39 million adults were estimated to have undiagnosed diabetes (International Diabetes Federation, 2017[14]).

Among OECD member countries, diabetes prevalence is highest in Mexico, Turkey and the United States, with over 10% of adults living with diabetes (age-standardised data). For OECD partner countries, diabetes prevalence is also high in South Africa, India and Brazil, at around 10% or higher.

Age-standardised diabetes prevalence rates have stabilised in many OECD member countries, especially in western Europe, but have increased markedly in Turkey and most OECD partner countries. Such upward trends are due in part to rising rates of obesity, poor nutrition and physical inactivity, as well as to their interactions with population ageing (NCD Risk Factory Collaboration, 2016[15]).

Diabetes is much more common among older people, and slightly more men than women have the condition. Diabetes also disproportionately affects those from disadvantaged socio-economic groups. The economic burden of diabetes is substantial. In OECD countries an estimated USD 572 billion was spent on treating diabetes and preventing complications (International Diabetes Federation, 2017[14]).

Definition and comparability

Data related to longstanding illnesses or health problems is based on the results of the European Union Statistics on Income and Living Conditions instrument (EU-SILC). The comparability of data on longstanding illnesses and health problems is limited by the fact that the indicator is derived from self-reported data, which can be affected by people's subjective assessment of their health and by social and cultural factors.

The sources and methods of the Non-communicable Disease (NCD) Risk Factor Collaboration are described in the *Lancet* article and appendix (NCD Risk Factory Collaboration, 2016[15]). Sources were selected among population-based studies that had collected data on measurement of diabetes biomarkers for type 1 or type 2 diabetics. Prevalence in sources was converted to meet the definition of diagnosed diabetes as defined in the WHO Global Monitoring Framework for NCDs. Bayesian hierarchical models were then applied to estimate trends in prevalence. The adult population covers those aged 18 and over.

The sources and methods used by the International Diabetes Federation (IDF) are outlined in the Diabetes Atlas, 8th edition (International Diabetes Federation, 2017[14]). The IDF produces estimations based on a variety of sources that met several criteria for reliability. The majority were national health surveys and peer-reviewed articles. Age-standardised rates were calculated using the world population based on the distribution provided by the WHO. This can lead to an underestimation of prevalence compared to age-standardisation based on the OECD population. Adult population here covers those aged between 20 and 79 with diagnosed type 1 or type 2 diabetes.

Figure 3.15. **People reporting a longstanding illness or health problem, by income quintile, 2019 (or nearest year)**
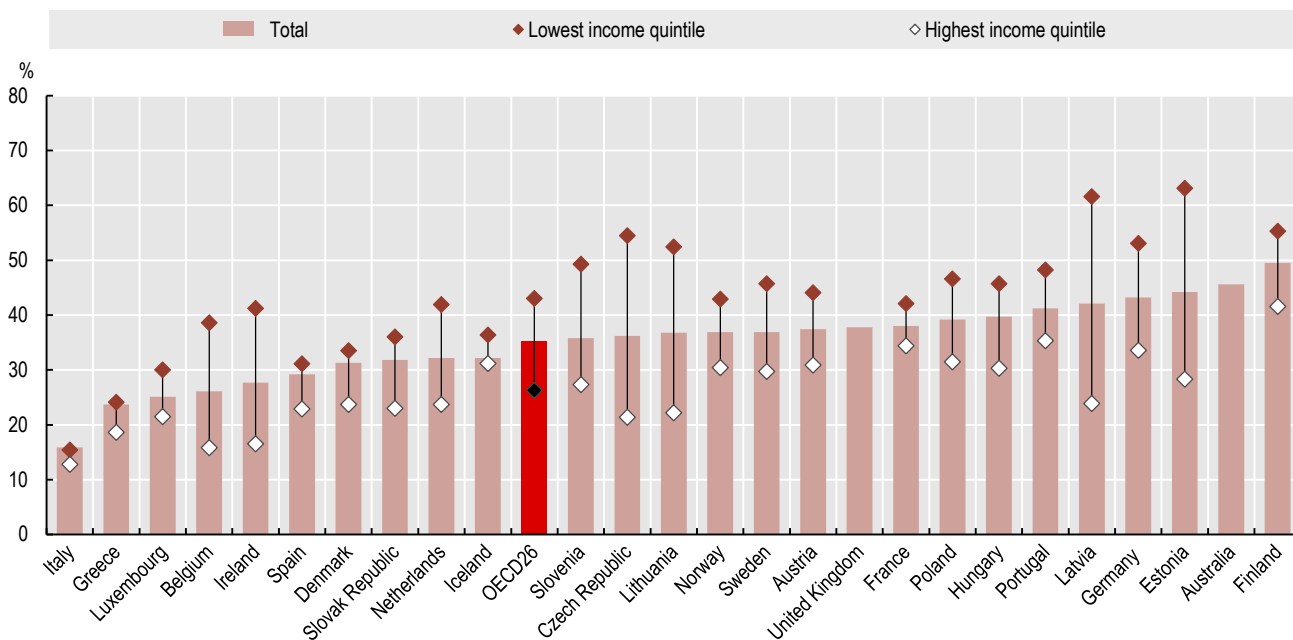
Notes: Data for Australia refer to people aged 18 and over living with at least one chronic condition, and refer to 2017-18.
Source: EU-SILC 2021 and national health surveys.

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Figure 3.16. **Type 1 and type 2 diabetes prevalence among adults, 2019 (or nearest year)**
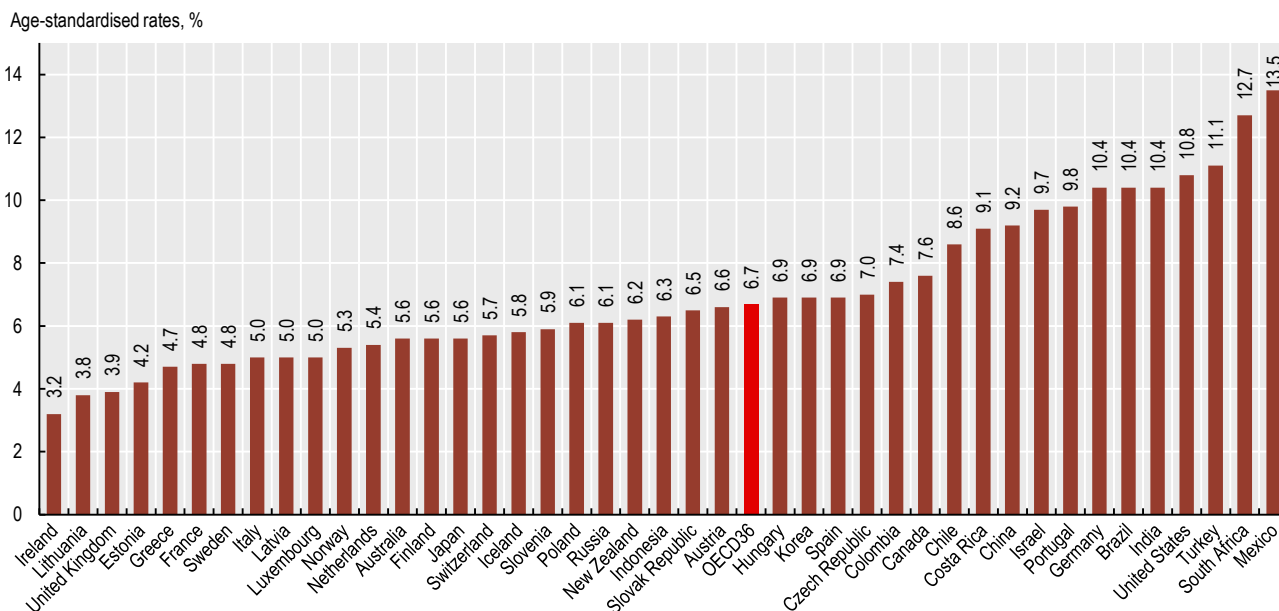
Source: IDF Diabetes Atlas, ninth edition, 2019.

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