

Diabetes is a chronic disease characterised by high levels of glucose in the blood. It occurs either because the pancreas stops producing the insulin hormone (type 1 diabetes), or through a combination of the pancreas having reduced ability to produce insulin alongside the body being resistant to its action (type 2 diabetes). People with diabetes are at greater risk of developing cardiovascular diseases such as heart attack and stroke if the disease is left undiagnosed or poorly controlled. They also have higher risks for sight loss, foot and leg amputation due to damage to the nerves and blood vessels, and renal failure requiring dialysis or transplantation.

Globally, an estimated 422 million adults had diabetes in 2014, compared to 108 million in 1980. The global prevalence (age-standardised) of diabetes has nearly doubled since 1980, rising from 4.7% to 8.5% in the adult population, according to WHO estimates. Over the past decade, diabetes prevalence has risen faster in low- and middle-income countries than in high-income countries (WHO, 2016).

The data on diabetes prevalence among adults in EU countries presented in this section come from the second wave of the European Health Interview Survey which was conducted in (or around) 2014. Overall, 7% of adults across EU countries in 2014 reported to have diabetes. Diabetes prevalence ranged from less than 5% in Lithuania, Denmark, Latvia, Romania, Sweden and Austria, to over 9% in Greece, Portugal and France (Figure 3.34).

People with the lowest level of education are more than twice as likely to report having diabetes than those with the highest level on average across EU countries (Figure 3.35). This may partly be due to the fact that a higher proportion of low-educated people are in older population groups and the risk of diabetes increases with age, but people with lower levels of education often have poorer nutrition and are more likely to be obese, which are important risk factors for diabetes (see indicator on obesity among adults in Chapter 4).

The economic burden of diabetes is substantial. Health expenditure in EU member states allocated to prevent and treat diabetes and its complications was estimated to be in the order of EUR 100 billion in 2013 (IDF, 2013). Over one-quarter of these health expenditure is spent on controlling elevated blood glucose, another quarter on treating long-term complication of diabetes, and the remainder on additional general medical care. People with diabetes also have a lower probability to be employed and, when they are employed, have more days of sick leave and generally earn less (see Chapter 1). The growing direct and indirect costs related to diabetes reinforce the need for effective preventive actions and the provision of quality care to effectively manage diabetes and its complications.

Type 2 diabetes is largely preventable. A number of risk factors, such as overweight and obesity and physical inactivity are modifiable, and can also help reduce the complications associated with diabetes. But in most countries, the prevalence of overweight and obesity continues to increase (see indicator on “Overweight and obesity among adults” in Chapter 4).

Definition and comparability

Estimates of the prevalence of diabetes are derived from the second wave of the European Health Interview Survey that was conducted in EU member states between 2013 and 2015 (with most countries carrying out the survey in 2014). Respondents were asked: “During the past 12 months, have you had any of the following diseases or conditions?” with the list including diabetes. The same survey also asked for information on age, sex and educational level.

Self-reported data on diabetes may be subject to under-diagnosis and reporting errors. Studies from several European countries show that self-reported data under-estimate the real prevalence of diabetes, as many diabetes cases are undiagnosed.

The percentage of missing values in the EHIS survey was between 5 to 10% for France and higher than 10% for Finland. Data are not age-standardised; aggregate country estimates are crude rates among respondents aged 15 years and over. The data, therefore, exclude the prevalence of diabetes among children (age 0-14 years).

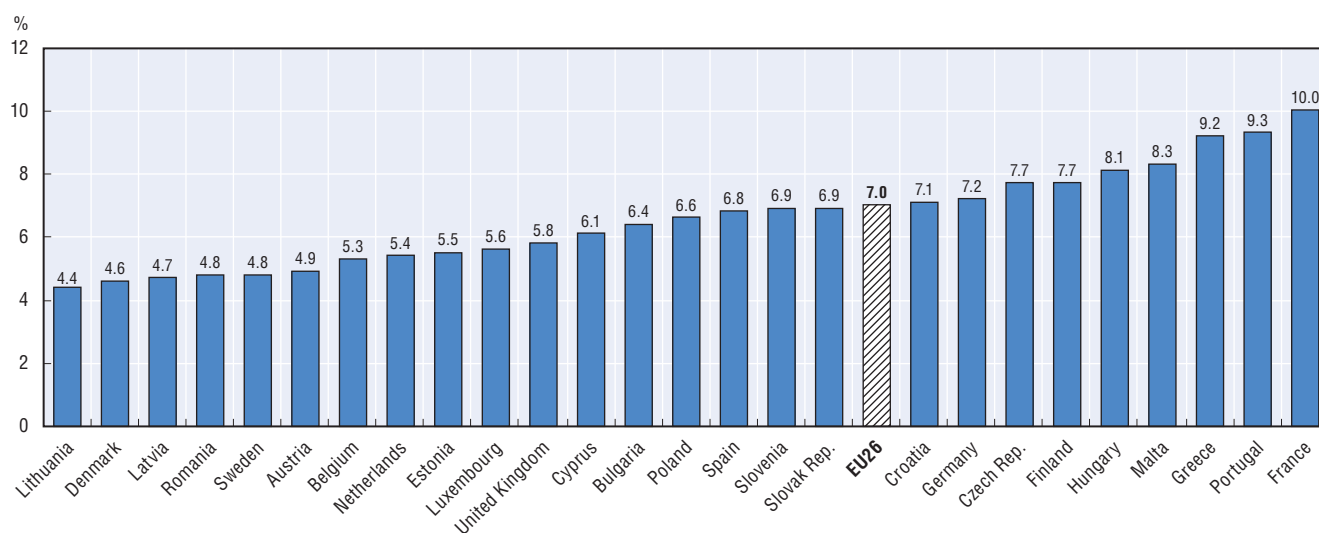
At the time of preparation of this publication, data from a few EU countries that conducted this survey in 2015 were not available yet.

Education level is based on the ISCED 2011 classification. Lowest education level refers to people who have a lower secondary education or below (ISCED 0-2). Highest education level refers to people who have tertiary education (ISCED 6-8).

References

- IDF (2013), *Diabetes Atlas, 6th edition*, International Diabetes Federation, Brussels.
- WHO (2016), *Global Report on Diabetes*, April 2016, Geneva.

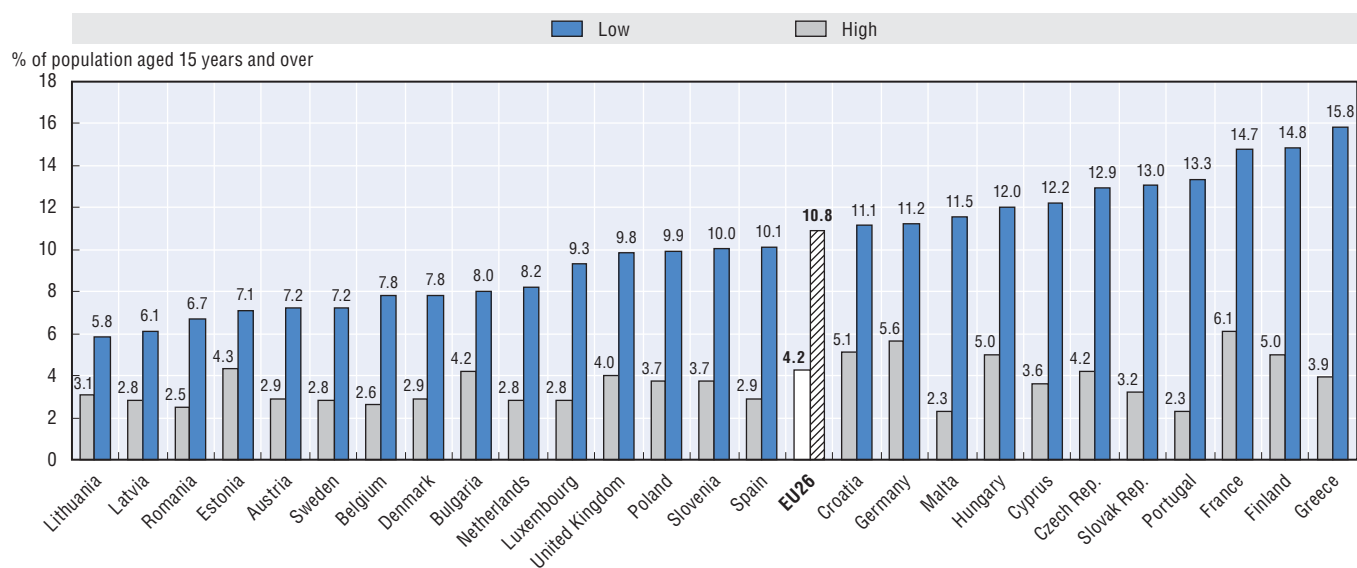
3.34. Self-reported diabetes, population aged 15 years and over, 2014 (or nearest year)



Source: Eurostat Database, based on Health Interview Surveys.

StatLink <http://dx.doi.org/10.1787/888933428845>

3.35. Self-reported diabetes by level of education, 2014 (or nearest year)



Source: Eurostat Database, based on Health Interview Surveys.

StatLink <http://dx.doi.org/10.1787/888933428852>



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