

Sleep Disorders and the Challenge of Long-Term Care: A Global Comparison

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Publish date: August 21, 2026

A comparison of six health systems — the United Kingdom, France, Germany, the United States, Australia, and Japan — reveals a consistent pattern: Despite radically different healthcare models, all exclude sleep disorders from chronic disease frameworks. OSA is managed episodically through device provision rather than long-term care pathways. The consistency of this pattern across systems suggests a structural design issue rather than a local policy failure, and points toward the need for OSA reclassification as a chronic condition requiring continuous management.

A comparison of six health systems — those in France, the United Kingdom, Germany, the United States, Australia, and Japan — reveals a consistent pattern: Despite radically different healthcare models, sleep disorders are excluded from chronic disease frameworks across all jurisdictions examined. OSA is managed episodically through device provision rather than long-term care pathways. The consistency of this pattern across systems points toward a structural design issue rather than a country-specific failure.

Despite significant differences in healthcare structures, several common themes emerge in the global management of sleep disorders, particularly obstructive sleep apnea (OSA), which remains one of the most clinically significant and well-studied sleep-related conditions.

First, sleep disorders are rarely integrated systematically into chronic disease frameworks. This limits their visibility within prevention strategies, primary care structures, and broader population health management systems. OSA is strongly associated with cardiovascular disease, metabolic disorders, neurocognitive decline,

and increased mortality, yet continues to sit outside many of the frameworks used to manage other long-term conditions.^{1,2}

This exclusion from chronic disease frameworks has concrete consequences for how care is financed. Reimbursement models are frequently structured around device provision and short-term adherence rather than sustained outcomes and long-term disease management. While these systems can support initial treatment uptake, they do not incentivize continuous engagement, coordinated care, or re-entry into treatment after interruption.

Third, follow-up pathways remain fragmented or narrowly defined. In many systems, responsibility for ongoing management is unclear, coordination between providers is limited, and long-term support mechanisms are underdeveloped. As a result, many patients who discontinue therapy fall out of the system without a structured pathway back into care.³

The comparison across healthcare systems highlights a broader structural issue rather than a country-specific one. Across jurisdictions, sleep disorders and OSA

specifically remain positioned outside the frameworks typically used to manage chronic conditions such as diabetes, hypertension, or cardiovascular disease.

such as within European driving license legislation, yet sleep disorders remain insufficiently integrated into broader chronic disease policy frameworks.⁶

What this means for patients and health systems

For patients, this translates into delayed diagnosis (up to 80% of moderate-to-severe OSA cases remain undiagnosed across major health systems³), inconsistent access to care, and limited long-term support. In the United Kingdom, OSA sits outside the Quality and Outcomes Framework, removing primary care incentives for detection. In the United States, CMS adherence thresholds require patients to use PAP for at least four hours per night on 70% of nights within the first 90 days; patients who do not meet this threshold lose reimbursement eligibility, with no structured pathway for re-engagement.⁴ For health systems, these gaps contribute to avoidable morbidity, increased healthcare utilization, and wider economic costs associated with untreated or undertreated OSA.⁵

The comparison also identifies a policy inconsistency. In some regulatory contexts, OSA is already recognized as a condition with significant public safety implications,

A clear path forward

Most health systems already operate chronic disease management frameworks for diabetes, hypertension, and cardiovascular disease. Extending these frameworks to OSA would not require new infrastructure. It would require recognition that OSA is a chronic condition — not an episodic technical problem — and that it merits the same systematic approach to identification, follow-up, and long-term support that other conditions of comparable clinical significance receive as a matter of course.

The global consistency of this gap suggests the solution is equally universal: formal reclassification and integration of OSA into chronic disease management frameworks across health systems.

References

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⁵ Benjafield AV, et al. *Lancet Respir Med*. 2025;13(5):403–413.

⁶ eur-lex.europa.eu. Available at: <https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32014L0085> (Accessed July 2026).