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OSA: A Chronic Health Challenge Hiding in Plain Sight

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Sleep disorders are among the most prevalent medical conditions globally; obstructive sleep apnea (OSA) alone affects nearly 1 billion adults yet remains structurally invisible within most health systems. Across six countries, a consistent pattern emerges: Despite strong clinical evidence linking OSA and other sleep disorders to cardiovascular disease, diabetes, and premature mortality, sleep health remains peripheral to chronic disease frameworks, prevention strategies, and long-term care pathways. This is not a gap in the evidence. It is a gap in policy recognition.

Sleep disorders represent a structurally underrecognized public health challenge across advanced health systems. Conditions such as obstructive sleep apnea (OSA), insomnia, and circadian rhythm disorders are associated with significant cardiovascular, metabolic, neurocognitive, and mental health consequences, yet remain insufficiently integrated into broader chronic disease and prevention frameworks.[1,2]

Among these conditions, OSA has emerged as one of the clearest examples of the gap between clinical evidence and health system design. A substantial body of research has linked OSA to hypertension, stroke, type 2 diabetes, cardiovascular disease, and increased mortality.[3] Despite this, OSA — like many sleep disorders — continues to be managed primarily through episodic or device-based approaches rather than long-term chronic disease models.

To understand the current approach to sleep disorders globally, we can look at systems across six countries representing diverse healthcare models.

Across these systems, which span Europe, Americas and Asia Pacific, consistent patterns emerge: Sleep disorders remain underdiagnosed, care pathways are fragmented, and reimbursement models frequently prioritize short-term treatment adherence over sustained outcomes and long-term patient engagement. While approaches differ between countries, sleep health remains largely peripheral within national noncommunicable disease strategies.

Several explanations are sometimes offered for this gap. OSA is managed primarily through a device-based treatment model rather than through pharmacological pathways, which has led some systems to classify it under medical device reimbursement frameworks rather than chronic disease management.

Diagnostic complexity — requiring sleep studies interpreted by specialists — makes it harder to integrate into primary care in the way that, say, hypertension screening is. And adherence to positive airway pressure (PAP) therapy is more variable than adherence to many pharmacological treatments, which has encouraged reimbursement models built around short-term compliance thresholds rather than long-term clinical management.[4] These are real structural constraints. But none of them change the clinical reality: OSA is a progressive, chronic condition with measurable consequences for cardiovascular, metabolic, and cognitive health.[5] The constraints explain the current approach; they do not justify it.

At the same time, some sleep disorders are already recognized within regulatory frameworks as conditions with significant public safety implications. European driving license legislation, for example, restricts driving in

Sleep disorders and long-term care across health systems

A comparative overview across six healthcare systems of how sleep disorders and OSA are classified, managed and reimbursed

	Classification	Care model	Follow-up	Structural gap
France	Not included in ALD framework	Adherence-passed PAP reimbursement	4-month and annual review[1]	Adherence-gated care model
Germany	Not included in DMPs	Device-centered SHI reimbursement	Fragmented across sectors[2]	Weak continuity of care
United Kingdom	Not integrated into chronic disease frameworks	NHS sleep service model	Limited, non-incentivized[3]	No structured primary care pathway
United States	Not formally integrated into chronic care structures	CMS adherence-based reimbursement	90-day compliance threshold[4]	Coverage linked to short-term adherence
Australia	Not formally classified within chronic disease policy	Mixed public-private funding model	No structured long-term pathway[5]	Significant access inequities
Japan	Not integrated into national chronic disease strategies	National reimbursement with monitoring	Compliance-linked review[6]	Focus on device usage rather than outcome

[1] Assurance Maladie. 2023; [2] Gemeinsamer Bundesausschuss (G-BA). 2022; [3] NICE. 2021; [4] May AM, et al. Am J Respir Crit Care Med. 2023;207(3):244–254; [5] Hynes D, et al. Aust Prescr. 2024;47:52–56; [6] Kadotani H. Sleep Biol Rhythms. 2022;20(1):3.

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individuals with untreated moderate-to-severe OSA unless effective treatment and compliance can be demonstrated.[6] This creates a policy inconsistency: Sleep disorders are increasingly acknowledged as clinically and socially significant, yet are not systematically integrated into chronic disease management structures.

Bringing sleep health into the light

The chronic nature of obstructive sleep apnea is well established clinically. What remains hidden is their status within health policy frameworks. OSA is associated with hypertension, cardiovascular disease, type 2 diabetes, and increased mortality. The evidence is extensive and consistent. What has not followed is formal recognition: inclusion in chronic disease classification, integration into prevention strategies, and the long-term care pathways that other conditions with comparable clinical profiles receive as a matter of course.

Making OSA visible — through formal inclusion in chronic disease classification and policy frameworks — would align health system design with clinical reality. The evidence is clear, but the real challenge is recognition.

References

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