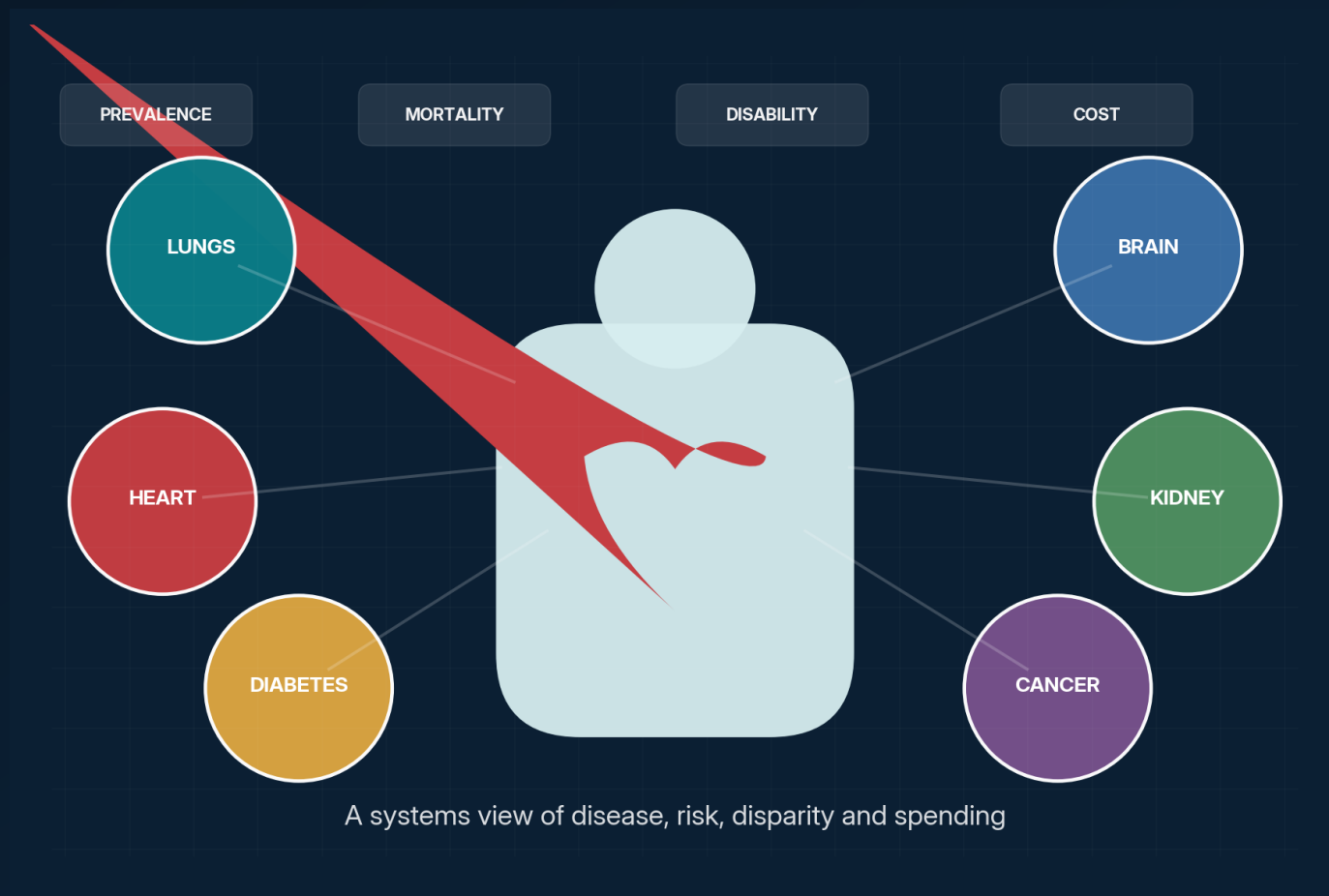


American Health and Disease Burden 2026

The most common diseases and health conditions in the United States - ranked separately by prevalence, incidence, medical use, mortality, disability and economic cost.



Executive Summary

Purpose. This report synthesizes the latest reliable U.S. surveillance, survey, claims, mortality, economic and international-comparison data available through July 2026. It is designed for policy, business, healthcare and journalistic use. It is not individualized medical advice.

There is no single scientifically valid answer to the question, "What is the most common disease in America?" Hypertension and obesity dominate population prevalence; respiratory infections dominate acute episodes; heart disease and cancer dominate mortality; low-back pain, depression and musculoskeletal disorders dominate disability; sepsis, heart failure and acute cardiovascular events dominate hospital cost; and chronic and mental health conditions together dominate national spending.

79.0

U.S. life expectancy at birth in 2024, up 0.6 year from 2023.

3.07M

Deaths registered in 2024; heart disease and cancer caused 42.4%.

76.4%

Adults reporting at least one selected chronic condition in 2023.

\$5.3T

National health spending in 2024 - \$15,474 per person.

Central conclusion: The United States has world-class capacity for acute rescue care and cancer screening, but unusually poor population outcomes for its level of spending. The largest avoidable gap is not a lack of medical technology; it is the failure to prevent, detect and continuously control common cardiometabolic, behavioral and social risks at population scale.

Headline findings

- **Most prevalent:** hypertension affects 47.7% of adults; prediabetes 42.6%; obesity 40.3%; any allergy 31.7%; chronic pain 24.3%; any mental illness 23.4%; and arthritis 21.2%. These estimates use different denominators and cannot be treated as a perfectly uniform rank.^{[3][4][5][7][8][10][17]}
- **Most lethal:** heart disease caused 683,491 deaths and cancer 619,876 in 2024, followed by unintentional injuries, stroke and chronic lower respiratory diseases.^[1]
- **Most disabling:** low-back pain, other musculoskeletal disorders, depressive and anxiety disorders, migraine, diabetes and substance-use disorders are major causes of years lived with disability; disability rankings differ from death rankings and rely partly on modeled estimates.^[33]
- **Most expensive:** U.S. health spending reached \$5.3 trillion in 2024. Hospital care alone cost \$1.63 trillion. In inpatient care, septicemia was the single most expensive condition in 2022 at about \$60.0 billion.^{[25][26]}
- **Most unequal:** 2024 age-adjusted mortality ranged from 317.6 per 100,000 among Asian women to 1,213.0 among American Indian or Alaska Native men after correction for death-certificate misclassification.^[1]
- **International position:** the United States spends roughly 2.5 times the OECD average per person while life expectancy is 2.7 years lower. It performs favorably on smoking, breast-cancer screening and 30-day survival after heart attack and stroke, but poorly on preventable mortality, obesity, avoidable admissions and overall longevity.^[28]

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Evidence labels used in this report

FINAL SURVEILLANCE

Completed vital statistics, cancer registries or administrative data.

SURVEY ESTIMATE

Weighted estimates from NHANES, NHIS, NSDUH or similar samples.

MODEL / PROJECTION

Modeled seasonal burden, DALYs or future cancer/dementia estimates.

INTERPRETATION

Editorial synthesis where no unified national ranking exists.

1. What "Most Common" Means

The word *common* can describe at least eight different phenomena. A chronic disease may affect tens of millions of people but cause relatively few deaths in a single year. An acute infection may produce the largest number of episodes but disappear within days. A rare disease can generate extraordinary cost per patient. A disease can be underdiagnosed yet still create large disability and mortality burdens.



Figure 1. Eight defensible meanings of "most common." A rigorous answer must specify the numerator, denominator, time period and data source.

Criterion	Question answered	Typical leaders	Main limitation
Prevalence	How many people are living with the condition now or during a period?	Hypertension, obesity, prediabetes, allergies, chronic pain, mental illness.	Definitions and denominators differ; undiagnosed disease is often missed.
Incidence / episodes	How many new cases or illness episodes occur each year?	Influenza and respiratory infections, injuries, sexually transmitted infections, cancer, diabetes.	Acute episodes may be modeled; repeated infections can count the same person more than once.
Diagnosed patients	How many people have a recorded diagnosis?	Hypertension, diabetes, arthritis, depression, asthma.	Strongly affected by insurance, access, screening and coding.
Outpatient use	Which problems generate office, urgent-care, emergency or telehealth encounters?	Hypertension, respiratory illness, musculoskeletal pain, diabetes, mental health, skin and digestive complaints.	No single current dataset captures all settings and all payers consistently.
Hospitalizations	Which principal diagnoses lead to inpatient stays?	Live births, septicemia, heart failure, osteoarthritis, pneumonia, acute myocardial infarction.	Principal diagnosis differs from comorbidity; obstetric stays complicate disease rankings.

Criterion	Question answered	Typical leaders	Main limitation
Mortality	Which underlying causes account for the most deaths?	Heart disease, cancer, injuries, stroke, chronic respiratory disease.	Death certificates can misclassify race, ethnicity and contributing disease.
Disability / DALY	Which conditions cause the most years lived with disability or healthy life lost?	Low-back pain, depression, anxiety, migraine, diabetes, cardiovascular disease, substance use.	DALYs are modeled and depend on disability weights and attribution rules.
Spending	Which conditions or service categories consume the most medical and economic resources?	Cardiovascular disease, diabetes, cancer, musculoskeletal conditions, mental disorders, sepsis.	Cost studies use different years and include different combinations of medical and productivity losses.

Do not add percentages across conditions. The same person may have hypertension, obesity, diabetes, arthritis and depression simultaneously. In 2023, 51.4% of adults reported two or more selected chronic conditions, making multimorbidity the rule rather than the exception in midlife and old age.^[9]

2. Separate National Rankings

2.1 Prevalence: conditions affecting the most people

Table 1 ranks selected high-prevalence conditions using the latest nationally representative estimate readily available for each. It is a practical burden table, not a perfectly standardized epidemiologic league table: age ranges, survey methods and diagnostic thresholds differ.

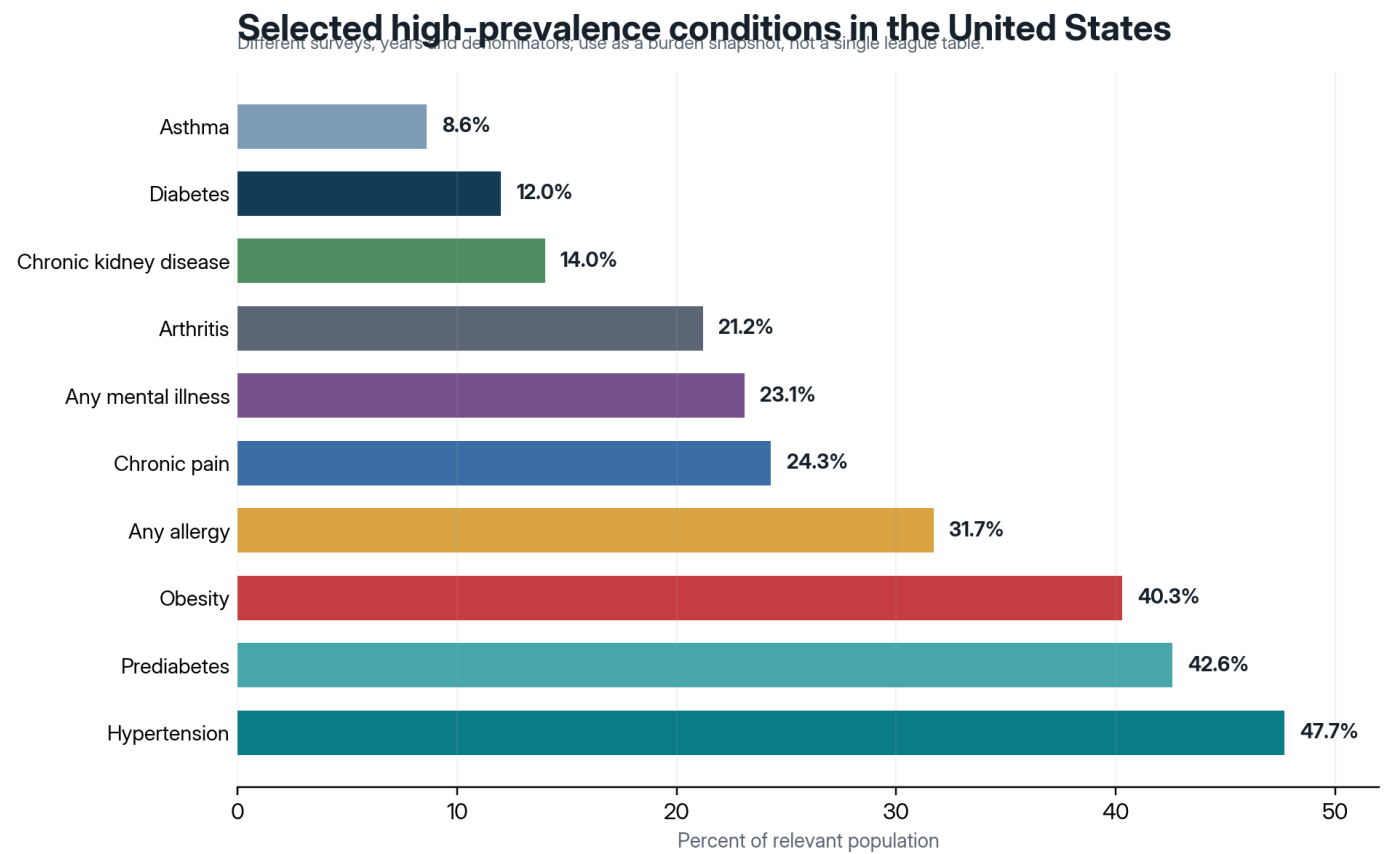


Figure 2. Selected prevalence estimates. Prediabetes is a risk state, not established diabetes; allergies combine multiple allergy types; mental illness is a one-year survey measure.

Rank*	Condition	Latest estimate	Population / year	Evidence	Interpretive note
1	Hypertension	47.7%	Adults 18+, Aug. 2021-Aug. 2023	MEASURED SURVEY	Defined as measured BP at least 130/80 mm Hg or current medication; only 20.7% of adults with hypertension were controlled. ^[3]
2	Prediabetes	42.6% (115.2 million)	Adults 18+, 2023 estimate	SURVEY ESTIMATE	About 8 in 10 were unaware; not all cases progress to diabetes. ^[5]
3	Obesity	40.3%	Adults 20+, Aug. 2021-Aug. 2023	MEASURED SURVEY	Severe obesity was 9.4% (9.7% age adjusted); obesity was lower among college graduates. ^[4]
4	Any allergy	31.7%	Adults 18+, 2024	SURVEY ESTIMATE	Includes seasonal allergy, eczema and food allergy; categories overlap. ^[10]

Rank*	Condition	Latest estimate	Population / year	Evidence	Interpretive note
5	Chronic pain	24.3%	Adults 18+, 2023	SURVEY ESTIMATE	High-impact chronic pain limiting life or work affected 8.5%. ^[7]
6	Any mental illness	23.4% (61.5 million)	Adults 18+, past year 2024	SURVEY ESTIMATE	Broad category ranging from mild to serious mental illness; 60.1 million adults received some mental-health treatment in 2024. ^[17]
7	Arthritis	21.2% (53.2 million)	Adults 18+, 2019-2021	SURVEY ESTIMATE	Major driver of pain, mobility limitation and work loss; projected to reach 78.4 million adults by 2040. ^[8]
8	Chronic kidney disease	14% (about 37 million)	Adults 18+, current CDC estimate	SURVEY/ MODEL	Nearly 9 in 10 are unaware; prevalence is much higher with diabetes and at older ages. ^[6]
9	Diabetes	12.0% (40.1 million)	All ages, 2023	SURVEY ESTIMATE	Includes diagnosed and undiagnosed diabetes; about 27.6% of adults with diabetes were undiagnosed. ^[5]
10	Asthma	8.6%	Adults 18+, 2024	SURVEY ESTIMATE	Current asthma; childhood prevalence was 6.5%. ^[11]
11	Coronary heart disease	5.0%	Adults 18+, 2024	DIAGNOSED SURVEY	Recorded diagnosis understates subclinical atherosclerosis and differs from broader cardiovascular disease definitions. ^[13]
12	COPD	3.8%	Adults 18+, 2023	DIAGNOSED SURVEY	Prevalence rises from 0.4% at ages 18-24 to 10.5% at ages 75+ and is higher in low-income and rural populations. ^[12]

*Rank is approximate because definitions, age ranges and reference periods differ. Meta-category: 76.4% of adults reported at least one of 12 selected chronic conditions in 2023 and 51.4% reported at least two.^[9]

2.2 Incidence and acute episodes

Approximate order	Disease / event	Annual incidence or episodes	What the number means
1	Seasonal influenza, 2024-25	43-73 million symptomatic illnesses	Preliminary modeled range; 19-32 million medical visits, 560,000-1.1 million hospitalizations and 38,000-99,000 deaths. This was a high-severity season. ^[23]
2	Sexually transmitted infections	More than 26 million infections estimated annually; over 2.4 million chlamydia, gonorrhea and syphilis cases reported in 2023	Reported cases substantially undercount asymptomatic and untested infections. Provisional combined cases declined in 2024. ^[24]
3	Cancer	2.115 million new invasive cases projected in 2026	Projection based on recent registry trends, not a final count. Breast, prostate, lung and colorectal cancers account for a large share. ^{[14][15]}
4	Newly diagnosed diabetes	About 1.5 million new diagnoses in 2023	Diagnosed incidence only; excludes undetected disease and does not count progression from prediabetes until diagnosis. ^[5]
5	Heart attack	About 805,000 events per year	Includes first and recurrent myocardial infarctions; estimates derive from cardiovascular surveillance. ^[13]
6	Stroke	More than 795,000 events per year	About 610,000 are first or new strokes and about 185,000 are recurrent strokes. ^[13]

Why colds are not ranked precisely: acute upper-respiratory infections are among the most frequent illnesses and visit reasons, but many are self-treated, never tested and coded under multiple diagnoses. A precise national count would create false accuracy. Influenza and selected respiratory viruses are better measured through surveillance and models.

2.3 Diagnosed patients and outpatient use

No current unified federal table ranks every diagnosis across physicians' offices, hospital outpatient departments, urgent care, retail clinics, telehealth and emergency departments. MEPS and NAMCS can produce estimates, but classification and setting coverage differ.^[40] The most defensible cross-system conclusion is that **hypertension, diabetes, respiratory infections, musculoskeletal pain, mental-health disorders, skin conditions, allergies/asthma and digestive complaints** generate the largest recurring volumes of ambulatory care.

Encounter group	Why visit volume is high	Typical services	Measurement caveat
Cardiometabolic management	Very high prevalence and need for repeated monitoring.	BP checks, medication management, lipid and glucose testing, nutrition counseling.	One patient can generate many visits; untreated people generate none.
Acute respiratory / infectious	High annual episode count and seasonality.	Testing, supportive care, antivirals or antibiotics when indicated, vaccination.	Many episodes never enter medical records.
Musculoskeletal and pain	Common, recurrent and often work-limiting.	Primary care, imaging, physical therapy, injections, surgery, pain management.	Symptoms can be coded by body site rather than underlying disease.
Mental health	High one-year prevalence and repeated therapy or medication visits.	Screening, psychotherapy, psychiatry, medication management, crisis care.	Treatment outside insurance claims and unmet need are substantial.
Allergy, asthma, dermatology and digestive disorders	Frequent symptom flares and quality-of-life effects.	Testing, inhalers, antihistamines, topical therapy, endoscopy, dietary management.	Self-treatment and over-the-counter medication reduce observed visits.

2.4 Hospitalization: most frequent and most expensive are different

The latest comprehensive national ranking of principal inpatient diagnoses is older than the latest spending table. In 2018, excluding normal newborn stays, septicemia, heart failure, osteoarthritis, pneumonia and diabetes complications were among the most frequent principal diagnoses.^[27] In 2022, the five most expensive inpatient condition groups were septicemia, liveborn infants, heart failure, acute myocardial infarction and COVID-19.^[26]

Rank by 2022 aggregate inpatient cost	Condition	Aggregate cost	Share of all inpatient cost	Interpretation
1	Septicemia	\$60.0 billion	10.9%	High volume, high acuity, long stays and complex organ support.
2	Liveborn infants	\$19.6 billion	3.6%	Not a disease; reflects the scale of childbirth and neonatal care.
3	Heart failure	\$18.2 billion	3.3%	Frequent admissions and readmissions among older adults with multimorbidity.
4	Acute myocardial infarction	\$16.3 billion	3.0%	Costly emergency intervention, intensive care and revascularization.
5	COVID-19	\$16.0 billion	2.9%	Large acute burden in 2022; mortality and hospitalization subsequently declined.

AHRQ estimated 32.9 million inpatient stays and \$548.5 billion in aggregate hospital costs in 2022. The 20 most expensive conditions accounted for 46.8% of aggregate costs.^[26]

2.5 Mortality: finalized 2024 ranking

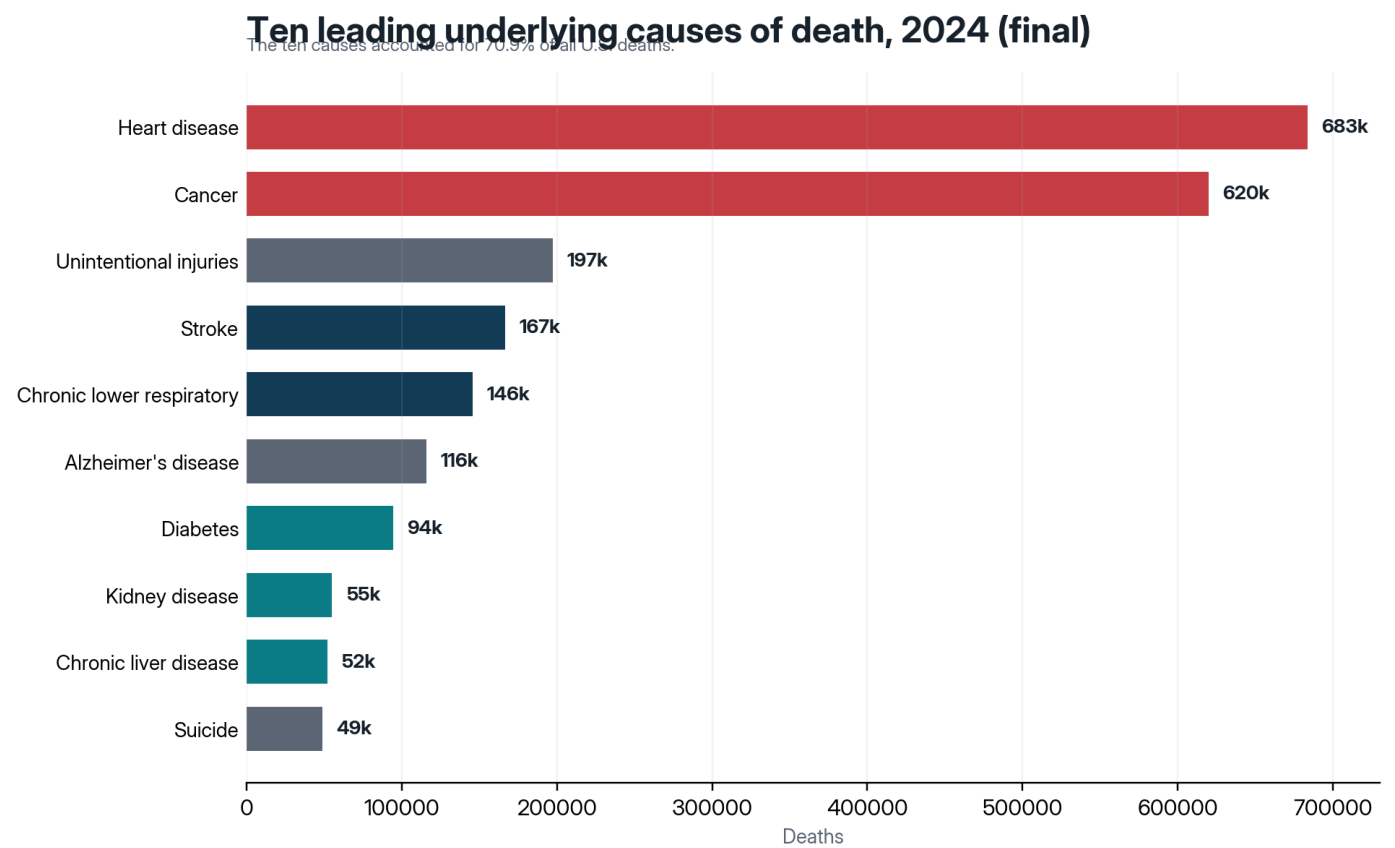


Figure 3. Final underlying-cause mortality. Rates and rankings may differ when multiple contributing causes are counted.

Rank	Underlying cause	Deaths	Share	Age-adjusted rate per 100,000
1	Heart disease	683,491	22.2%	157.6
2	Cancer	619,876	20.2%	139.4
3	Unintentional injuries	197,449	6.4%	53.3
4	Stroke	166,852	5.4%	38.6
5	Chronic lower respiratory diseases	145,643	4.7%	32.4
6	Alzheimer's disease	116,022	3.8%	27.1
7	Diabetes	94,445	3.1%	21.7
8	Kidney disease	55,081	1.8%	12.6
9	Chronic liver disease and cirrhosis	52,274	1.7%	12.7
10	Suicide	48,824	1.6%	13.7

Final data: 3,072,666 deaths; age-adjusted all-cause death rate 722.1 per 100,000. COVID-19 dropped to 15th with 31,426 underlying-cause deaths. Provisional 2025 data show a further decline in the age-adjusted death rate to 689.2, but those data can be revised. ^{[1][2]}

2.6 Disability and healthy life lost

Mortality statistics understate disorders that rarely kill directly but impair mobility, work, cognition or quality of life for years. Global Burden of Disease models consistently identify **low-back pain** as the leading U.S. cause of years lived with disability, with other musculoskeletal disorders, depressive disorders, anxiety disorders, migraine, diabetes, hearing loss, chronic respiratory disease and substance-use disorders also prominent. ^[33]

Burden lens	Conditions that rise in rank	Why they matter
Years lived with disability (YLD)	Low-back pain, neck pain, osteoarthritis, depression, anxiety, migraine, sensory loss.	Long duration, recurrent symptoms, impaired daily function and work loss.
Disability-adjusted life years (DALY)	Ischemic heart disease, cancer, injuries, diabetes, COPD, drug-use disorders, stroke, low-back pain.	Combines premature death with disability; rankings are modeled.
High-impact functional limitation	Chronic pain, arthritis, stroke, COPD, dementia, severe mental illness.	Directly limits employment, caregiving and independent living.

Evidence boundary: DALYs are valuable for comparing fatal and nonfatal conditions, but they are not direct counts. Results depend on disease models, disability weights and assumptions about comorbidity. This report uses them to identify broad burden patterns, not to claim exact national ranks.

2.7 Spending and economic burden

\$15,474 per person and 18.0% of GDP; out-of-pocket spending was \$566.6 billion.

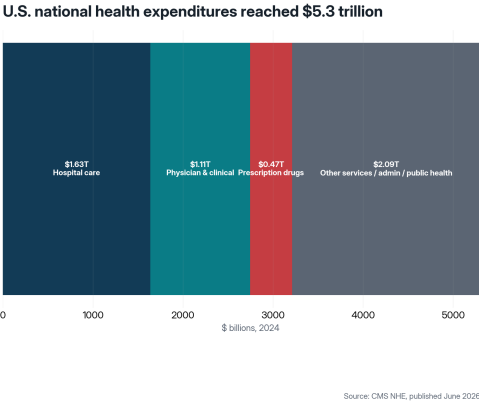


Figure 4. National Health Expenditure Accounts measure spending by service and payer, not only by disease. The "other" segment is the residual needed to reconcile the \$5.3 trillion total.

High-cost burden	Best current estimate	Year / scope	Key caveat
All U.S. health care	\$5.3 trillion ; \$15,474 per person; 18.0% of GDP	2024, final NHE	Service-based national accounts, not disease-attributable cost. ^[25]
Chronic and mental health conditions	About 90% of national health spending is associated with people who have chronic or mental health conditions	CDC synthesis, updated 2026	Association with patients, not the incremental cost caused by each diagnosis. ^[29]
Diabetes	\$640 billion in medical costs and lost productivity	2022 estimate	Method differs from national accounts; includes productivity loss. ^{[5][29]}

High-cost burden	Best current estimate	Year / scope	Key caveat
Heart disease and stroke	\$223.2 billion health-care cost plus \$191.5 billion lost productivity from premature death	CDC current estimate, based on recent years	Does not capture all informal caregiving and quality-of-life loss. ^[29]
Alzheimer's and other dementias	\$409 billion paid care in 2026; unpaid care valued above \$446 billion	2026 projection / 2025 caregiving	Association estimate; excludes some household burdens. ^[16]
Arthritis	More than \$300 billion in medical costs and lost earnings	2013 benchmark	Still widely cited but materially dated; current burden is likely higher. ^{[8][29]}
COPD	About \$24 billion annual medical costs among adults 45+	Current CDC summary using prior cost data	Excludes some productivity and informal-care costs. ^[12]

3. Major Disease and Condition Profiles

Each profile summarizes current scale, mortality, risk, symptoms, affected groups, prevention, treatment, complications, cost and recent trend. Clinical details are high-level and reflect established CDC, NIH and professional-society guidance current through July 2026; they are not treatment instructions for a specific patient.

3.1 Hypertension, coronary disease, heart failure and stroke

47.7% of adults have hypertension

850,343 heart-disease + stroke deaths in 2024

SCALE AND MORTALITY

Hypertension is the most prevalent major measured chronic disease in adults. Coronary heart disease is diagnosed in about 5% of adults, roughly 805,000 heart attacks and 795,000 strokes occur annually, and heart disease plus stroke caused more than 850,000 deaths in 2024.^{[1][3][13]}

SYMPTOMS

Hypertension is usually silent. Coronary ischemia can cause chest pressure, shortness of breath, sweating or atypical fatigue. Stroke warning signs include sudden facial droop, arm weakness, speech difficulty, vision loss, imbalance or severe headache. Heart failure causes exertional breathlessness, edema, fatigue and weight gain from fluid.

COMPLICATIONS

Myocardial infarction, stroke, heart failure, kidney failure, vascular dementia, limb ischemia and sudden death. Poorly controlled blood pressure damages multiple organs long before symptoms appear.

RISK AND AFFECTED GROUPS

Age, family history, high sodium intake, obesity, diabetes, kidney disease, smoking, inactivity, alcohol, sleep apnea and chronic stress are central risks. Men have higher hypertension prevalence before older age. Black adults experience especially high hypertension and stroke burden; rural areas face access and emergency-response gaps.

PREVENTION AND TREATMENT

Weight control, physical activity, a DASH-style diet, less sodium, tobacco avoidance, moderation of alcohol, sleep treatment and medication adherence are effective. Treatment includes antihypertensives, statins, antiplatelet or anticoagulant therapy when indicated, revascularization, heart-failure guideline therapies and rapid thrombolysis or thrombectomy for eligible stroke.

ECONOMIC BURDEN

Heart disease and stroke generate hundreds of billions of dollars in direct care and lost productivity. Their cost is amplified by recurrent hospitalization, rehabilitation and long-term disability.^[29]

Recent trend: Cardiovascular mortality has improved over the long run but remains the leading cause of death. Stroke prevalence increased 7.8% between 2011-2013 and 2020-2022, including larger relative increases among younger and less-educated adults. Hypertension control remains poor.^{[3][37]}

3.2 Cancer

2.115M projected new cases in 2026
619,876 deaths in 2024

SCALE AND TYPES

Cancer is not one disease. Breast, prostate, lung and colorectal cancers account for a large share of new cases; lung cancer remains the largest cancer killer. The American Cancer Society projects 2,114,850 new invasive cases and 626,140 deaths in 2026, while final vital statistics counted 619,876 cancer deaths in 2024.^{[1][14][15]}

SYMPTOMS

Symptoms vary: unexplained weight loss, persistent pain, bleeding, a new lump, persistent cough, bowel changes, abnormal fatigue or skin changes. Many early cancers are asymptomatic, making screening essential.

COMPLICATIONS

Metastasis, treatment toxicity, pain, cachexia, infertility, cognitive effects, financial toxicity and long-term cardiovascular or secondary-cancer risk.

RISK AND AFFECTED GROUPS

Age is the largest risk factor. Tobacco, alcohol, obesity, infections such as HPV and hepatitis, radiation, occupational exposures, environmental carcinogens and inherited variants contribute. Black men have especially high prostate-cancer mortality; American Indian and Alaska Native and rural communities often face delayed diagnosis; screening and survival differ by insurance and income.

PREVENTION AND TREATMENT

Tobacco control, HPV and hepatitis B vaccination, weight control, sun protection, reduced alcohol exposure and evidence-based screening can prevent or detect many cancers early. Treatment includes surgery, radiation, chemotherapy, endocrine therapy, targeted therapy, immunotherapy and increasingly biomarker-guided combinations.

ECONOMIC BURDEN

National cancer-attributable medical care exceeded \$200 billion in 2020 and continues to grow with higher incidence, longer survival and expensive therapies; household financial stress is unevenly distributed.

Recent trend: The overall cancer death rate has fallen about 34% since 1991, averting an estimated 4.8 million deaths. At the same time, incidence is rising for several cancers, including breast, prostate, pancreatic, endometrial and some liver and oral cancers. The falling mortality and rising incidence can coexist because detection and treatment improve while exposure and population aging increase.^[14]

3.3 Obesity

40.3% of adults
21.1% of children ages 2-19

SCALE

Obesity affects roughly two in five adults and one in five children. Severe obesity affects nearly one in ten adults. BMI is an imperfect individual measure, but at population level excess adiposity predicts diabetes, hypertension, cardiovascular disease, sleep apnea, osteoarthritis, liver disease and several cancers.^{[4][35]}

SYMPTOMS

Obesity may not cause a discrete symptom. Functional consequences can include shortness of breath, sleep disruption, joint pain, reduced mobility, reflux, fatigue and stigma-related distress.

COMPLICATIONS

Type 2 diabetes, cardiovascular disease, kidney disease, metabolic liver disease, infertility, osteoarthritis, sleep apnea, depression and elevated risk for at least 13 cancers.

RISK AND AFFECTED GROUPS

Food environment, portion size, ultra-processed foods, sugary drinks, sedentary work, sleep deprivation, stress, medications, genetics and neighborhood design interact. Prevalence is lower among adults with a bachelor's degree or more. Structural barriers make healthy food, safe exercise and preventive care less accessible in many low-income communities.

PREVENTION AND TREATMENT

Population prevention requires healthier default food environments, physical-activity infrastructure and childhood intervention. Individual treatment can include intensive behavioral therapy, nutrition and activity programs, treatment of sleep and medication contributors, anti-obesity medications including incretin-based therapies, and metabolic surgery for eligible patients.

ECONOMIC BURDEN

Obesity increases annual medical spending and productivity loss, but estimates vary by definition and year. The largest financial effect is mediated through diabetes, cardiovascular disease, cancer, musculoskeletal disease and disability.

Recent trend: Overall adult obesity prevalence was statistically stable over the last decade, but severe obesity increased from 7.7% in 2013-2014 to 9.7% age adjusted in 2021-2023. Childhood obesity rose from 13.9% in 1999-2000 to 21.1% in 2021-2023.^{[4][35]}

3.4 Diabetes and prediabetes

40.1M with diabetes

115.2M adults with prediabetes

SCALE AND MORTALITY

Diabetes affects 12.0% of the population; more than one quarter of adults with diabetes are undiagnosed. About 1.5 million adults received a new diagnosis in 2023. Diabetes was the underlying cause of 94,445 deaths in 2024, but its contribution is larger because it accelerates heart, stroke and kidney deaths.^{[1][5]}

SYMPTOMS

Frequent urination, thirst, blurred vision, fatigue, recurrent infection, slow wound healing and unintentional weight change. Type 2 disease can remain silent for years.

COMPLICATIONS

Heart disease, stroke, kidney failure, blindness, neuropathy, foot ulceration and amputation, infection, pregnancy complications and hypoglycemia.

RISK AND AFFECTED GROUPS

Overweight, family history, age, inactivity, gestational diabetes, sleep problems and social disadvantage are key risks. American Indian or Alaska Native, Black, Hispanic and several Asian populations carry higher diagnosed burden. Rural areas often have higher crude prevalence because of age, income and obesity patterns.

PREVENTION AND TREATMENT

Structured weight loss and activity can prevent or delay many type 2 cases. Treatment uses nutrition, exercise, glucose monitoring, metformin, GLP-1/GIP therapies, SGLT2 inhibitors, insulin and other agents selected for cardiovascular, renal and weight effects. Type 1 diabetes requires insulin and cannot currently be prevented.

ECONOMIC BURDEN

CDC estimates \$640 billion in medical costs and lost productivity for diagnosed diabetes in 2022; medical costs for people with diabetes are more than twice those for people without diabetes.^[5]

Recent trend: Diabetes prevalence and complications are increasing, including among younger adults. Updated CDC estimates are higher than earlier reports because of new data and methods. Prevention is high-yield because prediabetes is extremely common and largely unrecognized.^[5]

3.5 Asthma and chronic obstructive pulmonary disease

Asthma: 8.6% of adults

COPD: 3.8% of adults

SCALE AND MORTALITY

Asthma affects 8.6% of adults and 6.5% of children. Diagnosed COPD affects 3.8% of adults overall but 10.5% of adults 75 and older. Chronic lower respiratory diseases caused 145,643 deaths in 2024.^{[1][11][12]}

SYMPTOMS

Asthma causes episodic wheeze, cough, chest tightness and shortness of breath. COPD causes chronic cough, sputum, progressive exertional breathlessness, recurrent exacerbations and fatigue.

COMPLICATIONS

Emergency visits, hospitalization, respiratory failure, impaired exercise, anxiety, sleep problems and cardiovascular stress.

RISK AND AFFECTED GROUPS

Asthma reflects genetic susceptibility plus allergens, viral infections, pollution, smoke and occupational exposure. COPD is driven primarily by smoking, secondhand smoke, occupational dust/fumes and air pollution; alpha-1 antitrypsin deficiency is an uncommon genetic cause. COPD is more prevalent among women, older adults, low-income populations and nonmetropolitan residents.

PREVENTION AND TREATMENT

Avoid tobacco and occupational inhalants, improve indoor air quality, vaccinate against respiratory pathogens and use action plans. Asthma control centers on inhaled corticosteroid-containing therapy. COPD care uses smoking cessation, bronchodilators, selected inhaled steroids, pulmonary rehabilitation, oxygen when indicated and early treatment of exacerbations.

ECONOMIC BURDEN

COPD medical costs are estimated around \$24 billion annually among adults 45 and older; asthma adds substantial medication, emergency and productivity costs.^[12]

Recent trend: Smoking has declined, improving long-run risk, but COPD remains underdiagnosed and concentrated in disadvantaged groups. Climate-driven heat, wildfire smoke, ozone and allergens can worsen asthma and COPD even where tobacco exposure falls.

3.6 Infectious diseases: respiratory viruses, STIs and sepsis

Influenza: 43-73M illnesses in 2024-25
STIs: >2.4M reported cases in 2023

SCALE AND MORTALITY

Acute infections generate enormous episode counts but fluctuate by season. The 2024-25 influenza season was preliminarily estimated at 43-73 million illnesses and 38,000-99,000 deaths. COVID-19 caused 31,426 underlying-cause deaths in 2024 and ranked 15th. More than 2.4 million chlamydia, gonorrhea and syphilis cases were reported in 2023. Sepsis is not a single pathogen but a life-threatening dysregulated response to infection and the costliest inpatient condition.^{[1][23][24][26]}

SYMPTOMS

Respiratory infection commonly causes fever, cough, sore throat, fatigue and muscle aches. STI symptoms vary and are often absent. Sepsis warning signs include altered mental status, rapid breathing, low blood pressure, fever or hypothermia and organ dysfunction.

COMPLICATIONS

Pneumonia, myocarditis, neurologic injury, infertility, congenital infection, chronic pain, organ failure, post-infectious syndromes and death.

RISK AND AFFECTED GROUPS

Age extremes, pregnancy, immune suppression, chronic disease, crowding, occupational exposure, inadequate vaccination and limited access increase risk. Older adults account for a disproportionate share of respiratory-virus hospitalization; young adults carry high STI incidence.

PREVENTION AND TREATMENT

Vaccination, ventilation, hand hygiene, staying home when ill, testing, early antivirals for eligible patients, condoms, regular STI screening, partner treatment and prompt antibiotics for bacterial sepsis. Antibiotic stewardship is essential to slow antimicrobial resistance.

ECONOMIC BURDEN

Seasonal infections cause large productivity losses; septicemia alone cost about \$60 billion in 2022 inpatient care.^[26]

Recent trend: COVID mortality declined sharply, and provisional 2024 STI counts fell for a third year, but influenza severity rebounded in 2024-25. Respiratory-virus burden is volatile, so a low year should not be mistaken for elimination.^{[23][24][39]}

3.7 Chronic kidney disease

About 37M adults (14%)
55,081 deaths in 2024

SCALE

CKD affects about one in seven adults; nearly nine in ten do not know they have it. Prevalence is approximately 34% among adults 65 and older and is especially high among people with diabetes or hypertension.^{[6][29]}

SYMPTOMS

Early CKD is usually silent. Later disease can cause edema, fatigue, nausea, itching, appetite loss, sleep disturbance, shortness of breath and confusion.

COMPLICATIONS

Cardiovascular death, anemia, bone-mineral disorder, electrolyte imbalance, fluid overload, frailty and kidney failure.

RISK AND AFFECTED GROUPS

Diabetes and hypertension are the leading causes. Age, cardiovascular disease, obesity, family history, recurrent acute kidney injury, medications and environmental exposures also matter. Black, Hispanic and American Indian or Alaska Native populations experience disproportionate kidney failure, reflecting both clinical and structural risks.

PREVENTION AND TREATMENT

Screen at-risk patients with urine albumin and estimated filtration rate; control blood pressure and glucose; avoid tobacco and kidney-toxic drugs; use ACE inhibitor or ARB therapy and SGLT2 inhibitors when indicated. Advanced disease may require dialysis or transplantation.

ECONOMIC BURDEN

More than one in three Medicare dollars - about \$141.1 billion in a cited annual estimate - is spent on people with CKD, reflecting age and extensive comorbidity.^[29]

Recent trend: Aging, diabetes and obesity are expanding the at-risk population. New kidney-protective drugs improve prognosis, but benefit depends on earlier detection and equitable access.

3.8 Liver and digestive disorders

52,274 liver-disease deaths in 2024
GERD and IBS affect millions

SCALE AND MORTALITY

Chronic liver disease and cirrhosis caused 52,274 deaths in 2024. Metabolic dysfunction-associated steatotic liver disease is widely estimated to affect roughly one quarter or more of adults, but exact prevalence varies by imaging, laboratory and diagnostic criteria. GERD and irritable bowel syndrome are among the most common chronic digestive complaints; older national estimates often cited roughly one in five adults with weekly reflux and about one in eight with IBS.^{[1][21][22]}

SYMPTOMS

Liver disease may be silent until fatigue, jaundice, abdominal swelling, bleeding or confusion. GERD causes heartburn and regurgitation. IBS causes recurrent abdominal pain with altered bowel habits.

COMPLICATIONS

Cirrhosis, portal hypertension, liver cancer, transplant need, bleeding, malnutrition, anemia, sleep and work impairment.

RISK AND AFFECTED GROUPS

Alcohol, obesity, diabetes, viral hepatitis, medications, autoimmune disease and genetic disorders drive liver disease. Diet, obesity, medications, infection, stress and gut-brain interactions influence digestive disorders. Alcohol-related and metabolic liver disease often overlap.

PREVENTION AND TREATMENT

Vaccinate against hepatitis A and B when indicated; test and treat hepatitis B/C; reduce or eliminate harmful alcohol use; manage weight and diabetes; avoid unnecessary hepatotoxic drugs. GERD treatment uses lifestyle measures and acid suppression; IBS management may include diet, fiber, targeted medication and psychological therapies.

ECONOMIC BURDEN

Costs are distributed across outpatient therapy, endoscopy, hospitalization, transplant, cancer care and productivity loss; no single current national estimate covers the entire digestive category consistently.

Recent trend: Metabolic liver disease is rising with obesity and diabetes. Chronic liver disease remains a top-ten cause of death, and alcohol-related harm increased during the pandemic period. Estimates are sensitive to changing nomenclature and diagnostic thresholds.

3.9 Arthritis, low-back pain and chronic pain

53.2M adults with arthritis

24.3% of adults with chronic pain

SCALE AND DISABILITY

Arthritis affects 21.2% of adults and chronic pain 24.3%; 8.5% report high-impact chronic pain that frequently limits life or work. Low-back pain is the leading modeled cause of years lived with disability in the United States.^{[7][8][33]}

SYMPTOMS

Pain, stiffness, swelling, weakness, sleep disruption, reduced range of motion and activity limitation. Pain severity is not always proportional to imaging findings.

COMPLICATIONS

Work loss, disability, falls, depression, social isolation, opioid exposure, deconditioning and surgical complications.

RISK AND AFFECTED GROUPS

Age, prior injury, repetitive or heavy work, obesity, autoimmune disease, poor sleep, depression and social stress. Women report more chronic pain than men; prevalence rises to 36.0% at age 65+ and to 31.4% in nonmetropolitan areas. American Indian or Alaska Native adults have especially high reported pain prevalence.^[7]

PREVENTION AND TREATMENT

Maintain activity, healthy weight and workplace ergonomics; prevent injury. Treatment can include education, physical therapy, exercise, cognitive behavioral approaches, non-opioid analgesics, selected injections, disease-modifying drugs for inflammatory arthritis and joint replacement when indicated. Opioids require careful risk-benefit assessment.

ECONOMIC BURDEN

Arthritis-attributable medical costs and earnings losses exceeded \$300 billion in a 2013 estimate; the current burden is likely higher because of aging and medical inflation.^{[8][29]}

Recent trend: Chronic pain prevalence increased from 20.4% in 2019 to 24.3% in 2023, although survey and pandemic effects complicate causal interpretation. Arthritis is projected to affect 78.4 million adults by 2040.^{[7][8]}

3.10 Alzheimer's disease and other neurologic conditions

7.4M adults 65+ with Alzheimer's in 2026

116,022 deaths in 2024

SCALE AND MORTALITY

About 11% of adults 65 and older - 7.4 million people - are estimated to live with clinical Alzheimer's dementia in 2026; 74% are at least 75. Alzheimer's was the sixth leading cause of death overall in 2024 and fifth among people 65 and older.^{[1][16]}

SYMPTOMS

Progressive memory loss, impaired judgment, language and visuospatial problems, behavioral change and loss of independent function. Other common neurologic burdens include migraine, epilepsy, Parkinson's disease, neuropathy and stroke-related disability.

COMPLICATIONS

Falls, delirium, malnutrition, wandering, caregiver stress, institutionalization and loss of financial and legal capacity.

RISK AND AFFECTED GROUPS

Age and genetics are major risks. Cardiovascular risk, hearing loss, traumatic brain injury, inactivity, social isolation and lower educational opportunity may contribute. Almost two-thirds of people with Alzheimer's are women, largely reflecting longevity plus possible biological differences. Older Black and Hispanic adults have higher estimated dementia prevalence than older White adults.

PREVENTION AND TREATMENT

No guaranteed prevention exists, but control of blood pressure, diabetes and smoking; physical activity; hearing treatment; sleep; social and cognitive engagement; and injury prevention support brain health. Symptomatic drugs include cholinesterase inhibitors and memantine. Anti-amyloid therapies may modestly slow early disease in selected, biomarker-confirmed patients and require monitoring for brain swelling or bleeding.

ECONOMIC BURDEN

Paid care is projected at \$409 billion in 2026, with more than 19 billion hours of unpaid care valued above \$446 billion.^[16]

Recent trend: Deaths attributed to Alzheimer's increased 134% from 2000 to 2024. Population aging will raise case counts even if age-specific risk stabilizes. Prevalence estimates differ depending on whether diagnosis is clinical, functional or biomarker-confirmed.^[16]

3.11 Mental illness

61.5M adults with any mental illness in 2024
48,824 suicide deaths in 2024

SCALE AND MORTALITY

Nearly one in four adults had a mental illness in the past year in 2024. Depression and anxiety are especially common. Suicide caused 48,824 deaths in 2024; 14.3 million adults reported serious suicidal thoughts, 4.6 million made a plan and 2.2 million attempted suicide.^{[17][19]}

SYMPTOMS

Persistent sadness, loss of interest, anxiety, panic, irritability, sleep or appetite change, impaired concentration, psychosis, mania, hopelessness or thoughts of death. Symptoms exist on a continuum and may be episodic or chronic.

COMPLICATIONS

Suicide, substance use, cardiovascular and metabolic disease, unemployment, homelessness, incarceration, family stress and reduced life expectancy.

RISK AND AFFECTED GROUPS

Genetic vulnerability, trauma, chronic disease, pain, discrimination, isolation, financial stress, substance use and sleep disruption. Young adults have the highest prevalence of any mental illness. Women report more depression and anxiety; men have much higher suicide mortality. LGBTQ+ people, veterans, rural residents and people with disabilities can face elevated risk and access barriers.

PREVENTION AND TREATMENT

Early screening, social connection, sleep, exercise, trauma-informed care, school and workplace supports and lethal-means safety. Effective treatments include psychotherapy, antidepressant and other psychiatric medications, peer support, crisis services and coordinated care for serious mental illness.

ECONOMIC BURDEN

Mental disorders generate large outpatient, medication, emergency, disability and productivity costs. Direct cost estimates vary widely because many consequences occur outside medical claims.

Recent trend: Adult mental-illness prevalence remains elevated, particularly among younger adults. Treatment reach improved - 60.1 million adults received some mental-health treatment in 2024 - but need, quality and continuity remain uneven.^[17]

3.12 Substance-use disorders, overdose and alcohol-related harm

46.3M adults with a substance-use disorder in 2024
79,384 overdose deaths in 2024

SCALE AND MORTALITY

SAMHSA estimated 46.3 million adults with a past-year substance-use disorder in 2024. Final overdose deaths fell 26.2% to 79,384 in 2024 - the largest one-year decline recorded - but remained far above pre-fentanyl levels. Alcohol contributes to liver disease, cancer, injury, cardiovascular harm and fetal effects.^{[17][20]}

SYMPTOMS

Loss of control, craving, tolerance, withdrawal, hazardous use, continued use despite harm and failure to meet obligations. Overdose can cause slowed or stopped breathing, pinpoint pupils, cyanosis or unresponsiveness.

COMPLICATIONS

Overdose, infection, endocarditis, liver and pancreatic disease, trauma, incarceration, family disruption and neonatal complications.

RISK AND AFFECTED GROUPS

Trauma, pain, mental illness, social isolation, unstable housing, incarceration, job loss, high-potency illicit supply and inadequate treatment access. Overdose patterns vary by drug and geography; alcohol harm is broadly distributed.

PREVENTION AND TREATMENT

Evidence-based prevention includes safer prescribing, medication treatment for opioid use disorder (buprenorphine, methadone or naltrexone), naloxone, syringe services, fentanyl test strategies where legal, contingency management, counseling, recovery support and treatment of co-occurring illness. Alcohol-use disorder can be treated with behavioral therapy and medications such as naltrexone or acamprosate.

ECONOMIC BURDEN

Costs include emergency response, hospitalization, treatment, criminal justice, child welfare and lost productivity; published estimates vary substantially by substances and included sectors.

Recent trend:

The 2024 overdose decline is a major improvement and provisional 2025 data suggest further decline, but the drug supply remains volatile and some states worsened. The correct interpretation is progress, not resolution.^[20]

3.13 Allergies, eczema and food allergy

31.7% of adults report any allergy
29.5% of children report any allergy

SCALE

In 2024, 25.2% of adults reported seasonal allergy, 7.7% eczema and 6.7% food allergy; any allergy affected 31.7%. Among children, any allergy affected 29.5%, including seasonal allergy 20.6%, eczema 12.7% and food allergy 5.3%. Categories overlap.^[10]

SYMPTOMS

Nasal congestion, sneezing, itchy eyes, rash, wheeze, gastrointestinal symptoms or anaphylaxis. Eczema can impair sleep and increase infection risk.

COMPLICATIONS

Anaphylaxis, asthma exacerbation, sleep loss, missed school or work, nutritional limitation and anxiety.

RISK AND AFFECTED GROUPS

Genetics, early-life exposures, climate and pollen, air pollution, housing conditions, occupational allergens and atopic disease. Children carry substantial eczema and food-allergy burden; asthma commonly coexists.

PREVENTION AND TREATMENT

Trigger reduction, antihistamines, nasal or topical corticosteroids, moisturizers, asthma control, allergen immunotherapy for selected patients and epinephrine for anaphylaxis. Food avoidance should be diagnosis-based to prevent unnecessary restriction.

ECONOMIC BURDEN

Costs arise from chronic medication, specialist testing, emergency care, school management and household avoidance strategies; national totals are difficult to compare with other disease categories.

Recent trend:

Climate change can lengthen pollen seasons and intensify exposure. Rising awareness and diagnosis may increase recorded prevalence independent of biologic change.

4. Disparities and the Social Distribution of Disease

Disease is not distributed randomly. Biology matters, but social position shapes exposure, diagnosis, treatment, continuity of care and survival. Race and ethnicity should not be treated as biological destiny; observed gaps reflect a mixture of structural conditions, discrimination, geography, wealth, occupation, environment, access and, in some cases, genetic susceptibility.

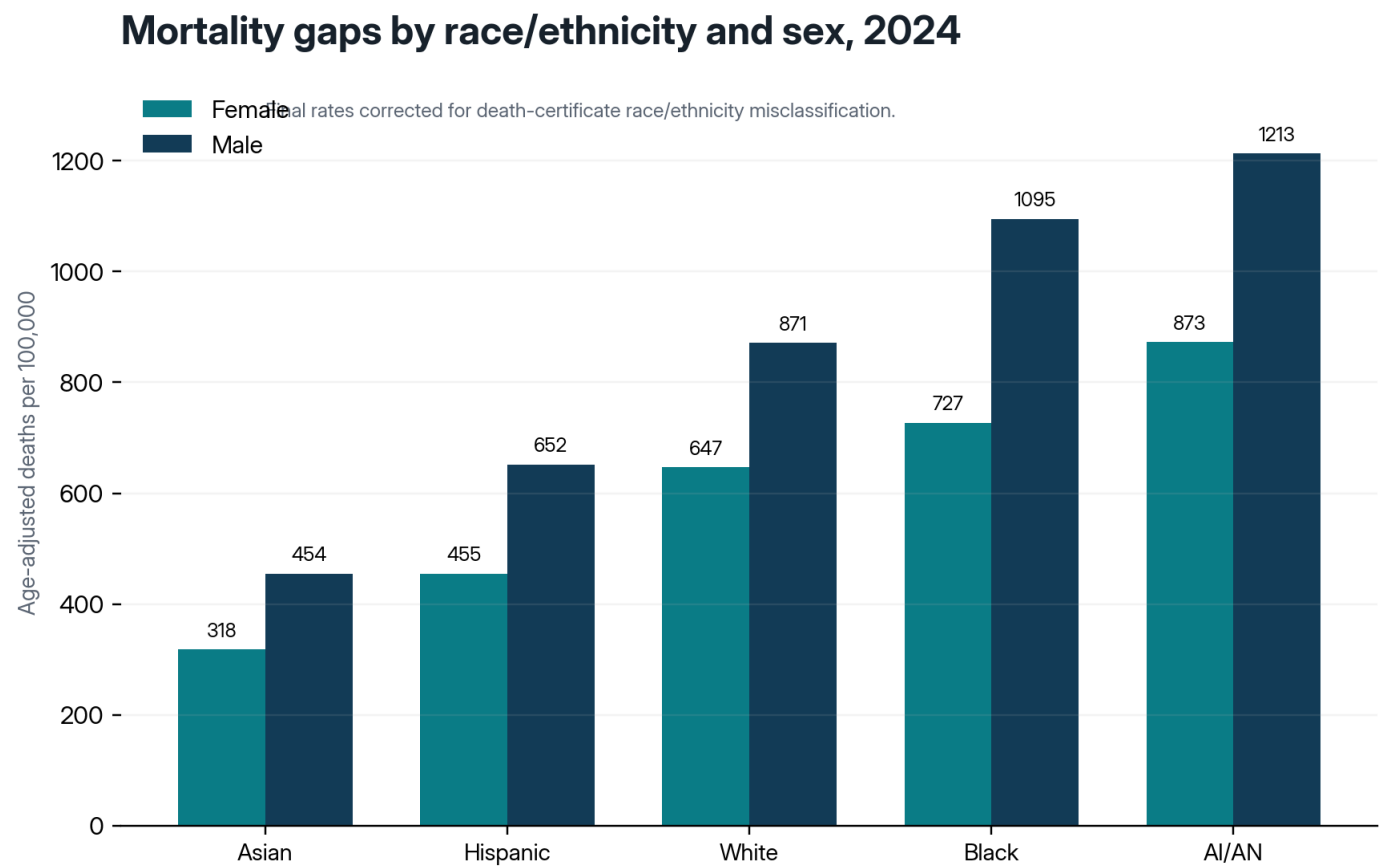


Figure 5. Final age-adjusted all-cause mortality rates, corrected for race and ethnicity misclassification. AI/AN = American Indian or Alaska Native. Categories are broad and conceal substantial within-group diversity.^[1]

4.1 Age

Age is the strongest common predictor of cancer, cardiovascular disease, COPD, CKD, arthritis and dementia. Yet several adverse trends are increasingly visible before old age: severe obesity, diabetes complications, stroke prevalence, colorectal and other selected early-onset cancers, chronic pain, mental illness and drug-related mortality. Age-specific data are essential because the aging population can increase total cases even when age-adjusted rates improve.

4.2 Sex and gender

Pattern	Men	Women	Interpretation
Overall mortality	Higher age-adjusted death rates in every major race/ethnicity group.	Longer life expectancy: 81.4 years vs. 76.5 for men in 2024.	Behavior, occupation, cardiovascular risk, violence, suicide and care-seeking all contribute. ^[1]

Pattern	Men	Women	Interpretation
Hypertension	50.8%	44.6%	Difference is concentrated before old age; women have somewhat higher awareness and treatment. ^[3]
Chronic pain	23.2%; high-impact 7.3%	25.4%; high-impact 9.6%	Biology, occupational history, caregiving, autoimmune disease and differential diagnosis may contribute. ^[7]
Mental health	Lower reported AML, higher suicide mortality.	Higher reported depression/anxiety and AML.	Reporting, help-seeking and method lethality affect the observed pattern.
Alzheimer's	About one-third of cases.	Almost two-thirds of cases.	Longer life expectancy explains much, but biological and social mechanisms are under study. ^[16]

4.3 Race and ethnicity

- **Black Americans:** higher mortality from heart disease, stroke, diabetes, kidney disease and several cancers; hypertension develops earlier and is more severe. Black men had an age-adjusted death rate of 1,094.9 per 100,000 in 2024.^[1]
- **American Indian and Alaska Native populations:** the highest 2024 corrected mortality rates in both sexes, with major burdens from diabetes, liver disease, injury, overdose and suicide. Death-certificate misclassification has historically understated AI/AN mortality by roughly one-third before adjustment.^[1]
- **Hispanic populations:** lower all-cause mortality than White populations in national vital statistics, but high diabetes and metabolic risk in many communities and substantial insurance, language and occupational barriers. National averages conceal origin-specific differences.
- **Asian populations:** the lowest broad mortality rate and lower COPD prevalence, yet aggregated data can hide elevated diabetes at lower BMI, hepatitis/liver cancer in some groups and major differences by country of origin.
- **Multiracial and smaller populations:** sample sizes often limit precise estimates, and broad categories can misrepresent identities and risk patterns.

4.4 Income, education and insurance

Lower income and education are associated with higher obesity, smoking, COPD, diabetes, uncontrolled hypertension, pain and premature mortality. Adult obesity was 44.6% among people with a high-school education or less and 31.6% among those with a bachelor's degree or more in 2021-2023.^[4] Insurance improves diagnosis and treatment but does not eliminate deductibles, medication cost, transportation, paid-leave and provider-supply barriers. Uninsured and underinsured people are more likely to delay screening and present with advanced disease, which can lower measured prevalence while increasing severity.

4.5 Geography, rurality and environment

Rural and nonmetropolitan populations have older age structures, longer travel times, fewer specialists, more hospital closures and higher burdens of COPD, chronic pain, injury, suicide and some cardiometabolic diseases. Chronic pain rose from 20.5% in large central metropolitan areas to 31.4% in nonmetropolitan areas in 2023.^[7] Regional mortality is generally higher in the South and parts of Appalachia and the Mississippi Delta. Urban residents face different risks, including air pollution, heat islands, housing crowding, violence and unequal neighborhood resources.

4.6 Occupation and disability status

Construction, agriculture, mining, manufacturing, transportation, warehousing, public safety and healthcare carry elevated combinations of injury, noise, dust/fume, heat, infectious and psychosocial exposures. Sedentary office work raises inactivity and musculoskeletal risk. People with disabilities experience higher multimorbidity and face inaccessible facilities, diagnostic overshadowing, transportation barriers and reduced preventive-service access. Occupational and disability data are fragmented across surveys, workers' compensation, employer claims and federal surveillance.

5. Health Burden Across the Life Course

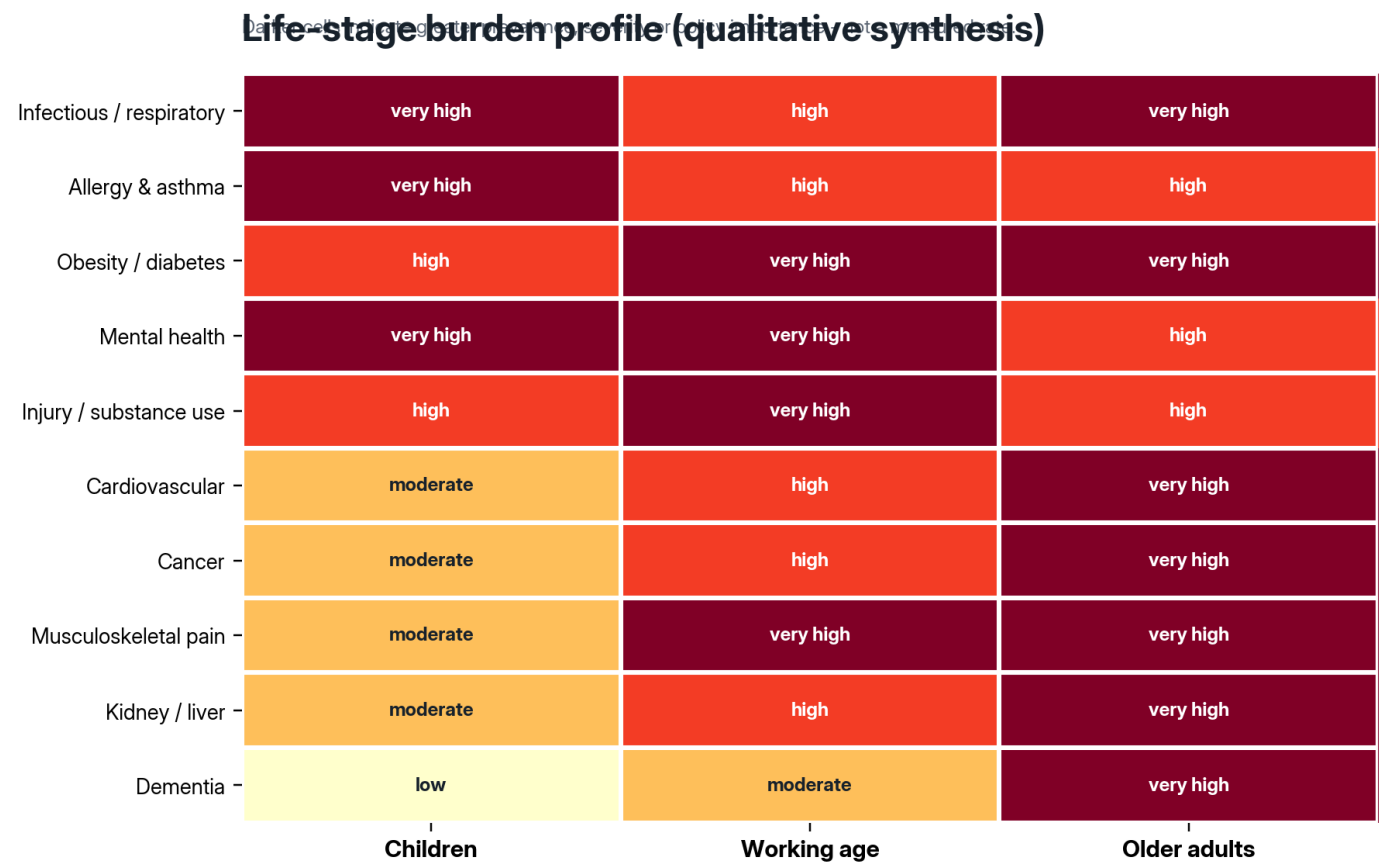


Figure 6. Qualitative synthesis of which disease families deserve the greatest attention at each life stage. The shading is editorial, not a statistical rate.

5.1 Children and adolescents

Core burden: acute respiratory infection, allergies and asthma, obesity, mental health, injury, developmental and neurobehavioral conditions.

- Allergy and asthma:** 29.5% of children had any allergy and 6.5% had current asthma in 2024.^{[10][11]}
- Obesity:** 21.1% of children ages 2-19 had obesity and 7.0% had severe obesity during 2021-2023; another 15.1% were overweight.^[35]

- **Mental health:** 20.1% of adolescents ages 12-17 had a major depressive episode in 2021, including 29.2% of girls and 11.5% of boys. Newer survey estimates use different measures, but youth distress remains a high priority.^[36]
- **Injury:** motor-vehicle injury, firearm injury, drowning, poisoning and suicide dominate mortality after infancy. Prevention depends heavily on safe environments and adult policy choices.
- **Infectious disease:** vaccination and school ventilation reduce influenza, COVID-19, pertussis, measles and other preventable outbreaks. The 2024-25 influenza season was high severity across age groups.^[23]

Highest-yield interventions: immunization, healthy school meals, physical activity, sleep, early developmental and mental-health screening, asthma action plans, safe storage of firearms and medications, traffic and drowning prevention, and access to pediatric primary and dental care.

5.2 Working-age adults

Core burden: obesity, hypertension, diabetes, depression and anxiety, substance use, chronic pain, injuries, reproductive health and early cardiovascular/cancer risk.

Working-age adults often appear healthy in mortality statistics while accumulating silent risk. Hypertension affects 23.4% of adults ages 18-39 and 52.5% at ages 40-59.^[3] Obesity is highest at ages 40-59 (46.4%).^[4] Mental illness is most prevalent among young adults, and chronic pain rises from 12.3% at ages 18-29 to 28.7% at ages 45-64.^[7] Drug overdose, suicide and motor-vehicle injury create large losses of potential life years.

Highest-yield interventions: benefit designs that make primary care and medication affordable; paid sick leave; smoking cessation; weight, blood pressure, cholesterol and diabetes screening; occupational safety; reproductive care; mental-health parity; medication treatment for substance-use disorders; and age-appropriate cancer screening.

5.3 Older Americans

Core burden: multimorbidity, cardiovascular disease, cancer, arthritis and pain, CKD, COPD, sensory loss, falls and dementia.

Among older adults, 93.0% report at least one selected chronic condition and 78.8% report at least two.^[9] Hypertension affects 71.6% of adults 60 and older.^[3] Chronic pain affects 36.0% of adults 65 and older.^[7] Alzheimer's affects about 11% of adults 65 and older and 35.8% of those 85 and older in the Association's 2026 clinical estimate.^[16]

Highest-yield interventions: medication reconciliation, fall prevention, strength and balance training, vaccination, hearing and vision care, management of blood pressure and diabetes without excessive treatment burden, caregiver support, advance-care planning and integrated geriatric care.

6. Behavioral, Environmental and Social Drivers

How disease burden accumulates

Upstream conditions shape exposure, behavior, detection, treatment and outcomes.

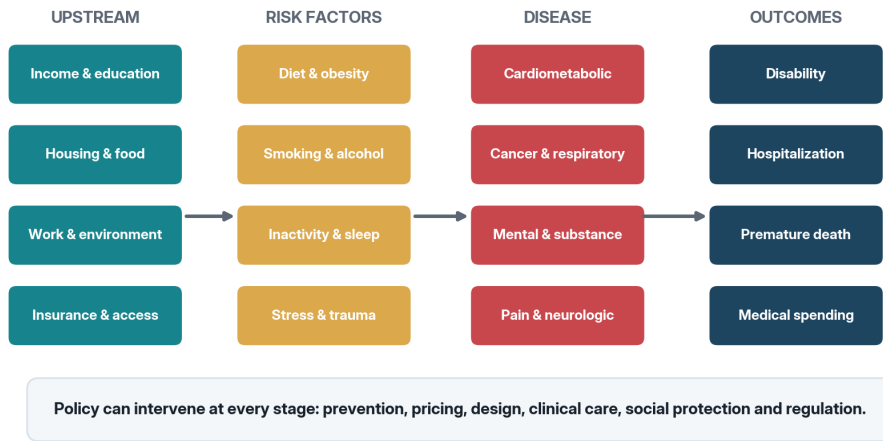


Figure 7. Disease burden is produced by interacting systems, not individual choices alone.

Driver	Major disease pathways	Current U.S. signal	Highest-yield response
Diet and obesity	Diabetes, hypertension, CVD, CKD, liver disease, osteoarthritis and cancer.	Adult obesity 40.3%; severe obesity rising. ^[4]	Healthy food procurement, beverage and marketing policy, nutrition support, treatment coverage and built environments.
Tobacco and nicotine	Cancer, COPD, CVD, stroke, pregnancy complications.	Daily smoking is lower than the OECD average, but smoking still causes nearly half a million premature deaths annually and more than 16 million Americans live with smoking-related disease. ^{[28][34]}	Taxation, smoke-free laws, cessation treatment, product regulation and youth prevention.
Alcohol and drugs	Injury, cancer, liver disease, hypertension, overdose, mental illness.	17.7% of adults reported binge drinking in 2022; overdose deaths fell sharply in 2024 but remained high. ^{[20][31]}	Screening, pricing and availability policy, medication treatment, naloxone, recovery services and safer prescribing.
Physical inactivity	Obesity, diabetes, CVD, depression, dementia, falls.	47.2% of adults met the aerobic guideline in 2024; the comparable OECD measure estimated 36% insufficient activity. ^{[28][30]}	Walkable communities, safe transit, active workplaces, school physical activity and exercise referral.
Environmental exposure	Asthma/COPD, cancer, CVD, heat illness, neurologic and reproductive effects.	U.S. average PM2.5 exposure is favorable versus the OECD mean, but local disparities, wildfire smoke, heat and occupational exposures are substantial. ^[28]	Air and water regulation, heat standards, indoor ventilation, housing remediation and worker protection.
Genetics and biology	Inherited cancer syndromes, familial hypercholesterolemia, sickle cell disease, type 1 diabetes, neurodegeneration.	Important for individual risk but explains only part of population disparities.	Family history, targeted testing, newborn screening, genetic counseling and equitable access to precision medicine.
Stress and social determinants	Mental illness, substance use, hypertension, obesity, sleep disorder, immune and inflammatory pathways.	Housing, food, debt, violence, discrimination and caregiving stress alter exposure and treatment continuity.	Income and housing security, paid leave, anti-discrimination enforcement, community safety and integrated social care.
Healthcare access	Late diagnosis and poor control across nearly all chronic disease.	93% have core service coverage, yet affordability, provider supply and avoidable admissions remain problematic. ^[28]	Continuous coverage, primary-care capacity, rural access, team-based care, lower drug costs and data-driven outreach.

Preventability is not binary. Type 1 diabetes and many cancers are not currently preventable, while much type 2 diabetes and tobacco-related disease is. Even when onset cannot be prevented, disability and death often can be reduced through vaccination, screening, early diagnosis, guideline treatment and social support.

7. United States Compared with High-Income Peers

The OECD comparison uses internationally harmonized indicators that may not match the newest national U.S. figures. For example, OECD's country note reports U.S. life expectancy of 78.4 years using the latest comparable data available across countries, while finalized U.S. data show 79.0 years in 2024. The apparent discrepancy is primarily one of timing and comparability, not contradiction.^{[1][28]}

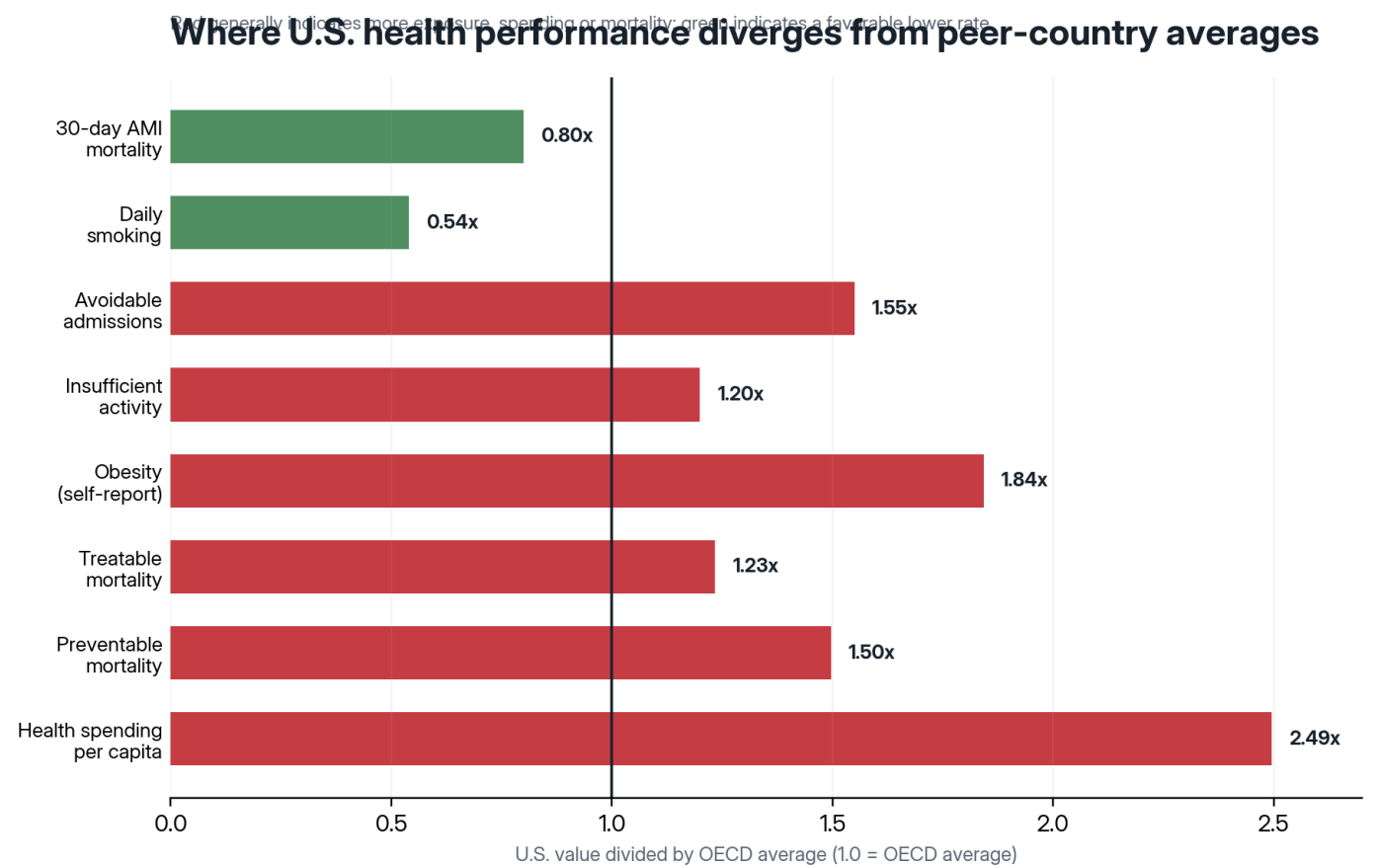


Figure 8. Ratio of U.S. to OECD-average values. Lower is favorable for mortality, obesity, inactivity, admissions and smoking; lower spending is not automatically better but the scale of the U.S. difference is economically important.

Indicator	United States	OECD average	Assessment
Life expectancy	78.4 years	81.1 years	Unfavorable: 2.7-year deficit.
Preventable mortality	217 per 100,000	145	Unfavorable: high burden from preventable causes.
Treatable mortality	95 per 100,000	77	Unfavorable: access and continuity gaps despite advanced care.
Suicide	15 per 100,000	11	Unfavorable.
Daily smoking	8.0%	14.8%	Favorable.

Indicator	United States	OECD average	Assessment
Alcohol consumption	9.5 liters per person	8.5	Unfavorable.
Insufficient physical activity	36%	30%	Unfavorable.
Self-reported obesity	35%	19%	Strongly unfavorable.
Breast cancer screening	80%	55%	Favorable.
Avoidable admissions	733 per 100,000	473	Unfavorable: weak primary-care control and access.
30-day mortality after heart attack	5.2%	6.5%	Favorable acute care.
30-day mortality after stroke	4.5%	7.7%	Favorable acute care.
Health spending per person	\$14,885 PPP	\$5,967 PPP	Extreme outlier: about 2.5 times the average.
Practicing doctors	2.7 per 1,000	3.9	Low physician supply.
Practicing nurses	12.4 per 1,000	9.2	High nursing supply.

The U.S. paradox is not uniformly poor medicine. It is excellent acute rescue capacity inside a system that often fails before and after the hospital - in prevention, primary care, affordability, continuity and social conditions.

8. Data Limitations and Interpretation

8.1 Underdiagnosis and unequal detection

Hypertension, diabetes, CKD, mental illness, COPD, cancer and dementia can be present before diagnosis. People with better insurance and access may appear to have higher prevalence because their disease is detected, while disadvantaged populations may appear healthier in records until they present with severe complications. CKD illustrates the problem: nearly nine in ten affected adults are unaware.^[6]

8.2 Different definitions produce different numbers

Hypertension prevalence changes when the threshold is 130/80 rather than 140/90. Obesity relies mainly on BMI, which does not measure body composition. COPD estimates vary between physician-diagnosed surveys and spirometry. Mental illness depends on symptom instruments and time windows. Dementia estimates differ between clinical, functional and biomarker definitions. Allergy categories overlap. "Liver disease" can mean diagnosed disease, imaging-defined steatosis, cirrhosis or an underlying cause of death.

8.3 Survey and sampling limitations

NHIS, NHANES and NSDUH are nationally representative but subject to nonresponse, recall and sampling error. Household surveys often exclude institutionalized populations, which is especially important for severe mental illness, incarceration, nursing-home dementia and disability. Small populations may have unstable estimates or be aggregated into categories that conceal heterogeneity.

8.4 Administrative data and coding

Claims reflect billing and access, not pure disease occurrence. Principal diagnoses identify the main reason for a stay, while comorbidities may be more clinically consequential. Coding changes, upcoding and payer-specific practices affect trends. National hospital data are released with lags.

8.5 Mortality attribution

Death certificates select one underlying cause although several conditions may contribute. Diabetes, obesity, CKD, dementia and substance use can therefore be underrepresented. Race and ethnicity misclassification is especially consequential for American Indian and Alaska Native populations; NCHS applied correction factors in the 2024 final report.^[1]

8.6 Modeled burden and projections

Influenza burden ranges, DALYs, 2026 cancer incidence and dementia counts are estimates or projections. They are useful when direct counts are incomplete, but uncertainty intervals and assumptions matter. This report labels them distinctly from final surveillance.

8.7 Economic cost is not one standardized measure

Some studies count only medical spending; others add lost productivity, premature mortality, informal care, criminal justice or household burden. Years differ, and health-price inflation is rapid. Cost numbers should be compared only when scope and year align.

8.8 Established evidence, estimates and interpretation

Category	Examples in this report	Confidence
ESTABLISHED / FINAL	2024 death counts; 2024 national health expenditures; final registry or administrative results.	High for the specified definition and period.
SURVEY ESTIMATE	Hypertension, obesity, pain, mental illness, allergies, asthma and COPD prevalence.	High at national level, with sampling and measurement limitations.
MODELED / PROJECTED	Influenza burden range, DALYs, 2026 cancer cases, 2026 Alzheimer's prevalence.	Useful but dependent on assumptions and uncertainty intervals.
EXPERT INTERPRETATION	Outpatient ranking, qualitative life-stage matrix, priority matrix and policy synthesis.	Reasoned synthesis; not a measured statistic.

9. Ten Priority Conditions and High-Impact Interventions

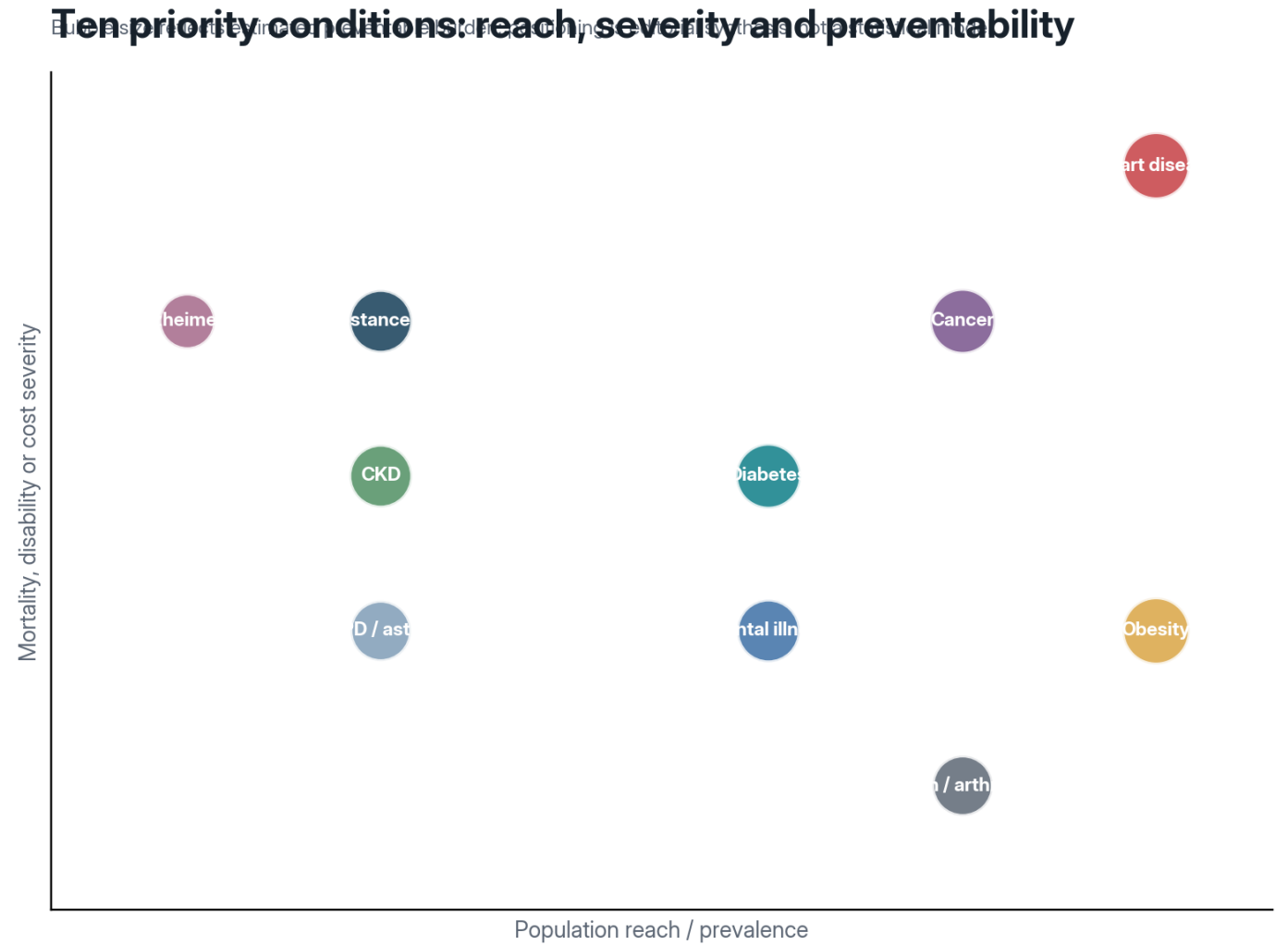


Figure 9. Editorial synthesis balancing population reach, mortality/disability/cost severity and preventable burden. Bubble size and position are not derived from a formal statistical model.

9.1 The ten most important disease and condition groups

#	Priority group	Why it belongs in the top ten	Most decisive intervention
1	Cardiovascular disease and uncontrolled hypertension	Largest cause of death; nearly half of adults have hypertension; large racial and geographic gaps.	Population-wide BP detection and control, tobacco prevention, lipid management and emergency stroke/MI systems.
2	Cancer	Second-largest cause of death, more than two million new cases projected annually, high treatment cost.	Tobacco control, vaccination, risk reduction, equitable screening and access to modern treatment.
3	Obesity	Two in five adults and one in five children; upstream driver of diabetes, CVD, cancer, CKD and disability.	Change food/activity environments and provide effective long-term obesity treatment.

#	Priority group	Why it belongs in the top ten	Most decisive intervention
4	Diabetes and prediabetes	40.1 million with diabetes and 115.2 million adults with prediabetes; \$640 billion burden.	Scale the Diabetes Prevention Program, weight treatment, early diagnosis and cardio-renal protective therapy.
5	Mental illness	Nearly one in four adults; major disability, suicide and productivity impact.	Integrate mental health into primary care, schools and workplaces with rapid access and continuity.
6	Substance-use disorders and preventable injuries	High premature mortality and social cost despite falling overdose deaths.	Medication treatment, naloxone, alcohol policy, injury prevention and safer environments.
7	Arthritis, low-back pain and chronic pain	Affects more than one in five adults and dominates years lived with disability.	Activity, weight management, occupational design, physical therapy and multimodal pain care.
8	Chronic kidney disease	About 37 million adults, severe underdiagnosis and high Medicare cost.	Screen high-risk patients and deploy BP, diabetes, SGLT2 and renin-angiotensin therapies early.
9	Chronic respiratory disease and asthma	High symptom burden, 145,643 deaths, rural and income disparities.	Tobacco cessation, clean air, vaccination, inhaled therapy and pulmonary rehabilitation.
10	Alzheimer's disease and dementia	Rapid growth with aging, major mortality, caregiving and financial burden.	Cardiovascular risk reduction, early evaluation, caregiver infrastructure and dementia-capable systems.

9.2 Fastest-growing or emerging threats

1. **Severe obesity and youth obesity:** severe adult obesity rose over the last decade, and childhood obesity is far above 1999–2000 levels.^{[4][35]}
2. **Diabetes and cardio-renal complications at younger ages:** more young and middle-aged adults are living with diabetes and complications.^[5]
3. **Dementia volume:** population aging will increase absolute cases and caregiving needs even if age-specific risk improves.^[16]
4. **Selected cancers in younger or previously lower-risk groups:** incidence is rising for several tumor types even while overall mortality declines.^[14]
5. **Metabolic liver disease:** obesity and diabetes are expanding fatty-liver and cirrhosis risk.
6. **Chronic pain and disability:** reported chronic pain increased between 2019 and 2023 and is concentrated in older, rural and disadvantaged adults.^[7]
7. **Climate-sensitive respiratory and environmental risks:** heat, wildfire smoke, ozone and longer pollen seasons threaten cardiopulmonary health.
8. **Antimicrobial resistance and infectious volatility:** influenza severity, measles outbreaks, novel pathogens and resistant bacteria require sustained preparedness even when a prior pandemic recedes.

Important countertrend: overdose deaths declined dramatically in 2024 and provisional 2025 mortality also improved. Public health should protect and extend that progress rather than describe overdose as uniformly worsening.^{[2][20]}

9.3 Most preventable sources of illness and death

- Commercial tobacco and secondhand smoke.
- Uncontrolled blood pressure, cholesterol and diabetes.

- Obesity-promoting food and physical environments.
- Harmful alcohol use and untreated substance-use disorder.
- Low vaccination and delayed treatment of infection.
- Missed evidence-based cancer screening and vaccination.
- Motor-vehicle, firearm, fall, occupational and poisoning injuries.
- Air pollution, lead, unsafe housing, heat and occupational exposure.
- Untreated depression, suicide risk and social isolation.
- Gaps in prenatal, maternal, infant and pediatric preventive care.

9.4 Priority actions by sector

Actor	Highest-priority actions
Individuals and families	Do not smoke; maintain vaccinations; know blood pressure, cholesterol and glucose; pursue sustainable weight and activity goals; use age-appropriate cancer screening; seek early mental-health and substance-use treatment; maintain sleep, hearing and dental care; learn stroke, heart attack, sepsis and overdose warning signs.
Healthcare institutions	Use team-based hypertension and diabetes control; integrate behavioral health and addiction medications into primary care and emergency departments; close screening gaps by race, language and insurance; improve sepsis, stroke and heart-attack pathways; support medication affordability; measure outcomes rather than visit volume.
Businesses and employers	Design benefits with affordable primary, mental-health and chronic-disease care; provide paid leave and flexible access; improve food and activity environments; prevent heat, injury, dust, noise and ergonomic exposure; reduce stigma; support caregivers; protect worker health data.
Communities	Build safe walking, cycling and recreation; improve food access, housing and indoor air; expand EMS, naloxone and crisis response; support violence and injury prevention; strengthen rural transport, telehealth and community health workers.
Government	Maintain insurance continuity; invest in primary care and public-health data; use tobacco, alcohol, nutrition and environmental policy; fund vaccination and preparedness; regulate unsafe products and workplaces; lower drug and care costs; align payment with prevention and outcomes; address housing, income and education as health infrastructure.

9.5 Final synthesis

America's health burden is a portfolio problem: high-prevalence cardiometabolic risks, high-mortality cardiovascular disease and cancer, high-disability pain and mental illness, high-cost acute hospital events, and deep inequities produced by access and social conditions.

The most rational national strategy is therefore layered. Prevent disease upstream; detect silent risk early; deliver evidence-based treatment reliably; reduce prices and administrative friction; protect against injury and infection; and target resources toward populations with the highest avoidable burden. No single drug, insurer, hospital or behavior can solve the problem. The measurable opportunity lies in coordinated execution across all of them.

Medical and editorial disclaimer. This report is an educational synthesis for public-health, policy, business and media analysis. It does not diagnose disease or replace professional medical advice. Statistics may be revised as agencies release new data. URLs and publication dates were verified or updated through July 2026.

References

1. Xu JQ, Murphy SL, Kochanek KD, Arias E. *Mortality in the United States, 2024*. NCHS Data Brief No. 548. National Center for Health Statistics. Published January 2026.
<https://www.cdc.gov/nchs/products/databriefs/db548.htm>
2. National Center for Health Statistics. *Provisional Mortality Data, United States, 2025*. Released July 2, 2026. Provisional figures are subject to revision.
<https://blogs.cdc.gov/nchs/2026/07/02/7934/>
3. Fryar CD, Ostchega Y, Hales CM, Zhang G, Kruszon-Moran D. *Hypertension Prevalence, Awareness, Treatment, and Control Among Adults Age 18 and Older: United States, August 2021–August 2023*. NCHS Data Brief No. 511. October 2024.
<https://www.cdc.gov/nchs/products/databriefs/db511.htm>
4. Emmerich SD, Fryar CD, Stierman B, Ogden CL. *Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023*. NCHS Data Brief No. 508. September 2024.
<https://www.cdc.gov/nchs/products/databriefs/db508.htm>
5. CDC. *National Diabetes Statistics Report / A U.S. Report Card*. Updated January–March 2026; estimates for 2023 and cost estimates for 2022.
<https://www.cdc.gov/diabetes/php/data-research/index.html>
6. CDC. *Chronic Kidney Disease in the United States*. Updated 2026.
<https://www.cdc.gov/kidney-disease/php/data-research/index.html>
7. Lucas JW, Sohi I. *Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023*. NCHS Data Brief No. 518. November 2024.
<https://www.cdc.gov/nchs/products/databriefs/db518.htm>
8. CDC. *Arthritis Prevalence Among U.S. Adults, 2019–2021, and Projections to 2040*. Preventing Chronic Disease. 2025.
https://www.cdc.gov/pcd/issues/2025/24_0393.htm
9. CDC. *Prevalence of Multiple Chronic Conditions Among U.S. Adults, 2023*. Preventing Chronic Disease. 2025.
https://www.cdc.gov/pcd/issues/2025/24_0539.htm
10. CDC/NCHS. *FastStats: Allergies*. 2024 National Health Interview Survey estimates; page updated 2025–2026.
<https://www.cdc.gov/nchs/faststats/allergies.htm>
11. CDC/NCHS. *FastStats: Asthma*. 2024 National Health Interview Survey estimates.
<https://www.cdc.gov/nchs/faststats/asthma.htm>
12. Weeks JD, Elgaddal N. *Diagnosed Chronic Obstructive Pulmonary Disease in Adults: United States, 2023*. NCHS Data Brief No. 529. April 2025.
<https://www.cdc.gov/nchs/products/databriefs/db529.htm>
13. CDC. *Heart Disease and Stroke Facts*. Updated 2024–2026; annual event estimates from AHA/CDC surveillance.
<https://www.cdc.gov/stroke/data-research/facts-stats/index.html>
14. American Cancer Society. *Cancer Facts & Figures 2026*. Published 2026.
<https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/2026-cancer-facts-figures.html>
15. CDC. *United States Cancer Statistics*. Incidence through 2023 and mortality through 2024 where available; pages updated June 2026.
<https://www.cdc.gov/cancer/data/index.html>
16. Alzheimer's Association. *2026 Alzheimer's Disease Facts and Figures*. Published April 2026.
<https://www.alz.org/alzheimers-dementia/facts-figures>
17. SAMHSA. *2024 National Survey on Drug Use and Health: Annual National Report and Companion Infographic*. Released July–August 2025.
<https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2024>
18. National Institute of Mental Health. *Mental Illness Statistics*. 2022 estimates; accessed July 2026.
<https://www.nimh.nih.gov/health/statistics/mental-illness>
19. CDC. *Suicide Data and Statistics*. Final 2024 mortality and 2024 survey estimates; updated 2025–2026.
<https://www.cdc.gov/suicide/data/index.html>
20. Spencer MR, Garnett MF, Miniño AM. *Drug Overdose Deaths in the United States, 2003–2024*. NCHS Data Brief No. 549. 2026.
<https://www.cdc.gov/nchs/products/databriefs/db549.htm>
21. CDC/NCHS. *FastStats: Chronic Liver Disease and Cirrhosis*. Updated 2025–2026.
<https://www.cdc.gov/nchs/faststats/liver-disease.htm>
22. National Institute of Diabetes and Digestive and Kidney Diseases. *Digestive Disease Statistics; Irritable Bowel Syndrome Definition and Facts*. Accessed July 2026.
<https://www.niddk.nih.gov/health-information/health-statistics/digestive-diseases>
23. CDC. *Influenza Disease Burden and 2024–25 Season Estimates*. Updated 2025–2026.
<https://www.cdc.gov/flu-burden/>
24. CDC. *Sexually Transmitted Infections Surveillance*. Final 2023 and provisional 2024 releases.
<https://www.cdc.gov/sti-statistics/annual/index.html>
25. Centers for Medicare & Medicaid Services. *National Health Expenditure Data: 2024 Fact Sheet*. Published June 24, 2026.
<https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>
26. Liang L, et al. *The Most Expensive Conditions by Payer, 2022*. HCUP Statistical Brief No. 316. Agency for Healthcare Research and Quality. 2026.
<https://hcup-us.ahrq.gov/reports/statbriefs/sb316-most-expensive-conditions-by-payer-2022.pdf>
27. McDermott KW, Roemer M. *Most Frequent Principal Diagnoses for Inpatient Stays in U.S. Hospitals, 2018*. HCUP Statistical Brief No. 277. AHRQ. July 2021.
<https://hcup-us.ahrq.gov/reports/statbriefs/sb277-Top-Reasons-Hospital-Stays-2018.pdf>
28. OECD. *Health at a Glance 2025: United States Country Note*. Published 2025.
https://www.oecd.org/en/publications/health-at-a-glance-2025_15a55280-en/united-states_3517f35e-en.html
29. CDC. *Fast Facts: Health and Economic Costs of Chronic Conditions*. Updated May 26, 2026.
<https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html>

30. CDC. *Active People, Healthy Nation: Physical Activity Data*. 2024 estimates; updated 2025-2026.
<https://www.cdc.gov/active-people-healthy-nation/php/data-research/index.html>
31. CDC PLACES. *Binge Drinking Among Adults: Measure Definition*. 2022 estimates.
<https://www.cdc.gov/places/measure-definitions/health-risk-behaviors.html>
32. Carroll MD, et al. *Total and High-density Lipoprotein Cholesterol in Adults: United States, August 2021-August 2023*. NCHS Data Brief No. 515. 2024.
<https://www.cdc.gov/nchs/products/databriefs/db515.htm>
33. Institute for Health Metrics and Evaluation. *Global Burden of Disease 2021: United States Results and State-level Burden*. Published 2024-2025.
<https://www.healthdata.org/research-analysis/health-by-location/profiles/united-states>
34. CDC. *Smoking and Tobacco Use: Health Effects and Economic Burden*. Updated 2025-2026.
<https://www.cdc.gov/tobacco/about/index.html>
35. CDC. *Child and Adolescent Obesity Prevalence: United States, August 2021-August 2023*. NCHS Health E-Stats. 2024.
<https://www.cdc.gov/nchs/data/hestat/hestat112.htm>
36. National Institute of Mental Health. *Major Depression Statistics*. 2021 estimates; accessed July 2026.
<https://www.nimh.nih.gov/health/statistics/major-depression>
37. CDC. *Prevalence of Stroke - Behavioral Risk Factor Surveillance System, 2011-2013 and 2020-2022*. MMWR. 2024.
<https://www.cdc.gov/mmwr/volumes/73/wr/mm7320a1.htm>
38. U.S. Preventive Services Task Force. *Published Recommendations*. Current recommendations accessed July 2026.
<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>
39. CDC. *Respiratory Virus Activity - United States, July 2024-June 2025*. MMWR. 2026.
<https://www.cdc.gov/mmwr/volumes/75/wr/mm7506a2.htm>
40. Agency for Healthcare Research and Quality. *Medical Expenditure Panel Survey, 2023 Medical Conditions and Office-Based Visits Files*. Released 2025.
https://meps.ahrq.gov/data_stats/download_data/pufs/h249/h249doc.shtml