Diabetes and prediabetes have risen in all communities since 2001, but not evenly—**Filipino Americans** have been hit the hardest, with **1 in 5 affected by diabetes and 1 in 3 by prediabetes.** Their diabetes rate has **nearly doubled** in two decades

Prevalence and trends of diabetes and prediabetes among 10 racial and ethnic groups in the United States, 2001 to 2022

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Background

Diabetes prevalence has been rising globally and, in the U.S., with significant **racial/ethnic disparities**. California's diverse population offers a unique opportunity to examine these disparities in detail over time.

Prior studies often aggregate Asian Americans, potentially masking important differences. **This study disaggregates 10 racial/ethnic groups** – non-Hispanic White (NHW), non-Hispanic Black (NHB), Hispanic/Latino, Chinese, Filipino, South Asian, Japanese, Korean, Vietnamese, and American Indian/Alaska Native (AIAN) – to uncover group-specific trends in diabetes and prediabetes.

Objective

This study aims to determine the 21-year trends in the prevalence of diabetes and prediabetes across 10 racial/ethnic groups in the United States
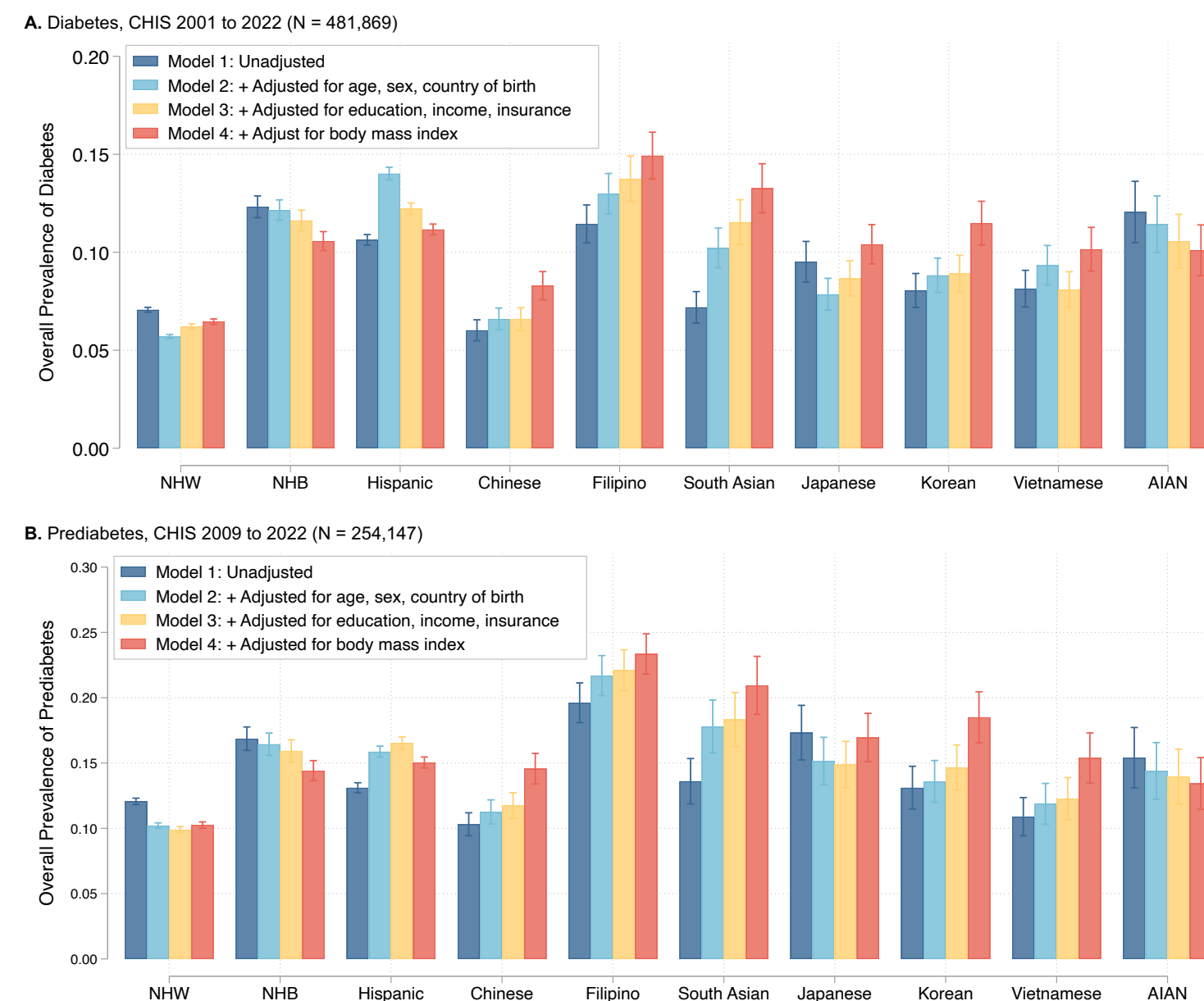
Methods / Pilot Design

Data Source: California Health Interview Survey (CHIS) 2001–2022, a statewide, population-based survey. Sample included **N=481,869 adults** for diabetes analysis and **N=254,147** for prediabetes (prediabetes data available from 2009 onward). All analyses applied sampling weights to yield representative statewide estimates.

Measures: Diabetes and prediabetes were based on self-reported physician diagnoses (ever told by a doctor that you have diabetes or prediabetes). Prediabetes was assessed in CHIS surveys starting in 2009.
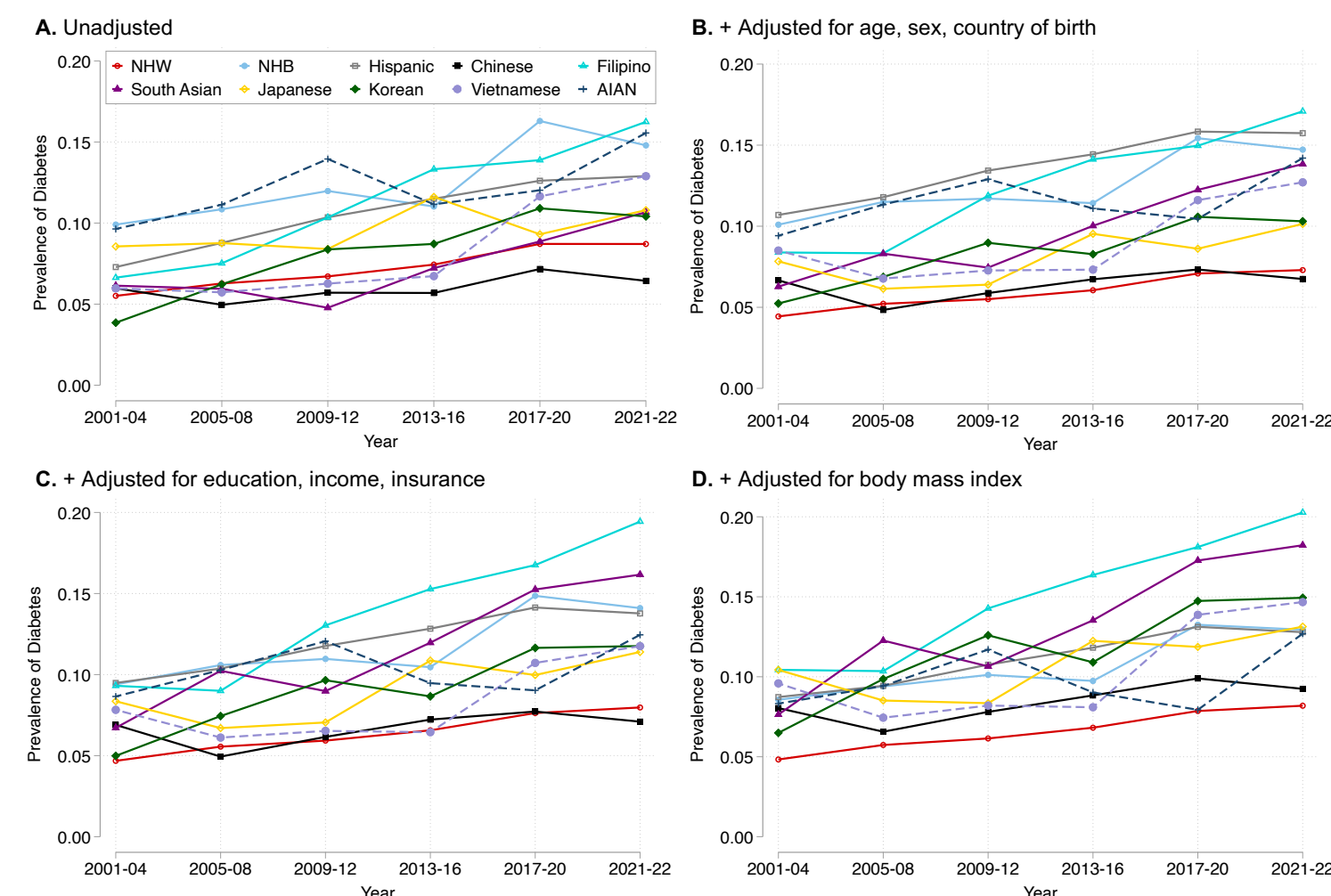
Analysis: Calculated prevalence of diabetes and prediabetes for each racial/ethnic group and for each survey period (e.g., 2001–2004 up through 2021–2022). Logistic regression models estimated **odds ratios (ORs)** of diabetes and prediabetes for each group compared to NHWs (reference), with sequential adjustment for age, sex, nativity, socioeconomic factors, health insurance, and BMI. We also examined **time trends** in prevalence by group.

Findings

Figure 1. Overall prevalence of (A) diabetes and (B) prediabetes by race and ethnicity, California Health Interview Survey (CHIS)
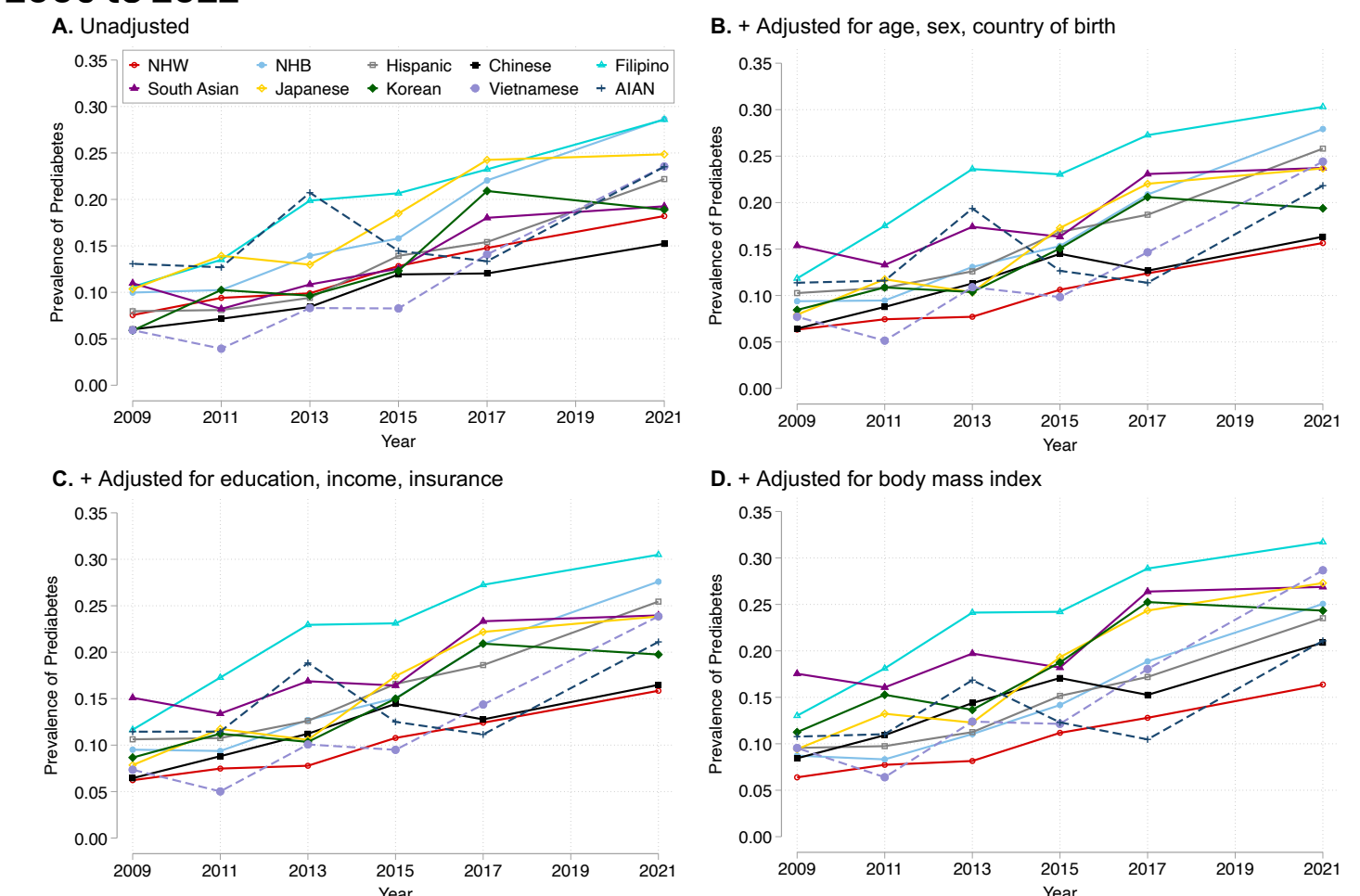

A. Diabetes, CHIS 2001 to 2022 (N = 481,869)

B. Prediabetes, CHIS 2009 to 2022 (N = 254,147)

Figure 2. The trends of prevalent diabetes by race/ethnicity from 2001 to 2022

A. Unadjusted
B. + Adjusted for age, sex, country of birth
C. + Adjusted for education, income, insurance
D. + Adjusted for body mass index

Findings

Figure 3. The trends of prevalent prediabetes by race/ethnicity from 2009 to 2022

A. Unadjusted
B. + Adjusted for age, sex, country of birth
C. + Adjusted for education, income, insurance
D. + Adjusted for body mass index

Conclusions

Overall increase: *Diabetes prevalence increased significantly from 2001 to 2022 in all racial/ethnic groups.*: among NHW adults, prevalence rose from **~9.0% in 2001–04 to approximately 12–13% in 2021–22** (Figure 2)

Wide disparities between groups: There were **large differences in diabetes prevalence by race/ethnicity: Filipino Americans had the highest diabetes prevalence** (approaching ~20% by 2021–22), while NH Blacks, Hispanics, and some other Asian subgroups also reached ~15–18%.

Filipino Americans – highest burden and rise: Filipino adults emerged as the **most impacted group**, with both the **highest overall prevalence** of diabetes and **the steepest increase over time**. Their diabetes prevalence roughly doubled over two decades (Figure 2/3), representing **the largest increase** observed among the ten groups.

Prediabetes trends: *Prediabetes prevalence has risen markedly* (and Figure 3). By 2021–22, a substantial proportion of adults in each group reported prediabetes. Mirroring diabetes patterns, **Filipino** and **Japanese** Americans also topped the list for prediabetes prevalence.

Discussion

Community health impact: A critical need for **community-tailored diabetes prevention and management programs**.

Policy and practice: Public health **policy makers should prioritize resources and screening efforts** for groups with the highest prevalence and fastest growth in diabetes.

Disaggregated data (as in this study) should become a standard in surveillance – for example, tracking Asian subgroups separately – so that high-risk populations are not overlooked.