**Prevalence and Support for ME/CFS, Fibromyalgia, and Long COVID in England**

**Prevalence in England (2023–2024)**

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| Condition | Prevalence (Latest Estimate) |
| ME/CFS (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome) | ~0.6% of the population (lifetime prevalence). A 2023 study suggests about **0.92% of women** and **0.25% of men** in England have had ME/CFS, totaling roughly **404,000** people . This is higher than the long-cited figure of ~250,000 (≈0.4%) and reflects a ~62% increase in estimated cases . |
| Fibromyalgia | Common – estimates range from **2% to 5%** of the population. The NHS notes **“nearly 1 in 20 people”** (≈5%) may be affected to some degree . This corresponds to around **1.7–2 million** adults in England & Wales . (Fibromyalgia is much more frequent in women; ~3.4% of women vs 0.5% of men .) |
| Long COVID (Post-COVID Syndrome) | Approximately **3%** of people. In early 2024, about **2 million** people in England and Scotland (3.3% of the population) self-reported Long COVID symptoms >4 weeks post-infection . Of these, ~1.5 million (75%) said daily activities were affected . Many have had symptoms for over a year . *(ONS data covers UK nations together; England alone would be the majority of this figure.)* |

**Prevalence of ME/CFS, Fibromyalgia, and Long COVID in England (2025)**

**Summary Comparison of Prevalence and Demographics**

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| **Condition** | **Prevalence (≈2025)** | **Age Groups Most Affected** | **Trend (2020–2025)** |
| **ME/CFS** (Myalgic Encephalomyelitis/Chronic Fatigue Syndrome) | **~0.6%** of population (≈404,000 people in England) . Women: ~0.9%; Men: ~0.25% . | Rare in children (~0.01% <18 years) . Prevalence rises in adulthood; **peaks in middle-age** (especially women ~50–59 years) . Female:male ratio ~4:1 overall (up to 6:1 in 40s–50s) . | **Increasing**. New research suggests ~60% higher prevalence than earlier estimates (historic ~250k vs ~400k now) , partly due to post-COVID cases. |
| **Fibromyalgia** (chronic widespread pain syndrome) | **~2–4%** of population (≈1.7–2.8 million people in the UK; majority in England) . Often cited ~2.5 million (~3% of UK in 2020) . More common in women than men. | **Most common in adults 25–55** years . Can occur in adolescents (~270k UK teens estimated) , but less frequent in youth. Generally underdiagnosed in older adults (symptoms often overlap with other conditions). | **Increasing** recognition. Prevalence was ~2% in 2011 , rising to ~3% by 2019/2020 (due to broader diagnostic criteria and awareness ). |
| **Long COVID** (post-COVID-19 condition) | **~3.3%** of population (≈1.8 million people in England as of early 2024) . UK-wide ~2.0 million in 2024 (similar ~3% prevalence) . | Affects all ages (including children), but **highest in working-age adults**. Prevalence increases with age into mid-adulthood ; surveys show peak in middle-aged groups (e.g. 35–54 years) . Slightly more common in females (but both sexes affected) . | **Surged in 2020–2022**, then **slight decline**. Peaked at ~2.1 million UK cases (~3.3%) in late 2022 . By Mar 2023 ~1.9 million (2.9%) ; by early 2024 ~1.8 million in England . |

**Sources:** Office for National Statistics (ONS) COVID-19 Infection Survey and Long COVID reports , peer-reviewed studies , and Versus Arthritis/NHS data (see citations in text below).

**ME/CFS in England**

**Prevalence in 2025**

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) is a relatively **uncommon but significant chronic illness**. Recent research in 2025 indicates a higher prevalence than previously thought. Using NHS England health records, a 2025 study estimated the *overall prevalence* of ME/CFS at roughly **0.6% of the population** . This equates to about **404,000 people in England** living with ME/CFS .

* For context, earlier figures often cited around 250,000 patients in the UK, but that was likely an underestimate . The new data (404k in England) reflects improved capture of diagnosed cases and possibly new post-viral cases after COVID-19 (discussed below).
* **Gender:** ME/CFS is much more common in women. About **0.92% of females vs 0.25% of males** in the population have had an ME/CFS diagnosis . In the NHS study, ~79% of identified cases were female . Overall, women are roughly 3–4 times more likely than men to have ME/CFS, and this gap is even larger in certain age ranges (see below).

**Age Distribution**

ME/CFS can affect all age groups, including children, but the prevalence varies markedly with age:

* **Children/Adolescents:** ME/CFS is *rare in youth*. Only about **0.01%** of those under 18 in England have an ME/CFS diagnosis . Pediatric cases do occur, but they represent a very small fraction of total cases. (Notably, some studies suggest higher rates in adolescents in other countries, but in England the diagnosed rate is extremely low .)
* **Adults:** Prevalence climbs in adulthood. ME/CFS is most commonly diagnosed in adult and middle-age groups:
  + **Middle-Aged Adults:** The highest prevalence is observed in **middle age**, though it differs by sex. Among women, ME/CFS prevalence peaks roughly in the **50–59 year** age range . In men, the peak appears later (in the 70s). One large study found the female-to-male case ratio was highest (~6:1) in the **fourth and fifth decades of life** (40s–50s) , indicating women in mid-life are particularly affected.
  + After age 60, the prevalence in women appears to decline slightly , whereas men reach their highest ME/CFS prevalence in older age (around **71–80 years** old) . This 20-year difference in peak timing might reflect historical underdiagnosis in older generations of women, or other cohort effects . In simpler terms, many women with ME/CFS are diagnosed by mid-life, whereas some men may not be diagnosed until they are seniors.
* **Implication:** The **accumulation of cases with age** (from young adulthood through middle age) means ME/CFS is primarily a condition of adults. By the 50s and 60s, a noticeable minority have ME/CFS. Few patients “recover” fully – ME/CFS tends to be long-term – so prevalence includes those who fell ill years prior and remain affected .

**Trends from 2020 to 2025**

**Prevalence Trend:** The overall prevalence of ME/CFS in England **has increased over the past several years**. Historically, epidemiological estimates in the UK and USA ranged from about **0.2% to 0.4%** of the population . The **newer estimate of ~0.6%** (404k people) in 2025 is a substantial rise. ME experts note this is about a **62% increase** over the long-standing figure of ~250k cases .

* Researchers attribute the rise partly to **better recognition/diagnosis** and partly to **new ME/CFS cases triggered by COVID-19**. Many patients with Long COVID meet ME/CFS diagnostic criteria (especially those with post-exertional malaise and long-term fatigue), effectively increasing the ME/CFS population . The ME Association in 2025 acknowledged that “the current estimate of around 250,000 people with ME/CFS is almost certainly an underestimate given … the large number of people who now have post-Covid ME/CFS,” with **true figures around 400,000** in the UK .
* **Incidence data:** Even before the pandemic, data suggested changing trends. A primary-care study (2001–2013) showed the incidence of ME/CFS diagnoses had variability but generally **increased in the late 2000s** . Now, post-2020, the influx of post-viral cases has further raised incidence.

**Public Health Impact:** Although ME/CFS affects fewer people than fibromyalgia or Long COVID, its public health burden is high relative to its prevalence. It is often severely disabling:

* **Quality of Life:** Patients with ME/CFS suffer very poor health-related quality of life and **only rarely recover** fully . A significant proportion are housebound or bedbound. Many require long-term care or support.
* **Healthcare Services:** ME/CFS has no confirmed curative treatment; management focuses on symptom relief. Historically, services for ME/CFS have been limited. (NICE issued new guidelines in 2021, and specialist clinics exist but are few.)
* **Economic Impact:** Due to its onset in mid-life and low recovery rate, ME/CFS causes long-term loss of productivity. Many patients cannot work or can only work part-time. (One U.S. survey reported ME/CFS as a leading cause of long-term illness-related disability in working-age adults .)

In summary, **ME/CFS prevalence in England ~0.5–0.6% (2025)**, mainly adults (peaking in 50s for women), with a marked increase in cases post-2020. It remains a significant *but often “invisible”* public health concern, given the chronic disability it causes in hundreds of thousands of people .

**Fibromyalgia in England**

**Prevalence in 2025**

Fibromyalgia (FMS) is a common chronic pain condition. It is **more prevalent than ME/CFS**, with estimates in the low single-digit percentages of the population. Precise prevalence varies with the criteria used, but most sources put it around **2–3% of adults**. Key points:

* According to Versus Arthritis and NHS data, **approximately 1.7 to 2.8 million people in the UK** are living with fibromyalgia . This range reflects different case definitions (the lower end using older, stricter diagnostic criteria; the higher end including newer criteria that capture more cases ). Given England’s share of the UK population (~84%), this translates to roughly **1.5–2.3 million fibromyalgia patients in England**.
* In 2019/2020, a nationwide survey of healthcare providers estimated about **2.5 million people in the UK (≈3% of the population)** had fibromyalgia . Earlier estimates around 2010 were closer to **2% of the population** . Thus, fibromyalgia is **one of the most common musculoskeletal conditions** – it is often cited as the third most frequent after back pain and osteoarthritis .
* **Gender:** Fibromyalgia is **disproportionately more common in women**. Historically, female-to-male ratios of diagnosis have been reported between 2:1 and up to 9:1 . (One 2011 estimate was 9:1 female:male , though with broader awareness the gap may be somewhat less extreme today.) Women tend to be diagnosed far more often, possibly due to both biological and social factors (men may be underdiagnosed).
* **Diagnosis:** There is no definitive lab test for fibromyalgia; it’s diagnosed based on clinical criteria (widespread pain, fatigue, sleep problems, etc., for at least 3 months). Changes in the diagnostic criteria in 2010 and 2016 broadened the definition to include cognitive symptoms (“fibro fog”), fatigue, and other somatic symptoms. This has the effect of **increasing measured prevalence** (capturing milder cases that might have been missed by earlier criteria) .

**Age Distribution**

Fibromyalgia can affect a range of ages but is most commonly a condition of adulthood, especially **young to middle-aged adults**:

* **Typical Onset:** Fibromyalgia **most often develops between ages 25 and 55** . It is frequently diagnosed in mid-life. Many patients report the onset of chronic widespread pain and fatigue in their 30s or 40s, often triggered by a stressor (infection, injury, or significant stress).
* **Working-Age Adults:** Prevalence is highest in the **middle adult years**. In general, *younger adults (20s–30s)* and *middle-aged adults (40s–50s)* have the highest rates of fibromyalgia diagnosis. This coincides with the peak years of symptoms and healthcare seeking. For example, one study noted fibromyalgia prevalence was highest in age categories below 55, with a peak around **35– Fifty** (particularly among women).
* **Older Adults:** Fibromyalgia certainly exists in older individuals (60s and beyond), but some evidence suggests it is *under*-diagnosed in older age groups. Symptoms in older patients might be attributed to other conditions (e.g. arthritis) or may lessen in severity for some. The lack of clear data on elderly prevalence makes it hard to say if rates truly drop or if diagnosis is simply less frequent. Nonetheless, fibromyalgia is *not primarily a disease of the very old* – its impact is felt most in mid-life.
* **Adolescents and Children:** Fibromyalgia is **less common in adolescents**, but it does occur. It’s estimated that around **270,000 adolescents (ages 11–18) in the UK** have fibromyalgia or fibromyalgia-like chronic pain syndrome . This suggests a prevalence in teens on the order of 1–2% (although diagnosis in that age is challenging). Juvenile-onset fibromyalgia is recognized by pediatric rheumatologists, and those affected often continue to have symptoms into adulthood. So while primarily an adult condition, **pediatric fibromyalgia** is a real, if relatively rare, entity.
* **Sex and Age:** Among *women*, fibromyalgia often hits in the 30s-50s; among *men*, those who do develop fibromyalgia might do so a bit later on average, but overall men are fewer in number. The female predominance is seen across all adult age groups (fibromyalgia is more common in women at every age).

In summary, **fibromyalgia primarily affects adults in their prime working years (25–55)** . It is one of the leading causes of chronic pain in that demographic. Youth and older age groups see fewer cases, though they are not immune.

**Trends from 2020 to 2025**

Fibromyalgia prevalence has shown an **increasing trend over the past decade**, though this may be partly due to better detection:

* **Rise in Diagnosed Cases:** Data from patient organizations and surveys indicate more people are being diagnosed with fibromyalgia now than in the past. For example, around **2011** it was estimated ~**1.8 million** Britons had fibromyalgia (~2%) . By **2019/2020**, estimates were **2.5–2.9 million** (roughly 2.5–4% depending on the source) . One educational source noted an increase from **1.5 million cases in 2016 to ~2.9 million in 2020** in the UK, reflecting growing recognition by GPs . While the exact numbers differ by source, the clear implication is an **upward trend** in diagnosed prevalence.
* **Reasons for Increase:** Several factors likely contribute:
  + *Broadening of criteria:* The revised ACR criteria (2010/2016) enabled more patients to meet the fibromyalgia definition (including those without classic tender point findings but with chronic widespread pain and fatigue). A 2015 study that applied different criteria found prevalence could more than double (e.g. from ~2% to ~5%) under the newer definitions . Thus, as clinicians adopt modern criteria, more patients are identified .
  + *Greater awareness:* Public and professional awareness of fibromyalgia has improved. There are fewer doctors now who completely dismiss fibromyalgia as “not real” (though stigma still exists). More patients who present with compatible symptoms are getting the label, where decades ago they might have been undiagnosed or misdiagnosed.
  + *Link with chronic stress and post-viral syndromes:* It’s hypothesized that the COVID-19 pandemic may indirectly lead to a rise in fibromyalgia cases as well. Some Long COVID patients develop chronic pain and may later be classified as fibromyalgia if widespread pain persists. (Fibromyalgia can be triggered by severe illness or stress – it is possible a subset of post-COVID patients fit fibromyalgia criteria, though solid data on this is still emerging.)
* **Incidence Data:** A study of UK general practice (2001–2013) showed an interesting pattern: fibromyalgia *incidence per 100,000* dipped in the mid-2000s then **rose again by the early 2010s** . Specifically, incidence fell from ~32 per 100k in 2001 to ~27 per 100k in 2007, then climbed to ~38 per 100k by 2013 . This suggests that after an initial lull, diagnoses picked up, possibly due to the 2010 criteria introduction. If this trend continued, one might expect incidence in the 2020s to be at or above those levels.

**Public Health Impact:** Fibromyalgia imposes a substantial burden, given its high prevalence:

* **Chronic Pain and Disability:** Fibromyalgia is characterized by chronic widespread pain, fatigue, and sleep disturbances. While not usually disabling to the extent of being bedbound, it **causes significant impairment**. About **1 in 10 fibromyalgia patients** may be unable to work full-time due to the condition, and many report difficulty with daily activities.
* **Mental Health Comorbidity:** The burden is amplified by mental health issues. Up to **70% of fibromyalgia patients have a lifetime history of depression** and about 60% have anxiety disorders . This overlap means fibromyalgia contributes to overall mental health burden and requires integrated care (pain management and psychological support).
* **Healthcare Utilization:** Fibromyalgia patients often are high utilizers of healthcare – frequent GP visits, referrals to rheumatology, pain clinics, etc. However, there is no single specialist managing fibromyalgia in the NHS; care can be fragmented. Lack of a clear treatment (besides exercise, cognitive behavioral therapy, and some medications for symptom relief) means patients often cycle through treatments, contributing to chronic healthcare costs.
* **Socioeconomic:** With millions affected, fibromyalgia has a wide ripple effect – lost work days, reduced productivity, and costs for disability benefits. Versus Arthritis has highlighted chronic pain (including fibromyalgia) as an “unseen, unequal, unfair” public health issue, noting that about **34% of the adult population in England has some form of chronic pain** and around **5.5 million (12%) have high-impact chronic pain** that interferes with daily life . Fibromyalgia is a major subset of this chronic pain population.

In conclusion, **fibromyalgia affects roughly 2–3% of people in England** in 2025, predominantly middle-aged women, and its recognized prevalence has been rising. Its public health burden is significant due to the sheer number of sufferers and the chronic pain and comorbidities they experience.

**Long COVID in England**

**Prevalence in 2025**

**Long COVID** (also called Post-COVID-19 Syndrome) emerged as a new chronic condition during the COVID-19 pandemic. By 2025, it has become a sizeable public health concern in England. Key prevalence data:

* As of early **2024**, an estimated **1.8 million people in England** were experiencing self-reported Long COVID symptoms that had persisted for more than 4 weeks after COVID infection . This is about **3.3% of the population** of England . (ONS data cover people in private households; the figure excludes those in hospitals or other institutions.)
* UK-wide estimates are similar in proportion. In March 2024, roughly **2.0 million people in the UK** (adults and children) had Long COVID, ~**3.3%** of the UK population . (England makes up the majority of these cases.)
* These figures include anyone with symptoms 4+ weeks post-infection, but many have much longer durations. Importantly, a large subset have had symptoms for **over a year**:
  + Of the 2 million UK long COVID sufferers in early 2024, **69% had been ill for at least one year**, and **41% for over two years** . In England alone, data from Feb 2024 showed hundreds of thousands had long COVID lasting >1 year . This underlines that a significant portion of long COVID is truly chronic.
* Long COVID prevalence at any time depends on the cumulative infections and recovery rates. By 2025, the acute pandemic waves have subsided, but a persistent core of long-haulers remains.
* **Definition:** Long COVID encompasses a range of post-COVID symptoms (fatigue, breathlessness, “brain fog,” etc.) lasting **>4 weeks**; often a cutoff of >12 weeks is used for “post-COVID syndrome” per NICE . The stats above generally consider self-reported symptoms of any duration >4 weeks.

**Age Distribution**

Long COVID can affect people of all ages who have had COVID-19, including children, but prevalence is **not uniform across age groups**:

* **Children and Teens:** Long COVID exists in children, though reported rates are lower than in adults. Estimates vary, but school-age children have the lowest prevalence of persistent symptoms. For example, one ONS release found around 1–2% of children had ongoing symptoms at any given time (much lower than adults). Young people often have milder acute COVID, which might translate to fewer long COVID cases, though some do suffer prolonged effects.
* **Young Adults:** Prevalence begins to rise in the 20s. However, some data (e.g., from the NHS GP Patient Survey 2023) suggest the **lowest odds of long COVID were in the youngest adults (under 25)** . This survey found those aged 16–25 had significantly lower rates of long COVID compared to older groups. Thus, late teens and 20-somethings have long COVID, but less so than older adults.
* **Middle-Aged Adults:** Long COVID **is most prevalent in middle age**. The ONS and other studies have consistently found that working-age adults – roughly **35 to 69 years** – report the highest rates of long COVID symptoms . In a 2023 NHS survey, the odds of having long COVID were highest in the **35–54** age group (even after adjusting for other factors) . This likely reflects both higher exposure/infection rates in working adults and possibly a greater susceptibility to long-term effects compared to younger people.
* **Older Adults (70+):** Interestingly, some UK data show a slight decline in long COVID prevalence in the oldest age groups. By pure biology, one might expect the elderly (who had the highest risk from acute COVID) to also have high long COVID rates. However, factors like survivor bias (some older COVID patients did not survive to experience long COVID) and less likelihood to self-identify symptoms as “long COVID” may play a role. That said, people in their 60s and early 70s do have substantial long COVID prevalence – just possibly a bit lower than middle-aged adults. Socioeconomic factors also interplay (younger retirees may not notice work-related impairments, etc.).
* **Gender:** Long COVID shows a **slight female predominance**. Surveys find women are somewhat more likely to report lingering symptoms (for example, 53–55% of long COVID cases are female) . This could be due to women’s immune responses, higher likelihood to seek help/report symptoms, or other factors. The difference is not as large as in ME/CFS or fibromyalgia, but it’s consistently observed that **females have a higher long COVID prevalence than males** .
* **Other Demographics:** (Beyond age) It’s worth noting long COVID prevalence is higher in certain groups: those with underlying health conditions, those in deprived areas, and some ethnic minority groups have reported higher rates . For instance, the GP Patient Survey found higher odds in deprived communities and among White Gypsy/Irish Traveller and mixed ethnicity individuals . But these are social determinants rather than age-related.

In summary, **long COVID in England primarily affects adults in mid-life**, though older adults and a segment of younger people are also impacted. Prevalence climbs from children (lowest) up through 30s/40s (highest), with a possible slight taper in the very old.

**Trends from 2020 to 2025**

Long COVID did not exist prior to 2020, and its trend is directly tied to the pandemic’s course. Over 2020–2025, the trend can be characterized as a **rapid rise and then a gradual fall/stabilization**:

* **Emergence and Rise (2020–2022):** During 2020, after the first COVID-19 wave, a small percentage of those infected did not fully recover in the expected time. Through late 2020 and early 2021, as more people were infected (especially during the Alpha and Delta waves), the number of long COVID cases climbed. By **late 2021**, with repeated waves, cumulative long COVID counts grew substantially. The highest absolute number of long COVID cases was reached around **summer–autumn 2022**, following the large Omicron wave of early 2022.

ONS data illustrate this peak: As of **1 October 2022**, about **2.1 million people in the UK** (3.3% of the population) were experiencing Long COVID . This was the highest recorded at that time. In England specifically, that corresponded to roughly ~1.8 million people (ONS did report ~1.8m of that UK total had first had COVID at least 12 weeks prior) .

* **Plateau and Decline (2023–2024):** After late 2022, the prevalence began to **slightly decline**. This is likely due to a combination of factors: fewer new infections (thanks to vaccines and lower virus circulation), some long COVID sufferers recovering over time, and possibly excess mortality (sadly, some of the most ill did not survive or older patients passed away from other causes). By **March 2023**, ONS estimated **1.9 million UK residents** had long COVID (down from 2.1m) . In percentage terms, that was about 2.9% of the population in March 2023, down from 3.3%.

The downward trend continued modestly into 2024. The **Winter 2023/24 ONS infection survey** reported about **1.8 million people in England (3.3%)** with long COVID in Feb–Mar 2024 . This suggests that long COVID numbers remained significant but were no longer rising; they were either plateaued or gradually decreasing. Notably, the UKHSA/ONS stopped continuous monthly surveillance in 2023, so data points are from periodic studies. No evidence suggests a resurgence in long COVID prevalence up to 2025; rather, it’s either holding steady or slowly resolving in aggregate.

* By mid-2025, many of the earlier cohorts of long COVID patients are ~2–3 years into illness. Some have recovered, while others have become chronic cases. The exact current number isn’t known without new surveys, but experts believe long COVID will continue to *persist* as a chronic issue for a subset of people, even as overall prevalence falls from the 2022 peak.

**Public Health Impact:** Long COVID has introduced a *new chronic illness* affecting millions, with significant health and economic consequences:

* **Symptom Burden:** Long COVID ranges from mild to disabling. Common symptoms include profound fatigue, cognitive impairment (“brain fog”), shortness of breath, chest pain, autonomic dysfunction, etc. ONS data from Oct 2022 showed **73% of long COVID sufferers had their daily activities adversely affected** (i.e., some functional impairment) . About **20%** reported their ability to carry out day-to-day activities was limited “**a lot**” (meaning severe debilitation) . Fatigue is the most prevalent symptom (reported by ~70% of long COVID patients) , followed by difficulty concentrating (brain fog, ~45%), and breathlessness (~42%) . This symptom burden is very similar to ME/CFS (indeed, a proportion likely meet ME/CFS criteria).
* **Duration and Healthcare Needs:** With around 40% ill for over 2 years , long COVID often behaves like a long-term condition. The healthcare system had to rapidly adapt – specialized **Long COVID clinics** were established. As of April 2024, NHS England had set up **90+ adult long COVID clinics** (plus ~10 pediatric hubs) across the country . These clinics provide multidisciplinary rehab, though there is no proven cure yet. The UK government allocated over **£300 million** for long COVID care and support by 2024 .
* **Employment and Economy:** Long COVID has significantly impacted the workforce. Many people of working age have reduced work capacity or have left employment due to ongoing symptoms. An analysis found that working-aged individuals with long COVID were **less likely to be in employment** compared to similar individuals without long COVID . Estimates suggest long COVID may be contributing to labor shortages and increased economic inactivity. One parliamentary report attributed **8–12% of the increase in work absenteeism/inactivity in 2021–22 to long COVID** (this was cited in a 2025 status report) . The overall economic cost includes lost productivity, increased healthcare expenditure, and need for social support for those unable to work.
* **Comparison with ME/CFS and Fibromyalgia:** In terms of sheer numbers, at its peak, long COVID (2 million+ UK) outnumbered ME/CFS (~0.4 million) by a wide margin and was of similar order as fibromyalgia (~2+ million). However, long COVID cases may decline over time (as some recover), whereas ME/CFS and fibromyalgia tend to be lifelong once established. All three conditions can cause severe fatigue and pain, but long COVID is unique in often involving organ-specific complications (lung, heart, etc.) in some patients. Long COVID also affected men and minorities in greater proportions than the other two conditions (which are more concentrated in women and white populations for ME/CFS) , meaning its burden is spread across different demographics, including some that historically haven’t engaged as much with chronic fatigue/pain services.

By 2025, **Long COVID remains a major public health issue in England**, though the worst wave of new cases seems to have passed. It highlights the long-tail of a viral pandemic – adding to the chronic disease burden with over a million sufferers who require medical follow-up, rehabilitation, and support.

**Comparative Public Health Burden**

All three conditions – ME/CFS, fibromyalgia, and long COVID – are chronic, often invisible illnesses that impose a significant public health burden. Below we highlight key similarities and differences:

* **Prevalence:** Fibromyalgia and long COVID each affect on the order of *millions* of people in the UK, whereas ME/CFS affects *hundreds of thousands*. Long COVID had the highest recorded prevalence (~3.3% of the population in late 2022) , closely followed by fibromyalgia (~2–3% and potentially higher if broad criteria are used) . ME/CFS is less common (~0.2–0.6%) but still significant. In England, an estimated ~**2 million have fibromyalgia**, **1.8 million have long COVID** (at present), and **0.4 million have ME/CFS** (though some overlap exists, e.g. people can have post-COVID ME/CFS).
* **Age Profile:** **Fibromyalgia** and **ME/CFS** are both primarily illnesses of **adulthood**, especially middle age (with fibromyalgia skewing a bit younger 30s–50s, and ME/CFS patients often 40s–60s). **Long COVID** has affected a somewhat broader age range including many middle-aged adults as well as a notable number of younger adults and some children; however, its highest prevalence is also in the middle-aged demographic . None of these conditions is common in young children, though teens can develop all three. Older adults (70+) are underrepresented in fibromyalgia and ME/CFS counts (possibly underdiagnosis or lower incidence), whereas long COVID does impact many older adults but may be partially offset by survivor effects.
* **Sex Differences:** **ME/CFS and fibromyalgia are strikingly gender-skewed**, with far more **women** than men affected . Long COVID shows a female majority too, but it’s more subtle (perhaps ~60% female, 40% male). This means the **public health burden of ME/CFS and fibromyalgia falls disproportionately on women**, aligning with broader patterns in autoimmune and pain conditions. Long COVID’s burden, while still slightly higher in women, has also significantly impacted men – many of whom were in front-line jobs or had risk factors during the pandemic.
* **Symptoms and Disability:** All three conditions can cause profound fatigue and pain, but with some differences:
  + **ME/CFS** is defined by *post-exertional malaise* – even minor physical or mental exertion can cause a severe relapse of exhaustion and flu-like symptoms. It often leads to severe disability; an estimated 25% of ME/CFS patients are housebound or bedbound at some point. Many have to drastically reduce activities to manage energy. **Long-term disability rates are high**, and only ~5% achieve full remission .
  + **Fibromyalgia** is defined largely by *chronic widespread pain*, along with fatigue, unrefreshing sleep, and cognitive fog. The pain can be debilitating, though fibromyalgia patients might maintain some level of activity with difficulty. While fibromyalgia can be disabling, a good number of patients are able to continue working (with accommodations), but their quality of life is significantly reduced. Depression and anxiety are part of the burden – as noted, up to 70% have depression at some stage . Fibromyalgia does not damage organs or tissues, but the suffering is very real and often lasts for years or decades (it is considered a lifelong condition, though symptoms can wax and wane).
  + **Long COVID** is a multi-system condition – its burden includes fatigue and pain (often similar to ME/CFS or fibromyalgia symptoms) *and* organ-specific issues (e.g., lung damage, cardiovascular issues, dysautonomia, etc. in some cases). About **19% of long COVID patients have significant limitation (“a lot” of activity limitation) in daily life** , which is a severe impact, and around 73% have at least some limitation . On the flip side, a portion of long COVID patients (~27%) report little impact on daily activities – meaning there is a spectrum from mild to severe. The existence of milder cases (who recover in <1 year) means not every long COVID case adds to long-term burden – many do eventually recover. However, those with long-lasting illness often resemble ME/CFS in their level of disability (some now meet the definition of ME/CFS). Long COVID also contributes to organ disease burden (e.g., increased risk of diabetes, blood clots, etc., seen in studies) which can strain healthcare systems beyond the scope of typical ME/CFS or fibromyalgia care.
* **Healthcare System Response:** Public health and healthcare services have had to respond differently:
  + **ME/CFS** historically received little support. Only a handful of specialist clinics existed and patients often felt ignored. There is still no biomedical test or approved drug specifically for ME/CFS. Guidelines emphasize pacing and symptom management. The burden largely fell on patients/families outside the healthcare system.
  + **Fibromyalgia** care has been mainly in primary care and pain clinics. While prevalent, it often doesn’t get a coordinated national strategy. Patients bounce between GPs, rheumatologists (who rule out lupus/RA, then diagnose fibromyalgia), and pain specialists. Treatment is symptom-based (pain relievers, antidepressants, exercise therapy, etc.). The public health burden of fibromyalgia (in terms of sheer numbers in pain) is huge, but it has been somewhat neglected in policy – treated as a medical issue to manage case-by-case rather than a concerted public health priority.
  + **Long COVID** prompted a more immediate public health reaction because of its sudden emergence and scale. The NHS stood up specialized **Long COVID clinics** within 2020–2021, and government funding was allocated for research and care . This is unprecedented compared to how ME/CFS was handled, for example. Long COVID forced recognition that post-viral conditions can no longer be ignored. Nonetheless, many long COVID patients still report difficulty accessing care, and clinics have waiting lists. As time goes on, if long COVID cases decline, sustaining these services will be a challenge – but the knowledge gained may benefit those with ME/CFS and fibromyalgia as well.
* **Overlap and Distinctiveness:** There is considerable overlap among the conditions: symptoms like fatigue, pain, and cognitive impairment occur in all three. In fact, some researchers consider long COVID with primarily fatigue/pain symptoms to be very similar to ME/CFS . Fibromyalgia co-occurs in some patients (for example, a person with ME/CFS or long COVID might also meet fibromyalgia criteria if widespread pain is prominent). However, from a public health perspective:
  + **ME/CFS** is often triggered by infections (including EBV, and now possibly COVID-19 in some cases) – it represents a long-term outcome in a subset of people after various triggers. It has remained relatively stable in prevalence except for the recent bump.
  + **Fibromyalgia** can be seen as part of the broader chronic pain epidemic – associated with stress, trauma, and conditions like arthritis (some fibromyalgia patients also have rheumatoid or osteoarthritis). It was already a growing issue pre-pandemic.
  + **Long COVID** is directly tied to the COVID-19 pandemic – a novel post-viral syndrome on an epidemic scale. Its future prevalence will depend on virus circulation and how many existing sufferers recover or develop permanent syndromes.

In terms of **public health burden** comparisons:

* **Fibromyalgia** likely has the highest *current* number of people affected (if we consider possibly up to ~3 million in the UK with some degree of fibromyalgia). Its burden is chronic pain and reduced quality of life spread across a large population, with associated healthcare costs in pain management and mental health.
* **Long COVID** had about **2 million sufferers at peak**, with many severely affected, causing a noticeable blip in national disability and economic stats in 2021–2023 . It placed new demands on health services (creation of clinics, rehab programs) in a short time. Over time, if prevalence continues to fall, its burden may ease, but many individuals will likely remain chronically ill (some effectively joining the ME/CFS or fibromyalgia populations in terms of needs).
* **ME/CFS** has a smaller population (~0.4 million in England) but a very high per-person burden. Many of these patients are among the most debilitated (comparable to late-stage kidney failure or COPD in terms of quality of life scores). ME/CFS historically received the least support, so the burden fell on patients (with significant unmet needs in medical care, social support, and research funding).

A **summary** in qualitative terms:

* **Prevalence:** Fibromyalgia ≈ Long COVID (in the low millions) > ME/CFS (hundreds of thousands).
* **Trend:** Fibromyalgia – gradual increase; ME/CFS – relatively stable until a post-COVID uptick; Long COVID – spike and now decreasing.
* **Demographics:** All are more common in mid-life and females, though long COVID impacts men and a broader age range more than the others.
* **Chronic burden:** All three cause chronic suffering. Long COVID and ME/CFS can cause *profound* disability; fibromyalgia causes chronic pain/discomfort that can be severe but often managed at some functional level.
* **Public health response:** Long COVID got rapid attention due to the pandemic; ME/CFS and fibromyalgia have been long-standing but under-recognized issues – though now there is hope that lessons from long COVID (e.g., in pacing, rehabilitation, research into post-viral mechanisms) might benefit these conditions too.

**References**

* Office for National Statistics (ONS) – **COVID-19 Infection Survey (Long COVID)** results and Parliamentary reports summarizing them. For example, as of Feb–Mar 2024 about 1.8 million people (3.3%) in England had self-reported long COVID symptoms , with a breakdown by duration (69% over 1 year) and considerable impact on daily life . Long COVID prevalence peaked around Oct 2022 at ~2.1 million UK (3.3%) and was ~1.9 million (2.9%) by March 2023 – indicating a slight decline.
* **House of Commons Library & Lords Library Briefings** – Provided detailed summaries: e.g., **HoC Library (Oct 2024)** noted 1.9 million UK long COVID cases in March 2023 and that prevalence *increases with age and is slightly higher in women* . **Lords Library (Nov 2022)** confirms the Oct 2022 peak and that 73% of long COVID patients had activity limitation (with fatigue, difficulty concentrating, etc. being common) .
* **Peer-Reviewed Research on ME/CFS:** A 2025 study in *BMC Public Health* analyzed NHS England data for ME/CFS diagnoses. It found ~100,000 diagnosed cases since 1989 and estimated *lifetime prevalence* up to 0.92% of females and 0.25% of males – roughly **404,000 individuals (0.6% of the population)** . It highlighted diagnostic disparities: older females and ethnic minorities are underdiagnosed . It also noted very low pediatric prevalence (0.010%) and the gender ratio peaking at 6:1 in mid-life . Another study (Collin et al. 2017) documented incidence trends in ME/CFS and fibromyalgia, showing changing patterns over 2001–2013.
* **The Guardian (Apr 2025)** – Reported on the new ME/CFS prevalence research. Headline: *“Over 150,000 more people in England have ME than previously thought”* . It reiterates the findings: **0.92% of women and 0.25% of men in England** (≈404k people) may have ME/CFS , versus the old ~250k figure. It also mentions **post-COVID ME/CFS** as a contributor and highlights disparities (diagnosis “postcode lottery”) .
* **Versus Arthritis & NHS Data on Fibromyalgia:** Versus Arthritis’ *State of Musculoskeletal Health 2024* and patient info booklets provide prevalence ranges. Fibromyalgia is estimated to affect **1.7–2.8 million in the UK** and “most commonly presents between ages 25–55” , with a note that it’s more common in women . An earlier fibromyalgia report (Fibromyalgia Action UK, 2011) said ~2% of the population (with a 9:1 female ratio) , while a 2019/20 survey suggested ~2.5 million people (~3%) . These sources also discuss comorbidities: e.g., up to 70% depression in fibromyalgia .
* **Herbal Reality (Integrative medicine site)** – Summarized fibromyalgia prevalence and healthcare surveys. Noted fibromyalgia is the third most common musculoskeletal disorder and highlighted the jump from ~2% (2011) to ~3% (2020) of the UK population . It also pointed out that 3 out of 10 GPs surveyed did *not* diagnose fibromyalgia, citing uncertainty or skepticism – illustrating some of the historical under-recognition.
* **NHS and Government Reports:** NHS England data on long COVID clinics and funding (e.g., £314 million invested in long COVID care by 2024) ; Quality and Outcomes Framework (QOF) data in primary care (not directly cited above but QOF 2018 recorded fibromyalgia under “chronic pain” in some cases); and the DWP/ONS data on work impact of long COVID (some was mentioned in Parliament written answers).
* **Academic Studies on Long COVID:** For example, *Health Expectations* (Woodrow et al. 2025) used the GP Patient Survey of England – found **4.8% prevalence of long COVID in 2023** and **9.1% unsure if they have it**, with highest odds in 35–54 and among females, deprived groups, etc . This underscores that official ONS figures (based on self-report and a specific definition) might even be conservative – some people aren’t sure they have long COVID despite symptoms.

Each of these sources reinforces the quantitative picture presented: **ME/CFS ~0.6%** (rising due to COVID); **Fibromyalgia ~2–3%** (gradually rising with new criteria); **Long COVID ~3%** in 2024 (peaked at >3% in 2022, then slightly declining) – and provides context on age and impact. The public health burden, while difficult to compare directly, is significant for all three, and ongoing monitoring and support are needed.