

THE STATE OF ARTHRITIS IN CANADA

REPORT CARD
2026



TABLE OF CONTENTS

Executive summary	3
Methodology	5
Findings – provincial and territorial ranking – overall grades	8
Overall key findings	9
2026 Access to care and treatment category results	10
Explaining the access category indicators	13
2026 Wellness category results	16
Explaining the wellness category indicators	19
2026 Research and innovation category	21
Call to action and recommended next steps	23
Appendix	25

EXECUTIVE SUMMARY

Arthritis is Canada's hidden health crisis, demanding more attention and more investment.

As this country's most common chronic disease, arthritis affects more than six million people — **more than those living with diabetes, heart disease, cancer, stroke, and dementia combined**. It strikes children, working-age adults, and seniors, and disproportionately impacts women and Indigenous communities. Arthritis has profound physical, mental, social, and financial consequences for individuals and families, exacting an estimated **\$45.9 billion toll on Canada's economy each year** through healthcare costs and impacts on the workforce.

This 2026 report, The State of Arthritis in Canada, is the second pan-Canadian assessment of how well health systems are responding to this growing burden. Our 2023 Report Card identified serious gaps in access to care and treatment, wellness outcomes, and commitment to research and innovation. **This latest evaluation shows many of the same challenges persist. Our health systems continue to fail those with arthritis.**

The findings are clear and concerning.

Wait times for joint replacement surgeries and specialist appointments continue to be too long. Concern remains about health workforce capacity and significant gaps in access to community-based arthritis programs. In addition, key health data — such as wait times to see a rheumatologist and time to diagnosis — are still not collected or publicly reported. This lack of data limits transparency, undermines accountability, and impedes evidence-informed decision-making.

Despite arthritis being the leading cause of disability in Canada, arthritis research funding has not kept pace with the scale, complexity, or growing prevalence of the disease. **While overall health research funding has grown, arthritis-specific investment has declined, representing less than 2% of investments awarded through Canada's largest federal health research funder.** This widening investment gap slows innovation, limits the development of improved treatments and care models, and delays progress toward prevention and cures.

EXECUTIVE SUMMARY CONT'D

In response to these findings, we are releasing **Arthritis Action Now: The Plan to End Arthritis in Canada**, which establishes a national strategy to prevent, better treat, and ultimately cure arthritis. Developed by an unprecedented alliance of 21 organizations, the Plan outlines the policy reforms and research investments required to reverse current trends.

Incremental change is not enough. **Three priorities require immediate action: improve access to arthritis care, strengthen health data systems, and increase sustained investment in arthritis research.**

Governments and decision-makers at all levels must invest in coordinated solutions. *Arthritis Action Now: The Plan to End Arthritis in Canada* provides a clear roadmap to strengthen access to care, accelerate research breakthroughs, and reduce the human and economic burden of arthritis. Decisive leadership and ongoing commitment are required to deliver lasting change for the millions of people in Canada with arthritis.



A handwritten signature in blue ink that reads "Trish Barbato".

Trish Barbato
President & CEO

About Arthritis Society Canada

Arthritis Society Canada represents more than six million people in Canada living with arthritis today, and the millions more who are impacted or at risk. Fueled by the trust and support of our donors and volunteers, Arthritis Society Canada is fighting arthritis with research, advocacy, innovation, information and support. We are Canada's largest charitable funder of cutting-edge arthritis research. We will not give up our efforts until everyone is free from the agony of arthritis. Arthritis Society Canada is accredited under Imagine Canada's Standards Program. For more information, visit arthritis.ca.

METHODOLOGY

This evaluation provides a broad picture of the state of arthritis in Canada by analyzing publicly available data to assess how provinces and territories address this significant health condition. The first Report Card released in 2023 included 12 indicators that were grouped under three broad categories: Access to Care and Treatment (6 indicators); Wellness (4 indicators); and Research and Innovation (2 indicators).

For this Report Card, a review of the 2023 indicators was conducted, including a search for updated data. After reviewing and consulting with an expert working group, changes were made to the indicators for this edition. For the 2026 Report Card there are now 11 indicators:

- Access to Care and Treatment (7 indicators)
- Wellness (4 indicators)

Based on the lack of availability data, a decision was made to not include indicators in the Research and Innovation category; instead, a commentary on the current state of arthritis research in Canada is provided. Also not included is the Arthritis Impact on Physical Activity Level indicator as updated information was not available at the time of producing this Report Card. Two new indicators were added, Community-Based Arthritis Care in the Access to Care and Treatment category and People with Arthritis-related Disability who Receive Sufficient Help from Allied Health Care Services in the Wellness category.

Jurisdictions were graded on a points system based on their performance on each of the 11 indicators, which were weighted based on their importance and relevance. Provinces and territories were graded out of a total of 100 points based on the 11 indicators with each indicator worth a maximum of 10 points. Category 1: Access to Care and Treatment is weighted the heaviest at 70 points and Category 2: Wellness at 30 points. Individual scoring scales were developed for each indicator, and these are available upon request.

It is important to note that in many cases, data for indicators for the territories were not available. This meant that for territories some indicators could not be scored, and the overall scores were adjusted so jurisdictions could be compared on the same scale.

We recognize that new data and improved data sources emerge regularly. Therefore, it is important to clarify that our analyses are based on the data that were available up to December 31, 2025.

METHODOLOGY CONT'D

Category 1: Access to Care and Treatment

70 raw points total; 70 weighted points overall

Indicator

Main data source

Availability of medications

Arthritis Consumer Experts
Arthritis Medications Report Card, 2025 ¹

Wait times for joint replacements

Canadian Institute for Health Information.
Joint Replacement Wait Times ²

Wait times to see an orthopaedic surgeon

Fraser Institute - Waiting Your Turn: Wait Times for Health Care in Canada, 2025 Report ³

Number of rheumatologists in the workforce

College of the North Atlantic student project/
provincial Rheumatology Associations ⁴

Number of orthopaedic surgeons in the workforce

Canadian Orthopaedic Association ⁵

Number of individuals without a regular primary care provider

Canadian Community Health Survey, 2022
Canadian Community Health Survey, 2024/
ACREU ⁶

Access to community-based arthritis programs

2024 GLA:D Annual Report/
Jurisdictional scan ^{7,8}

¹ Arthritis Consumer Experts. (2025). *ACE Arthritis Medications Report Card*. Accessed on December 12, 2025: <https://www.jointhehealth.org/programs-jhreportcard.cfm?locale=en-CA>

² Canadian Institute for Health Information. *Joint Replacement Wait Times*. Assessed December 11, 2025.

³ Mackenzie Moir and Nadeem Esmail. *Waiting Your Turn, Wait Times for Health Care in Canada, 2025 Report*. Fraser Institute. Accessed on December 11, 2025: <https://www.fraserinstitute.org/sites/default/files/2025-12/waiting-your-turn-2025-17913.pdf>

⁴ College of the North Atlantic 2025 student project (available upon request)

⁵ Canadian Orthopaedic Association. (2025). *2025 COA graduate snapshot*. Accessed on February 25, 2026: <https://coa-aco.org/wp-content/uploads/2025/11/2025-COA-Graduate-Snapshot-5.pdf>

⁶ Statistics Canada. (2022). *Canadian Community Health Survey – Annual Component (CCHS)*. Accessed on January 26, 2026: <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&Id=1383236>
Statistics Canada. (2024). *Canadian Community Health Survey – Annual Component (CCHS)*. Accessed on January 26, 2026: <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&Id=1531795>

Territorial data used for these indicators are based on the Canadian Community Health Survey (CCHS) 2022, which is the most updated available data. Provincial data for these indicators are based on findings from the CCHS 2024. Most of the data accessed by the Arthritis Community Research and Epidemiology Unit (ACREU) in the CCHS for this report are not readily available to the public. ACREU thanks the Statistics Canada Research Data Centres Program for providing access to the data files.

⁷ R Wong, et al. *GLA:D® Canada 2024 Annual Report*. University Health Network [June 1, 2025]. Accessed on March 1, 2026: https://gladcanada.ca/wp-content/uploads/2026/02/GLAD_Canada_Annual_Report_2024_FINAL.pdf

⁸ The AI platform Agentiiv was utilized to help with the scoring and jurisdictional scan for this indicator.

METHODOLOGY CONT'D

Category 2: Wellness

40 raw points total; 30 weighted points overall

Indicator

People with arthritis-associated disability who receive sufficient help from allied health care (AHC) services

Main data source

Canadian Survey on Disability, 2022/ACREU⁹

Obesity rates within the arthritis population

Canadian Community Health Survey, 2022
Canadian Community Health Survey, 2024/
ACREU⁶

Impact of arthritis pain on activities

Canadian Community Health Survey, 2024/
ACREU⁶

Impact of arthritis on employment

Canadian Community Health Survey, 2022
Canadian Community Health Survey, 2024/
ACREU⁶

Category 3: Research and innovation

For this edition of the Report Card, there are **no indicators in this category**. Instead, we provide a commentary on the current state of arthritis research funding in Canada.

⁹ Statistics Canada. (2022). Canadian Survey on Disability (CSD). Accessed on January 26, 2026: <https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3251>
Data accessed by the ACREU in the Canadian Survey on Disability for this report are not readily available to the public. ACREU thanks the Statistics Canada Research Data Centres Program for providing access to the data files.

FINDINGS

PROVINCIAL AND TERRITORIAL RANKING OVERALL GRADES

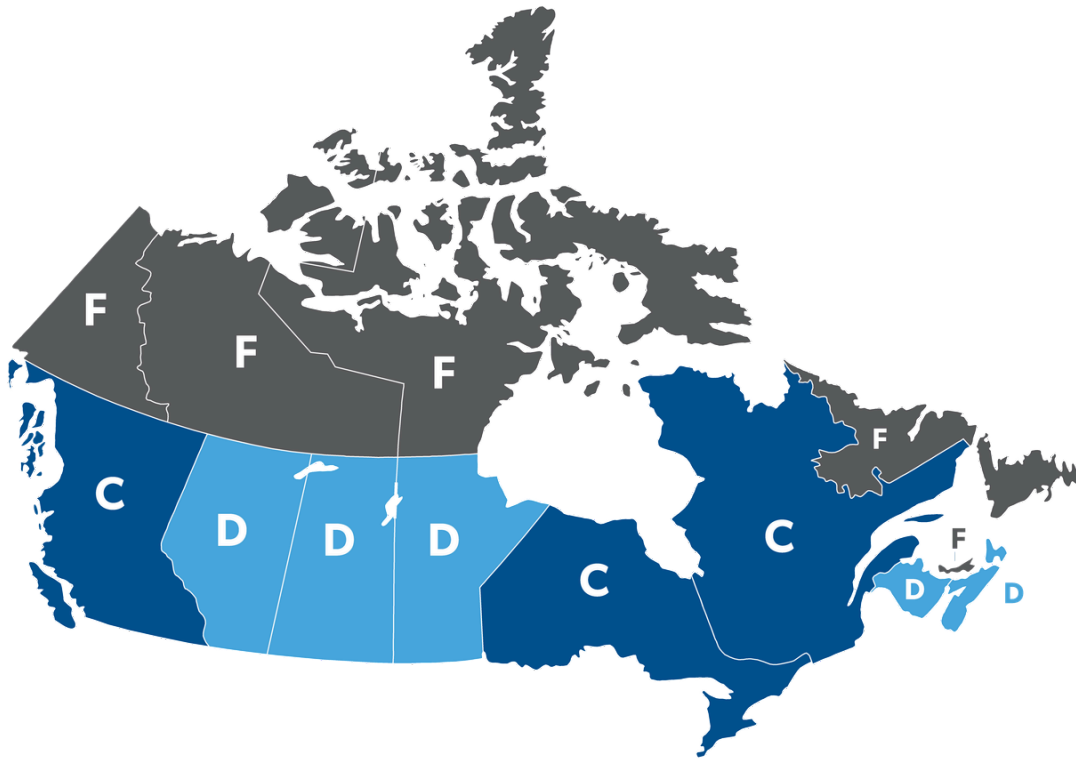
The following provides a comprehensive breakdown of the points awarded to each jurisdiction within the two categories, culminating in a final score out of 100 points, and accompanied by corresponding letter grades.

Jurisdiction	Access category points / 70	Wellness category points / 30	Total score / 100	Letter grade 2026
British Columbia	39	17	56	C
Alberta	41	11	52	D
Saskatchewan	36	12	48	D
Manitoba	31	13	44	D
Ontario	49	12	61	C
Quebec	41	16	57	C
New Brunswick	32	9	41	D
Nova Scotia	35	10	45	D
Prince Edward Island	24	14	38	F
Newfoundland and Labrador	29	8	37	F
Northwest Territories	17	10	27	F
Yukon	21	15	36	F
Nunavut	5	7	12	

GRADES: 85-100 A | 70-84 B | 55-69 C | 40-54 D | 0-39 F

Note: Due to data limitations, no indicators are included for the Research & Innovation category; instead, a commentary is provided. Also, two new indicators were added, and one indicator was removed because updated data was unavailable. These changes may affect comparisons with the first Report Card.

OVERALL KEY FINDINGS



KEY FINDING 1

Despite clear evidence and recommendations from the 2023 Report Card, jurisdictions have made little to no progress. Most indicators show no meaningful change over the three-year period.

While British Columbia, Ontario, and Quebec scored highest among jurisdictions, none achieved a grade above a "C," underscoring the significant work still required to meet the needs of people with arthritis.

Atlantic provinces (which have some of the highest rates of arthritis) and the Territories (which have the most gaps in data) continue to have the lowest scores.

KEY FINDING 2

Persistent limitations in available data remain, making it difficult to comprehensively assess the state of arthritis in Canada, reinforcing the need for improved data collection, transparency, and access.

KEY FINDING 3

Arthritis research in Canada remains chronically underfunded, being awarded less than two percent of investments from the largest federal funder of health research, despite affecting one in five people.

2026 ACCESS TO CARE AND TREATMENT CATEGORY RESULTS

2026 ACCESS TO CARE AND TREATMENT CATEGORY RESULTS

The Access category includes seven indicators that provide insight into access to arthritis care and treatment across jurisdictions. Provinces and territories were assessed based on their performance across each of these indicators, with a maximum score of 10 points per indicator.

Higher scores reflect greater availability of medications through public drug plans, more people receiving hip and knee replacements on time, shorter waits to see orthopaedic surgeons, having the recommended number of rheumatologists and orthopaedic surgeons for the population, more people with a regular healthcare provider, and better access to community-based arthritis programs. Overall scores suggest that people living in higher-scoring regions may have better access to arthritis care and treatment.

Overall caveats:

A crucial caveat that continues from the last Report Card is the lack of data for wait times to see a rheumatologist, and time to diagnosis. As timeliness of diagnosis of inflammatory arthritis, and subsequent treatment plans, are strongly linked to patient outcomes, these indicators would serve as one of the most important metrics for evaluating arthritis patients' access to care and treatment.

It should also be noted that data for the two indicators, Wait Times for Joint Replacements and Wait Times to see an Orthopaedic Surgeon, were not reported for the Northwest Territories and Yukon. As a result, these two territories received scores out of 50 rather than 70.

For Nunavut, data for the three indicators, Availability of Medications, Wait Times for Joint Replacements, and Wait Times to see an Orthopaedic Surgeon were not reported, resulting in a score out of 40 points instead of the original 70 points.

New this year is the indicator on Access to Community-Based Arthritis Care. It is important to note that this indicator was difficult to assess due to limited and inconsistent data across provinces about arthritis programs, locations, and patient capacity. The scores reflect best estimates based on available information and input from Arthritis Society Canada's AI platform; however, actual patient accessibility may differ. This highlights the need for better tracking and collection of data on community-based arthritis care across Canada.

2026 ACCESS TO CARE AND TREATMENT CATEGORY RESULTS

Jurisdiction	Availability of medications	Wait times for joint replacements	Wait times to see an orthopaedic surgeon	Rheumatologists in the workforce	Orthopaedic surgeons in the workforce	Individuals without a regular primary care	Community-based arthritis care	Total raw points out of 70	Total points out of 70
British Columbia	6	6	6	7	3	7	4	39	39
Alberta	7	7	6	8	3	7	3	41	41
Saskatchewan	7	5	5	6	4	7	2	36	36
Manitoba	7	5	0	6	3	8	2	31	31
Ontario	9	9	8	6	3	8	6	49	49
Quebec	9	5	9	9	4	5	0	41	41
New Brunswick	7	5	2	3	5	7	3	32	32
Nova Scotia	7	7	0	8	4	6	3	35	35
Prince Edward Island	7	4	2	3	2	4	2	24	24
Newfoundland and Labrador	7	4	0	4	6	6	2	29	29
								Total Raw Points out of 50/40	
Northwest Territories	6	*N/A	*N/A	0	3	2	1	12	17
Yukon	5	*N/A	*N/A	0	3	6	1	15	21
Nunavut	*N/A	*N/A	*N/A	0	3	0	0	3	5

*The data for these jurisdictions were not available

EXPLAINING THE ACCESS CATEGORY INDICATORS

Access indicator 1: Availability of medications

The data source for this indicator is the Arthritis Consumer Experts Arthritis Medications Report Card. To assess the availability of medications for arthritis, this report was used to tally the total number of drugs for inflammatory arthritis that were listed, under review and declined on the jurisdiction's formulary.

It is essential to note that the report mainly focuses on provision of reimbursement for medications approved for inflammatory arthritis rather than their accessibility. Being listed on the formulary does not guarantee access to those medications. Furthermore, access to most of these drugs is typically dependent on the availability of and accessibility to rheumatologists, who are responsible for prescribing them.

Access indicator 2: Wait times for joint replacements

The data source for this indicator came from the Canadian Institute for Health Information (CIHI)'s Wait times for Priority Procedures in Canada, 2025. The report provides information on the percentages of hip and knee replacements that were performed within the recommended wait time target of 6 months, for the period of 2023-2024. The wait time reported is the number of days between the date the patient and the specialist agree to a hip or knee replacement and the date the patient receives the surgery, often referred to as Wait 2. It does not include the wait from when the referral is received to the date of the first consultation with the specialist occurs, generally referred to as Wait 1, which can be many months.

It is worth noting that this indicator focuses on hip and knee replacements and does not account for other patients with arthritis who require other types of joint replacements.

Access indicator 3: Wait times to see an orthopaedic surgeon

The data source for this indicator was the Fraser Institute – Waiting Your Turn: Wait Times for Health Care in Canada, 2025 Report. This report provides information on the number of months patients have to wait to see different specialists.

While measuring the wait times for rheumatologists and orthopaedic surgeons separately would have been preferable, the data for wait times to see a rheumatologist were not available. Therefore, it was decided to use the wait times for patients to see an orthopaedic surgeon after referral from a general practitioner for this indicator rather than using the wait times to see a general specialist. Additionally, these data are based on patients' referrals to an orthopaedic surgeon for any condition or problem, not just for arthritis.

EXPLAINING THE ACCESS CATEGORY INDICATORS CONT'D

Access indicator 4: Number of rheumatologists in the workforce

The data sources for this indicator were the College of the North Atlantic student project in partnership with Arthritis Society Canada and provincial Rheumatologist Associations that provided data on the number of rheumatologists in each jurisdiction, updated in 2025.

The recommended ratio of rheumatologists per population, according to a study by Stephanie C. Kulhawy-Wibe et al., is between 1 rheumatologist per 75,000 and 2 rheumatologists per 100,000 population. This was used as a baseline to score each jurisdiction.

¹⁰

Importantly, it should be noted that rheumatologists are not only dedicated to treating arthritis, but they also specialize in a diverse array of conditions that extend beyond arthritis. These include connective tissue diseases, vasculitis, lupus, and various other ailments. Also, it was difficult to determine the practice status of the rheumatologists (fulltime, parttime, or academic) which may have led to an overestimation.

Access indicator 5: Number of orthopaedic surgeons in the workforce

The data source for this indicator was the Canadian Orthopaedic Association who provided data on the number of orthopaedic surgeons in the workforce per 100,000 population in 2025.

While there is no recommended ratio of orthopaedic surgeons per 100,000 population in Canada, it was suggested we evaluate this indicator based on the recommended ratio used in the United States. Therefore, we used the ratio of 8 to 10 practicing orthopaedic surgeons per 100,000 population to develop a scoring method for this indicator.

While orthopaedic surgeons provide treatment for arthritis patients, they also care for a wide range of other conditions, such as trauma and fractures.

¹⁰ Stephanie C. Kulhawy-Wibe, et al. Results From the 2020 Canadian Rheumatology Association's Workforce and Wellness Survey. *The Journal of Rheumatology*, June 2022, 49 (6) 635-543. Accessed February 25, 2026: <https://www.jrheum.org/content/jrheum/49/6/635.full.pdf>

EXPLAINING THE ACCESS CATEGORY INDICATORS CONT'D

Access indicator 6: Number of individuals without a regular primary care provider

The data for this indicator were provided by Arthritis Community Research and Epidemiology Unit (ACREU) derived from Statistics Canada's Canadian Community Health Survey (CCHS). This is an annual survey that collects information related to health status, health care utilization and health determinants for the population in Canada. The analysis of the survey used for this report covers the population 18 years of age and over, living in the ten provinces and three territories from 2022 to 2024.

Initially, the aim was to evaluate multidisciplinary care, including occupational therapy, physical therapy, social work, and kinesiology. However, due to limitations in data sources and payment models, this was not possible. Instead, this indicator focuses on the percentage of individuals without a primary care provider as an indicator of their navigation and entrance into the health care system. This was ascertained from the CCHS which asks individuals if they have a family doctor, nurse practitioner, or another health professional that they regularly consult with when they need care or advice for their health.

It should be noted that the prevalence of arthritis in Canada is likely underestimated, as many people do not know that they have the condition, in part due to a lack of primary care providers and access to primary care providers who can diagnose and refer patients to appropriate care.

Access indicator 7: Community-based arthritis care

Information for this indicator came from a scan of provincial community-based arthritis programs and the GLA:D Canada 2024 Annual Report, which together provide an overview of arthritis services offered in community settings across the country, including publicly funded arthritis community-based programs and GLA:D osteoarthritis programming. GLA:D (Good Life with osteoarthritis in Denmark) is an evidence-based education and exercise program that helps people with hip or knee osteoarthritis reduce pain, improve mobility, and better manage their symptoms. In addition, artificial intelligence tools were used to support the analysis and scoring for this indicator.

It is essential to note that data limitations, availability of data, and varying provincial payment models made this indicator difficult to analyze comprehensively. Program existence does not guarantee patient accessibility due to capacity constraints, waitlists, and funding restrictions. For GLA:D programs, their specific locations and frequency of offering remain unknown, and access often depends on healthcare provider referrals with programs concentrated in urban centres.

2026 WELLNESS CATEGORY RESULTS

WELLNESS CATEGORY RESULTS

The Wellness category is made up of four indicators that together provide insight into the well-being of individuals living with arthritis in each jurisdiction. In our assessment, provinces and territories were evaluated on their performance across these indicators, with a maximum of 10 points available for each.

For the indicator on access to allied health care services, higher scores reflect more sufficient access to allied health care among people with arthritis-related disabilities. For the indicators on obesity rates, interruption of physical activity due to pain, and employment rates, higher scores indicate smaller gaps between the Canadian population's average and the average for the population of people with arthritis, indicating a more comparable experience to the overall population in Canada.

Although physical activity is an essential aspect of wellness for people living with arthritis, the Arthritis Impact on Physical Activity Level indicator could not be included in this edition due to the absence of updated national data. This gap in available data limits the ability to consistently monitor physical activity level among people with arthritis and highlights the need for renewed investment in consistent, accessible data collection to better support evidence-informed policy and advocacy efforts.

For the indicator, Impact of Arthritis Pain on Activities, updated data were not available for the Northwest Territories, Yukon and Nunavut. As a result, the territories received scores out of 30 rather than 40.

2026 WELLNESS CATEGORY RESULTS

Jurisdiction	People with arthritis-associated disability who receive sufficient help from AHC services	Impact of arthritis pain on activities	Obesity rates within the arthritis population	Impact of arthritis on employment	Total raw points out of 40	Total weighted points out of 30
British Columbia	2	4	9	7	22	17
Alberta	2	3	4	6	15	11
Saskatchewan	2	4	4	6	16	12
Manitoba	2	4	3	8	17	13
Ontario	2	3	6	5	16	12
Quebec	3	6	7	5	21	16
New Brunswick	4	3	1	4	12	9
Nova Scotia	3	3	3	4	13	10
Prince Edward Island	4	3	6	6	19	14
Newfoundland and Labrador	3	3	4	1	11	8
					Total Raw Points out of 30	
Northwest Territories	1	*N/A	0	9	10	10
Yukon	1	*N/A	6	8	15	15
Nunavut	0	*N/A	6	1	7	7

*The data for these jurisdictions were not available

EXPLAINING THE WELLNESS CATEGORY INDICATORS

Data for the following four indicators in the Wellness category were provided by Arthritis Community Research and Epidemiology Unit (ACREU) derived from Statistics Canada's Canadian Survey on Disability (CSD) and Canadian Community Health Survey (CCHS). The CSD collects information every five years from people in Canada who reported being limited in their ability to complete daily activities because of a long-term condition or health problem in the Activities of Daily Living question on the long-form Census questionnaire. The CSD uses Disability Screening Questions to identify those with disabilities within 10 functional domains and further categorizes the reported main and secondary conditions that cause them the most difficulty using the ICD-10 coding scheme. The analysis of the survey used for this report card covers people in Canada aged 15 and over, living with arthritis-associated disability in the ten provinces and three territories in 2022. The CCHS is an annual survey that collects information related to health status, health care utilization and health determinants for the Canadian population. The analysis of the survey used for this report covers the population 18 years of age and over, living in the ten provinces and three territories from 2022 to 2024.

Wellness indicator 1: People with arthritis-associated disability who receive sufficient help from allied health care (AHC) services

The data for this indicator are derived from CSD survey questions that asked individuals with arthritis-associated disability about their need for allied health care services and whether these needs were met. These services include physiotherapy, massage therapy or chiropractic treatments, occupational therapy, counselling services from a psychologist, professional nursing care at home, support group services, life sustaining therapies or specialized medical care, addiction services, life skills services, naturopathic, homeopathic or osteopathic treatments, acupuncture, nutrition or dietary services, specialized vision care, and other therapies or services. We calculated the proportion of individuals with arthritis-associated disability who require access to one or more of these services and could not access sufficient help from these services.

Arthritis contributes to pain, mobility, flexibility, and dexterity-related disabilities. Disability is a large driver of health-related burden and decreased social participation in the population. Over half of those with an arthritis-associated disability report needing help from one or more allied health care services. The most frequently reported needed services among this group are rehabilitative services, which are reported by nearly 50% of respondents. Therefore, this indicator highlights the current unmet needs of those with arthritis-associated disability in both clinical and clinically adjacent settings.

EXPLAINING THE WELLNESS CATEGORY INDICATORS CONT'D

Wellness indicator 2: Impact of arthritis pain on activities

The CCHS data for this indicator were collected through a survey question asking individuals how many activities their pain or discomfort prevents them from doing. We compared the proportion of individuals with arthritis who reported pain or discomfort that prevented them from performing activities with the percentage of the overall Canadian population reporting the same.

As individuals with arthritis may experience more pain and discomfort during physical activities, this indicator is particularly important in understanding the impact of arthritis pain on the daily lives of affected individuals.

Wellness indicator 3: Obesity rates within the arthritis population

The CCHS data for this indicator were collected through a survey question asking individuals to report their height and weight, which was then used to calculate Body Mass Index (BMI). This allowed for the comparison of the proportion of individuals with arthritis who are considered obese in each jurisdiction to the overall proportion of obese individuals across Canada.

Given the debilitating nature of arthritis, individuals may face challenges in daily routine activities or physical exercise activities. This indicator helps to identify the excess prevalence of obesity within the arthritis population in each jurisdiction.

Wellness indicator 4: Impact of arthritis on employment

These CCHS data look at the age and sex standardized prevalence ratio of not being in the labour force for individuals between the ages of 20-64, comparing individuals with arthritis to the general population.

Arthritis can have a significant impact on an individual's ability to work, and this, in turn, can impact their employment levels. Statistics show that individuals with arthritis have a higher risk of unemployment and work disability compared to those without the disease. While there are many other factors to consider, employment levels can be one indication of how well an individual is able to manage their arthritis.

A more holistic approach to understanding the impact of arthritis on employment may involve looking at workplace strategies and support for individuals with arthritis.

2026 **RESEARCH & INNOVATION CATEGORY**

2026 RESEARCH & INNOVATION CATEGORY

Unlike the previous edition of this Report Card, this category does not include scored indicators. This is not an oversight; it reflects systemic gaps in the availability, consistency, and transparency of arthritis research data across jurisdictions in Canada. Due to persistent inconsistencies in data collection and public reporting, meaningful cross-jurisdictional ranking in research and innovation was not feasible.

High-quality, standardized, and publicly accessible data on investment in research and innovation are essential to accountability and evidence-informed decision-making. Without them, outcomes and progress cannot be reliably measured, and opportunities for system improvement and innovation are constrained.

Yet even within these data limitations, one fact is unmistakable: arthritis research in Canada remains chronically underfunded.

Arthritis affects approximately one in five people in Canada yet is awarded less than two per cent of investments from the country's largest federal funder of health research. While Canada's largest health research funding agency has increased overall funding by 29% since 2017, arthritis-specific research investment has declined nearly 24%, now representing just 1.2% of the research funding it awards. **As prevalence continues to rise, this trend is unsustainable.**

Research is essential to improving outcomes for people in Canada with arthritis. It strengthens pain management, advances models of care, and improves quality of life. It is also the pathway to earlier diagnosis, innovative therapies, prevention strategies, and ultimately cures. Sustained investment determines whether that progress accelerates or stalls.

The consequences of underinvestment are immediate. Arthritis Society Canada receives more than triple the number of research proposals it can support and declines approximately 70 per cent of strong, peer-reviewed applications due to lack of funding. In the most recent funding cycle alone, 46 promising studies representing more than \$6 million in research could not proceed.

This gap demands action. **Arthritis Action Now: The Plan to End Arthritis in Canada** moves beyond identifying gaps; it defines the specific actions needed to close them. Its Research and Innovation priorities call for increased investment, stronger institutional alignment, and a coordinated national strategy to accelerate discovery. This will position Canada as a leader in arthritis prevention and treatment innovation.

All levels of government must invest to reflect the scale and urgency of arthritis. Without sustained funding and improved data transparency, innovation will stall, pressure on health systems will intensify, and preventable costs will continue to rise.

¹¹ Arthritis Research at Risk: 70% of Promising Innovations Go Unfunded. Accessed January 25, 2026. <https://www.newswire.ca/news-releases/arthritis-research-at-risk-70-of-promising-innovations-go-unfunded-810762098.html>

CALL TO ACTION & RECOMMENDED NEXT STEPS

CALL TO ACTION & RECOMMENDED NEXT STEPS

The first State of Arthritis in Canada Report Card, released in October 2023, delivered a clear warning. Low and failing grades across provinces and territories exposed serious gaps in access to care, wellness outcomes, and investment in arthritis research and innovation. It called for decisive action.

This second Report Card shows that progress has been limited. Too many of the same challenges remain, and people in Canada with arthritis continue to experience barriers to access, delays in care, insufficient support, and the consequences of chronic underinvestment in research. The evidence is clear: incremental change is not delivering meaningful improvement.

In response, Arthritis Society Canada and its partners are launching **Arthritis Action Now: The Plan to End Arthritis in Canada**, a concrete, solution-oriented national plan. Key recommended actions for government are to:

1. Enhance data quality and accessibility

The Report Card highlights the need for better and more accessible data for researchers and the public. It is critical to determine the appropriate types of data to collect and establish standardized collection methods to ensure comparability. Arthritis Society Canada supports the ongoing pan-Canadian efforts to standardize health data and strengthen interoperability across health systems.

2. Improve access to arthritis care

People with arthritis in Canada face significant challenges in accessing necessary care and programs. There is a pressing need to expand and invest in arthritis care pathways to enable access to timely, appropriate and inclusive arthritis care and support.

3. Increase investment in arthritis research

Arthritis represents one of Canada's greatest health and economic challenges, yet it remains an underfunded area of health research — arthritis research is awarded less than two percent of research funding. To correct this imbalance, the federal government should fund arthritis research as prioritized by Canada's scientific community in **Arthritis Action Now: The Plan to End Arthritis in Canada**.

With leadership, collaboration, and sustained investment, Canada can change the trajectory of arthritis and build a more responsive, innovative, and sustainable system of care. **This is how we make meaningful progress and provide hope for millions of people in Canada with arthritis.**

APPENDIX

Thank you to all those who contributed to updating this report:

Dr. Claire Barber, Associate Professor Cumming School of Medicine University of Calgary, Scientific Director Bone & Joint Health Strategic Clinical Network, Alberta Health Services

Dr. Siân Bevan, Chief Science Officer, Arthritis Society Canada

Shawn Brady, Vice President, Arthritis Rehabilitation and Education Program & Innovation, Arthritis Society Canada

Melissa Cavallo, Research Analyst, Schroeder Arthritis Institute, University Health Network, Arthritis Community Research and Epidemiology Unit (ACREU)

Dr. Carolyn Goard, Director, Knowledge Translation and Exchange, Arthritis Society Canada

Margretha Gonsalvez, Manager, Public Policy & Government Affairs, Arthritis Society Canada

Kelly Gorman, Senior Director, Public Policy & Government Affairs, Arthritis Society Canada

Kelly Lendvoy, Vice President, Communications & Public Affairs, Arthritis Consumer Experts

Chelsea Patriquin, Director, Strategic Initiatives, Canadian Orthopaedic Association

Dr. Anthony V. Perruccio, Director, Arthritis Community Research and Epidemiology Unit (ACREU), Senior Scientist, Schroeder Arthritis Institute, University Health Network, Associate Professor, Institute of Health Policy, Management & Evaluation, University of Toronto

Michelle Tice, Executive Director, Arthritis Research Canada

Dr. Jessica Widdifield, Holland Chair in Musculoskeletal Clinical Research Senior Scientist, Sunnybrook Research Institute, ICES, Associate Professor, Institute of Health Policy, Management & Evaluation, University of Toronto

Jessica Wilfong, Research Associate, Schroeder Arthritis Institute, University Health Network, Arthritis Community Research and Epidemiology Unit (ACREU)

Dr. James J. Young, Scientific Associate, Schroeder Arthritis Institute, University Health Network, Executive Director, GLA:D Canada

Dr. Ahmad Zbib, Chief Executive Officer, Canadian Rheumatology Association