Special Report:

Inequalities in the Burden of Arthritis in Canada

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FINAL VERSION

Executive Summary

Arthritis is a collection of over 100 conditions affecting joints and other tissues that cause pain, restrict mobility, contribute to disability, and diminish quality of life. Arthritis can involve almost any part of the body, most often affecting the knees, hands, and spine and often presents in multiple joints. Some forms of arthritis can also affect other parts of the body. Arthritis is a chronic condition, meaning that it affects people on an ongoing, constant or recurring basis over months, years, and even a lifetime. As life expectancy increases, the number of years lived with arthritis will also likely increase.

Arthritis is the most common chronic disease in Canada and places a tremendous burden on the healthcare system and the 6 million people who live with its effects. Arthritis affects people in Canada of all ages, across the entire country, and the number of people in Canada living with arthritis is expected to grow by 50% by 2040.

This report examines whether any inequalities in health related to arthritis in Canada are evident in population-based data. It is intended to take a critical step toward enabling action to advance health equity among all people in Canada with arthritis.

Inequalities were identified in the prevalence of arthritis across different sociodemographic groups, most notably among Indigenous Peoples in Canada.

- People in Canada who identify as Indigenous living off-reserve were significantly more likely to report arthritis compared to any other racial/cultural group whose data were analyzed.
- Among those who identify as Indigenous, those who identify as First Nations or Métis were more likely to report arthritis compared to those who identify as Inuk.
- Canadians of any racial/cultural background who report low income or low education were more likely to report arthritis compared to those with higher income or education.
- Indigenous people in Canada living off-reserve with arthritis were more likely to report poor health outcomes associated with arthritis compared to the general Canadian population with arthritis.
- Indigenous people in Canada living off-reserve with arthritis were also more likely to report barriers to accessing healthcare compared to the general Canadian population with arthritis.
- Data for Indigenous people in Canada living on-reserve were not available in the population datasets used for this analysis, and the understanding of the burden of arthritis in this subpopulation remains limited.

Differences in arthritis prevalence and arthritis-related health outcomes across groups can in part be related to differences in complex biological systems between individuals. However, it is well understood that differences in social determinants between groups also can have significant impacts on arthritis-related outcomes and access to care. It is important to gain a better understanding of how sociodemographic factors contribute to arthritis-related health inequalities (including modifiable and non-modifiable factors) and access to healthcare to inform programs and policies for reducing inequalities and improving arthritis care across the country.

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Preamble

Arthritis places a tremendous social cost and health burden on people in Canada and has significant impacts on the lives of those living with the condition and their families and other relationships. It is a highly costly disease, associated with direct medical and surgical costs, and even greater indirect costs attributed largely to long-term disability and loss of productivity. While often perceived as a disease of older age, the reality is that many people are diagnosed with arthritis during their peak period of earning potential, with up to a third diagnosed before age 45. Furthermore, as a consequence of there being no cure, people can live with arthritis and its effects for many years.

The purpose of this report is to determine whether any health inequalities are evident in (i) the prevalence of arthritis, and (ii) health outcomes and access to resources among people living with arthritis in Canada. Inequalities have the potential to affect peoples' ability to maintain and improve their health and manage their arthritis over their lifetimes.

Introduction to the Data

In Canada, population-level health data are most frequently gathered through Statistics Canada's health surveys. This report is based on data from six cycles of the Canadian Community Health Survey (CCHS), collected between 2015 and 2020. The CCHS consists of core questions that remain consistent each year, and theme questions that change every 1-2 years. Core questions ask about sociodemographic characteristics and chronic conditions while themed content questions are focused more on specific health-related experiences.

The CCHS is a cross-sectional survey that collects self-reported information related to health status, healthcare utilization, and health determinants for individuals aged 12 years or older living in Canada. The CCHS does not cover children under 12 years old, people living on reserves, or members of the Canadian Armed Forces. Information from the CCHS can be used to plan and implement programs, conduct research, and raise awareness – all with the intention of improving health for Canadians. Participation in the survey is voluntary, and data used for research purposes are de-identified to ensure respondent confidentiality.

In order to maintain sufficient numbers to produce reliable estimates, the analyses described in this report included CCHS respondents aged 30 years and older. The report is divided into three major sections:

- Prevalence of arthritis across different sociodemographic groups (CCHS 2015-2020)
- Health outcomes in arthritis across different racial and cultural groups (CCHS 2019-2020)
- Healthcare access among people with arthritis across different racial and cultural groups (CCHS 2019-2020)

Arthritis Diagnosis

The CCHS asks about long-term health conditions diagnosed by a health professional, and the arthritis question reads: "Do you have arthritis, for example osteoarthritis, rheumatoid arthritis, gout or any other type, excluding fibromyalgia?"

Racial or Cultural Groups

CCHS respondents are also asked: "Are you an Aboriginal person, that is, First Nations, Métis, or Inuk (Inuit)? First Nations includes Status and Non-Status Indians." If the response is "Yes", participants are further asked to identify specifically which group(s) they belong to.

For the purposes of this report, we use the term "Indigenous" to refer to people who identify as First Nations, Métis, or Inuk. Due to limited numbers of respondents identifying as Indigenous, comparing between Indigenous groups was not always possible.

In the CCHS, those who respond "No" to the question on being an Aboriginal person are then asked to identify the racial or cultural group(s) they belong to. The survey question reads: "You may belong to one or more racial or cultural groups on the following list. Are you…?" Participants are provided a list including White, South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean, Japanese, and other.

For analyses in this report, based on available number of respondents, the following groups were derived: those who identified as Indigenous only; White only; South Asian only; Chinese only; Black only; Filipino only; Latin American only; and, Other (which includes the limited number of respondents who identify as Arab, Southeast Asian, West Asian, Korean, or Japanese, and those who identify as belonging to multiple racial or cultural groups).

One final consideration is that the data analysed are self-reported by survey respondents. Therefore, responses to some questions may be impacted by how different individuals and groups report on disease and symptoms from a social or cultural perspective.

Analyses

Arthritis Prevalence

To assess for inequalities in the prevalence of arthritis across different sociodemographic groups in Canada, a *direct standardization* procedure was used.

Age and sex assigned at birth are strongly associated with arthritis. If the age and sex composition of one group is different from that of another group, then any observed difference in arthritis prevalence between the groups may simply be related to differences in their age and sex compositions. The direct standardization approach allows us to remove this age and sex effect, and it facilitates comparisons across groups defined by other characteristics (e.g., racial or cultural identity). It allows us to determine the prevalence of arthritis for each group as if they all had the same age and sex compositions (i.e., if they all had a standardized age-sex population

structure). For this report, arthritis prevalence data were age- and sex-standardized using demographics estimated for the general population in the pooled CCHS 2015-2020 datasets.

Health Outcomes and Healthcare Access

The main focus of this report is variations in health outcomes and healthcare access among people with arthritis (i.e., not in people without arthritis). Therefore, the sizes of groups analyzed were smaller than for the analyses examining the prevalence of arthritis.

With smaller sample sizes, a more appropriate method of standardization is *indirect standardization*. We used indirect standardization to make comparisons in health outcomes and healthcare access across racial and cultural groups. Using this method, the proportion of each outcome in each age and sex group for the standard population, in this case the Canadian population included in the CCHS, is calculated. These proportions are then applied to the corresponding age and sex groups in a specific racial or cultural group to determine the number of individuals that would be expected to have the outcome if the group had the same age and sex distribution as the standard population. The total expected number of individuals (summing across age and sex groups) is compared to the observed (actual) number of individuals with the outcome in the specific group. From these, standardized prevalence ratios are calculated, which are the ratio of the observed number of events to the expected number of events. A ratio greater than 1.0 indicates that the observed numbers in a group are greater than the expected numbers at the standard population rate, while a ratio less than 1.0 indicates that observed numbers in a group are lower than the expected numbers at the standard population rate. The standard population used for our analyses was the general CCHS 2019-2020 Canadian population with arthritis.

Prevalence of Arthritis across Different Sociodemographic Groups

Racial and Cultural Background

Having accounted for the age and sex compositions across self-identified racial/cultural groups, arthritis is most prevalent among people in Canada who identify as Indigenous and live off-reserve, with a prevalence of 34.4% (95% CI: 33.4-35.4%). This group is significantly more likely to report arthritis compared to any other racial/cultural group. Those who identify as White only report the second highest standardized prevalence of arthritis, 27.5% (95% CI: 27.3-27.7%), and are significantly more likely to report arthritis compared to every other racial/cultural group besides people identifying as Indigenous. The lowest standardized prevalence of arthritis is found among Canadians who identify as Chinese only, 12.7% (95% CI: 11.6-13.7%). This group is significantly less likely to report arthritis compared to any other racial/cultural group.

Figure 1: Age-sex standardized prevalence of arthritis by racial/cultural group

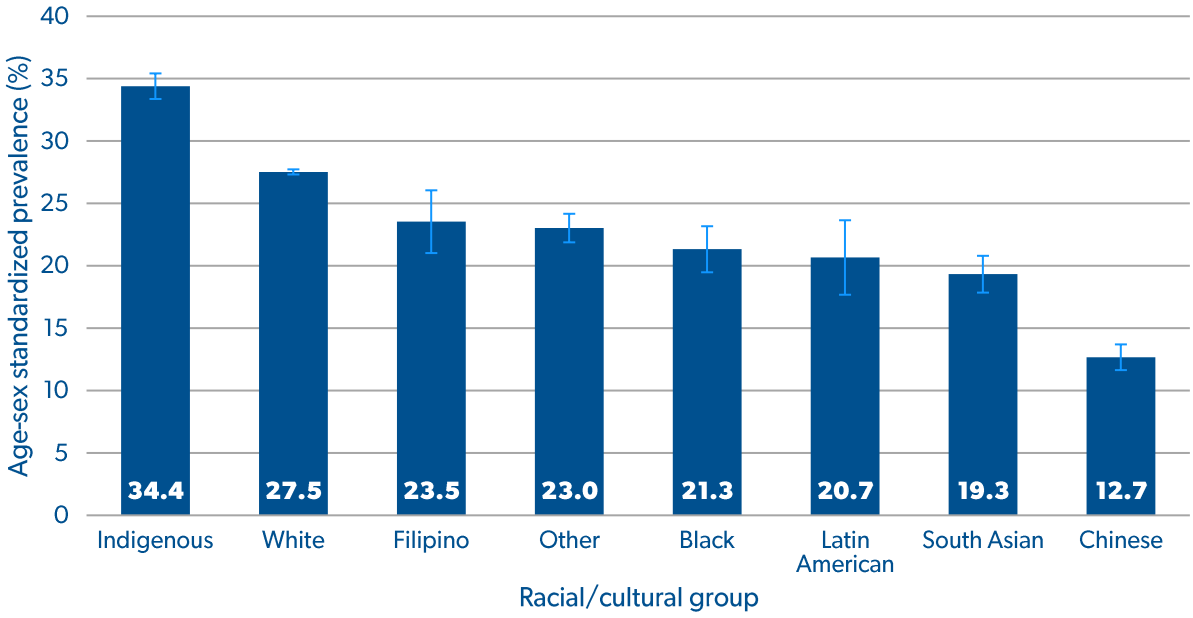

Figure 1: Respondents were asked about diseases diagnosed by a health professional and the arthritis question reads: "Do you have arthritis, for example osteoarthritis, rheumatoid arthritis, gout or any other type, excluding fibromyalgia?"

Respondents were also asked: "Are you an Aboriginal person, that is, First Nations, Métis, or Inuk (Inuit)? First Nations includes Status and Non-Status Indians." Those who responded "no" to the above question were then asked, "You may belong to one or more racial or cultural groups on the following list. Are you White, South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean, Japanese, or other?". For analyses, respondents were grouped as: Indigenous only; White only; South Asian only; Chinese only; Black only; Filipino only; Latin American only; other (includes those who identify as Arab Southeast Asian, West Asian, Korean, Japanese, and those who identify as multiple racial or cultural groups).

Error bars represent 95% confidence intervals.

Indigenous Identity

Among respondents who identify as Indigenous and live off-reserve, those who identify as First Nations or Métis are significantly more likely to report arthritis compared to individuals who are Inuk, with standardized prevalences of 35.5% (95% CI: 33.9-37.1%) and 34.7% (95% CI: 33.2-36.3%), respectively, compared to 27.4% (95% CI: 23.8-30.9%).

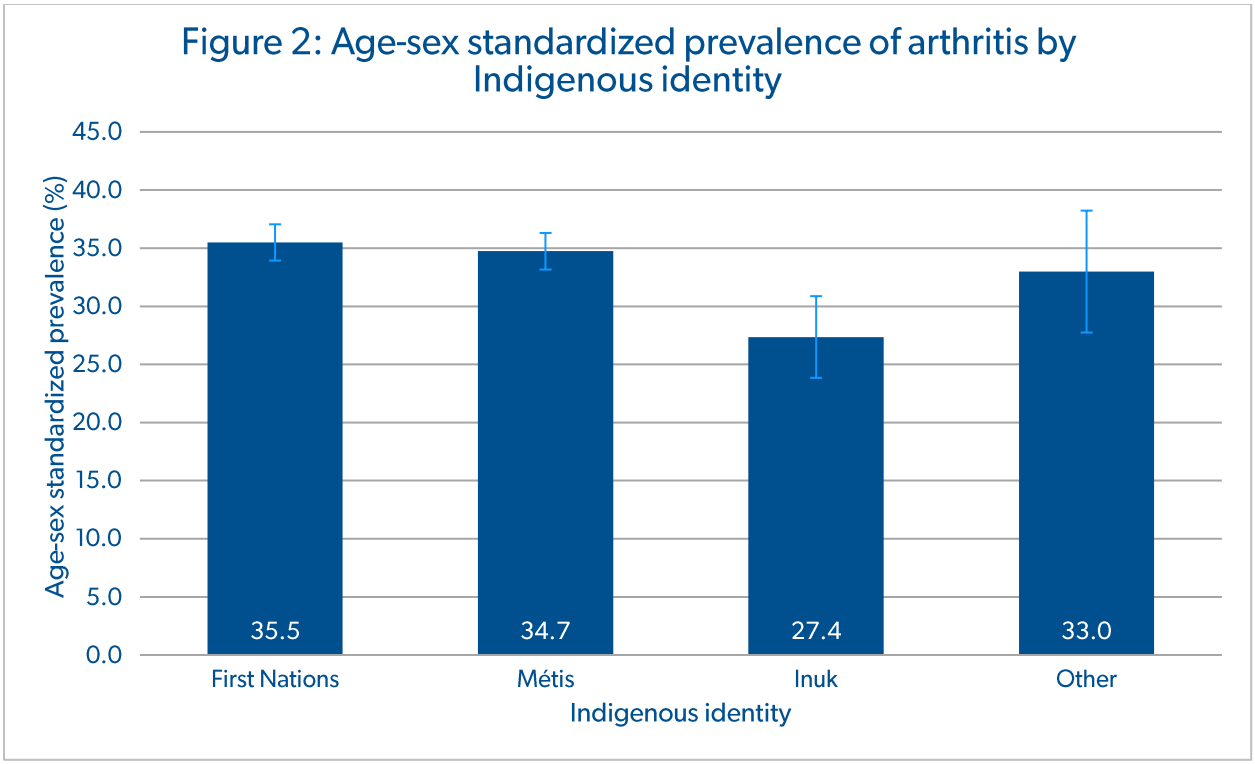

Figure 2: Respondents were asked: "Are you an Aboriginal person, that is, First Nations, Métis, or Inuk (Inuit)? First Nations includes Status and Non-Status Indians." Those who responded 'yes' were further asked to identify which specific group(s) they identify with. Responses were categorized as individuals who identified as First Nations only, Métis only, Inuk, only, or any combination of the three labelled as 'Other'.

Error bars represent 95% confidence intervals.

Sexual Orientation

In the 2015-2018 CCHS respondents were asked, "What is your sexual orientation?" and given the options, 'heterosexual'; 'homosexual, that is lesbian or gay'; and 'bisexual'. In 2019-2020 the response options were updated to 'heterosexual'; 'gay or lesbian'; 'bisexual or pansexual'. We note that the terms for sexual orientation used in the CCHS do not necessarily capture the evolving terminology used in the 2SLGBTQIA+ community and may not accurately capture all identities. In this report, we refer to people attracted to the same sex or gender as gay or lesbian, recognizing that these terms may not resonate for all those who experience same sex or gender attraction. We also acknowledge that respondents who selected bisexual may also include other identities such as those who are pansexual, or who more broadly identify with the term queer.

The standardized prevalence of arthritis among Canadians who identify as bisexual is 32.1% (95% CI: 29.6-34.5%), which is a significantly higher rate than that reported by either Canadians who identify as heterosexual, 27.0% (95% CI: 26.8-27.2%), or Canadians who identify as gay or lesbian, 27.3% (95% CI: 25.3-29.4%).

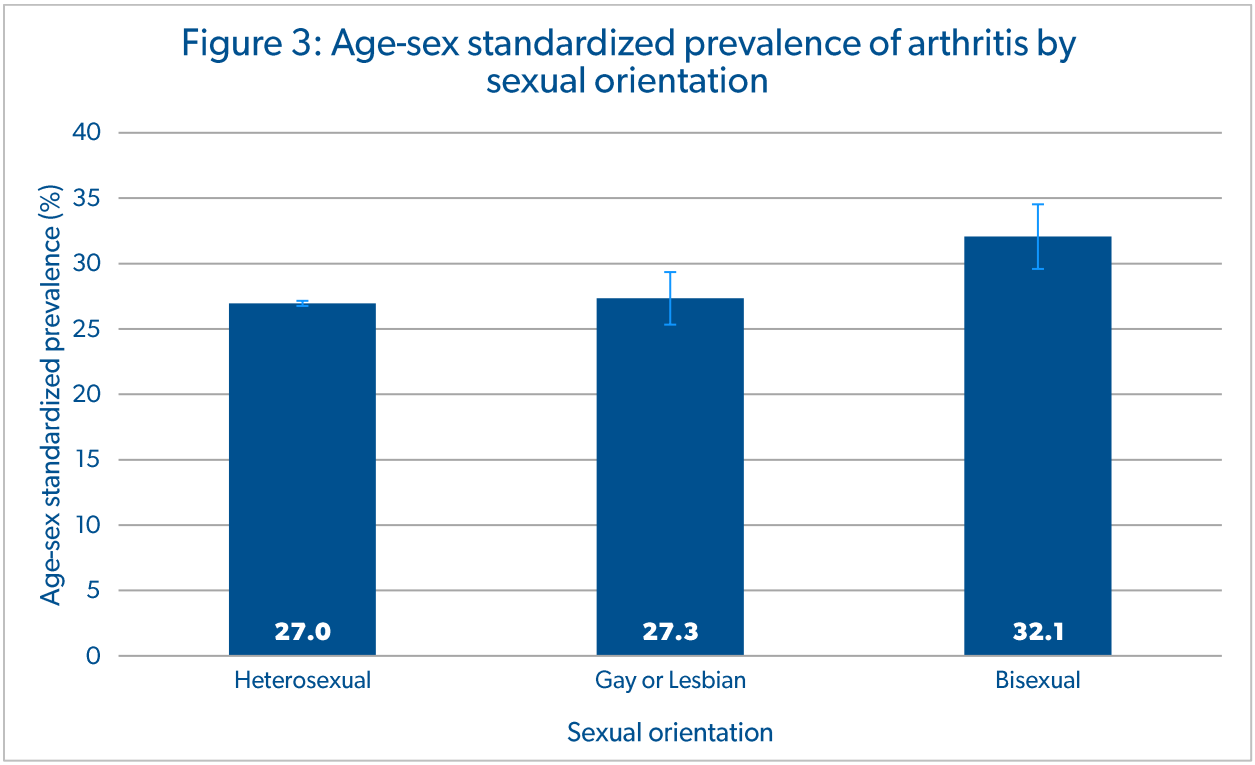

Figure 3: In the years 2015-2018 respondents were asked: "What is your sexual orientation?" with response options heterosexual; homosexual, that is lesbian or gay; bisexual. In the years 2019-2020 the response options were updated to read heterosexual; gay or lesbian; bisexual or pansexual.

Immigrant Status

Overall, the standardized prevalence of arthritis among immigrants is lower than that among non-immigrants in Canada. Among immigrants, those living in Canada for a longer period of time (>10 years) are significantly more likely to report arthritis than more recent immigrants (≤10 years). The standardized prevalence of arthritis is 16.1% (95% CI: 14.4-17.9%) among more recent immigrants to Canada, 22.6% (95% CI: 22.1-23.1) among longer-term immigrants to Canada, and 28.2% (95% CI: 28.0-28.4%) among non-immigrants.

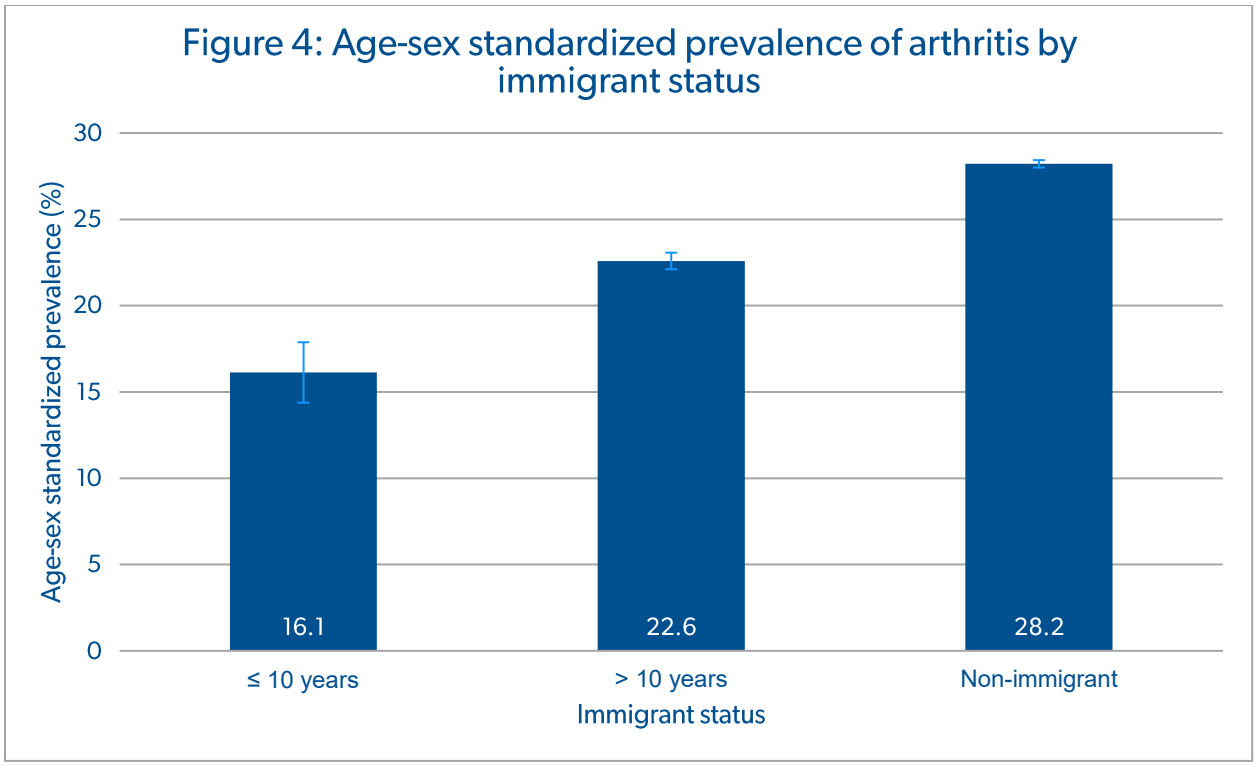

Figure 4: The question in the CCHS 2015-2020 read: "Are you now, or have you ever been a landed immigrant in Canada?". For those who responded 'yes', they were asked, "In what year did you first become a landed immigrant in Canada?"

Error bars represent 95% confidence intervals.

Level of Income

Having accounted for age and sex composition differences, the prevalence of arthritis among Canadians reporting a low household income is 31.4% (95% CI: 31.0-31.8%). This is 1.2 times higher than the prevalence among Canadians reporting a mid to high household income, 25.4% (95% CI: 25.2-25.6%).

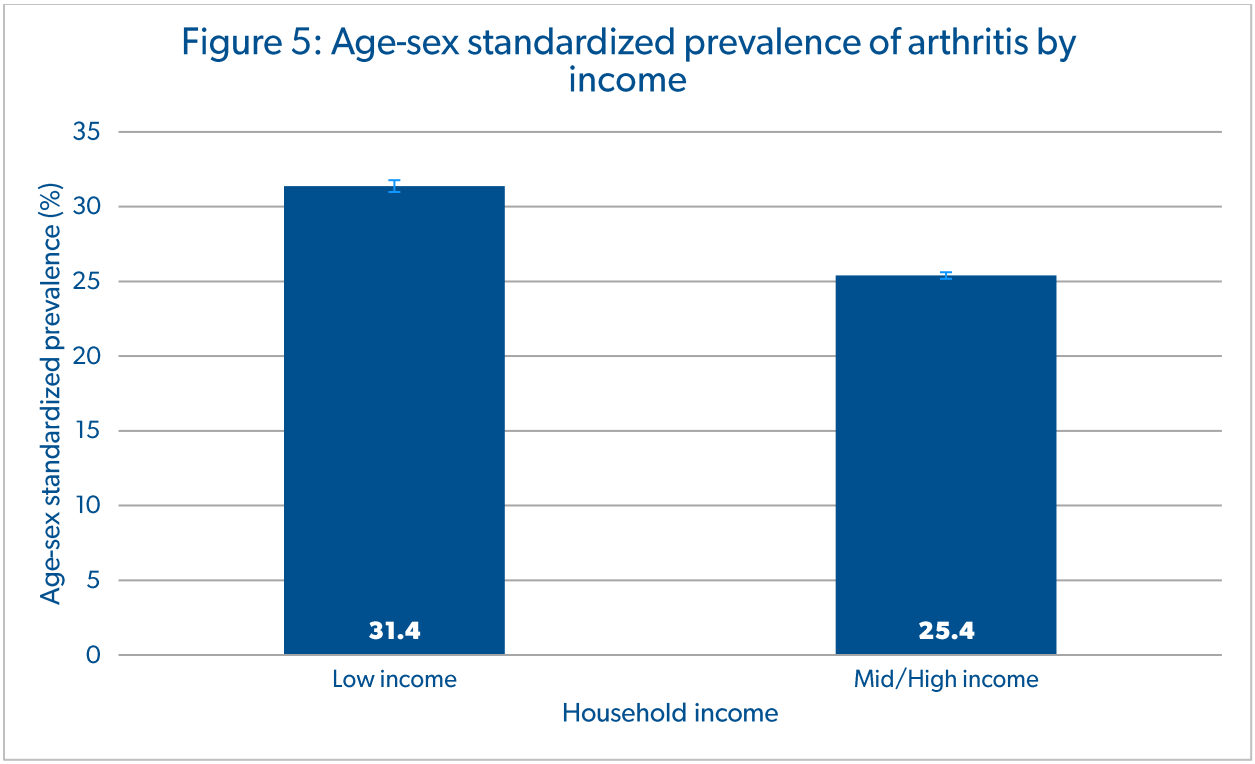

Figure 5: Low income was defined based on the distribution of household income. Respondents were allocated into deciles (i.e., 10 categories including approximately the same percentage of residents for each province or territory) of the ratio of their total household income to the low income cut-off corresponding to their household and community size. This provided, for each respondent, a relative measure of their household income in relation to the household income of all other respondents. The three lower deciles were used to classify people in the low income category.

Error bars represent 95% confidence intervals.

Level of Education

Standardized arthritis prevalence findings by level of education are similar to those when examined by level of income; a higher prevalence of arthritis is reported among those reporting a lower level of education. Specifically, the standardized prevalence of arthritis among Canadians reporting lower educational attainment (i.e., secondary school or less) is 30.1% (95% CI: 29.7-30.4%), which is 1.2 times greater than the standardized prevalence among Canadians reporting higher educational attainment (i.e., post-secondary), 25.5% (95% CI: 25.3-25.8%).

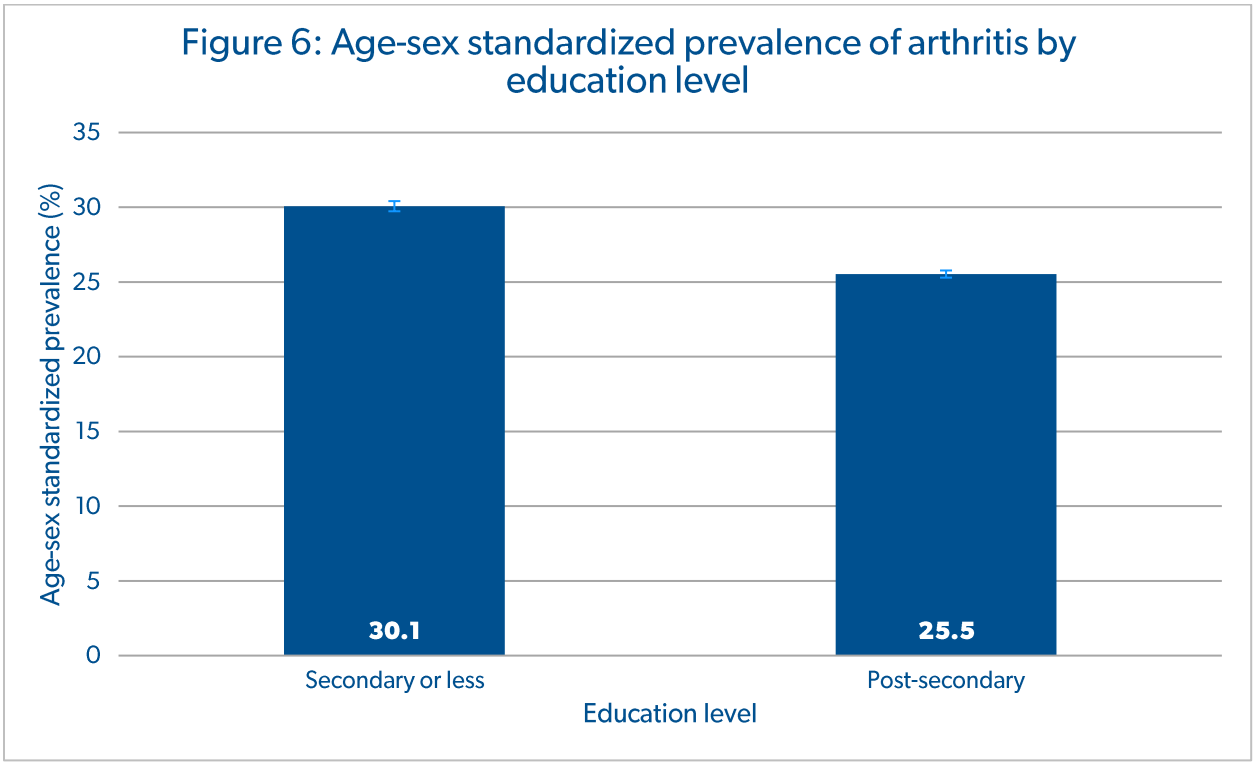

Figure 6: Low education was defined based on respondents' highest level of education attained. Respondents with secondary education or less were classified as having low education.

Error bars represent 95% confidence intervals.

Rural/Urban Residence

The standardized prevalence of arthritis among Canadians living in urban areas is 26.6% (95% CI: 26.4-26.8%), which is significantly lower than that among Canadians living in rural areas, 28.3% (95% CI: 27.9-28.7%).

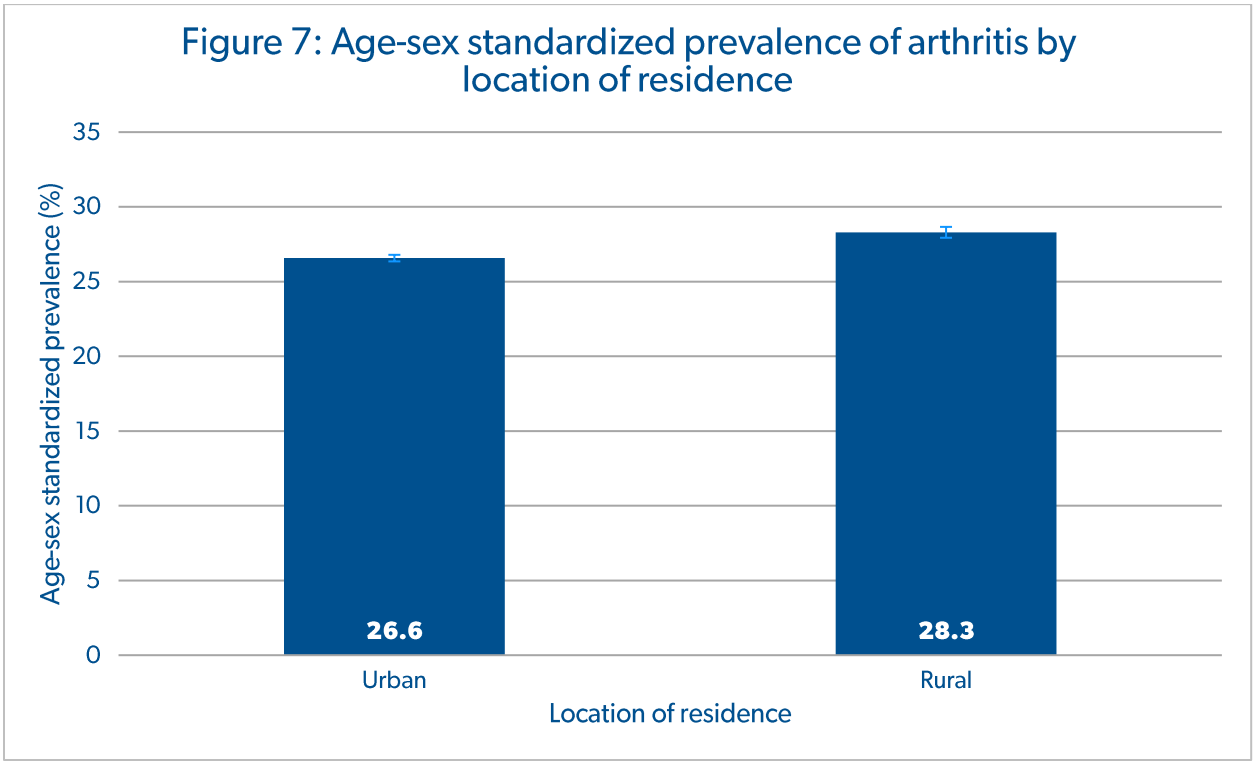

Figure 7: Urban was defined as living within a population centre, a continuously built-up area having a population concentration of 1,000 or more and a population density of 400 or more per square kilometre based on Census population counts. All other areas are defined as rural.

Error bars represent 95% confidence intervals.

Health Outcomes in People with Arthritis across Different Racial/Cultural Groups

Moderate to Severe Pain

The number of Indigenous people living off-reserve with arthritis reporting moderate or severe pain is significantly higher than the number expected based on the rates observed in the general Canadian population with arthritis. The age and sex standardized prevalence ratio (SPR) is 1.19, which means that the rate of moderate or severe pain among this Indigenous population with arthritis is 19% higher than would be expected given overall rates in the general Canadian population with arthritis.

Canadians with arthritis who identify as Chinese, Filipino, and those included in the 'Other' racial/cultural group, all have significantly lower rates of moderate or severe pain than would be expected based on general population rates, with SPRs of 0.62, 0.66, and 0.83, respectively. This means that the rate of reported moderate or severe pain among Canadians with arthritis who identify as Chinese, Filipino, and those included in 'Other', are 38%, 34%, and 17% lower than would be expected, respectively.

Observed rates for those with arthritis who identify as White, South Asian, Black, or Latin American were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 8: Standardized prevalence ratio of people with arthritis reporting moderate or severe pain

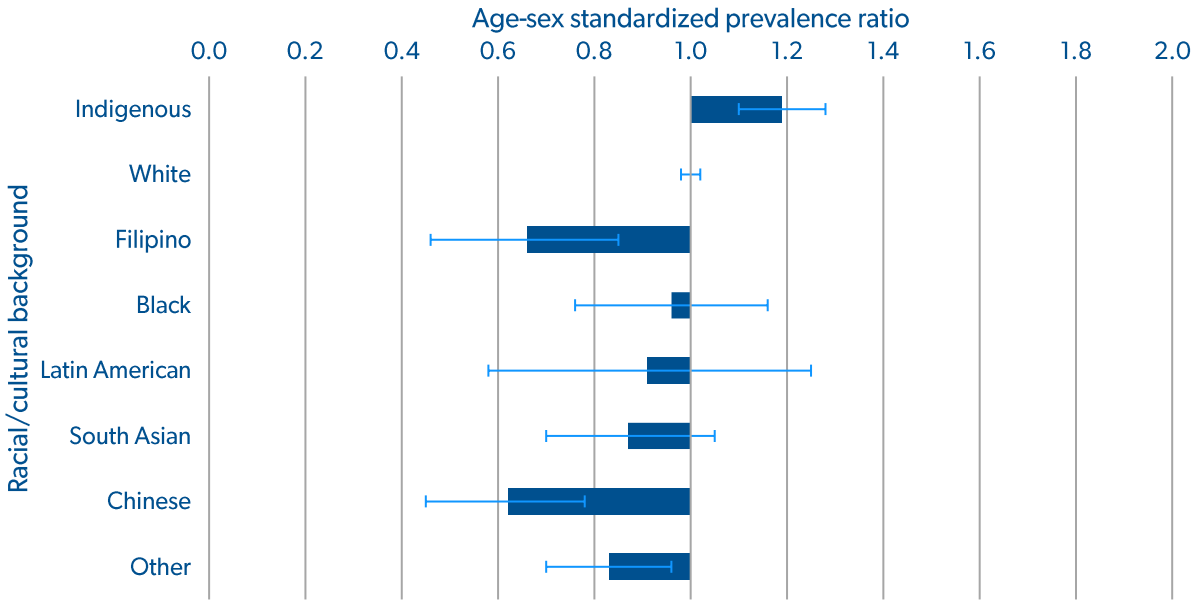

Figure 8: Respondents were asked "Are you usually free of pain or discomfort?". Those who responded 'no' were asked, "How would you describe the usual intensity of your pain or discomfort?" with response options 'mild', 'moderate', 'severe'. Responses of 'moderate' or 'severe' were combined.

Error bars represent 95% confidence intervals.

Moderate to Poor Function

The Health Utilities Index consists of specific questions of functional ability and impact around eight attributes: vision, hearing, speech, mobility, dexterity, emotion, cognition, and pain. Responses to these specific questions are combined to produce an overall Health Utilities Index score that reflects an individual's overall health-related quality of life.

Compared to the general Canadian population with arthritis, the rate of experiencing moderate to poor function among Indigenous people living off-reserve with arthritis is 22% higher than expected (SPR = 1.22). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 9: Standardized prevalence ratio of people with arthritis reporting moderate to poor function

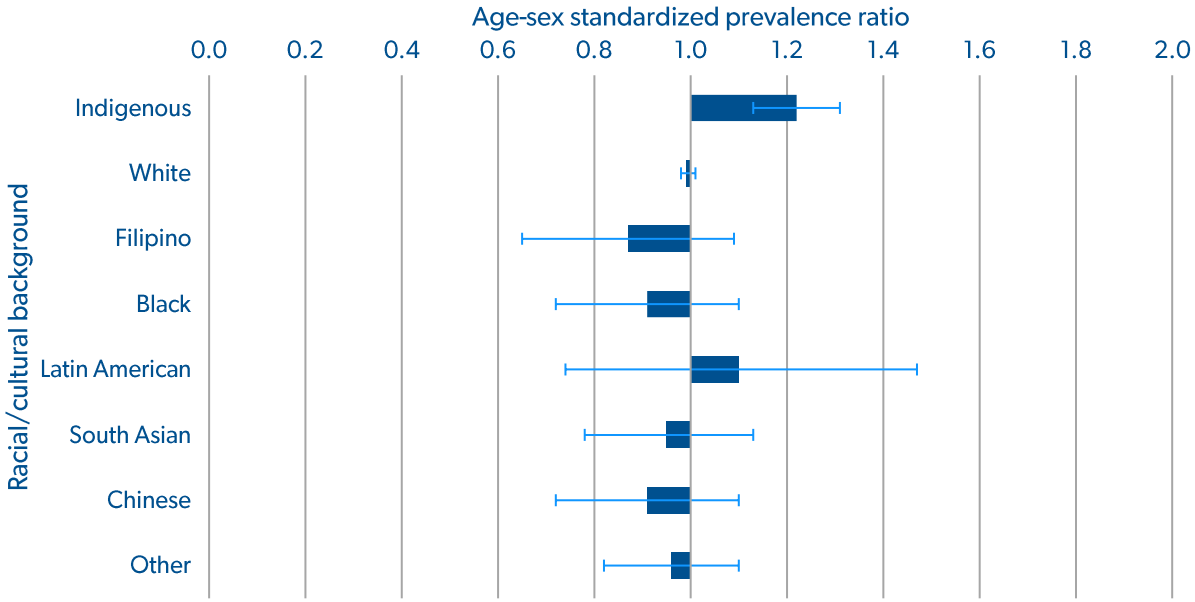

Figure 9: Respondents provided answers to questions on eight attributes of the Health Utilities Index: vision, hearing, speech, mobility, dexterity, emotion, cognition, and pain. The index is designed to produce an overall health utility score that is a measure of an individual's perceived health-related quality of life. The health utility score ranges from 1.0 (perfect health) through 0.0 (health status equal to death) to -0.359 (health status worse than death). Moderate to poor functional health is defined as scores less than 0.8.

Error bars represent 95% confidence intervals.

Poor Mobility

Mobility health status is based on the ability to walk or be mobile around the neighbourhood or for short distances. The use of mechanical supports or a wheelchair as well as the help required from other people is taken into consideration when determining mobility health status.

Looking at the specific attribute of mobility in the Health Utilities Index among people with arthritis in Canada, those who identify as Indigenous living off-reserve are 26% more likely to report poor mobility compared to the general population with arthritis (SPR = 1.26). On the other hand, Canadians with arthritis who identify as Chinese are 50% less likely to report poor mobility compared to the general population with arthritis (SPR = 0.50). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 10: Standardized prevalence ratio of people with arthritis reporting poor mobility

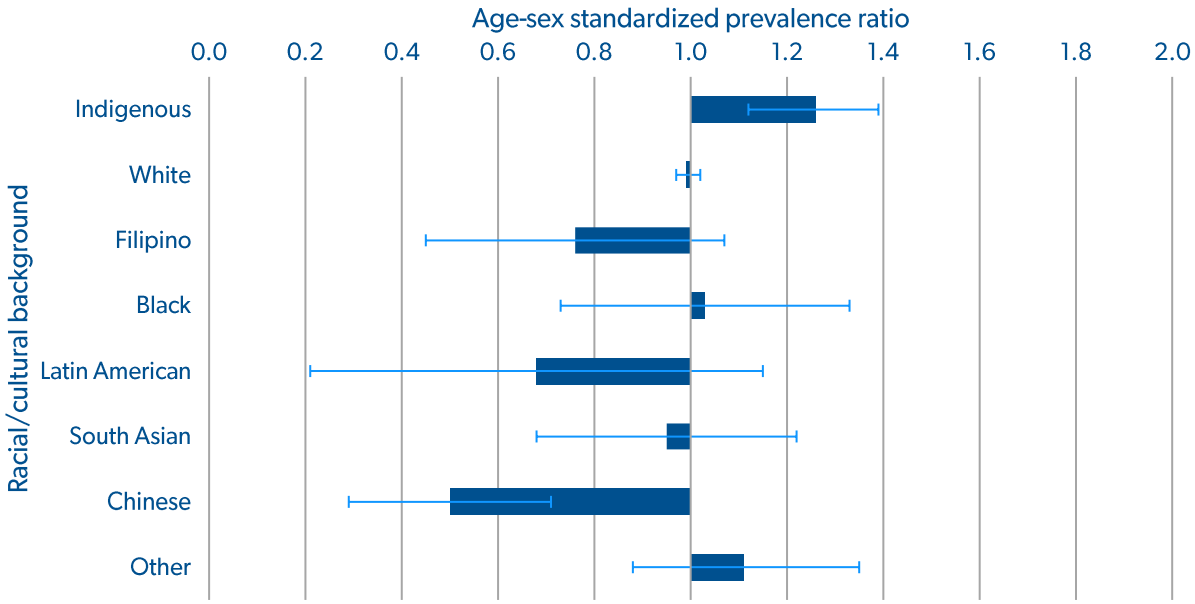

Figure 10: Respondents provided answers to questions related to their mobility, or their ability to get around. Those who reported any difficulty walking were categorized as having poor mobility.

Error bars represent 95% confidence intervals.

Self-rated Health

People in Canada with arthritis who identify as Indigenous living off-reserve or Black are more likely to report having only fair or poor self-rated health compared to the general Canadian population with arthritis (SPR = 1.50 and SPR = 1.33, respectively). This means that the rate of fair or poor health among this Indigenous population with arthritis is 50% higher, and among Black Canadians 33% higher, than would be expected given rates in the general Canadian population with arthritis.

Canadians with arthritis who identify as Filipino are 33% less likely to report having fair or poor self-rated health compared to the general population with arthritis (SPR = 0.67). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 11: Standardized prevalence ratio of people with arthritis reporting fair or poor self-rated health

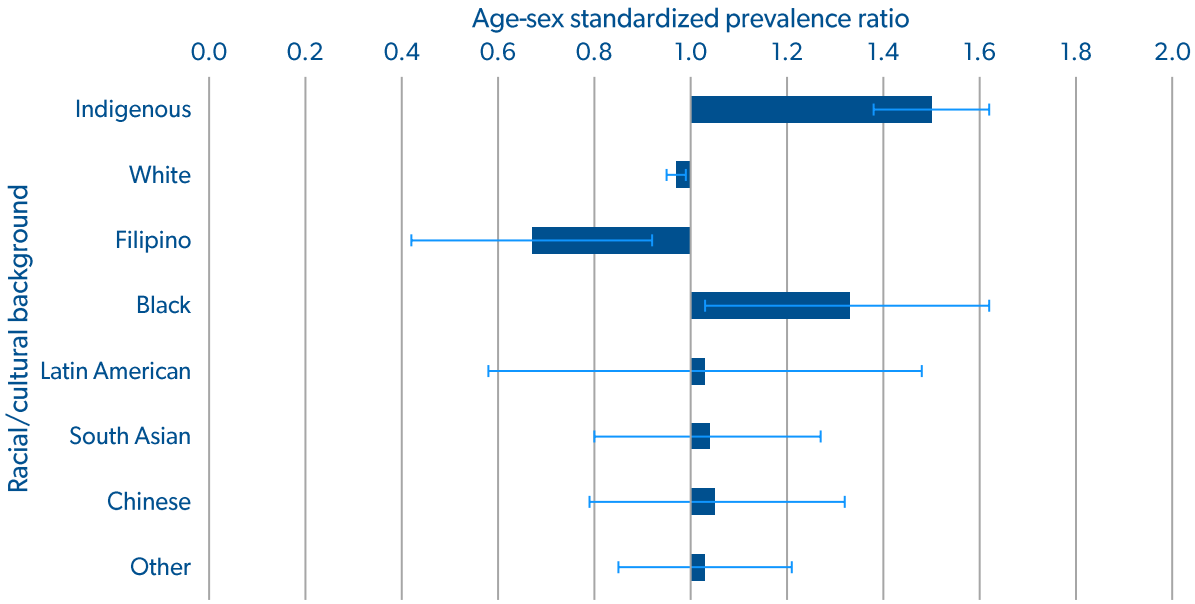

Figure 11: Respondents were asked, "In general, would you say your health is: excellent, very good, good, fair, or poor?' Responses of 'fair' or 'poor' were combined.

Error bars represent 95% confidence intervals.

Co-occurring Conditions

Among individuals living with arthritis in Canada, those who identify as Indigenous living off-reserve are 54% more likely to report having four or more co-occurring conditions along with their arthritis, compared to the general population with arthritis (SPR = 1.54).

Those who identify as Chinese or Latin American are 37% and 49% less likely, respectively, to report having four or more co-occurring conditions along with their arthritis, compared to the general population with arthritis (SPR = 0.63 and SPR = 0.51, respectively). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 12: Standardized prevalence ratio of people with arthritis reporting 4 or more co-occurring conditions

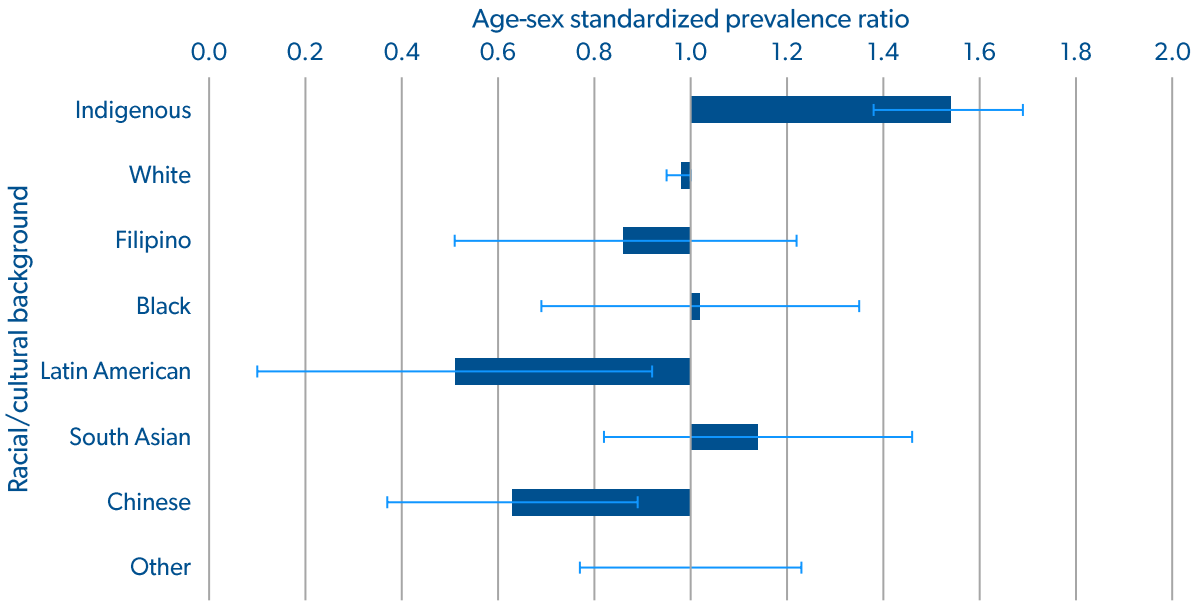

Figure 12: Respondents were prompted: "Now I'd like to ask about certain long-term health conditions which you may have. We are interested in 'long-term conditions' which are expected to last or have already lasted 6 months or more and that have been diagnosed by a health professional." This was followed by a list of 50 individual chronic conditions. 'Yes' responses were used to calculate the number of other chronic conditions.

Error bars represent 95% confidence intervals.

Self-rated Mental Health

People in Canada with arthritis who identify as Indigenous living off-reserve are 50% more likely to report they have only fair or poor mental health compared to the general population with arthritis (SPR = 1.50).

Canadians with arthritis who identify as Filipino are 66% less likely to report they have fair or poor mental health compared to the general population with arthritis (SPR = 0.35). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis. While the significant variability within individual groups may explain the estimates between most groups being statistically non-distinguishable, we note that the prevalence ratio estimate was greater than 1.0 not only for those identifying as Indigenous, but also for those individuals identifying as Black, suggesting that some in this group likely experience inequalities.

Figure 13: Standardized prevalence ratio of people with arthritis reporting fair or poor self-rated mental health

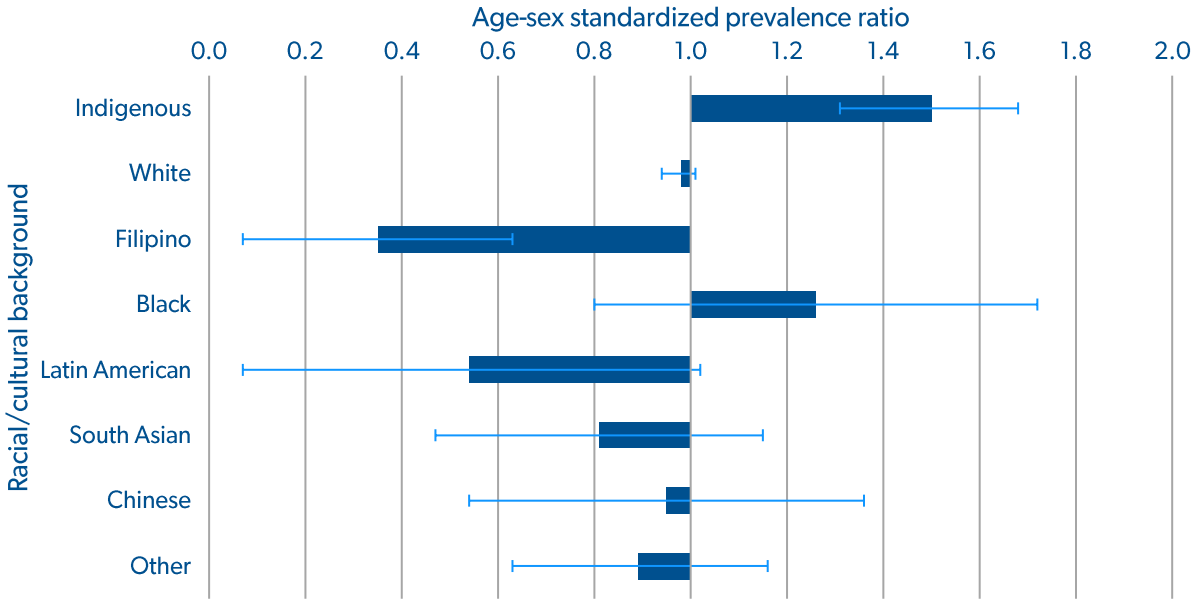

Figure 13: Respondents were asked, "In general, would you say your mental health is: excellent, very good, good, fair, or poor?" Responses of 'fair' or 'poor' were combined.

Error bars represent 95% confidence intervals.

Life stress

People in Canada with arthritis who identify as Indigenous living off-reserve are 17% more likely to report high life stress compared to the general population of Canadians with arthritis (SPR = 1.17).

Canadians with arthritis who identify as Chinese are 31% less likely to report high life stress compared to the general population of Canadians with arthritis (SPR = 0.69). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 14: Standardized prevalence ratio of people with arthritis reporting high life stress

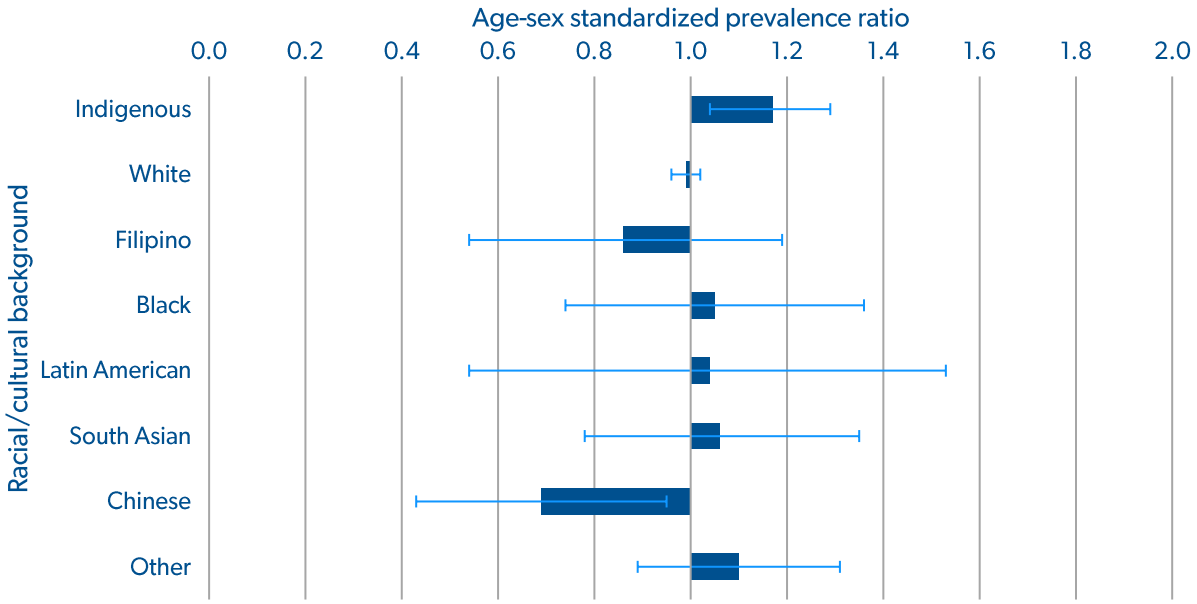

Figure 14: Respondents were asked, "Thinking about the amount of stress in your life, would you say that most days are: not at all stressful, not very stressful, a bit stressful, quite a bit stressful, or extremely stressful?" Responses of 'quite a bit stressful' or 'extremely stressful' were combined.

Error bars represent 95% confidence intervals.

Labour Force

Among working aged people in Canada (30-65 years old) with arthritis, those who identify as Indigenous living off-reserve are 24% more likely to report being out of the labour force compared to the general population with arthritis (SPR = 1.24). Labour force participation could include working or studying.

Among Canadians with arthritis, those who identify as Filipino are 54% less likely to report being out of the labour force compared to the general population with arthritis (SPR = 0.46). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis.

Figure 15: Standardized prevalence ratio of people with arthritis reporting being out of the labour force

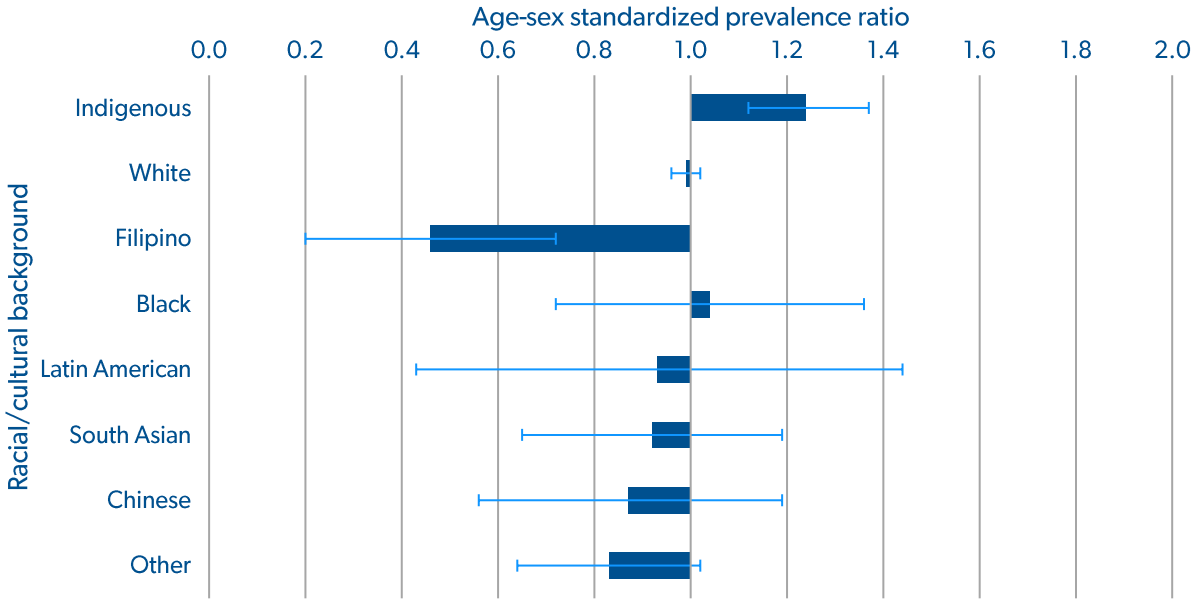

Figure 15: Labour force participation was determined from the survey questions on employment and schooling. Respondents who were working-aged (30-65 years old) and in school or who worked through all or part of the year were considered as being in the labour force.

Error bars represent 95% confidence intervals.

Healthcare Access among People with Arthritis across Different Racial/Cultural Groups

Regular Healthcare Provider

Regular access to a healthcare provider is important for obtaining proper diagnoses, managing disease symptoms, referrals to specialists, and monitoring health over time.

Indigenous people living off-reserve in Canada with arthritis are 49% more likely to report that they do not have access to a regular healthcare provider compared to the general Canadian population with arthritis (SPR = 1.49).

South Asian Canadians with arthritis are 37% less likely to report that they do not have access to a regular healthcare provider compared to the general Canadian population with arthritis (SPR = 0.63). Observed rates for all other groups analysed were not statistically distinguishable from those expected based on the general Canadian population with arthritis. While the prevalence ratio for individuals identifying as Black was not statistically different from 1.0, we note that this was only very marginal, suggesting that inequalities are likely also experienced by this group.

Figure 16: Standardized prevalence ratio of people with arthritis reporting not having a regular healthcare provider

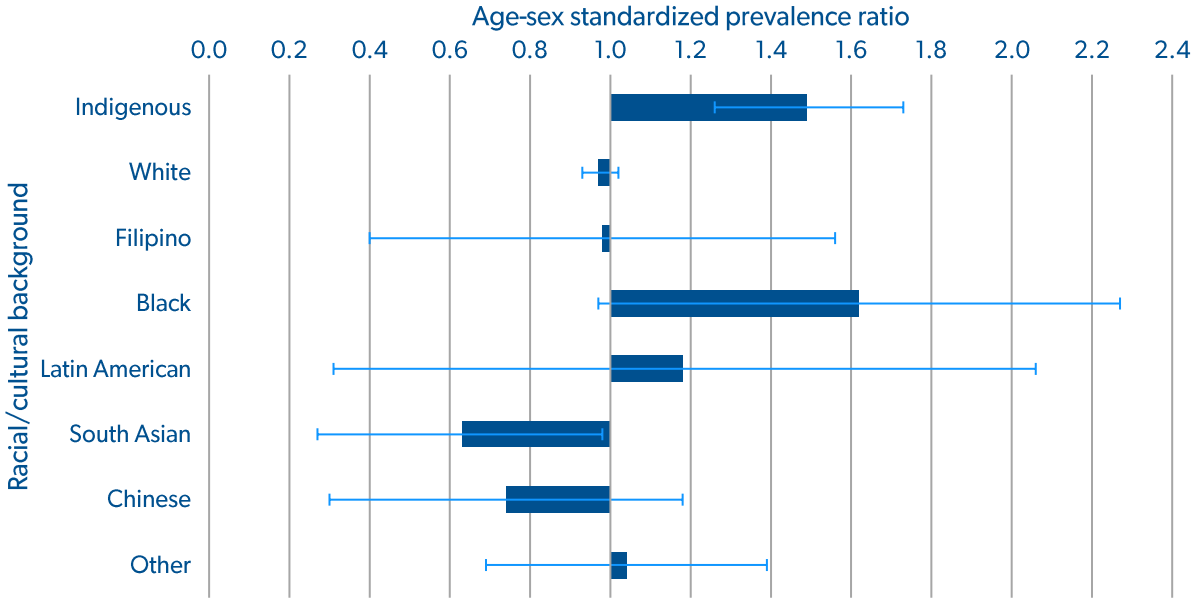

Figure 16: Respondents were asked, "Do you have a regular health care provider? By this, we mean one health professional that you regularly see or talk to when you need care or advice for your health."

Error bars represent 95% confidence intervals.

Conclusions

Arthritis places a substantial burden on all people in Canada. The findings in in this report suggest that the burden of arthritis may be greater within some subgroups of the population. Most notably, Indigenous populations living off-reserve report consistent and pervasive inequalities in both how many individuals are impacted by arthritis and how they experience health outcomes and access to healthcare. The data also point towards inequalities experienced in other groups such as Black Canadians.

The data presented in this report lay the foundation to support evidence-based policy and programs aimed at equitable access to arthritis care for all Canadians and improvements in respectful and meaningful health surveillance data collection across diverse groups and communities in Canada.

For more information, please reach out to mission@arthritis.ca.