

The State of Public Health in Canada 2026

Chief Public
Health Officer of
Canada's Report



Public Health
Agency of Canada

Agence de la santé
publique du Canada

Canada

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Message from the Chief Public Health Officer of Canada

Since becoming Canada's Chief Public Health Officer (CPHO), I've been connecting with and learning from people and partners across the country. Those conversations have reinforced for me the importance of sharing accurate and reliable information about the health issues affecting our communities. I hope this report contributes to that effort by providing a snapshot of key trends in Canada.

The trends highlighted here have caught my attention because of what they tell us about the health of our populations. While every community is unique, looking at the national picture helps us see shared patterns. The report examines some of these by exploring recent changes in life expectancy, mental health, toxic drug harms, sexually transmitted and blood-borne infections, measles, cancer, and wildfires.

While these topics offer important insights into population health, they do not provide a comprehensive overview. Many other issues, including vector-borne and other zoonotic diseases, antimicrobial resistance, tuberculosis, chronic diseases, digital environments, and health security, remain significant public health priorities. I look forward to continuing to explore, address, and report on these areas in the future.

As I reflect on where we are today, and consider the trends in this report, a few observations stand out to me.



Dr. Joss Reimer

Canada's Chief Public Health Officer

Concerning trends among younger people have important implications for both current and future health. The experiences of young people today will shape their health for years to come, underscoring the importance of supporting health early on and throughout the life course.

Some groups continue to experience worse health outcomes than others.

These inequities are driven by the social determinants of health, such as income and housing, and structural determinants, such as systemic racism and colonialism. Together, these factors create advantages for some people and disadvantages for others.

Because many public health issues share these underlying drivers, improving health outcomes requires collaboration across communities, sectors, and systems.

The way we measure and report on health may not always reflect the experiences of all communities or populations in Canada. For example, population health indicators may not fully capture the holistic and relational understandings of health and wellness shared among many First Nations, Inuit, and Métis Peoples. We can better support well-being and advance equity by continuing to integrate positive and strengths-based ways of measuring health.

My experience has shown me that addressing many of the issues highlighted in this report depends on our ability to work together. This becomes even more important as climate change, new technologies, and the spread of misinformation and disinformation reshape how we live, with important implications for our health. Strong relationships and sustained trust are critical in this context.

While trust is built in communities and through people's everyday experiences, I believe an important part of my role is working to foster that trust. This includes sharing clear, relevant, and accurate health information, and being transparent about what we know and what we are still learning. It also means listening to diverse perspectives and lived experiences from across the country.

Public health efforts often happen behind the scenes, but they make a big difference to people's lives. I want to thank the public health professionals, researchers, community organizations, and many others whose dedication and resilience make this work possible. They continue to meet urgent needs while also digging deeper to better understand what drives and improves health outcomes. This report reflects some of what we are learning, and those lessons will continue to shape how we approach the path ahead. I look forward to working together to build healthy communities.

About this Report

Each year, the CPHO reports on important issues influencing the state of public health in Canada. The 2026 report highlights select examples of trends in population health and draws upon the best available national evidence to briefly explore key context, drivers, and inequities. It is intended to be a snapshot of some key trends and focuses on seven areas with notable recent developments:

- Life expectancy and health-adjusted life expectancy
- Mental health
- Toxic drug harms
- Sexually transmitted and blood-borne infections
- Measles
- Cancer
- Wildfires

The selected topics represent the diversity and evolving nature of health and well-being in Canada. While national indicators offer valuable insight into broad patterns, they cannot fully capture the complexity of population health and should be interpreted alongside additional evidence, research, and community knowledge.

The report is intended for a range of audiences interested in national population health, including public health professionals, policymakers, researchers, community stakeholders, and partners across relevant sectors.

The report is organized by topic area. Each section summarizes key recent trends (**What is changing?**) and considers their implications for public health (**Why does this matter?**). These are followed by a concluding **Looking Forward** section that highlights CPHO priorities.

Additional Resources

Readers interested in exploring the issues discussed in this report in greater depth, or in accessing additional national public health data, are encouraged to consult the following resources:

- [Health of People in Canada Dashboard](#)
- [Health Inequalities Data Tool](#)
- [Quality of Life Hub](#)
- [Positive Mental Health Surveillance Indicator Framework](#)
- [Canadian Chronic Disease Surveillance System](#)
- [Opioid- and Stimulant-related Harms in Canada](#)
- [Canadian Notifiable Disease Surveillance System](#)
- [Canadian Wildland Fire Information System](#)

Land and Water Acknowledgement

This report was developed on the traditional lands and waters of First Nations, Inuit, and Métis Peoples across what is now known as Canada. We wish to acknowledge the strength, resilience, and wisdom of Indigenous Knowledges that have been nurtured and passed down through generations by First Nations, Inuit, and Métis Peoples. We also wish to acknowledge the following lands and waters, where the core work on this report was undertaken:

- Halifax, also known as K'jipuktuk, which is part of the ancestral, unceded, and unsurrendered territory of the Mi'kmaq People. The area and its connection to the Atlantic Ocean have sustained the Mi'kmaq People since time immemorial and continue to hold deep cultural, spiritual, and ecological significance. This territory is covered by the Treaties of Peace and Friendship which Mi'kmaq, Wolastoqiyik (Maliseet), and Passamaquoddy Peoples signed between 1725 and 1779. The treaties did not deal with the surrender of lands and resources but, instead, recognized Mi'kmaq, Wolastoqiyik (Maliseet), and Passamaquoddy title and established the rules for an ongoing relationship of peace and friendship between nations.
- Montreal, also known as Tiohtià:ke, the traditional, unceded, and unsurrendered territory of the Kanien'kehá:ka. Montreal is now home to many diverse urban First Nations, Inuit, and Métis Peoples. Located along the Kaniatarowanenneh (St. Lawrence River), Tiohtià:ke has long been a place of gathering, travel, trade, and exchange, serving as an important meeting place for many First Nations, including the Kanien'kehá:ka of the Haudenosaunee Confederacy, Wendat, Abenaki, and Anishinaabeg.
- Ottawa, also known as Adawe, located on the traditional, unceded, and unsurrendered territory of the Anishinabe Algonquin People, including the members of the Anishinabek Nation Governance Agreement. Ottawa is now home to many diverse urban First Nations, Inuit, and Métis Peoples. Located where the Kichi Sibi (Ottawa River) and Pasapkedjinawong (Rideau River) meet, this area has long been a place of gathering, travel, trade, and cultural exchange, with these waterways continuing to hold deep significance for the Algonquin People.
- Toronto, also known as Tkaronto, located on the traditional territory of many nations, including the Mississaugas of the Credit, the Anishinaabeg, the Chippewa, the Haudenosaunee, and the Wendat Peoples and is now home to many diverse urban First Nations, Inuit, and Métis Peoples. Situated along the northwestern shore of Niigani-gichigami (Lake Ontario) and connected through the waterways of the Great Lakes, Tkaronto has long been an important place of gathering, travel, and exchange. Toronto is within the lands protected by the Dish with One Spoon Wampum Belt Covenant, an agreement between the Haudenosaunee and Anishinaabeg and allied nations to peaceably share and care for the resources around the Great Lakes.
- New Westminster, located on the unceded and unsurrendered land of the traditional Halkomelem speaking peoples from the Coast Salish, and in particular the qiqéyt (Qayqayt) and xʷməθkʷəyəm (Musqueam) Nations. Situated along the Stó:lō (Fraser River), whose waters have sustained Coast Salish Peoples since time immemorial, these lands and waterways remain central to culture, governance, trade, and stewardship.
- Central Saanich, located on the traditional territory of the STÁUTW and WJOLÉLP First Nations, two of the five communities that constitute the WSÁNEĆ Nation. This area is also within the lands covered by the Douglas Treaties, specifically the South Saanich and North Saanich Treaties. The region is surrounded by the waters of the Á,LENENEÇ ŁTE (Salish Sea), including the STÁUTW (Saanich Inlet) and Haro Strait. These marine waters have sustained the WSÁNEĆ Peoples since time immemorial and continue to be central to their culture, governance, and way of life.

Key Trends in National Population Health

Public health systems at national, provincial, territorial, and regional levels collect and analyze information on physical and mental health outcomes, determinants of health, health-related behaviours, and health system use.¹⁻⁴ These data help detect emerging issues, monitor changes over time, and inform policies and programs that support population health. The trends presented in this report highlight selected areas that provide insight into how population health is changing in Canada.

Life expectancy is returning to pre-pandemic levels, but fewer years are spent in good health

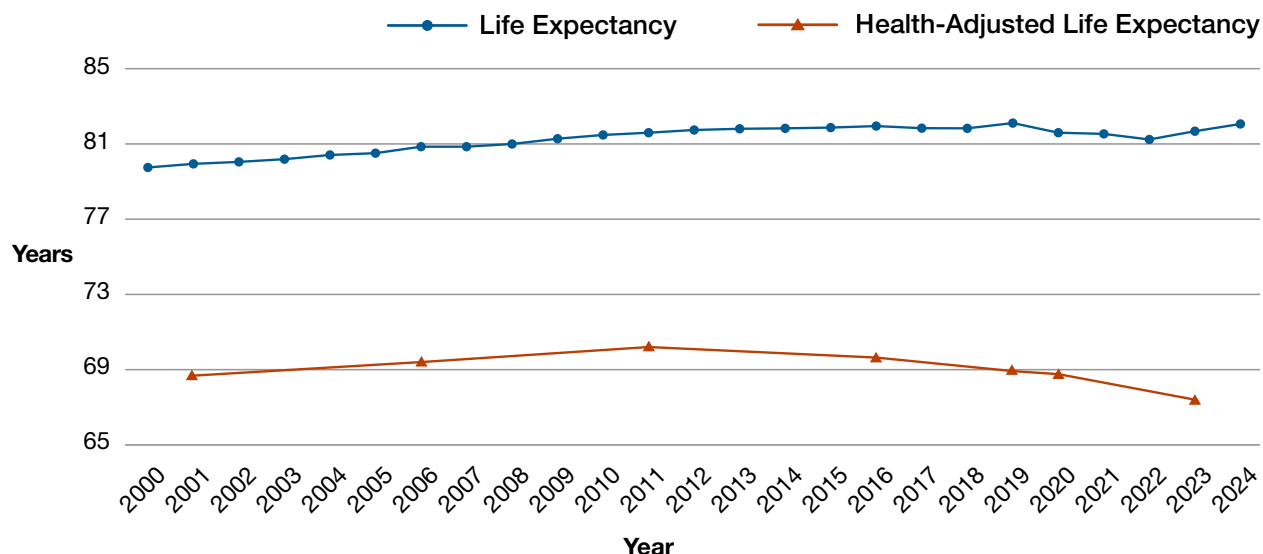
What is changing?

Life expectancy at birth in Canada has been mostly increasing for the past century, but the pace of gains began to slow in 2010 as a result of the toxic drug crisis.⁵⁻⁷ Between 2019 and 2022, life expectancy dropped from

82.2 years to 81.1 years, the largest decrease ever recorded in Canada.^{5, 8} The decline was likely driven by impacts of the COVID-19 pandemic, including both deaths directly attributable to COVID-19 and a rise in deaths related to the toxic drug crisis, particularly among younger men.^{7, 9, 10}

Recent data show a rebound. Life expectancy at birth has increased for two consecutive years, reaching 82.1 years in 2024, nearly returning to pre-pandemic levels ([Figure 1](#)).¹¹

Figure 1: Life Expectancy and Health-Adjusted Life Expectancy in Canada, 2000 to 2024^{5, 12, 13}



Notes: Health-adjusted life expectancy data prior to 2019 are three-year estimates plotted at their midpoint while data from 2019 to 2023 are single year estimates. Life expectancy data from 2000 to 2024 are single year estimates.

Just as important as how long people live is how healthy they are during those years. Health-adjusted life expectancy measures both the length and quality of life.¹⁴ It estimates how many years a person is likely to live in good health if current patterns of mortality and health remain unchanged. This measure reflects the total time spent in good health across the lifespan, whether accumulated through consecutive or non-consecutive periods of good health.¹⁴

Recent trends in health-adjusted life expectancy raise concern. In 2023, a person in Canada could expect to spend an average of 66.9 years in good health.¹⁵ This is nearly two years lower than in 2019 and more than three years below the peak reached in the early 2010s, reversing gains made since the early 2000s ([Figure 1](#)).¹⁵

New evidence points to deteriorating emotional health among people under the age of 65 as the primary contributor to this decline.¹⁶ While the prevalence of high emotional health decreased across all adult age groups between 2015 and 2024, the largest declines were observed among younger adults, particularly those aged 18 to 34 years.¹⁶

Why does this matter?

Life expectancy and health-adjusted life expectancy are central to understanding the health of a population. Health-adjusted life expectancy provides valuable context by capturing not only whether people are living longer, but also whether they are living well throughout their lives.

Ideally, gains in life expectancy would be accompanied by similar or greater gains in health-adjusted life expectancy. Instead, recent trends suggest that on average people in Canada are living longer while spending a smaller share of their lives in good health before age 65. This has implications for quality of life and highlights the need to support health and well-being throughout the life course.

These measures can also be used to examine health inequities across populations.¹⁷ Life expectancy has been consistently shorter among First Nations, Inuit, and Métis Peoples than among the non-Indigenous population, influenced by the historic and ongoing impacts of colonialism, systemic racism, and intergenerational trauma on health.^{18–21} While life expectancy improved among Indigenous Peoples between 2006 and 2019, progress was uneven, and substantial gaps remained.²⁰ Between 2016 and 2021, life expectancy was 13.6 years lower for First Nations living on-reserve, 9.0 years lower for First Nations living off-reserve, 13.1 years lower for Inuit, and 4.5 years lower for Métis.²¹

There are also differences in life expectancy and health-adjusted life expectancy by income and sex. Nationally, in 2023, people living in the lowest income neighbourhoods lived five years less than people living in the highest income neighbourhoods and could expect to live eight years fewer in good health on average.¹² Although females consistently live longer in both total number of years and healthy years, males spend a greater proportion of their lives in good health (83% compared to 81%).¹⁵

Examining these indicators across different populations helps identify where health gains are occurring and where systemic barriers to longer, healthier lives persist.

While some indicators of mental health have worsened, there are early signs they may be levelling off

What is changing?

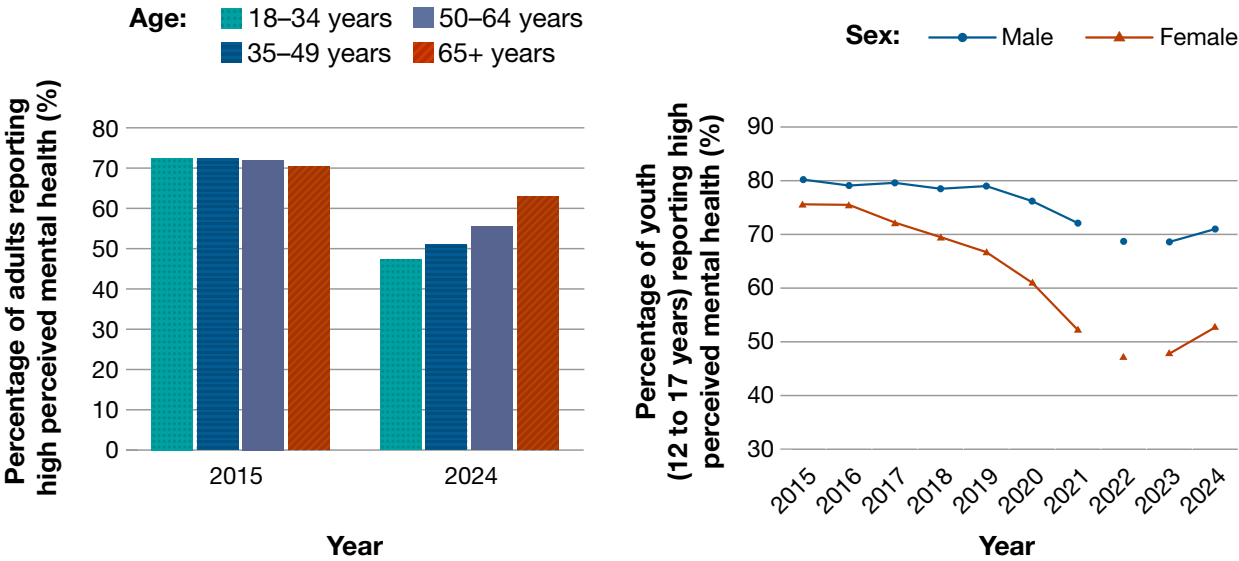
Over the past decade, some mental health indicators have been worsening in Canada. In 2015, 72% of adults reported their mental health was very good or excellent, but in 2021 this dropped to 59%.²² Similarly, for youth aged 12 to 17 years, this percentage was 78% in 2015 and dropped to 62% in 2021.^{23, 24} Declines in high perceived mental health did not appear to continue from 2023 to 2024.^{25, 26} While most people in Canada report high perceived mental health, and recent data suggest the trend may be stabilizing, levels remain below those seen a decade ago.²²

Similar trends were observed in rates of mood disorder and of anxiety disorder, the two most common types of mental illnesses, which both appeared to be increasing between 2015 and 2021.²² For mood disorders, increases did not appear to continue between 2023 and 2024 (similar analysis for anxiety disorders was not feasible as a result of data limitations).²⁵ Continued collection of comparable data is needed to determine whether these early signals reflect a true change in prevalence and whether the trend will continue in the future.

There are also differences in mental health between population groups that have emerged recently. For example, while there have been declines among all age groups, due to larger declines over time among younger adults, adults 65 years and older are now the most likely to report high perceived mental health (Figure 2).²⁵ Additionally, for

youth aged 12 to 17 years, males and females were more similar in 2015 than in more recent years, where estimates of high perceived mental health are considerably lower for females (Figure 2).^{23, 26} Young women in particular are most likely to meet the diagnostic criteria for a mood or anxiety disorder.²⁷

Figure 2: Age and Sex Differences in High Perceived Mental Health in Canada, 2015 to 2024^{23, 25, 26}



Notes: For adults all estimates are from the Canadian Community Health Survey. For youth (12 to 17 years of age) estimates from 2015 to 2022 are from the Canadian Community Health Survey and estimates from 2023 to 2024 are from the Canadian Health Survey on Children and Youth. As a result of a survey redesign, caution is needed when comparing Canadian Community Health Survey data before and after 2022. Estimates from the Canadian Community Health Survey and the Canadian Health Survey on Children and Youth should not be compared because of different sampling and data collection methodologies.

Why does this matter?

Good mental health supports overall health and the ability of individuals, communities, and societies to function and thrive.^{28–30}

Therefore, any changes in mental health can have broad implications, underscoring the importance of understanding how these trends may shape health and well-being over time.

Part of the overall worsening seen in the past decade may reflect greater awareness and openness around mental health, which could make people more willing to report worse mental health.^{31–34} However, evidence suggests these factors alone do not fully explain the trends seen in Canada and some comparable countries, particularly among younger people.^{32, 35–37} Understanding what is driving these changes remains an ongoing area of research. It is likely that multiple, interconnected forces are at play, including broader global challenges, such as the climate crisis, economic instability and affordability challenges, changing digital environments, and lasting impacts of the COVID-19 pandemic.^{35–39}

Some groups of people experience significantly worse mental health than others, reflecting the influence of the social and structural determinants of health.⁴⁰ As a result, certain populations are exposed to more risk factors (e.g., discrimination, financial difficulties, food insecurity) and fewer protective factors (e.g., access to culturally safe mental healthcare services).^{28, 40–43} This leads to inequities in mental health outcomes.^{28, 40, 42}

It is important to note that although there is no singular Indigenous perspective on mental health, for many First Nations, Inuit, and Métis populations, mental wellness is often understood holistically, and supported by community, culture, family, language, land, Elders, and connection to traditional practices.⁴⁴ These dimensions of wellness may not be fully reflected in conventional Western mental health indicators.^{42, 44, 45}

As the unregulated drug supply changes, so do its health harms

What is changing?

Canada has witnessed a substantial rise in fatal and non-fatal harms associated with toxicity in the unregulated drug supply between 2016 and 2023.⁴⁶ This was largely driven by the introduction of fentanyl and other synthetic opioids.^{46, 47} A notable decline in fatalities has since occurred nationally, with a 17% decrease in apparent opioid toxicity deaths between 2023 and 2024, and a further 23% decrease from 2024 to 2025.⁴⁸ This trend varies significantly by region.⁴⁸

The national decline in fatalities appears to be influenced by multiple factors, including changes in the toxicity of the drug supply and better access to naloxone.⁴⁹ However, the unregulated drug supply remains highly toxic and unpredictable, driving continued risk. For example, a number of public health authorities across Canada published drug alerts in early

2026 flagging new contaminants.^{50–52} While naloxone is recommended for all overdoses, additional medical interventions may be needed to address any effects of these new contaminants which naloxone does not directly reverse.⁵³ Changes in the drug supply can also alter the risk of non-fatal harms, such as brain injury or infection.^{54–57}

Another shift during the toxic drug crisis has been the rise in polysubstance exposure, which is when more than one substance or drug is taken together, either intentionally or unintentionally. There has been an increase in deaths involving multi-drug toxicity, particularly those involving both opioids and stimulants.^{58–61}

Why does this matter?

The toxic drug crisis has had innumerable impacts on individuals, families, healthcare providers, and communities. This impact is ongoing, with 2025 apparent opioid toxicity deaths still higher than pre-pandemic levels in 2019, and almost twice as high as those observed at the beginning of the crisis in 2016.⁴⁸ Opioid-related emergency department visits, hospitalizations, and emergency medical services calls have also remained high.⁴⁶ This underscores the need to sustain and strengthen comprehensive prevention, harm reduction, and treatment efforts.^{62, 63}

Furthermore, shifting trends in the supply of unregulated substances make it difficult to predict the nature and severity of future harms. This may impact the relevance and effectiveness of public health interventions, reinforcing the value of learning from people with lived and living experience.^{64–67}

Understanding how these evolving harms are experienced across populations can inform effective public health responses. People who use drugs can come from all walks of life. However, the harms of the crisis fall more heavily on men, and inequitable outcomes are influenced by a number of social determinants of health, including income, housing, employment, and education.^{46, 67–72}

First Nations, Inuit, and Métis populations are also disproportionately harmed by the toxic drug crisis due to ongoing impacts of colonialism, racism, and intergenerational trauma.^{73, 74} Indigenous and public health leaders have highlighted the need for Indigenous-led approaches, partnerships with Indigenous organizations, and culturally safe care that centres Indigenous Knowledges.^{62, 63, 73, 75–77}

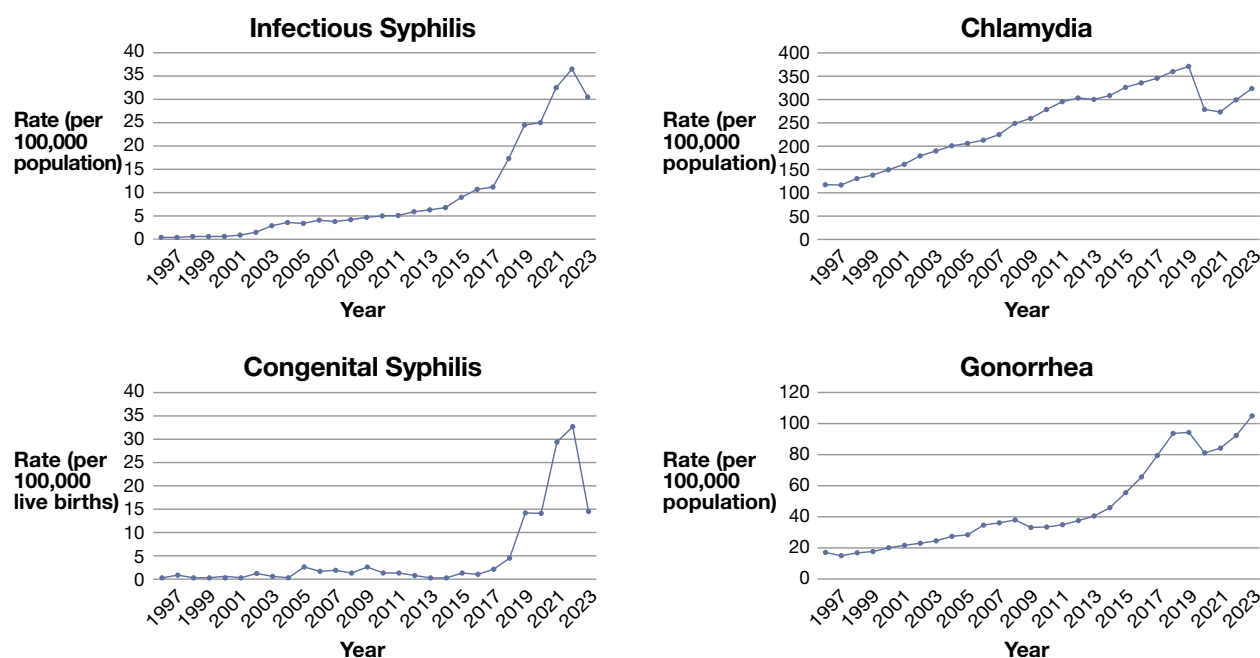
Rates of some sexually transmitted and blood-borne infections continue to rise

What is changing?

Over the past decade, patterns in sexually transmitted and blood-borne infections (STBBIs) have shifted. National rates of syphilis, chlamydia, and gonorrhea are increasing (Figure 3). In particular, infectious syphilis

has risen substantially over the past decade, with more than a four-fold increase in rates between 2014 and 2023.⁷⁸ This surge has led to a more than three-fold increase between 2018 and 2023 in the rate of congenital syphilis, when syphilis is passed to babies during pregnancy or at birth.^{78–80} The rate of reported cases declined in 2023, but more data are needed to determine whether this will be a persisting trend.⁸¹

Figure 3: Syphilis, Chlamydia, and Gonorrhea in Canada, 1996 to 2023^{78, 82, 83}



Notes:

Infectious syphilis

Infectious syphilis includes primary, secondary, early latent, and infectious neurosyphilis (<1 year after infection) stages of infection. Data were collected through routine (1996 to 2017) and enhanced (from 2018 onwards) surveillance systems. For 2023, data were received from 12 of 13 jurisdictions; Alberta estimates were projected from partial-year data. Data for 2023 are preliminary.

Congenital syphilis

Data include reported confirmed early congenital syphilis cases (diagnosed within two years of birth) based on the national case definition in effect until December 31, 2023. Data were collected through routine (1996 to 2017) and enhanced (from 2018 onwards) surveillance systems. Quebec data from 2013 to 2016 may include probable cases.

Chlamydia

Data from Nunavut are only included from 2000 onwards.

Chlamydia remains the most commonly reported sexually transmitted infection, with rates generally rising over the past three decades.⁸¹ Although reported rates dipped in 2020 and 2021, likely due to COVID-19-related disruptions to testing, recent patterns suggest cases are increasing again.⁸¹ The rate of reported gonorrhea cases also increased rapidly prior to the COVID-19 pandemic and was three times higher in 2023 than in 2010.⁸¹

Some STBBI trends are encouraging. Reported hepatitis B rates have remained low, and reported hepatitis C rates have declined since reaching a recent peak in 2018.⁸¹ Other trends are more nuanced. For example, the rate of new HIV diagnoses was relatively stable in Canada between 2012 and 2019. Following a substantial decline in 2020, likely due to reduced access to testing services, rates increased each year from 2021 to 2023 before decreasing slightly in 2024.^{84, 85} This recent decrease should be interpreted cautiously, as it is too early to determine whether it reflects a sustained downward trend, and the rates observed in 2023 and 2024 were higher than at any point in the previous decade.^{85, 86} Certain populations also continue to be disproportionately affected.^{85, 87} Within national trends there is great variability across geographic regions and communities, with some reporting rates of certain STBBIs that are much lower or higher than the national average.^{86, 88}

Why does this matter?

Communities, researchers, and governments have worked collaboratively on improving the prevention, diagnosis, and treatment of STBBIs. This has also included efforts to reduce stigma and raise the quality of life for people living with or affected by these infections.⁸⁹ Yet the health impacts of STBBIs can be significant. For example, congenital syphilis can have serious consequences including stillbirth and infant death.^{78, 79} There are also implications for treatment. For instance, more gonorrhea cases are being detected in which the bacteria have developed resistance to one or more of the drugs used to treat the infection.⁹⁰

Higher rates of STBBIs among certain groups reflect the influence of broader forces, like colonialism and discrimination, as well as inequities in conditions such as income, housing, food security, and access to health and social services.^{91, 92} Many complex and interconnected factors intersect to both increase exposure to STBBIs and create barriers to STBBI prevention, testing, and treatment for some people.⁹¹ Rising STBBI rates and persisting inequities underscore the need for timely, high-quality data and coordinated responses across sectors that respond to the realities and needs of affected populations.^{91, 93, 94}

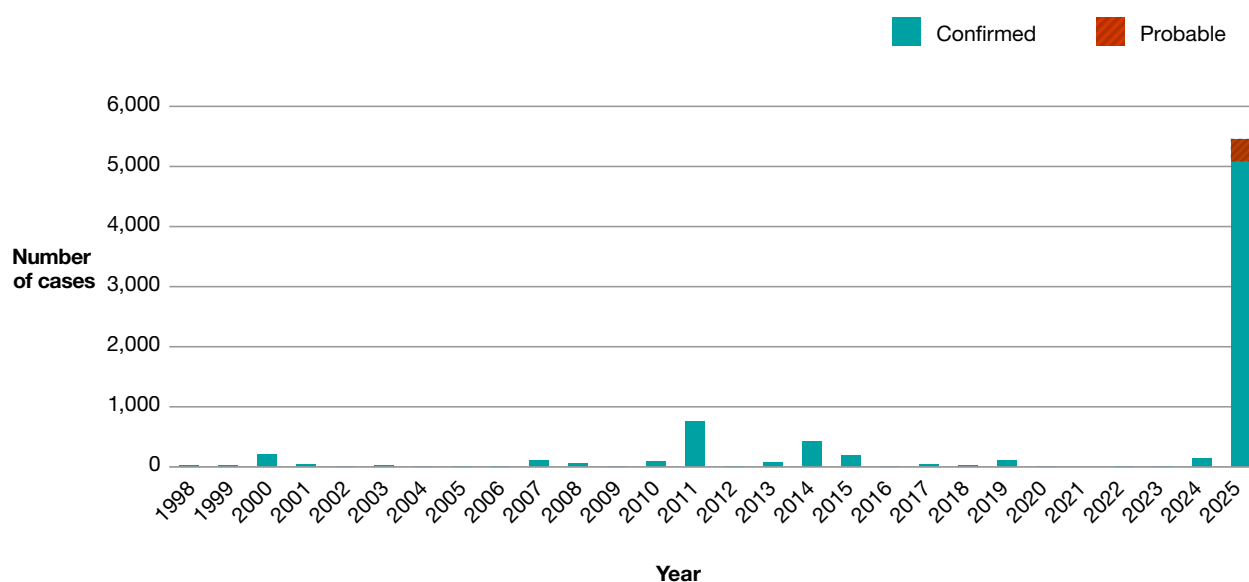
Measles outbreak highlights the importance of vaccination

What is changing?

Since the introduction of routine 2-dose vaccination programs in 1996 to 1997, measles has been rare in Canada.^{95, 96} Between 1998 and 2024, there were an average of 91 cases reported annually, predominantly associated with infections imported through international travel from areas where measles is endemic, with limited subsequent spread within Canada.^{95, 97, 98}

Against the backdrop of a global resurgence of measles, a large multijurisdictional outbreak began in late 2024.^{97, 99} In 2025, Canada lost measles elimination status as a result of more than a year of sustained transmission of the same measles virus strain.¹⁰⁰ There were a total of 5,462 measles cases reported in 2025, with most linked to this multijurisdictional outbreak ([Figure 4](#)).⁹⁷ Spread slowed significantly in 2026 and in October the outbreak was declared over.⁹⁷

Figure 4: Measles Cases in Canada, 1998 to 2025¹⁰¹



Notes: Cases are plotted based on year of rash onset. Probable cases are only included for 2025. They are excluded in previous years as they are not systematically reported to the Canadian Measles and Rubella Surveillance System.

The initial case leading to this outbreak was linked to exposure outside Canada, but then spread continued in Canada, mainly in under-vaccinated communities.^{95, 98} Within the outbreak, 94% of cases were in unvaccinated people or those with unknown vaccination status.⁹⁷

Why does this matter?

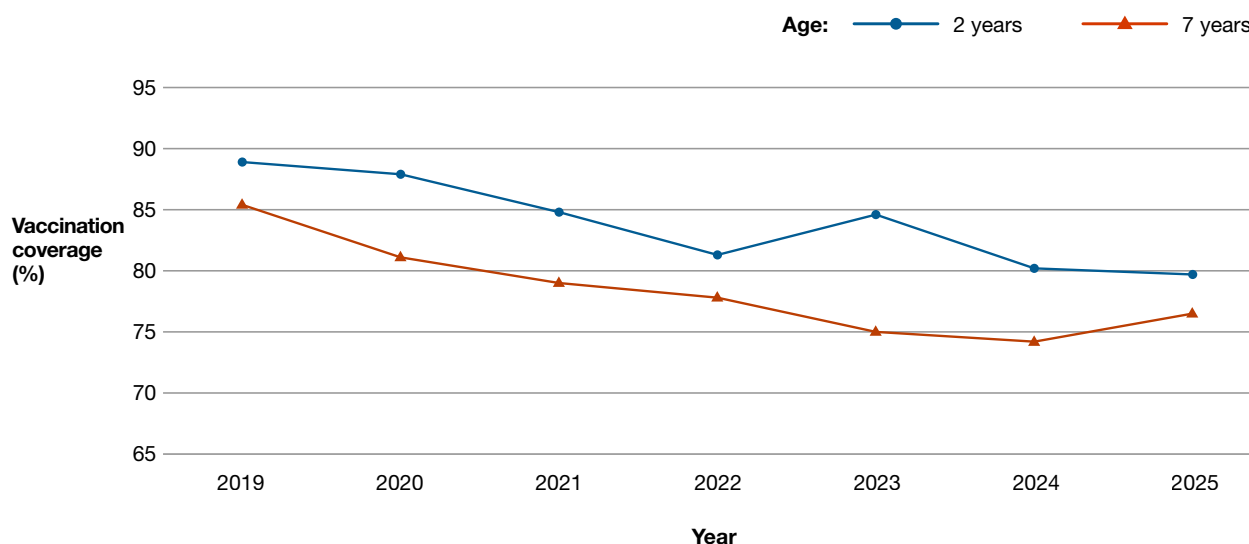
Measles is a highly contagious infectious disease that can have severe health consequences.⁹⁶ Since Canada achieved measles elimination status in 1998, high overall vaccination coverage combined with public health responses to the small number of imported cases limited measles transmission.⁹⁵ Global measles outbreaks and the resumption of international travel after the COVID-19 pandemic subsequently highlighted significant immunity gaps in under-vaccinated communities in Canada.⁹⁵

Maintaining continued high vaccination coverage is needed to protect Canada's population as a whole, including infants too young to be vaccinated, pregnant people, individuals who cannot be vaccinated for medical reasons, or others who have limited immune protection. The resurgence of measles

highlights the importance of addressing disparities in vaccination coverage. Overall vaccination coverage estimates may not fully capture how immunity is distributed geographically or within communities. While achieving and maintaining high vaccination coverage at a population level is essential, clusters of under-vaccinated individuals can increase the risk of localized outbreaks.^{102, 103}

In some provinces and territories, there appears to have been a decrease in measles vaccination coverage among children aged two and seven years from 2019 to 2023 ([Figure 5](#)).^{104–106} In 2024/2025, this decline appears to have stabilized, but coverage has not recovered.¹⁰⁵ Vaccine uptake can be driven by a variety of factors including ease of access to vaccines, the level of concern about vaccine-preventable diseases, and vaccine confidence.^{107, 108} Some populations face greater structural barriers to vaccine access, which could include competing pressures on resources to book vaccine appointments or travel to clinics.^{109, 110} Facilitating vaccine uptake is critical to strengthen protection against measles and enhance preparedness for future infectious disease threats.¹⁰⁹

Figure 5: Measles Vaccination Coverage in Canada, 2019 to 2025¹⁰⁵



Notes: Figure shows measles vaccination coverage in provinces and territories reporting to the Standardized Reporting on Vaccination (STARVAX) surveillance system. For those aged two years this is one or more dose of a vaccine against measles and for those aged seven years this is two or more doses of a vaccine against measles. Reference date is December 31 of each year. Only provinces and territories that reported for all years from 2019 to 2025 are included. For two-year-olds this includes Alberta, Saskatchewan, Manitoba, New Brunswick, and Yukon and for seven-year-olds this includes Alberta, Saskatchewan, Manitoba, and Yukon.

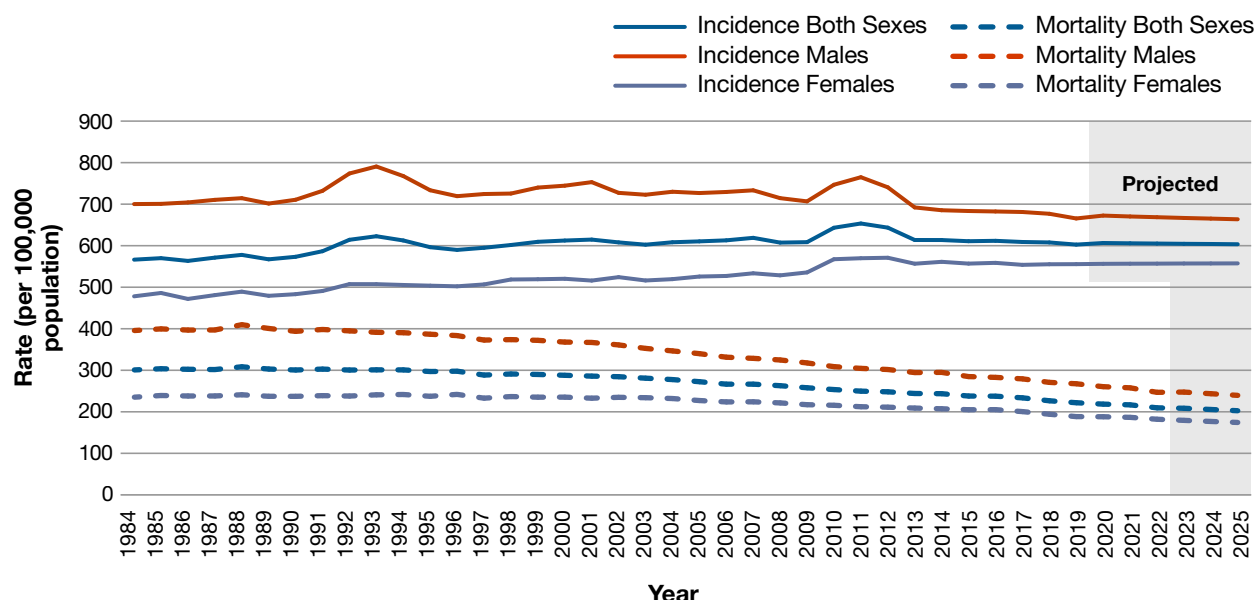
Cancer outcomes are improving overall, but population health impacts remain high and some patterns are shifting

What is changing?

Over the past several decades, there have been promising trends in overall cancer cases and deaths in Canada. As of 2021, the rate of new cancer cases, adjusted for age, had

decreased by 1.2% annually since 2011 for males and 0.4% annually since 2012 for females (Figure 6).¹¹¹ Since peaking in the late 1980s for males and mid 1990s for females, overall cancer death rates have declined significantly, by 42% in males and 28% in females (Figure 6).¹¹¹ These declines are evident across several of the most common cancer types, including lung cancer, likely driven by long-term reductions in tobacco use, and colorectal cancer, in part due to screening programs.¹¹¹

Figure 6: Cancer Incidence and Mortality in Canada, 1984 to 2025¹¹¹



Notes: Figure adapted from Canadian Cancer Statistics 2025, which provides details of the estimation methods. Incidence and mortality rates are age-standardized to the 2021 Canadian standard population.

Cancer remains a complex and evolving group of more than 100 diseases, and trends have not been the same across all types. For example, continuing increases in incidence are projected for melanoma, uterine, and pancreatic cancers.¹¹² Cervical cancer incidence has stopped declining after many years of progress.^{111–113} Rates of certain types of cancer, such as breast and colorectal, appear to be rising among younger people in Canada and other comparable countries.^{114–117}

Why does this matter?

Emerging trends, such as cervical cancer rates no longer declining and increasing rates of some cancers among younger people, warrant continued monitoring and further research to better understand how and why cancer patterns may be evolving.^{111, 112} In this context, population-level cancer prevention measures, such as increasing HPV vaccination access and uptake, remain important.¹¹¹ Evidence from Canada and other countries shows the profound impact that combining effective and widespread vaccination and cervical screening programs can have on moving toward cervical cancer elimination.^{118–120}

Additionally, inequities in cancer incidence, mortality, and survival persist, shaped by differences in exposure to risk factors and access to screening and timely care.^{111, 121}

Inequities can occur due to many social factors, such as income or education. They can also be underpinned by broader forces, including discrimination and stigma, that create barriers for some groups across cancer prevention, early detection, diagnosis, and treatment.^{111, 121} These determinants intersect in complex ways to influence who develops cancer, the types of cancer they develop, and their chances of survival.¹²¹

Observed progress across several cancer outcomes reflects sustained advances in prevention, early detection, and treatment.^{111, 112} However, cancer remains the leading cause of death in Canada, and it is estimated that about two in five people will be diagnosed with cancer in their lifetime.^{111, 122, 123} Additionally, the total number of new cases and deaths attributed to cancer each year are expected to remain high. This trend is largely driven by Canada's aging population, as the risk of developing many cancers increases with age.¹¹¹ By 2068, more than one in four people in Canada are expected to be aged 65 years or older, and the number of people aged 85 years or older is projected to more than triple.¹²⁴ As a result, the overall impact of cancer on individuals, communities, and health systems is expected to remain substantial even as outcomes improve.

Wildfires are increasing in size and intensity, with wide-ranging impacts on health

What is changing?

Climate change is driving rapid changes in wildfire patterns across Canada.^{125–127} Fire is a natural and essential part of forests in Canada. However, wildfire seasons are lengthening, and wildfires are growing larger and more destructive, increasingly disrupting people's daily lives and livelihoods, including in new or historically lower risk areas.^{128–130}

Urban and industrial development is also expanding into wildlands, increasing the number of wildfires that happen where wildland vegetation and the built environment meet or mix.¹³¹

As a result of these developments, more people living in Canada are being exposed to the health, social, and economic impacts of wildfires and wildfire smoke. This includes people who are forced to evacuate, sometimes for weeks or months at a time.^{132–134}

Data collection on the annual number of evacuees began in 1980, but seven of the 10 worst years occurred in the past decade.¹³⁵

Why does this matter?

Wildfires can create various immediate and long-term health risks for local populations and wildland firefighters. They also more broadly affect the well-being of communities, including through the destruction of homes, businesses, and infrastructure. Evacuating due to wildfires can affect people's health in many ways. For instance, it can negatively impact mental health, disrupt social and community support, interrupt access to necessary health care, and lead to lost income from missed work.^{136–140} These effects can be long-lasting, emphasizing the importance of long-term community support during recovery.¹⁴¹

Wildfires and wildfire evacuations have disproportionate impacts on Indigenous communities.¹⁴² Between 1980 and 2021, 41.9% of wildfire evacuations involved communities with predominantly Indigenous populations.¹³⁴ Evacuations can have unique consequences for Indigenous Peoples, including the effects of prolonged separation from community, family, and land-based cultural practices as well as a lack of culturally safe care in host communities.^{136, 138, 143–145} Since Indigenous Peoples maintain deep cultural, spiritual, and livelihood connections to their lands, the impacts of displacement can be broad, complex, and long-lasting.^{138, 143} First Nations, Inuit, and Métis Peoples have supported the natural rhythm of ecosystems since time immemorial by stewarding the lands, waters, and ecosystems through diverse systems of knowledge, governance, and reciprocal relationships with the natural world. This place-based stewardship includes the intentional application of fire on the landscape (beneficial fire, or cultural burning) to sustain ecosystem health, enhance biodiversity, reduce wildfire risk, support culturally important species and landscapes, strengthen community resilience, and uphold cultural practices, languages, and knowledge transfer to future generations.^{146–148}

The effects of wildfire smoke can extend far beyond local communities, with the potential to affect people who live hundreds or even thousands of kilometres away. Pollutants from wildfire smoke exposure have been associated with a number of adverse health outcomes, including increased risk of premature mortality, as well as respiratory, cardiovascular, and developmental effects.¹⁴⁹ Additionally, wildfire smoke may be associated with neurological effects, cancer, and skin and eye conditions.¹⁴⁹ Research has identified greater impacts of wildfire smoke for some groups, including children and older adults, people who are pregnant, people who are unhoused, people living with chronic illness, and people who work outdoors.^{132, 133, 136, 150} These differences can be due to higher exposure, greater susceptibility to negative health outcomes, and inequitable access to the resources that help people protect themselves.^{139, 140, 149, 151}

Looking Forward

Across the trends examined in this report, the following three themes stand out:

- Some health outcomes among younger populations are changing in ways that may have important implications for future population health.
- Many of the challenges highlighted reinforce the value of prevention and preparedness.
- Responding effectively to emerging and evolving health issues depends on strong evidence, trusted institutions, and effective public health leadership.

Together, these point to overarching priority areas for the CPHO's mandate. Across each of these, advancing health equity and supporting reconciliation remain essential. Persistent inequities continue to shape who experiences risks and who benefits from opportunities to be healthy. Social, economic, geographic, and demographic factors intersect and compound over time to drive these differences in many interconnected health outcomes. Public health systems play an important role in drawing attention to the social and structural determinants that shape health, and working with partners across sectors to address the conditions that create inequities.

Public health professionals also have a responsibility to advance reconciliation and uphold Indigenous rights and self-determination. This includes strengthening partnerships with First Nations, Inuit, and Métis Peoples, furthering culturally safe and responsive approaches, advocating for Indigenous Knowledges to be incorporated into evidence systems, and supporting Indigenous-led priorities that promote health and well-being.

Supporting the Health and Well-Being of Younger Populations

The experiences and health of young people today will shape population health for decades to come. Patterns across several topics in this report suggest that some health outcomes among younger populations are changing, including mental health, health-adjusted life expectancy, sexually transmitted and blood-borne infections, and some types of cancer. These outcomes do not affect all younger people the same way and vary across diverse social and economic contexts.

Responding to these trends requires a life course approach that promotes health and well-being throughout all stages of life. This perspective helps identify opportunities to improve outcomes and reduce inequities by recognizing how health is shaped by the cumulative impact of experiences, environments, and opportunities. Mental health promotion can complement this approach by emphasizing action at individual, community, and societal levels to strengthen protective factors and create conditions that support lifelong well-being.

Given the complexity of the world today, we must continue efforts to better understand drivers of health outcomes, including how a rapidly changing climate and evolving social and digital environments affect health. Building this evidence base will be critical for identifying the most effective ways to support young people.

Strengthening Prevention and Preparedness

The resurgence of measles, worsening mental health outcomes, the ongoing toxic drug crisis, and the growing impacts of wildfires serve as reminders that public health systems must prioritize both prevention and preparedness. Prevention focuses on addressing risks before health problems occur, while preparedness is about being ready to respond to new and emerging threats when they arise.

The greatest benefits of prevention come from creating a foundation of health-promoting behaviours and environments across the population. This includes reducing exposure to risks and ensuring everyone has access to resources that help them stay healthy.

To be prepared, public health systems must be able to anticipate, adapt to, and recover from evolving threats, including the growing impacts of climate-related events, misinformation and disinformation, and changing geopolitical contexts. This includes maintaining a skilled, supported, and diverse workforce, strengthening collaboration and governance across jurisdictions, and ensuring that public health organizations can respond effectively to emerging risks and new evidence.

Initiatives that support vaccination are key examples of preventative efforts. The recent measles outbreak is a cautionary signal that progress in reducing vaccine-preventable diseases cannot be assumed to be permanent. Public health systems can learn from this experience to strengthen preparedness for future diseases that may emerge or re-emerge in the years ahead.

Building Knowledge, Trust, and Public Health Leadership

Public health organizations need strong, interconnected research, data, and evidence systems to understand emerging health challenges and guide actions. This includes generating knowledge through interdisciplinary, community-based, and Indigenous approaches that bring together diverse ways of knowing.

For example, there is a growing need to better understand how information systems, artificial intelligence, and online environments shape health and well-being, as well as the opportunities and risks they present. Continued research can inform policies, programs, and communications that help people navigate and thrive in increasingly complex digital spaces. Successfully applying these insights will depend on evidence-informed guidance and appropriate governance and infrastructure. This work should also be grounded in equity while engaging young people as partners in shaping solutions, and bringing their perspectives and lived experiences into the decisions that affect them.

Building an understanding of how information shapes health is also critical to fostering trust. Public health institutions can earn trust through demonstrating how evidence is used to make decisions, learning from and partnering with communities, and communicating in ways that are clear, timely, and responsive to people's concerns.

New pressures and rapidly changing environments necessitate strong public health leadership at all levels. This leadership is critical for meaningful collaboration with communities, translating evidence into action, and fostering the partnerships that are essential to support population health and well-being. People and relationships are the foundation of public health systems, and a strong public health workforce is essential to protecting and promoting health.

Methodology

The development of this report involved identifying, appraising, and synthesizing the best available evidence on select public health topics. This included surveillance, survey, and administrative data from public health and other key government partners, academic and community-based research, and input from internal public health and government experts. Canadian research and representative data were prioritized.

Topic Selection

- The 2026 report presented an opportunity to reflect on population health at the beginning of the CPHO's mandate. A range of public health topics were assessed that had notable recent developments.
- Multiple criteria were used to select topics for inclusion, including the availability of Canadian evidence, whether recent developments made the issue timely for inclusion, and whether the topic could be meaningfully examined in the context of a national trends-focused report.

Indicator Data

- Key data on each topic were identified, with a focus on recent, relevant, and high-quality national outcome data. To identify emerging and urgent issues, there was also a focus on data availability over time to allow for an analysis of trends. Where possible and relevant, disaggregated data was included.

- Public health data sources included population health surveys, surveillance data, and health system outcome and administrative data.
- Data from other government sources included vital statistics, census data, and specialized databases (e.g., Canadian Wildland Fire Evacuation Database).

Evidence Reviews

- Targeted academic literature searches were completed by the Office of the Chief Public Health Officer for each public health topic, using online databases, such as MEDLINE and Scopus. Grey literature searches were also completed for government publications, public health agency reports, and reports from national and international organizations. Canadian research was prioritized.
- Research questions for these searches were focused on understanding the context, drivers, and public health impact for each selected public health topic, as well as key equity considerations.

Engagement and Feedback Process

- Report drafts were submitted for internal review across the Public Health Agency of Canada as well as to experts in other government departments. An iterative feedback process was used to help identify and prioritize indicators, ensure use of the most relevant and recent data, interpret data trends, explore drivers and determinants, and understand context for each public health topic.
- Report drafts were also shared with external First Nations, Inuit, and Métis organizations and the National Collaborating Centres for Public Health.

Limitations

- Data and evidence availability vary across topic areas.
- Data limitations include availability and timeliness, variability in data collection and reporting across the country, challenges with surveys using self-report methods, underrepresentation of some populations, and limited opportunities for disaggregation.
- Indicator data explores how things are changing over time but cannot explain why these changes are occurring. Where possible, based on research availability and the scope of the report, brief additional information is provided to explore the factors that influence health outcomes. Understanding the factors that drive trends and inequities in population health requires disaggregated data, community knowledge, and a focus on determinants.
- The report focused on a small subset of public health topics and does not represent all important dimensions of population health.

Inclusive Language

- Wherever possible, the report focuses on inclusive and culturally appropriate language related to each public health topic. However, as a report focused on indicator data, epidemiological terms are often used (e.g., male and female) as reflected in the original source, rather than more inclusive language that represents the diversity and complexity of identity, health, and well-being.

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