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Changing the osteoarthritis narrative in Aotearoa New Zealand

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Osteoarthritis (OA) is a common long-term condition in Aotearoa New Zealand (NZ), affecting about 1 in 10 adults, with numbers and the significant economic burden expected to increase.[1] Despite this burden, OA has historically been a low priority in health care, with no national model of care, resulting in fragmented management across primary care.[2,3] Perpetuating this fragmentation is the prevailing narrative that describes OA as unavoidable *wear and tear* and *irreversible*, fostering fatalism and delaying help-seeking.[4] Although there is no cure, OA can be managed effectively with appropriate care. International research calls for a shift from a narrow impairment focus to a biopsychosocial approach that employs empowering, strengths-based language and reframes the OA story.[5]

In 2019, a Community of Practice, Osteoarthritis Aotearoa, was established to transform the understanding and management of OA nationwide. A key initiative has been the Aotearoa Osteoarthritis Summits, designed to gauge the national landscape of OA needs in NZ.[6] The 2025 Summit adopted a lifespan approach, including a workshop to examine the 'rebranding' of OA in NZ, building on the foundational work of Jinks *et al.*,[5] which advocated for a global change in the OA narrative. The workshop aimed to co-produce stakeholder-informed priorities and actionable strategies to shift OA narratives towards early, strengths-based management and to identify barriers and facilitators to equitable access to OA care in NZ. To achieve this, we used six open-ended prompts that explored: perceptions and beliefs about OA, current sources of OA knowledge, preferred sources/formats for OA knowledge, barriers/facilitators to accessing OA care (including equity considerations), strategies to support lifelong joint health, and ideas to 'rebrand' OA and change public perceptions.

Summit attendees participated in a 60-min, facilitated workshop in pragmatic/self-selected groups, with facilitators providing instructions, timekeeping, and prompts to support participation. Group responses were submitted anonymously via Microsoft Forms (QR code), allowing multiple ideas per prompt. The resulting dataset included 33 de-identified free-text group responses across six prompts, with no identifying information collected, helping reduce 'dominant voice' effects and avoiding forced consensus. We conducted a directed content analysis guided by the candidacy framework domains[5] and developed an initial categorisation and thematic summary that we checked against the raw data to refine descriptions and ensure equity-related content was retained and accurately represented. Although demographic data were not collected (limiting examination of representativeness), attendees represented multiple stakeholder groups, including those with lived experience ($n = 14$), clinicians ($n = 40$), researchers ($n = 16$), and advocates ($n = 12$). Findings are reported as cross-stakeholder themes and not attributable to participant role.

What people told us at the Summit

Change the language around OA, bust myths, and focus on equitable solutions

Attendees emphasised reframing how OA is discussed to counter negativity. As one attendee wrote, 'Talk about it more positively, with less focus on pain, and get rid of the outdated language. It's not a disease of the old!' Many cautioned that 'wear & tear' messaging is harmful and 'promotes a misconception about what OA is, and what can be done about it.' Groups called for myth-busting, correcting beliefs that OA is inevitable or an old person's disease, and to avoid confusion with other forms of arthritis. Crucially, people wanted a solutions-focused, strengths-based narrative that highlights living well with OA. One group advised we should 'focus on the positives … identify and promote high-functioning individuals who have [OA] yet still live a fulfilling life. [Show] it's something that can improve, that can be managed, and doesn't have to limit life.' Another group urged making resources 'available in different languages [and] close to home, involving your whānau and community.'

Consistent messaging, trusted sources of information

Attendees reported fragmented and inconsistent information, often relying on Google, social media, or family, particularly when they 'can't get in' to see a clinician. They requested trustworthy and consistent messaging with practical guidance. As one group put it, they would like to 'get accurate, informative information from and not just, 'Sorry, it's arthritis.'' Too many felt told 'it's a bit of OA, get on with it,' instead of being offered hope and a plan. Participants suggested proactive scripts, eg 'Yes, it's OA – here's how we treat it: with lifestyle changes, physio, exercise, nutrition', and alignment of language across healthcare professionals. Information should be accessible and delivered through channels people already use, from digital tools to 'posters in GP surgeries, websites, trusted health professionals, [and] podcasts'. Peer networks were seen as vital: one suggestion was to foster 'community groups in as many locations as possible … people with OA who share their experiences and how to get advice and support that's free and reliable.'

Focus on non-surgical options and early, lifelong management

Attendees urged a shift away from surgery-centric thinking. Many still see joint replacement as the 'fix,' but attendees stressed proactive, conservative care: 'Surgery isn't the only solution. Managing osteoarthritis starts with the right support, not the waiting list.' Effective community management involves early and ongoing attention to weight management, strength and aerobic exercise, pain management strategies, mental health, and social support. A 'lifetime of joint health' lens was advocated, emphasising early education, through schools, sports clubs, and public campaigns, to help individuals learn how to reduce OA risk and maintain mobility before significant changes occur. As one group wrote, 'Empowerment comes through education from as early an age as possible … The lifetime aspects of OA, its causes and prevention strategies – should be communicated in schools, workplaces, community groups, GP clinics, sports clubs, churches, marae, etc.'

Where to from here?

The groups who bear the biggest burden of this disease in NZ are women, Māori, Pasifika, rural, and low-income communities, many of whom face disproportionate barriers, limited access, financial constraints, and services that are not culturally appropriate.[7–9] A new OA narrative must centre equity and honour Te Tiriti o Waitangi. Without upstream policy change, major primary care efforts to address the burden of disease risk are under-resourced. However, although all changes come with financial considerations, we believe the increasing economic burden of OA[1] necessitates grassroots action as outlined by participants: integrate community exercise programmes with primary care; embed allied health professionals within general practice to deliver on-site OA education and support; develop centralised online hubs offering reliable resources; and ensure consistent messaging across clinicians and public channels. Consistency could be operationalised through a shared 'OA messaging toolkit' spanning clinical and public-facing channels, including brief diagnostic scripts, agreed myth-busting statements, and standardised patient resources hosted in a single hub with culturally adapted versions. Implementing these innovations requires greater inclusion of allied health, health coaches, non-governmental organisations, and community support workers. Adapting evidence-informed OA models could offer a consistent national framework for conservative management.[10]

Changing the OA narrative requires continuous collaboration among clinicians, patients, and communities. By using empowering language, dispelling myths, and enhancing education, we can reduce stigma and encourage earlier engagement. Prioritising equity and community-based solutions will ensure strategies reach everyone in need. The community's message is clear: by changing how we speak about OA and supporting those words with practical actions, we can improve outcomes for New Zealanders. Next steps could involve a scalable, evidence-informed framework that encourages earlier engagement, diminishes stigma, and ensures consistent care across NZ.

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