HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

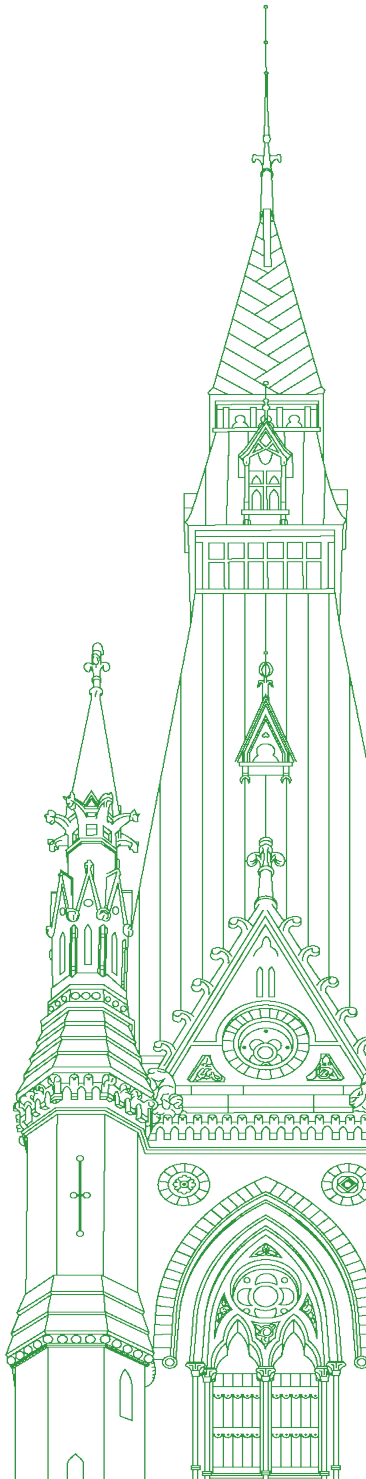
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 094

Wednesday, December 6, 2023



Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, December 6, 2023

● (1830)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 94 of the House of Commons Standing Committee on Health.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders, although I don't think we have any virtual participants for the first panel, so we can dispense with that.

Pursuant to Standing Order 108(2) and the motion adopted on November 8, 2023, the committee is resuming its study of the government's advance purchase agreement for vaccines with Medicago.

I'd like to welcome the Honourable Mark Holland, Minister of Health, as well as the officials accompanying him this evening. From the Department of Health, we have Dr. Celia Lourenco, associate assistant deputy minister, health products and food branch. From the Public Health Agency of Canada, we have Heather Jeffrey, president; and Dr. Donald Sheppard, vice-president, infectious diseases and vaccination programs branch.

Thank you all for taking the time to appear this evening.

Before I call on Minister Holland to begin his opening statement, I want to remind colleagues that we have a convention here that the witness is allowed as much time to answer as the person used posing the question. You have discretion as to whether to let him go longer. I will make sure that he gets at least as much time, and it's up to you whether to give him more.

With that, Minister, welcome to the committee. You have the floor for the next five minutes.

Hon. Mark Holland (Minister of Health): Thank you, Mr. Chair.

It is a pleasure to be here with you today again, back at the health committee. I thank members for the opportunity to talk about the contract with Medicago, and more specifically, to talk about the government's action to ensure that all Canadians had access to a vaccine during the pandemic.

Maybe I'll start with global context, where we were when the darkness of COVID-19 first fell over this country. Folks will remember that there were open questions about whether or not a vaccine would be possible, perhaps for five or 10 years. It is an absolute miracle of science that vaccine solutions were found. I want to thank deeply and profoundly the officials with both PHAC and Health Canada for their incredible work during those incredibly difficult times.

In April of 2020, Canada established a COVID-19 vaccine task force. This was a multidisciplinary team of external experts and industry leaders in the fields of vaccines and immunology. They were tasked with looking at the viable options for a vaccine, and there were seven. Those seven options, based on science and technical ability to produce, were identified for Canada to move forward, to try to ensure that, if they did develop, we would have the opportunity for Canadians to have access.

Advance purchase agreements were entered into. The idea of entering into an advance purchase agreement was to mitigate the risk, to ensure timely delivery and, frankly, to make sure that every Canadian had a dose of the vaccine they needed to save their lives.

By their very nature, they were flexible, and it was also contemplated from day one that not all seven would be successful. Remember, we didn't know which one would be successful. We knew there were seven viable options, but there was no way of knowing which one would manifest as that which would be able to save lives, which was so essential to Canadians.

I think it's important to recognize that this strategy of using advance purchasing agreements.... I'm going to turn to it, because I think it's worth noting. An estimated 800,000 lives in Canada were saved. Some 1.9 million hospitalizations were averted, and 34 million COVID cases were averted. That was, again, all without knowing which solution would provide that answer.

When we take a look at Medicago, which is the one that's before us today and was one of those seven options.... This was Canadian-based, and it shared an exciting, innovative technology that used a plant base for the first time. As you will be aware, most were egg-based. This was the first in the world, an ability.... Of course, we don't know how that might be used in the future. It's a really important innovation that I hope will be able to make a huge difference.

With the Government of Canada's support, Medicago developed a safe and effective vaccine. In fact, on February 24, 2022, it was authorized for use in Canada. Now, if it hadn't been for the fact that there were other vaccines that were approved and in the market—and not, at that point, even on an ancestral strain but actually up to date with what the most current variants were—it could very well have been a world where we needed Medicago.

The reality is that Canada was well under way with an enormously successful vaccination campaign and many other products. As a result, there wasn't a need to proceed with the Medicago vaccine. That, of course, still meant that we had to honour that stab in the dark that we took to try to make sure that one of those seven options was there.

I would say, though—just around transparency, because I know there have been a number of questions in this committee on that—that the Public Health Agency of Canada and Public Services and Procurement Canada have shared all the relevant details of this contract, as with the other advance purchase agreements. They have shared it with the Standing Committee on Public Accounts and with the Auditor General, with appropriate confidentiality provisions in place.

I would also state that, as a final step, the Public Health Agency has publicly disclosed the amount paid as part of the public accounts.

Subsequent to the tabling of the public accounts, the company agreed to further public disclosure of additional details to identify the company and the amount of the non-refundable advance payment as well to confirm that the terms of the payment that had been met and that the contract was terminated by mutual consent.

I would also highlight that the Office of the Auditor General recently finished auditing the financial transactions of the Public Health Agency of Canada for the third fiscal year in a row and has confirmed the accuracy and the reliability of the financial information.

● (1835)

Further, committee members will recall that in December 2022 the Auditor General published an audit of COVID-19 vaccines covering the period of January 1, 2020, to May 31, 2022. This report found that the procurement, authorization, allocation and distribution of vaccines were efficient.

In conclusion, at a moment of great confusion, when we didn't know if any solution would be present, Canada took a bet on seven options, and thank goodness we did. We could never have known which one would work out and, from the beginning, the advance purchase agreements contemplated that not all of them would. Medicago is one that did pan out but it panned out in a time frame where it was rendered not necessary because of the success of the other options.

I want to close by thanking, once again, the incredible officials who have done unbelievable work to ensure that Canada had one of the best COVID-19 responses anywhere in the world, along with one of the lowest death rates that was seen anywhere in the world.

With that, Mr. Chair, it would be my pleasure to take questions.

The Chair: Thank you very much, Minister.

We'll now begin with rounds of questions, starting with Dr. Ellis, please, for the Conservatives for six minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Mr. Chair.

Thank you, Minister, for being here.

We know very clearly that this Liberal government has had millions of dollars of wasteful spending. *At Issue*, tonight, is talking about this deal with Medicago. What was lost was $323 million of Canadian taxpayers' money.

What was the plan to protect Canadian taxpayers in this contract with Medicago?

Hon. Mark Holland: To be clear, the amount we're talking about today is $150 million, and that has to do with doses secured. There's a separate question around ISED. I expect that Minister Champagne will have news on that—and good news on that—soon.

However, with respect to the contract that's in front of us right now, what was done to ensure responsibility was to enter into an advance purchase agreement where we were able to ensure the doses. I will put the question to you, if you will permit me to ask it, what would you have done if Medicago were the only viable option?

Mr. Stephen Ellis: Thank you very much, Minister. The time is mine and not yours. I appreciate that. Also, the time to ask questions is for me and not for you. The time is for you to attempt to answer them. Again, we'll get to that.

What you're telling us is that there's no protection for Canadians in this contract.

Hon. Mark Holland: No, that's not what I'm saying. I'm saying that there were absolutely assurances. However, in order to get the vaccines we needed, we needed to be able to enter into an advance purchase agreement. That advance purchase agreement contemplated that not every one would work out.

Therefore, there was going to be a cost. I'm not clairvoyant. I expect you aren't either. Nobody was. At that moment in time, we could not have known which of those seven options would work out.

Therefore, it was prudent to make an investment in each one to ensure that whatever one worked out would be available to Canadians. That's exactly what happened, and it's exactly why we had such a successful vaccination program.

● (1840)

Mr. Stephen Ellis: Again, with respect to Medicago, what you're avoiding, Minister, is really that there were absolutely no protections for Canadians here. This Liberal government invested $173 million in Medicago to start with and then paid them out $150 million more and received zero vaccines. That was in a contract that—if I'm not mistaken, Minister—was signed after the pharma tech giant Pfizer had already been approved for use in the United States.

Hon. Mark Holland: What I'm saying is that, at the moment in time in which advance purchase agreements were entered into, Canada had a responsibility—I would argue—to make sure that the doses and the right vaccine would be available. If, as an example, Medicago turned out to be the only vaccine that worked—and, by the way, there's no way that we could have known that wouldn't be the case—then you wouldn't be sitting here in this committee asking questions, because it would have been Medicago's vaccine that saved all of those lives.

Instead, you're asking the questions today because there were other vaccines that were successful.

Mr. Stephen Ellis: Again, I'll interrupt you, because it's very clearly known that a tobacco company was a major investor in Medicago. Everybody knew that. Surely somebody at Health Canada must have known that Canada signed on to the convention for tobacco control and that this would never be accepted on the international stage.

Hon. Mark Holland: Sir, I've been called by Imperial Tobacco an "anti-tobacco radical". I was the chair of the Heart and Stroke Foundation. I was on the Ontario campaign for action against tobacco. However, what did not occur, and I—

Mr. Stephen Ellis: Minister, this has nothing to do with pedigrees.

Hon. Mark Holland: Sure, it has everything to do with it, because—

Mr. Stephen Ellis: It has absolutely nothing to do with the question.

Hon. Mark Holland: —a minority position—

Mr. Stephen Ellis: If you don't want to answer the questions, just feel free to say, "I don't know the answer". It's okay.

Hon. Mark Holland: It doesn't appear that you want the answer.

Mr. Stephen Ellis: Unless nobody did their due diligence or nobody cared, somebody must have known that Canada signed onto the convention for tobacco control.

Hon. Mark Holland: Sir, the reason I gave the other context is that I am no fan of tobacco companies. I have worked my entire life to ensure that the tobacco is reduced.

Mr. Stephen Ellis: That's not true. You've actually allowed nicotine products to be approved in Canada as well.

Hon. Mark Holland: What I'm saying.... I don't know whether you want me to answer. It appears you don't.

Mr. Stephen Ellis: I want the answer, but all you do is dance—

Hon. Mark Holland: If you do want an answer to the question, my answer is that a minority position that did not advance the interests of either nicotine or tobacco in Medicago....

Let me ask you the question. Would you use—

Mr. Stephen Ellis: It's not the time for you to ask questions.

Hon. Mark Holland: Sure it is.

Mr. Stephen Ellis: Do you know what? In two years, Minister, you can have your chance to ask some questions. When you're sitting on the other side, you can have your chance.

Hon. Mark Holland: I've been on the other side and—

Mr. Stephen Ellis: When I have the opportunity to sit there, then you can ask the questions—

Hon. Mark Holland: Mr. Chair, I don't know. What do you want here?

The Chair: Go ahead, Dr. Ellis. You have the floor.

Mr. Stephen Ellis: Thank you very much, Mr. Chair.

Very clearly, two million Canadians are visiting food banks, and your government lost another $323 million without any accountability. The answer, really, is that you don't care.

Hon. Mark Holland: I would characterize it this way: If we didn't take a bet on all seven, then we wouldn't have been able to save those 800,000 lives.

I don't know what kind of price you put on 800,000 lives. I put a pretty high price on 800,000 lives.

The reality is that we didn't have clairvoyance. I don't know what psychic abilities you had, but neither I nor the department had the psychic ability to know which vaccine would work out, so we had to take a bet on all seven.

We knew when we took those advance purchase agreements that not all of them would work out and that, yes, that would cost some money, but that's what we did to make sure that we saved 800,000 lives. That's what we did to make sure that we avoided 1.9 million hospitalizations.

Mr. Stephen Ellis: Thank you very much, Minister.

Mr. Chair, we're clearly not getting answers from the minister.

Mitsubishi is the largest company in Japan. Health Canada, your department, entered into a contract with the largest company in Japan—and, if I'm not mistaken, the 45th-largest company in the world—and you gave them another $323 million, with no protection for Canadians. You also gave them the intellectual property. You received no vaccines, and you lost 400 jobs in Quebec.

Tell me: Is that value for money? Tell Canadians it's value for money.

Hon. Mark Holland: What I think, Dr. Ellis, is that if Canada had not entered into any advance purchase agreements for vaccines—you're right—we would have saved a little bit of money. However, that would have meant that we didn't have vaccines for the Canadian population. It would have meant—

Mr. Stephen Ellis: You're saying that $323 million is a little bit of money.

Hon. Mark Holland: —that 800,000 people would have died. It would have meant tens of billions of dollars of lost economic activity. It would have meant millions more people in hospitals, with hospitals being shut and people dying from other preventable illnesses.

Sir, if we didn't make those investments, it would have been a catastrophe.

Mr. Stephen Ellis: Thank you very much, Minister.

Thank you, Mr. Chair.

The Chair: Thank you, Dr. Ellis and Minister Holland.

Next we have Mr. Jowhari, please, for six minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair.

Welcome, Minister, to the committee.

Let's start bringing facts to the table. There is a $172-million investment, and there's a $150-million investment.

Can you briefly tell us what the $172-million investment was, and what was the result of it?

● (1845)

Hon. Mark Holland: That is with respect to ISED. That's with respect to the development of the actual intellectual property itself.

The $150 million had to do with the vaccines and the distribution of the vaccines.

Mr. Majid Jowhari: Had Canada and Medicago been in a position to be able to launch this product, not only within Canada but also internationally, what would that $150 million go toward? The $172 million, naturally, went to ensuring that we did the R and D, set up the facility and made sure we were ready to produce.

We have now an approved product, which faced some challenges—and we'll get to that—but what was the $150 million specifically earmarked for?

Hon. Mark Holland: This is the point that I'm making. I wish we were clairvoyant. If we were clairvoyant, then we wouldn't have had to make the decision that we did, but of course, we were not.

There were seven options that were deemed to be technically feasible on a science-based basis of having the potential to produce a vaccine. The advance purchase agreements that were entered into in all seven instances made sure that no matter which one hit, no matter which one won, Canada was ready to have the vaccines it needed.

It's very easy, in hindsight, to say that we should have just picked the one that won. That's a little like saying that you should have just bought the lottery ticket that won. If you knew which lottery ticket was going to win, why would you bother buying the other ones?

The reality is that we were in a circumstance at that moment in time where we didn't know what would succeed, so that $150 million was a down payment to ensure that the vaccines would be delivered and that they'd be available to Canadians.

Mr. Majid Jowhari: Minister, I'm really glad that you used the concept of a down payment.

However, before we get to that, I want to go back and try to deal with another piece of misinformation that's going around: that Canada violated the World Health Organization Framework Convention on Tobacco Control.

Specifically in this case as it relates to securing vaccines, do you believe this applies to that circumstance or not?

Hon. Mark Holland: No, I do not. I think the minority position that Philip Morris held in Medicago....

Let me put it to you this way—and it is a question that the Conservatives didn't want to let me ask, but I'll pose it because I think that, as a hypothetical, it's a really valuable question to ask: If Medicago had developed the only successful vaccine—and that's a very real probability, because we didn't know—are the Conservatives saying that they would not have allowed Canada to use that vaccine to save hundreds of thousands of lives because Philip Morris had a minority position that didn't advance the interests of either nicotine or tobacco? Of course they wouldn't. Of course they absolutely would have made sure that vaccine.... It would have been reprehensible to do otherwise.

We were in a circumstance where we needed to look at which options were technically viable. The minority position that was held in Medicago did not advance the interests of either nicotine or tobacco.

Mr. Majid Jowhari: I'm glad you used the terminology “down payment”. We made a $150-million down payment to Medicago for production of vaccines upon approval, which happens in Canada and in the federal government.

Did we make such an allowance...? The terminology “at-risk manufacturing” has been thrown around. I asked Ms. Andrachuk on Monday what that term means. I assume that's the down payment, and it's almost like a down payment on an insurance policy that we are getting.

Did the other seven advance purchase agreements have such a clause as well?

Hon. Mark Holland: Yes, they did. That's right.

Mr. Majid Jowhari: Okay. Great.

We made the down payment. Again, I'm a layman. We want to buy a house and we put in the down payment. At some point, we decide that we don't want to buy that house, for whatever reason, and we mutually walk away. I lose my down payment. Can I simplify it to that level?

Hon. Mark Holland: I think you can put it better this way. If you went out and bought an insurance policy and then didn't need the insurance policy, you don't go back to the insurance company and ask for your premiums back.

The reality is that you make a bet because you're trying to protect yourself, and that's what Canada did. We bet on seven different options and that bet—of course, without knowing which one would materialize—ensured we had the vaccines that Canadians needed.

By putting an investment in each and every one, we were guaranteeing that Canada would have the vaccines that it needed. If we bet on one or two—as it seems the Conservatives are suggesting we should have done—then it would have been highly likely that we would have missed the one that was successful, which would have seen the loss of hundreds of thousands of lives in this country.

● (1850)

Mr. Majid Jowhari: Out of the seven, I understand that three or four got approval from the World Health Organization. All of the seven had this at-risk manufacturing clause in them. We are not talking about the others, yet we're talking about Medicago.

You just confirmed the fact that, under this circumstance, Canada would not have violated any World Health Organization framework mentioned. Why do you think we are having this conversation?

Hon. Mark Holland: I think it's easy to create misinformation in this space.

Let's contemplate a world where Medicago was the vaccine that was first and ended up being the one that Canadians took. Instead, we would be here potentially getting questions about why we made investments in Pfizer or why we made investments in AstraZeneca. That's exactly what they're saying. They're saying that any one that wasn't successful was a waste of money, as if somehow the government could have known which one would be successful.

If there's an alternative universe in which Medicago was the successful vaccine, we'd instead be sitting in this committee being attacked for having made investments in Pfizer or AstraZeneca or Moderna.

Mr. Majid Jowhari: Thank you.

The Chair: Thank you, Minister and Mr. Jowhari.

[*Translation*]

Mrs. Vignola, you have six minutes.

Mrs. Julie Vignola (Beauport—Limoilou, BQ): Thank you very much, Mr. Chair.

Mr. Minister, Dr. Lourenco, Ms. Jeffrey, and Dr. Sheppard, thank you for being here.

The $150 million, which was recorded in the losses in the Public Accounts of Canada, is a payment made for the receipt of vaccines ordered by Canada. We agree on that. These are vaccines that would have been approved in the United States and were also approved in Canada. However, the World Health Organization decided not to include them in the possible solutions, because one of the minority shareholders was a tobacco company.

Canada signed on to the Framework Convention on Tobacco Control in 2005. Earlier, you told us that we could not guess what the World Health Organization would do. In fact, it was clear that the WHO would reject the vaccine if there were alternatives. However, if this vaccine had been the only one available, it can be argued that the WHO would have accepted it.

Before the WHO made its decision, did you look into the possibility of Mitsubishi Tanabe Pharma getting rid of the Philip Morris shareholder before the WHO approved the vaccine? Was that one of the requirements you would have asked Medicago for?

Hon. Mark Holland: Thank you very much for the question. Allow me to answer in English, because it's easier for me when it comes to technical questions.

[*English*]

First of all, regarding the question of whether or not it was predictable who would reject it, there are two things I would say in response.

Number one, Canada had the sole ability to be able to approve this vaccine. When it was approved in February 2022, that would have allowed for its use in Canada. The decision made by WHO would not have affected that.

Number two, I reject in its entirety the idea that WHO took its position...or that it affected our position. Those are two separate things. With regard to the decision at WHO at that point in time, not only were the other vaccines available, those vaccines were actually for the current variants, as opposed to the ancestral strain. WHO was making its decision at a time when all of the other options were available in the world.

I would posit to you that WHO would have made a very different decision if Medicago had the only viable vaccines. It had to do with the competitiveness of the other options, as opposed to the fact that the minority position existed in Medicago from Philip Morris.

[*Translation*]

Mrs. Julie Vignola: We agree on that.

In fact, I don't think the WHO even evaluated the vaccine, just the shareholders. At the end of the day, they didn't reject the vaccine; they rejected the shareholders.

Before concluding the agreement, and even before the WHO decided to look into the situation, did the Government of Canada require Medicago to remove Philip Morris International from its shareholders? Has the Government of Canada offered any possible solutions to allow Philip Morris International to withdraw as a shareholder?

● (1855)

[*English*]

Hon. Mark Holland: I think there are two important things.

Again, at the time the WHO made its decision, first of all, that was independent of the decision that would happen in Canada. The vaccine that was developed by Medicago, if it were first out of the gate, would have been the one that Canada was using.

Second, with respect to rejecting the shareholders, they were doing that because at that moment in time there was a bevy of other options that were not on the ancestral strain but in fact on the most current strain.

On the last point you made about divestment of Philip Morris, Philip Morris has completely divested itself. It had a minority position in Medicago and it no longer has a position in Medicago, so I suppose it's an academic exercise.

[*Translation*]

Mrs. Julie Vignola: Who owns the intellectual property of Medicago now?

[*English*]

Hon. Mark Holland: This is a question that Minister Champagne is looking at and continues to pursue. It's outside of the $150 million that we're talking about today, and it's an important question. He's working on that, and I expect that there will be more information on that in the near future.

[*Translation*]

Mrs. Julie Vignola: Medicago's head office in Sainte-Foy was bought out by Aramis Biotechnologies. Do you know if that buyout included intellectual property rights, or is that another aspect of the discussion that Mr. Champagne will eventually get back to us on?

[*English*]

Hon. Mark Holland: That's more a question for Minister Champagne.

I will say that one of the things that is important to note is that the innovative technology that was developed by Medicago, which is plant-based as opposed to egg-based, has tremendous potential in the future with respect to future vaccine efforts, so its intellectual property is extremely important.

[*Translation*]

Mrs. Julie Vignola: Plant-based technology is completely new and allows people with egg allergies to be vaccinated, which was previously impossible.

In the negotiations with Medicago, were there any special clauses concerning the termination and protection of intellectual property rights?

[*English*]

Hon. Mark Holland: There are certain aspects that I can and can't speak to, because there are confidentiality provisions. I would turn to the officials, because I want to make sure that I'm not answering in a way that would be inappropriate.

The Chair: Give a brief response if you can, Ms. Jeffrey.

Ms. Heather Jeffrey (President, Public Health Agency of Canada): I would say that the provisions of the contracts are subject to non-disclosure and confidentiality arrangements. They were disclosed to the public accounts committee, but in a public forum we can't speak to the other details of the contracts.

The Chair: Thank you.

Thank you, Madame Vignola.

Next is Mr. Davies, please, for six minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Thank you, Minister, for being here.

Minister, was Philip Morris International's 21% ownership in Medicago known by the federal government at the time it signed its advance purchase agreement?

Hon. Mark Holland: It was.

Mr. Don Davies: Was the fact that Medicago was headed by the tobacco giant's former vice-president of regulatory and scientific affairs known to the government at the time it signed its advance purchase agreement?

Hon. Mark Holland: Yes, it was known.

Mr. Don Davies: Thank you.

The WHO has confirmed that it disapproves of tobacco industry involvement in drug companies and believes, “There is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests.”

Do you agree with that view?

Hon. Mark Holland: I do.

Mr. Don Davies: We've already talked about the WHO Framework Convention on Tobacco Control. Guidelines on implementing that treaty state that governments should not “accept, support or endorse partnerships...with the tobacco industry or any entity or person working to further its interests.”

Given that Philip Morris International owned 21% of Medicago shares at the time the Government of Canada signed its advance purchase agreement with the company, can you explain why the government didn't believe that this entity was working to further the interests of the tobacco industry?

Hon. Mark Holland: I completely agree with everything you said around the need to not advance the interests of nicotine and tobacco.

That wasn't what was at stake here. What was at stake here was a Canadian-based company that had an innovative solution. Yes, there was a minority position held by Philip Morris, but the interests of being able to produce a vaccine for Canada and the innovative nature of this technology meant that the minority position, which did not advance the interests of tobacco or nicotine, weighed on the decision by the expert panel that this was an important option to pursue.

● (1900)

Mr. Don Davies: At the time the government signed its advance purchase agreement, did it give any consideration to the fact that the WHO may end up rejecting Medicago's vaccine because of its ties to the tobacco industry?

Hon. Mark Holland: Again, there are two important points here.

First is that, in a Canadian context, the decision by the WHO would not affect our ability to distribute and approve the vaccine. In fact, the vaccine was approved for use in Canada in February 2022. That's point one.

For point two, I very much feel that if Medicago had been the only viable option in front of it, the WHO would have made a different decision. The decision the WHO made at that point in time was based on a moment in time when not only was it not on the ancestral strain but it was on the evolved strain of the coronavirus, and a bevy—a wide range—of vaccines were available.

Mr. Don Davies: That seems fair from the Canadian government's point of view, but here's what actually happened.

In March 2022, the WTO decided not to accept Covifenz for emergency use because of Medicago's ties to the tobacco industry. They came to a different conclusion than the Government of Canada would have.

Here's the thing. The reason that Covifenz was not proceeded with was not because the Government of Canada decided not to.

A February 2023 Mitsubishi Chemical Group Corporation news release said, “after a comprehensive review of the current global demand and market environment for COVID-19 vaccines and Medicago’s challenges in transitioning to commercial-scale production, the Group has determined that it will not pursue the commercialization of COVIFENZ.”

Isn't it true, Minister, that the reason Medicago didn't proceed was because it was not commercially viable for them to produce this vaccine if they couldn't sell it to the world? They certainly wouldn't have proceeded with full commercialization if only Canada was going to proceed with it.

Isn't that right?

Hon. Mark Holland: What is true is that Medicago had challenges stabilizing the vaccine for mass production, as I understand it. Further investments would have been needed to be able to get it into a position of broad-scale distribution.

Certainly, if it were the only viable option—if it were at a different place—those investments would have been made. I don't think you can ignore the fact that a large number of very successful vaccines were already in wide deployment, so those investments wouldn't have been logical.

Mr. Don Davies: I understand that.

Minister, I'm not ignoring the hypothetical of if it were the only one. That's hypothetical.

I'm pointing at the fact that Medicago couldn't sell its vaccine because the WHO said it was not going to approve it for emergency use worldwide. There was no way, in that environment, that any vaccine manufacturer was going to proceed with a vaccine when it couldn't sell it anywhere, except for maybe in Canada.

Hon. Mark Holland: The problem is that it's not a hypothetical. At the moment you're talking about, a wide range of vaccines were approved, not for the ancestral strain but for the most current strains of the virus at that moment in time, so there simply wasn't the need. Why would the investment have been made?

What I'm saying is, if that situation didn't exist and we didn't have a vaccine, then that certainly would have been a different circumstance. Of course, it would have to be.

Mr. Don Davies: Here's the bottom line.

Your government signed a treaty to not accept or support the tobacco industry or any entity working to further its interests. You then signed a contract with a pharmaceutical company that was 21% owned by the tobacco industry.

Square that for me.

Hon. Mark Holland: There was only one Canadian-based option that showed it had the technological and scientific ability to develop a vaccine. The minority position that Philip Morris had in it did not advance the interests of tobacco or nicotine. It certainly was a viable option in order to save hundreds of millions of lives in the moment that we were dealing with, when we did not know whether or not we would have any vaccine and when we were all worried for our families and loved ones.

I think the decision made to make sure that the country had a vaccine was the right decision.

The Chair: That's your time. Thank you, Mr. Davies.

Thank you, Minister.

We are going back to the Conservatives now for five minutes, beginning with Dr. Ellis, please.

Mr. Stephen Ellis: No, it's Mr. Perkins.

The Chair: Mr. Perkins, go ahead, please, for five minutes.

Mr. Rick Perkins (South Shore—St. Margarets, CPC): Thanks, Mr. Chair.

Minister, you're painting these hypothetical worlds to justify a $323-million loss to the Canadian taxpayer.

Before this contract was signed either to develop the vaccine or to buy the massive number of 76 million doses, the U.S. had already approved Pfizer, so this world that you say didn't exist because you didn't know whether or not a vaccine would exist actually existed months before that. It was already approved by the U.S.

● (1905)

Hon. Mark Holland: That's simply not true. I don't have the timeline with me, but I could turn to—

Mr. Rick Perkins: It was approved in the summer. The contract was—

Hon. Mark Holland: If you're interested in the answer, I can refer it to Mr. Sheppard. If you're making a political point and don't want an answer, I can move on.

Mr. Rick Perkins: If he has it at his fingertips, he can get it. If not, you can send it to the committee in writing.

Hon. Mark Holland: It's simply not true. If you want the truth, then we can provide it, but what you've said is not factually true. It's not true in substance or in fact.

Mr. Rick Perkins: The other thing that's not true, because.... Have you read the contract?

Hon. Mark Holland: Have I read it? Look—

Mr. Rick Perkins: Answer yes or no.

Hon. Mark Holland: Have I read the contract?

Mr. Rick Perkins: Have you read the contract to buy the vaccines?

Hon. Mark Holland: I have not read the full contract.

Mr. Rick Perkins: If you had, you'd know, unlike the government Liberal members, that the $323 million that's been wasted and the $150-million penalty payment you've paid is not a down payment. It's not insurance. It's not a mortgage. It's none of those things. There is no clause in that contract that requires any money up front. It's a penalty payment for not meeting your commitments under the contract.

Isn't that true?

Hon. Mark Holland: No. I've described the nature of the advance purchase agreements. I can turn to—

Mr. Rick Perkins: In what clause does it say you have to pay a payment—

The Chair: Let him finish, Mr. Perkins.

Hon. Mark Holland: Again, if you're interested in badgering me, you're succeeding. If you're interested in an answer, I'll return to Ms. Jeffrey.

Ms. Heather Jeffrey: The $150 million was the advance payment for the at-risk manufacturing of those vaccines to guarantee Canadian access to doses from Medicago.

Mr. Rick Perkins: There's no advance payment clause in the contract.

In fact, will you release the contract publicly? Before public accounts, the president of Mitsubishi said that he would release an unredacted copy of it publicly. Will you release it, since the president was willing to release it?

Hon. Mark Holland: I can respond to that.

The contract has been released in its entirety, unredacted. The public accounts committee, under the Auditor General—

Mr. Rick Perkins: Publicly.... He said he would release it publicly.

Hon. Mark Holland: Releasing contracts publicly would place Canada's ability to enter into contracts with any company in vast jeopardy. Of course, you know that, and that's the game you're playing.

Mr. Rick Perkins: It's the same reason why you're not releasing the Stellantis contract—

Hon. Mark Holland: No. It's the game you're playing to try to create misinformation.

Mr. Rick Perkins: —because you're hiding the fact that what you're saying here is simply not true. It doesn't require you to pay this. It's a penalty because you entered a contract that said you had to buy 76 million doses.

I'll ask you again: Who owns the IP?

Hon. Mark Holland: The question of the IP is an ongoing matter, and it's not the subject of this committee's discussion.

Mr. Rick Perkins: It is, because you're spending $323 million of Canadians' taxpayer money, and the president of Mitsubishi, before public accounts, publicly said that he would release the contract publicly. He also said that the IP was owned by them, not by the Government of Canada.

Has Mitsubishi sold the IP?

Hon. Mark Holland: I'm not going to respond to questions around IP today. Those matters are being dealt with by Minister Champagne. He will respond to them, but I will say to you that, looking backwards, with the knowledge that you have now of what worked and what didn't is a very curious way to approach this.

I certainly hope that no future government would be saddled with the kind of decision-making that you're inferring we should have taken.

Mr. Rick Perkins: Yes, it's true. We would never sign a contract that doesn't make sure that $200 million of Canadian taxpayer money.... Canadians don't own the IP. We would never sign a contract that says I'm going to have to pay $150 million in a penalty because I didn't receive a single vial of a vaccine. We would never sign a contract that allows the largest company in Japan to sell Canadian-financed IP to anyone in the world.

The level of incompetence of this government in signing these contracts.... When ministers don't even read the contracts.... You haven't read them. You weren't the minister at the time, but I would have thought that, in preparation for this meeting, you would have read the contract.

Hon. Mark Holland: Sir, the officials who operate.... One day—and I hope it doesn't happen—if you are in government.... The experts and the individuals we rely upon to enter into these contracts do so at arm's-length. We do not make a decision—me, as a minister—to tell them how we enter into contracts.

Mr. Rick Perkins: I didn't say you made—

Hon. Mark Holland: If you're suggesting that you would reach over and tell—

Mr. Rick Perkins: No. What I'm suggesting is that I would read a contract.

The Chair: Mr. Perkins....

Hon. Mark Holland: —the bureaucracy how you would do contracts, I'm saying there would be no contracts—

Mr. Rick Perkins: He got equal time.

Hon. Mark Holland: —and you would not have protected this country.

The Chair: No, he didn't—not yet.

Hon. Mark Holland: I haven't had time for his question....

I don't know, Mr. Chair.

Mr. Rick Perkins: What I'm saying is that I would read a contract before I signed it and before I pissed away $323 million of Canadians' taxpayer money.

The Chair: Mr. Perkins, your question took 40 seconds. You interrupted him after about eight seconds, and he's not finished his answer. You don't have time to ask another question because you're out of time.

You have time to complete your answer, Minister. Go ahead.

Hon. Mark Holland: Thank you.

What I would say, Mr. Chair, is let's actually think about what has just been said. The member just suggested that, were he in government, he would have extended beyond the powers of government to tell and dictate terms to bureaucrats about how they should enter into contracts.

Of course, they're going to make a point of order because they don't want me to make this point.

● (1910)

The Chair: Just a second, Minister.

Yes.

Mr. Stephen Ellis: I guess I'm requesting clarification that the time is related to the actual person asking the question. I would suggest to the chair that there's no convention to say that the minister has the ongoing ability to elaborate well beyond the time allotted per session to answer the question. I would suggest to you, Chair, that it would be exceptionally beneficial if the times for the rounds were as prescribed.

The Chair: Thank you, Dr. Ellis.

Mr. Perkins asked his question with one minute and 19 seconds left in his turn. With 40 seconds left, he finished his question. That meant the remaining 40 seconds of his turn was for Minister Holland. He was interrupted incessantly during those 40 seconds.

Minister Holland can finish his answer. Then we're going to move on.

Mr. Rick Perkins: On a point of order, the five-minute allotment is my allotment to ask questions or make comments. It isn't a guarantee. I could use the whole five minutes on a speech.

Chair, I believe you are wrong in that interpretation. That five minutes ends at five minutes whether I'm speaking or whether the witness is speaking.

The Chair: Thank you, Mr. Perkins.

Hon. Mark Holland: If there is another round, I'm happy to wait to be asked the question. It seems that they don't want to hear my answer, but I would be happy to give the answer if I were asked by members who wanted to hear it.

The Chair: Thank you, Minister Holland.

Ms. Atwin, go ahead, please, for five minutes.

Mrs. Jenica Atwin (Fredericton, Lib.): Thank you very much, Mr. Chair.

I'll thank the minister and the officials for being here with us this evening. It's getting quite late.

I really appreciate this conversation. I appreciate it for many reasons, I think predominantly because the worst of the pandemic is in the rearview mirror. We learned so many lessons over this very difficult time. I've had hundreds of conversations with constituents about this time and the ongoing impacts we're still feeling in the community. We've talked about some of the fears and the misinformation. We've talked about procurement. We've talked about our ability to respond in the future as well.

I'm often asked about our internal capacity or domestic capacity around vaccine production. I know that the Auditor General's report on COVID-19 vaccines indicated that Canada had very limited domestic capacity to produce vaccines and, therefore, was reliant on international imported products.

Why was this?

Hon. Mark Holland: I don't think we made the investments that were necessary in the past. I think that has been a failure of successive governments.

I had an opportunity to visit, just outside of Montreal, the facility that Moderna is building to allow us to have that domestic capacity. We're doing that for mRNA vaccines. We also have a facility being built in Canada that will be operated by Sanofi and that is going to be able to produce the influenza vaccine.

I would like, with your indulgence, to be able to make the point that I wasn't allowed to make earlier.

Mrs. Jenica Atwin: Please do.

Hon. Mark Holland: It's an important point, because folks have to understand fundamentally the role of government. When a government is elected and you get the honour of being a minister, you do not have the opportunity to dictate the terms of a contract. That would be entirely inappropriate.

You would approve a contract, but saying that you would get into the details of a contract and order a department how to do a contract and put your hand into the writing of the contract would be wholly inappropriate. I think it is very concerning to hear the Conservatives say that they would not have signed advance purchase agreements, and they would not have made the investments in those different options. I don't hear them saying they would have picked one winner. What I'm hearing is that they wouldn't have entered into any kind of agreement. They wouldn't have listened to experts around what terms needed to be entered into in order to get those advance purchase agreements.

What we're hearing very clearly from the Conservatives is that if—and thank goodness it didn't occur—they had been in power, they wouldn't have signed advance purchase agreements. That means this country wouldn't have vaccines, which means we would have had a disastrous public health outcome. Thank goodness that didn't happen.

Mrs. Jenica Atwin: On that piece, how did Canada exercise due diligence on the seven vaccine companies they entered into the APAs with?

Perhaps that would be a question for the officials.

Ms. Heather Jeffrey: There was an independent arm's-length group of advisers—the expert advisory committee and vaccine task force. They assessed all the different technologies that were available. They recommended that Canada pursue a portfolio approach to conclude APAs. That portfolio, the seven APAs that we did conclude, comprised a wide variety of technologies ranging from mRNA to protein subunit to viral vector-based vaccines and a variety of platforms, including the plant-based innovative technologies of Medicago.

● (1915)

Mrs. Jenica Atwin: Minister, in your opening, you really highlighted that the decision-making process was really built around ensuring everyone had access to these life-saving vaccines. I think about vulnerable populations across the country. I think about indigenous communities, and I'm particularly proud about how the government responded in first nations communities.

Can you speak to how this diversification of portfolios actually helped us to be able to respond, including in all of those populations that were potentially more vulnerable or would have been more at risk?

Hon. Mark Holland: Let's, first of all, praise science. The number of vaccines that ended up being available and successful is a testament to human ingenuity, and absolutely incredible. What ended up happening was that we had a variety of vaccines that were available to Canadians, which meant, in different health circumstances and in different ways, we could deploy exactly what was needed.

Of course, if we didn't make those advance purchase agreements and make a bet on those seven different options, which an independent expert panel looked at.... By the way, it ended up being correct, because they picked a number of the ones that ended up being successful. If they hadn't done that, then that means we wouldn't have had that kind of success.

In indigenous communities, as you point out, because we had the right mixture and approval of vaccines, it meant that we were able to get an incredibly high rate of vaccination, which saved untold lives. It's a remarkable success story.

Mrs. Jenica Atwin: Do I have any more time, Mr. Chair?

The Chair: You have about 20 seconds, if you have a short question.

Mrs. Jenica Atwin: I'll thank the officials, in particular, for their hard work during that time.

Thank you, Minister, for being here with us.

The Chair: Thank you very much, Ms. Atwin.

[*Translation*]

Mrs. Vignola, you have two and a half minutes.

Mrs. Julie Vignola: Thank you very much, Mr. Chair.

Mr. Minister, were there termination clauses in the contracts, whether it was the contract with Medicago or any other contract, yes or no?

[*English*]

Dr. Donald Sheppard (Vice-President, Infectious Diseases and Vaccination Programs Branch, Public Health Agency of Canada): Yes, there were specific clauses for cancellation.

[*Translation*]

Mrs. Julie Vignola: Thank you. Do these clauses form part of the confidential provisions of any contract?

[*English*]

Ms. Heather Jeffrey: Yes, we would require confidentiality.

[*Translation*]

Mrs. Julie Vignola: Okay.

Mr. Minister, why didn't you require Mitsubishi to pay back the money?

[*English*]

Hon. Mark Holland: As I said, with the way the advance purchase agreement was structured, we knew that it was going to be lost. Let's be very clear. The advance purchase agreements were structured with seven different vendors. If they didn't end up being successful, that was going to be lost money. We went into that with eyes wide open.

[*Translation*]

Mrs. Julie Vignola: Thank you.

Was a risk analysis done on Medicago before the funding was granted? If so, would it be possible to provide it to the committee?

[*English*]

Hon. Mark Holland: I talked about the COVID-19 vaccine task force. It was an independent, multidisciplinary team of external experts and industry leaders. They were the ones who made the determination of what had scientific viability. Again, I think it's quite remarkable that they identified the ones that were successful, including Medicago.

[*Translation*]

Mrs. Julie Vignola: Can that analysis be tabled with the committee?

[*English*]

Hon. Mark Holland: No, that's not possible.

[*Translation*]

Mrs. Julie Vignola: Mr. Sheppard, why can't that analysis be tabled with the committee?

[*English*]

Dr. Donald Sheppard: It's my understanding that the details of the deliberations and recommendations were ministerial communications and, therefore, are confidential at this present time.

[*Translation*]

Mrs. Julie Vignola: Thank you.

[*English*]

The Chair: Thank you, Madame Vignola.

Next we have Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thanks, Mr. Chair.

Minister, on February 24, 2022, Health Canada announced, in a news release, that it authorized Medicago's COVID-19 vaccine. The same day, Medicago put out a press release, and Takashi Nagao, the present CEO of Medicago, said, “We're...grateful for the Government of Canada's support in the development of this new vaccine, and we are manufacturing doses to start fulfilling its order.”

Why didn't we receive the doses?

Hon. Mark Holland: As I indicated, after the approval it became clear that we had the doses we needed. The other vaccines that were available meant that the doses from Medicago, a division of Mitsubishi, were not required.

Mr. Don Davies: Did the government inform Medicago that we would not be needing the doses?

● (1920)

Hon. Mark Holland: I'm not sure I can answer with that level of granularity. I would defer to Mr. Sheppard.

Dr. Donald Sheppard: Discussions were ongoing with Mitsubishi, and more specifically Medicago, about what our needs were and what their production capacity was. They were ongoing from the time of approval through, as you had already—

Mr. Don Davies: Did Canada tell them that we don't need the vaccine doses because we already had enough?

Dr. Donald Sheppard: As you had mentioned, initially there were challenges with commercial-scale production. When they were in a position to provide it on a commercial scale, they were informed at that point in time, which is when we refer to as having all the other vaccines, that we were not in need of production.

Mr. Don Davies: In February of 2023, Mitsubishi Chemical Group announced its decision to cease all its operations at Medicago. Did we not have a clause in the contract that said, if Medicago closed down and didn't produce the vaccines we paid for, we would get our money back?

Hon. Mark Holland: I can answer that.

Again, the nature of the advance purchase agreements is that you're taking a risk because there were seven viable options, all of which were large companies that we expected to maintain viability, but there was a risk. In that risk, we ensured—

Mr. Don Davies: Minister, if the company shuts down and doesn't fulfill its part of the bargain, that's not a risk. That's a party breaching a contract.

Hon. Mark Holland: The reason it shut down was due to the success of the other vaccines.

Mr. Don Davies: That's not what they said. They said they shut down because of Medicago's challenges in transitioning to commercial-scale production. That's what they said in their own release on why they shut down.

Hon. Mark Holland: That's correct, because as in any marketplace you are against your competitors. If there were no competitors, if they were the only one in the market, then they would have proceeded. The reality is that the marketplace was replete with vaccine options.

Mr. Don Davies: Wouldn't it have been better to at least have the doses? At least we would have had something for the value—

Hon. Mark Holland: They were not needed, and we had the doses that we needed from the vendors we had.

The Chair: Thank you.

[*Translation*]

Mr. Paul-Hus now has the floor for five minutes.

Mr. Pierre Paul-Hus (Charlesbourg—Haute-Saint-Charles, CPC): Thank you, Mr. Chair.

Good morning, Mr. Minister. Good morning, Dr. Sheppard, Dr. Lourenco and Ms. Jeffrey.

Mr. Minister, when the agreements were signed with the seven companies, you knew there was a problem. When the Medicago vaccine was authorized, and the WHO rejected it, we asked questions, but everyone was dodging, and no one wanted to answer.

We now know that the government was fully aware that there was a problem because it had signed the Framework Convention on Tobacco Control on February 27, 2005. Last week, officials from Public Works and Government Services Canada confirmed that. The director general and the deputy director general confirmed that the government knew there was a problem. Today, we learned that we are losing $323 million and that the government has taken a risk.

Are you prepared to admit today that this risk was known and that you went ahead anyway?

[*English*]

Hon. Mark Holland: All the advance purchase agreements, every single one of them, was a known risk, and we knew that not all seven would pan out, first of all.

Second, as I previously indicated, Medicago was in fact approved on February 24, 2022. The decision by the WHO is separate and apart from the use in a Canadian context, but 100%, all seven, came with risks. We had to do that, because there was no way we would get companies to agree to enter into advance purchase agreements without placing money on the table to ensure that they would have their investments covered.

[*Translation*]

Mr. Pierre Paul-Hus: You were fully aware that there was a problem. That has been confirmed. First, you knew that Medicago would not be authorized by the WHO and that Canada was in violation of the Framework Convention on Tobacco Control. Second, after the federal government invested $323 million, that company left, without reimbursing any money.

The Government of Quebec also had an agreement with that company, but it had provided for reimbursement provisions, and Mitsubishi confirmed that it would reimburse the Government of Quebec. Why didn't the federal government include these kinds of clauses, or, if it did, why don't you disclose them?

[*English*]

Hon. Mark Holland: First of all, I wholly and completely disagree that we knew there was a problem. The fact of the matter is that, as I said, WHO and the decision it made was under the context of having all kinds of other vaccines available. The decision was completely separate and apart from the decision made in Canada, which was to approve the vaccine. It was in fact available. The reality is that the vaccine was available. The WHO decision did not affect that.

Second, the WHO decision was in the context of all kinds of other vaccines that were already approved. Trying to simplify it that way is simply not accurate.

[*Translation*]

Mr. Pierre Paul-Hus: That's fine, Mr. Minister.

The vaccine has been approved by Canada. You said earlier that even if the WHO didn't agree, it could have been used in Canada. Many people didn't want to have the other vaccines, including those from Pfizer and Moderna, because they were mRNA vaccines, but they would have liked to have the Medicago vaccine. Why not make this vaccine available to people who preferred to have another type of vaccine?

● (1925)

[*English*]

Hon. Mark Holland: The reason was that we had what we needed. You're right—there was mRNA hesitancy, but we had non-mRNA options that were already on the table. Actually, that's a success of the advance purchase agreement we did, because that way we not only had mRNA, but we had non-mRNA options. At that point in time, Canada had the vaccines it needed, and it meant that we didn't need to proceed with Medicago. Therefore, that was the right decision.

[*Translation*]

Mr. Pierre Paul-Hus: However, I'll go back to my original question: Do you admit that you made a mistake when you signed an agreement with Medicago?

There were already six other companies with vaccines in development, and you invested $323 million in a company that, by its own admission, was going to take much longer to develop its vaccine and was far from certain of the outcome. It took them two years, less time than they had anticipated, but whether it was an unnecessary risk at the time remains to be seen.

[*English*]

Hon. Mark Holland: Fundamentally, no. If I were the health minister at that time, I would have 100% made this decision. It was the right decision. We could not have known which of the seven would work out. I'm deeply proud not only of the government but of officials entering into these agreements and ensuring that Canada had them.

Look, if I could go back in time and not sign a contract with the knowledge that I have now, I sure would. However, I didn't have that knowledge. No one had that knowledge. No one was clairvoyant.

[*Translation*]

Mr. Pierre Paul-Hus: Thank you.

[*English*]

Hon. Mark Holland: There was no JoJo the psychic to call.

Mr. Pierre Paul-Hus: Thank you, sir.

[*Translation*]

I have one last question, which has to do with contracts.

When I was at the Standing Committee on Government Operations and Estimates, we did all the checks on Pfizer and Moderna to get prices. The Minister of Health at the time, Ms. Anand, always said that it was secret. Meanwhile, the United States, Israel and the European Union were disclosing the price of their vaccines. We know that the Americans were paying $7 a dose. In Canada, we did some calculations, and we came up with about $25.

Why, even today, are we unable to know how much the vaccines have cost?

[*English*]

Hon. Mark Holland: When we enter into contracts as a government, there are confidentiality agreements that are signed. Those confidentiality agreements, frankly, assure us the companies will sign contracts with us. If we didn't do it, we would do no business with anybody. It is an absolute requirement of our doing business, but what is important is that the public accounts committee and the Auditor General receive the full, unredacted documents. On the Auditor General—if you want to give me a moment—I can read what she said in explaining exactly.... The Auditor General said:

> In such an environment, advance payments and obligations for minimum purchase were required. Furthermore, Canada had very limited domestic capacity to produce vaccines and therefore was reliant on international imported products.

She continued:

> We found that, although a non-competitive approach was taken, Public Services and Procurement Canada exercised due diligence on the 7 vaccine companies by conducting assessments to examine the companies'—

Mr. Stephen Ellis: I have a point of order, Mr. Chair.

The Chair: Yes, go ahead, Dr. Ellis.

Mr. Stephen Ellis: Again, I do want to significantly object to the minister's grandstanding and moving well beyond the five minutes. It's 50 seconds, indeed well beyond the Conservative member's time of five minutes, which sadly, Chair, gives him an opportunity to grandstand his clairvoyance that he wishes he had, doesn't have or thinks he has. It's totally inappropriate at this committee.

The Chair: Thank you, Dr. Ellis.

It seems there's a bit of grandstanding going on all over the place.

Mr. Rick Perkins: I have a separate point of order, please.

The Chair: Go ahead, on a separate point of order.

Mr. Rick Perkins: Thank you, Mr. Chair.

Since the Liberal Minister of Health, a couple of times tonight, has thrown the Liberal Minister of Industry under the bus on the intellectual property side, I think it's incumbent upon this committee to urgently have the Minister of Industry before it to answer for the lack of IP ownership and the failure, by his efforts, to ensure it was in.

By the minister's own standards, he's not responsible. As part of the point of order, can you inform us when the Minister of Industry will be here?

The Chair: Thank you, Mr. Perkins. That is not a point of order. The Minister of Industry has been invited. We have not yet been successful in securing a date, but he has been invited.

We are now going to go to the last questioner for this round, and that's Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you, Minister, for being here.

Thank you, officials, also, for attending. Thanks for answering some tough questions. You did ask a couple of tough questions as well.

I'm picking up on a theme that my colleague, Ms. Atwin, started. How would you describe Canada's domestic vaccine manufacturing capacity before March 2020?

Hon. Mark Holland: It simply wasn't there. COVID-19 illuminated a lot of areas where we had to do better. At the time, I was the whip. I think back to that moment and looking at the parliamentary pandemic preparedness plan. I asked for it, and I was given a single piece of paper. Nobody could have imagined what was coming.

We have to take the lessons, and one of those is making sure we have domestic manufacturing. That's why we are developing the ability right now to develop mRNA and influenza vaccines here, domestically. That's huge. It's huge for industry and it's huge for protection of public health.

● (1930)

Mr. Brendan Hanley: Yes.

Can you describe how we got to that position, where we'd lost vaccine-manufacturing capacity?

Hon. Mark Holland: There were cuts made by successive governments, most particularly by the Conservatives, who cut deeply into these areas. I think that's one of the things we have to be very careful about in public health. The Conservatives talk about cutting, so they have to cut. You can cut and cut in public health, but when you cut, you don't always see the impacts of those cuts right away.

When you have a public health emergency, or when, over the span of time, you have the impact of underinvesting in public health.... Of course, having those cuts ends up being much more costly and damaging.

Mr. Brendan Hanley: Therefore, you might say that more shortsighted governments are inclined to cut public health spending when they see success in programs, rather than proactively investing to be prepared for emergencies and crises.

Hon. Mark Holland: If you take the comments made by the Conservatives today at their face value, they wouldn't have entered into advance purchase agreements. They wouldn't have had vaccines for the country. You have to wonder, then, with all their talk of the cuts they would make, whether or not they would be investing in domestic manufacturing.

When they talk about cuts and cuts, but don't tell us where they are going to be.... We have to look back to their past. The decisions they made were to cut in places like public health, to devastating effect.

Mr. Brendan Hanley: Thank you.

In terms of the seven APAs, would you call that, in general, risk mitigation—having seven different APAs with different vaccine technologies in play?

Hon. Mark Holland: One hundred per cent. I think we had to take a bet on all viable options. Of course, it wasn't us making that decision. There was an external group convened of experts in virology and immunology, and industry leaders. They were brought together to advise the government on what the viable options were, and then to go and get advance purchase agreements.

Again, it's easy now. Mrs. Atwin was talking about the environment we're in now, where we're largely feeling safe. Go back to the beginning of the pandemic. None of us was feeling safe. We were terrified about what was going to happen to the people we loved.

If the government made the decision to follow the advice the Conservatives were talking about—not entering into advance purchase agreements and just letting the wind blow to see what happens—I can't imagine the thousands of lives that would have been lost.

Mr. Brendan Hanley: Thanks.

I have a couple more questions.

In your opinion.... I know you were not involved as a minister. Clearly this was, as you say, recommended by a panel of experts. However, do you see Medicago as one of the candidates chosen on its own merits, or was there also an element of building domestic manufacturing capacity that weighed into that decision? Are these two separate influences in considerations?

Hon. Mark Holland: No. It was very much on its technical merit. This was an innovative, plant-based technology. Most vaccines are developed off of eggs. Of course, we now have mRNA, but having additional options.... We can't imagine what that will mean for us. While we don't need Medicago right now, this innovative technology could very well save countless lives in the future. We do not know the direction of this pandemic, future pandemics or other viral threats, so having more options at our disposal is excellent.

However, the technical, scientific merit of Medicago was present, as evidenced by the fact that they manifested a viable vaccine.

The Chair: Thank you, Dr. Hanley.

Thank you, Minister.

That concludes our rounds of questions.

We genuinely appreciate your making yourself available. I would have to say I share in the kind words that you have passed along to your team for their work throughout. Thanks to you all. You're welcome to stay, but you're free to leave.

Colleagues, we're going to suspend, because we need to do some sound tests for the next panel.

The meeting stands suspended for about five minutes.

● (1935)

_____(Pause)_____

● (1940)

The Chair: I call the meeting back to order.

Pursuant to Standing Order 108(2) and the motion adopted on May 16, 2022, the committee is now going to resume its study of women's health.

As we have some remote participants, I'd offer the following comments for their benefit.

You have at the bottom of your screen interpretation available to you. There are three channels: floor, English and French. Please don't take screenshots or photos of your screen.

I would like to welcome our panel of witnesses. Appearing today as an individual, we have Dr. Steven Narod, senior scientist.

[*Translation*]

We also have Jacques Simard, who is a full professor in the department of molecular medicine at Université Laval.

[*English*]

We also have with us Dr. Anna Wilkinson, doctor of medicine. Representing Dense Breasts Canada, we have Jennie Dale, co-founder and executive director, and Dr. Paula Gordon, both appearing by video conference.

Thanks to all of you for being here with us today. You each have five minutes for your opening statements.

We're going to begin with Dr. Narod.

You have the floor. Welcome.

● (1945)

Dr. Steven Narod (Senior Scientist, As an Individual): Thank you very much.

I'm a professor at the Dalla Lana school of public health at the University of Toronto, and I'm grateful to the federal government. I hold the Canada research chair in breast cancer, which I've held for the past 21 years. I've been a professor at Women's College Hospital and, for 25 years, have focused almost entirely on breast cancer.

One of my topics of interest is early detection and screening. In 2014, I published what was considered kind of a landmark paper. I was the senior author responsible for the statistical analysis and the write-up of the Canadian national breast cancer screening study, which was a study of mammography.

In that study, which started in 1983, we took 90,000 women across Canada and randomized half of them—by chance, randomly—to a mammography every five years. The other 50% received a physical examination. We followed them for 25 years, and I published in 2014 with my mentor, Dr. Tony Miller. After the 25 years of follow-up, we saw almost exactly the same number of deaths from breast cancer in those women who received five mammograms—500—as in those who received no mammogram—505.

That led me to the conclusion that mammography was capable of early detection. The mammographically detected cancers were smaller. They were less likely to be node-positive cancers. Also, the survival of the women with the mammogram-detected cancer was much better, but unfortunately it didn't result in any reduction in the number of deaths.

In fact, there were 177 women who had their nonpalpable breast cancer detected by the mammogram—they found the breast cancer by the mammogram—who were alive at the 30-year mark. I believe that 177 of those women thought the mammogram had saved their lives and would testify to it and do a testimonial saying, “We really believe in mammograms. I had a mammogram and it caught my breast cancer before it was palpable, before you could feel it as a mass.” However, the number of deaths was the same.

The study has been criticized. To a large extent, people criticize that which they don't like. I've written hundreds and hundreds of papers—730 papers on breast cancer—and that was probably the one that had the most response to it, I think largely because we showed that we didn't believe mammography was capable of reducing mortality from breast cancer. A lot of allegations were made against the paper, generally in the lay press.

Anyway, I took the allegations seriously, went back to the data, reviewed all the data as to whether the allegations were consistent with the findings and came to the conclusion that they were not. I hold the paper to be the standard of scientific research. I think it remains the best breast cancer screening study done, and I think the results are valid.

I could go on, but is that my five minutes?

The Chair: You have another minute, if you want it.

Dr. Steven Narod: I have another minute? Okay.

I've been studying breast cancer in all its formats for 25 years. Much of what I study is early detection. We have to think of the concept that mammography works. Mammography finds cancers when they're small and node-negative. There's no doubt that a mammogram will pick up a cancer when it's small and node-negative. Those have good prognoses.

The last five years I've devoted myself to trying to interpret why it doesn't save lives. I've come to a different conclusion from most of the other physicians on the planet. That is, if breast cancer is going to spread, it will spread very early on. There's a kind of breast cancer that becomes metastatic early on and one that doesn't become metastatic over the course of its clinical time.

In the past year, I have written a 300-page book about it. It will be finished tomorrow on the train ride home. I got the first half proofread today. The other half I'll do tomorrow coming home.

Anyway, I thank the committee for inviting me to express my opinions.

● (1950)

The Chair: Thank you, Dr. Narod.

Dr. Steven Narod: They are opinions. I mean, there are no facts here. There are scientific interpretations. There are facts and then the interpretation of them. We all have our own way of interpreting data.

The Chair: Thank you, Dr. Narod. I'm sure you'll get a chance to expand on that during the rounds of questions.

[*Translation*]

Welcome to the committee, Mr. Simard. You have the floor for five minutes.

[*English*]

Mr. Jacques Simard (Full Professor, Department of Molecular Medicine, Université Laval, As an Individual): Thank you.

I would like to thank the committee for this opportunity to expose some of our work.

For 21 years I have been the holder of a Canada research chair in cancer genetics. I'm also a fellow of the Royal Society of Canada.

A screening program will be sustainable if it delivers more benefit than harm, demonstrates value for money, is feasible to implement, is accepted by both the users and the providers and ensures equitable accessibility.

Currently, breast screening programs determine eligibility based on age, primarily targeting women aged 50 to 74 years of age with mammograms every two years. However, the risk of developing breast cancer varies a lot among women. There are no national guidelines for screening individuals deemed high risk. Screening protocols vary across jurisdictions, and the definition of high risk of developing breast cancer also varies across Canada.

Typically, women are identified as high risk based on a family history of breast cancer followed by testing for BRCA1 and BRCA2 gene mutations. This identification process is often initiated ad hoc by the affected individual and their care provider rather than through systemic population-based identification strategies. This approach overlooks women without a known family history but with a significant genetic predisposition and women at high risk due to the combination of other risk factors like polygenic risk, lifestyle and hormonal factors and mammographic breast density.

Polygenic risk scores represent the combined effect of multiple genetic variants on cancer risk identified through genome-wide association studies—called the genomic approach—and provide a powerful risk prediction approach with the potential to identify many more individuals at high or low cancer risk than is possible by screening based on age alone. In this regard, comprehensive risk prediction tools, including both genetic and non-genetic risk factors, have shown promise in providing personalized risk prediction and informing cancer-screening strategies.

A risk-stratified program involves assessing the risk of breast cancer for each woman in the population, stratifying the population into several risk groups, assigning individuals to their respective risk groups and tailoring the screening strategy to each risk group. This approach may result in some women starting mammographic screening at a younger age, having different screening intervals or having supplemental screening with another imaging modality such as MRI. Additionally, women deemed to be at the highest risk of breast cancer could be offered prophylactic preventative treatment.

Evidence from simulation studies so far shows that risk-stratified screening allows for better trade-offs between benefits and harms. By focusing more intensive screening efforts on high-risk individuals, it is possible to detect cancers earlier in this group while reducing unnecessary screening of low-risk populations. This targeted approach would potentially lead to earlier detection and improved outcomes and reduce overdiagnosis and overtreatment. Also, these studies have shown that risk-stratified screening programs are more cost-effective than the current age-based screening, allowing more efficient use of resources within health care systems.

For 25 years I've been the principal investigator of an international interdisciplinary team. Our last large-scale project was called "Personalized Risk Assessment for Prevention and Early Detection of Breast Cancer: Integration and Implementation", which is the first study that will provide real-world evidence on the optimal implementation of approaches within the Canadian health care system. The Perspective I and I study leverages resources available through the existing screening program, including infrastructure, data collection, methods and analytical tools. This will enable seamless integration into the existing health care infrastructure and facilitate adoption into clinical practice.

Our project will inform collection of saliva sample and questionnaire-based risk information at the population level, risk communication preferences, psychological and emotional outcomes following communication of breast cancer risk information, adherence to the risk-based recommendations of screening, outcomes of screening—cancer detection rates, false positive rates, stage of diagnosis—using multifactorial risk levels and also the relative contribution of self-reported risk factors, mammographic density and the polygenic risk score to breast cancer risk level estimates by the comprehensive CanRisk prediction tool.

● (1955)

This assessment is to strike a balance between the accuracy of risk assessment and the practicality of collecting this information at the population level.

Identifying screening protocols will optimize the cost-effectiveness and a benefit-harm balance of a risk-stratified screening program. We're also looking for a strategy to increase the health care organizational readiness to implement a risk-based breast screening program.

So far, we have learned that it's feasible to collect samples and data for risk estimation. More than 4,000 women participated in Ontario and Quebec in this real-world implementation study. Risk-based screening is acceptable to the woman and to the health care provider. Using multifactorial risk levels compared to age, family history or breast density alone may provide more appropriate recommendations by reducing over-screening in those at average risk and increasing screening for those at higher risk.

Thank you for your time.

The Chair: Thank you, Professor Simard.

Next is Dr. Wilkinson, please.

Welcome to the committee. You have the floor.

Dr. Anna Wilkinson (Doctor of Medicine, As an Individual): Thank you, Mr. Chair.

Thank you to this committee for your important work, especially today, on the National Day of Remembrance and Action on Violence Against Women.

Very few people see the impact of breast cancer screening guidelines the way I do. I am a family doctor. I train future family doctors, and I am a GP oncologist, working on the cancer wards caring for patients who are too sick to be at home. I am also a researcher. I work with Statistics Canada to understand the impacts of Canadian guidelines on breast cancer outcomes. I became a researcher almost accidentally. I could not understand why, as a family doctor, I was told not to screen women in their forties, but as a GP oncologist I was seeing so many women in their forties and early fifties dying of cancer.

If you walk a day my shoes, you will see what it's like to have to tell a woman in her forties that she has incurable cancer. I talk with these women and their families. I sit with them. I walk them through the transition to palliative care. It's not something I forget. These women stay with me, as do their children and spouses who have journeyed alongside them.

The Canadian Task Force on Preventive Health Care determines the recommendations for screening in Canada. In 2011 the task force recommended against screening women in their forties. However, some provinces continued organizing screening programs and some did not, creating a natural experiment in our country. Together with Statistics Canada, Dr. Seely and I used these differences in provincial screening practices to perform an audit of the impact of the task force guidelines.

We reviewed more than 55,000 breast cancer cases over seven years. We found that the proportion of incurable or metastatic breast cancer increased by 10% in women in both their forties and fifties after the guidelines changed in 2011. When we compared jurisdictions that screened with those that did not, we found that women in their forties had significantly more advanced cancers and significantly lower survival than if there was no screening. We also saw a knock-on effect where women in their fifties had significantly more advanced cancers if they weren't screened in their forties. We saw an overall significant increase in the total number of breast cancer cases being diagnosed in women in their fifties if they weren't screened in their forties.

I've also investigated the cost of breast cancer treatment. The cost of treating just one case of metastatic breast cancer is half a million dollars. Compare that with $68 for a mammogram.

Working with Statistics Canada, we found that non-white women—Black, indigenous, Chinese, South Asian and Filipina—have a peak age of breast cancer diagnosis in their forties, while white women have a peak age in their sixties. This means that the majority of breast cancer cases in non-white women are diagnosed before screening even starts. Finally, we found that the incidence of breast cancer has increased rapidly in younger women over the last few years.

Currently, I am an expert for the evidence review team in the guideline update process. Our team creates the evidence base from which the task force makes their guidelines. We experts have recommended against using 40-year-old to 60-year-old trials, which were performed in primarily white populations with primitive and now obsolete technologies. This aligns with what the U.S. task force did for their new guidelines.

However, the Canadian task force dictated the inclusion of these outdated trials, thereby ensuring that the guidelines would not change. We wrote to Minister Holland to demand that the evidence base be established independently. I remain skeptical that the new guidelines will change, as I feel that this is a flawed process, with co-chairs who publicly state their bias against screening, place an overemphasis on harms and have limited openness to adjusting methodologies to embrace modern data.

The U.S. and many of our provinces have recommended that women 40 to 49 be screened. However, family doctors deeply respect the task force guidelines and follow their edicts, even if they are contrary to what the patient in front of them wants. Until the task force recommends screening women in their forties, most family doctors in Canada will not advise their patients to be screened, even if there is a provincial screening program.

My asks of the committee are as follows.

Ensure that the task force process is transparent and uses inclusive, modern evidence. We cannot be basing our 2023 recommendations on trials from 1963.

Ensure that experts can vote and that there is oversight so that individual biases cannot drive the outcome of the process.

● (2000)

As well, in the longer term, develop a guideline process that is responsive to new evidence, with scheduled frequent reviews and a mechanism to evaluate the effectiveness of guidelines once they are in place.

Thank you.

The Chair: Thank you, Dr. Wilkinson.

Next, we're going to hear from Dense Breasts Canada, with Ms. Dale and Dr. Gordon.

I understand you have a joint statement, so you have five minutes to use as you will.

Welcome.

Dr. Paula Gordon (Doctor, Dense Breasts Canada): Thank you.

I am Dr. Paula Gordon, and I'll start.

Thank you for the opportunity to be here today.

I am a breast radiologist. I've been in practice for over 40 years, reading mammograms and ultrasounds, and doing needle biopsies and other breast procedures. I've volunteered with Jennie Dale and Dense Breasts Canada for seven years as their medical adviser, advocating for optimal breast cancer screening.

Breast cancer is common. One in eight Canadian women will be diagnosed with breast cancer during her lifetime. Mammograms are low-dose X-rays of the breasts that allow us to detect cancers earlier, before there are symptoms. Breast cancer treatments are less intensive and outcomes are better, when cancers are diagnosed at an early stage. The five-year survival rate for stage 1 breast cancer is 99%, but it's only 22% for stage 4.

Some breasts have more normal glandular tissue than fat, and we call these “dense breasts”. These people have a higher risk of getting cancer, and mammograms are less effective at finding their cancers. They benefit from supplemental imaging, typically with ultrasound or MRI, based on the patient's risk.

The current task force guidelines recommend against screening women younger than 50 and older than 74, against additional screening for people with dense breasts, and against doing breast self-exams. Experts disagree with these guidelines, which were created using a flawed process. The same process has impaired other guidelines on women's health. The Canadian task force is an arm's-length body with no accountability and no requirement to monitor the impact of their guidelines.

In the past, the task force has intentionally excluded subject matter experts from their guideline panels. Without expert input, the task force based recommendations on decades-old trials that included, almost exclusively, white women, so they discriminate against racialized women. The guidelines discriminate against women with dense breasts and against women older than 74, who have the highest mortality from breast cancer. The guidelines have led to inequity of access among provinces. A Canadian woman's access to early detection of breast cancer should not depend on where she lives.

The panel for the 2024 update includes family doctors, a nurse practitioner, a gastroenterologist and a kidney specialist. For the first time, four experts are included; however, the task force methods manual states, “Clinical and content experts do not provide input or vote on the direction or strength of recommendations”.

To ensure Canadian women have access to equitable and optimal breast screening, we ask that the guideline process be reformed to ensure appropriate oversight, use of current research and meaningful input from experts.

Jennie.

● (2005)

Ms. Jennie Dale (Co-founder and Executive Director, Dense Breasts Canada): I am Jennie Dale. I am a breast cancer patient. In 2016, I co-founded Dense Breasts Canada, a non-profit that raises awareness and advocates for optimal breast cancer screening. I've spoken with hundreds of breast cancer patients across Canada, and it's an honour to be here tonight to represent them.

I could spend hours telling you about the damage the current breast screening guidelines are doing. I could tell you about Jennifer and Carolyn, who are in the committee room tonight. Both were diagnosed with later-stage breast cancer after not being given access to screening in their forties because of the current guidelines. Instead of lumpectomy and radiation, they were subjected to aggressive treatment—mastectomy, chemotherapy and lymph node dissection. I could tell you how they both missed critical years of work, how their families worried they would lose them and how they worry now about metastases. I could tell you they live with lingering pain and debilitating side effects, and I could tell you that the task force members who created these guidelines believe all of these are acceptable costs for Jennifer and Carolyn to pay in the name of not screening.

I could also tell you that, if Jennifer and Carolyn lived in B.C., Nova Scotia, P.E.I. or the Yukon, they could have self-referred for mammograms in their forties and been spared much of what they've gone through. I could tell you that, even though current research shows clear benefits to early detection, members of the task force don't believe that earlier screening results in better outcomes for enough women. Instead, they cling to the flawed findings of 40- to 60-year-old studies—like the CNBSS—that have now been discredited.

I could tell you more, but the one message I want to leave with you is that the current guidelines are harming Canadians and causing avoidable deaths. The very guidelines that everyone would expect to protect Canadians are doing the opposite. The task force is denying us the opportunity to access preventive health care that results in better outcomes. Their overstatement of harms and understatement of benefits are not based on modern science. Their paternalistic concern about anxiety caused by screening is not borne out by patients' lived experiences. Their insistence on shared decision-making perpetuates power imbalances between doctor and patient. Finally, their dismissal of the impact of the guidelines on patients' quality of life is reductive at best and callous at worst.

Please bring Canada into the modern era by using relevant, current and inclusive evidence. Don't allow a group of biased non-subject matter experts to continue to destroy Canadians' lives by denying us health care.

Thank you.

The Chair: Thank you, Ms. Dale and Dr. Gordon.

We're now going to begin rounds of questions, starting with the Conservatives and Mrs. Vecchio, please, for six minutes.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much, Chair.

Ms. Dale, I want to begin with you, because one of the first things I see here is a note in which you opined that the Trudeau government had broken its promise to update the screening guidelines for breast cancer. I just want to hear a bit from you on that.

Can you tell me why you believe it broke that promise?

Ms. Jennie Dale: A commitment was made during an election campaign that the government would address better guidelines, and after the election, it did not address the guidelines. It was not until this past June that the commitment was fulfilled—and it was fulfilled.

Mrs. Karen Vecchio: I usually do not try to get political on women's health issues because I think this is really important, but this government has said it's going to be doing a gender-based analysis on everything it's supposed to be doing. I'm extremely concerned. We're hearing about the discrepancies.

I would like to speak to you, Ms. Wilkinson, about this because you talked about the fact that we see gender gaps. For people who are non-white, we are looking at their forties. For people who are white, we're looking up into their sixties. We're also talking about the regional disparities as well.

Can you please share a bit more on that, because I hear you loud and clear. We obviously need to do something, because women are dying and we know that there are disparities. What would you like to see this government do, and how can we assure that more women survive?

Thank you.

Dr. Anna Wilkinson: What you're referring to are the inequities that we are seeing. These inequities are driven by these guidelines. The inequities that are created by the task force guidelines happen on so many levels.

They happen on a provincial level because they create differences in provinces. Some provinces have the resources to create their own programs and some don't. They create inequities in patient levels, because when the task force says, “Don't screen”, family doctors really listen. The College of Family Physicians really pushes that mandate. Patients really have to know to advocate for themselves.

Having these national guidelines really drives inequity among individuals, particularly individuals who are marginalized; who are Black, who have worse outcomes with breast cancer; and who have lower socio-economic status—which we see with lung cancer, because these guidelines also refer to many different areas of preventative care, including lung cancer screening.

What would I like to see? Although health care is a provincial matter, these national guidelines really drive what the provinces do. Until we have a clear and transparent mechanism for creating guidelines that include modern, relevant evidence, we're going to continue, as a country, to be behind the eight ball, dragged back to really old data and not moving forward in an innovative fashion.

● (2010)

Mrs. Karen Vecchio: I want to continue with you, because you talked about the screening being done under the age of 50, because of that 40 age. I'm a happy 52-year-old woman, but you look at that.... What would you say is the best way of screening? Does it start off with a mammogram? Do we do biopsies? What is the procedure if a woman is concerned, or if she is that 40-something and we're looking at screening?

What should that protocol be to ensure that we're doing health right?

Dr. Anna Wilkinson: It's really simple. A mammogram is where we start. With screening, a mammogram is an X-ray of the breast.

What I and many other experts believe is that screening should start at age 40. Women in their forties should probably have annual mammograms, and then that should continue every two years. If a woman is really healthy and has a good life expectancy in her seventies, then that should continue, probably, to 80.

The biopsies...those kinds of things only come into play if there are abnormalities or suspicions of cancer noted on the mammogram.

Mrs. Karen Vecchio: Wonderful. I have two more minutes.

Continuing on with that, when we talk about genetics, because genetics are obviously a big part of this.... I think I've heard that from each of the panellists today.

Dr. Narod, I want to start with you. When we're talking about genetics and screening, when we're looking at that, when should we start doing the proper screening if we know that breast cancer is in a family's history?

Dr. Steven Narod: There are three levels of genetics. One, as Dr. Simard pointed out, is polygenic risk scores, which give you a risk based on 313 variants. That is his study. There are also major genes BRAC1, BRAC2 and PALB2. Jacques and I were actually working on that together back in the 1980s. Finally, there's family history.

Mrs. Karen Vecchio: Should we be doing that at a certain age? When a woman is 20, 30 or 40...? Is there a certain age at which we should start doing a special screening for women with a history?

Dr. Steven Narod: It's not so much that we should do the screening as we should do the testing.

One of the most important things, I believe, is that the current policy in Ontario and in most provinces is that we do genetic testing once a woman has developed breast or ovarian cancer. By that time, I think it's a little late.

I set up a program at the Women's College Hospital—the only one in the world—where we make genetic testing available to every woman in Canada from the age of 18 on a pay-per-service basis. We've done several thousand. The premise is that, if we find them before they have cancer, then we can offer them special screening.

In the high-risk women, we do offer MRIs. It's covered by the Ontario government, OBSP. We offer preventive surgery. We offer mammography as well.

Mrs. Karen Vecchio: Thank you so much, Dr. Narod.

I believe my time is up. I really appreciate that.

The Chair: It is indeed. Thank you.

Next we have Dr. Bennett, please, for six minutes.

Hon. Carolyn Bennett (Toronto—St. Paul's, Lib.): Thanks very much to everyone.

I just have to say that, in a study on women's health, I hope that we will be able to move more broadly in terms of the social determinants but also in terms of women's responsibility as the health care provider for their families and the fact that we actually do need, I think, to look at the big picture.

I'd like to ask a question of Dr. Narod from Women's College. One of the things, I think, in women's health research is listening to women about what's worrying them. At the beginning, I think it was women worrying that their sisters or their nieces or their daughters were going to get breast cancer, and I think that obviously the discovery of the BRCA gene has been very important.

I would like you to tell us what you think the future would be in terms of cancer genetics and prevention, testing versus screening and how that could eventually move to treatment with precision medicine.

● (2015)

Dr. Steven Narod: Yes, that's a pretty good question.

I've been working on prevention. I've been working on screening. I've been working on treatment over the last 25 years. I was co-discoverer of BRCA1 and BRCA2. I've spent a lot of time thinking.

In 1991, when we did the first paper in The Lancet on BRCA1, I thought that, by the time we got to 2023, we'd have something better to offer than removing the breasts. So far, we don't. We just published a paper that using tamoxifen in several thousand women with BRCA1 mutations reduced the risk by about 20%. It's not really good enough.

I could talk all day about prevention. I'm not one who would think that we can tackle the breast cancer problem to a large extent in Canada by current preventive means. We recommend against alcohol. We recommend against obesity—weight loss, etc. Interestingly, for women under 40, being overweight is protective. No one ever talks about that, but it's very strongly protective.

Having worked in all three areas for 30 years, I would emphasize treatment. I think so. I mean, it's a matter of funding.

In terms of prevention, we have an idea of how we think we can do it, but it hasn't received funding yet.

I think a lot of the points made by the other speakers are valid. I do say though that, in our study, the end point was death. There were 500 deaths in one group and 505 deaths in the other group. I applaud Dr. Simard for his effort in trying to change it, but his study doesn't have death as the end point. None of the other studies have death as the end point.

You show me, Dr. Simard, that your program reduces the number of deaths, and I will be a convert to your program.

Interestingly though, Dr. Simard—I've been friends with him forever—is recommending a risk-based study rather than an age-based study. It's really interesting. Currently, the age base is 50 to 70. If we reduce the age base to 40 rather than 50, the genetic risk scores probably go out the window because, even for those people with a high risk score, the recommendation would be to start screening at 40 rather than 50.

Now, I heard all these things about outdated data for the national breast cancer.... Yes, it's outdated, but there are still 170 women who had breast cancer identified and are still alive. It doesn't mean.... You show me the current data. In my understanding, and having read every paper about it, I don't see any current data that supports using mammography to the extent to which the panel thinks it does.

One can talk anecdotally about this and that. The only other study that is always neglected to be mentioned is a U.K. age study done by Stephen Duffy and colleagues, published in 2022. It showed that, in randomized screening in the U.K., when women started at age 40 versus age 50—and we followed them until death or to age 60—it made no difference to the mortality rate, but you will never see that paper cited.

That paper was was written in 2020, and I've been communicating with Dr. Duffy. He actually gave me the information. You will never see the U.K. age study that actually showed that screening from age 40 was exactly the same outcome as screening from age 50.

Hon. Carolyn Bennett: You found that there were some mutations in the ethnically diverse populations. Do you think that mutation will affect the way different cancers or different patients are treated?

Dr. Steven Narod: Do you mean the mutations?

Hon. Carolyn Bennett: If it's a mutated cancer, will it take...? Once you find the genetics are different, then I presume the treatment might be different.

Dr. Steven Narod: Those are good questions. They're not really about screening, but you are 100% right.

I'm running an international study of 8,000 women with the BRCA1 mutation and collecting comprehensive information on their treatments. Dr. Simard published a paper two weeks ago in JNCI, which looked at BRCA1 and BRCA2 mutations in 2,500 women from many countries, including Canada. We are studying that. We do see that the treatments had different effects, certainly.

Nevertheless, I do believe preventing it is better than treating it. The best we can do with treatment.... My goal, as a physician working to cure breast cancer, is to get the survival rate to 90%. My goal, as a preventive physician working in screening, is to get the survival rate to 100%.

● (2020)

The Chair: Thank you.

Thank you, Doctor.

[*Translation*]

Ms. Larouche, you have the floor for six minutes.

Ms. Andréanne Larouche (Shefford, BQ): Thank you, Mr. Chair.

It's very interesting to hear what our witnesses are telling us this evening as part of this study. I think many of us have known people who have had breast cancer. I would like to take a moment to remember Nathalie, a friend who was diagnosed with breast cancer several years ago. She was in her late forties, and she passed away a few years later, just in her early fifties.

This cancer affects far too many women and takes them away from us far too soon. This brings me to the whole issue of screening and treatment.

Dr. Narod, you mentioned a study in Great Britain. That's interesting. A lot of questions have been asked by my colleagues about age and national guidelines, but what's happening internationally?

Mr. Simard, you are part of an international research group, so I invite you to comment on that as well. What could we learn from the work being done internationally?

Dr. Gordon, in your brief, you talk about statistics and data from other countries. What can these studies that are done elsewhere bring us here?

Mr. Jacques Simard: I'm fortunate to be part of an international consortium that studies data from 400,000 women in more than 35 countries on six continents. Thanks to these participants, we have been able to develop new tools to evaluate something called polygenic risk, which has been validated in more than a dozen prospective studies.

It should be noted that approximately one woman in 200 or 300 carries a mutation of a rare predisposition gene. So it's quite rare. We also studied the frequency of mutations in the BRCA1 and BRCA2 genes, which I was involved in discovering, in certain ethnic groups.

What we're proposing is the use of about 300 markers that are very frequent. By combining this signature with other risk factors, such as breast density, certain lifestyle patterns, and hormone factors, we could assess personal risk and stratify it into three groups.

For example, we followed 4,000 women in our study. Of these, 80% were at or near the same risk as the general population, 15% were at intermediate risk, meaning that they would have to start doing an annual mammogram at age 40, and 5% were at high risk. In their case, they should start doing an annual mammogram immediately, in addition to using magnetic resonance imaging, because there is indeed more than just mammograms. You know the statistics better than I do, but we know that 17% of all breast cancer diagnoses are made before the age of 50, so it's very important to take action.

Internationally, we are also working on risk prediction models or tools, such as genomic signatures, that are specific to various ethnic groups, such as Asians and Hispanics. It's very important.

Ms. Andréanne Larouche: Thank you.

Go ahead, Dr. Gordon.

[*English*]

Dr. Paula Gordon: Thank you very much.

I'd like the committee to know how futuristic and wonderful Dr. Simard's work is, but it is futuristic. Certainly, Dr. Narod's discovery of the breast cancer gene was pivotal, but we're dealing with guidelines now that deal with average-risk women. Only 5% of women are high risk, and the vast majority of women who get breast cancer have no risk factors, not even a mother with breast cancer. In fact, having dense breasts is the most prevalent risk factor.

What the committee should understand—and I'm sorry to hear that Dr. Narod does not know this—is that the study with which Dr. Narod was associated, the Canadian national breast screening study, has been discredited. Although it was supposed to be a randomized trial, the randomization was flawed—corrupt you could say—and that explains why that study was the only randomized trial among eight others that did not show mortality reduction. We know why that study didn't show reduced deaths among women in the mammogram group.

For average-risk women, they should have a risk assessment. Right now, not all women can have the polygenic risk score that Dr. Simard spoke so well about, but women should be assessed for their risk. There are online risk tools that are free and easy to use, and average-risk women should start at age 40. If a women is shown to be at increased risk or at very high risk, she might start sooner, but otherwise, it should start at age 40 and, ideally, be annual because when women are premenopausal, the hormones made by their ovaries cause their breast cancers to grow faster.

That's why we must start screening women, especially Black, Asian and Hispanic women.... Indigenous women, in fact, have the same analogous inequities that we see for Black American women. They tend to get more aggressive cancers, and they're more likely to die from their cancers. Those inequities have to be addressed.

The other big inequity is for women with dense breasts. Now, that's something that no one can control. You can't control your breast density, yet women with dense breasts are more likely to get cancer, and we have a harder time seeing those cancers on their mammograms. We know that we can find them. We can find them with ultrasounds. If they're really high risk, we can find them with MRIs, but of course, MRIs are much more expensive and less accessible. It's not their fault that they have dense breasts. They deserve the same opportunity for early detection as women with non-dense breasts.

● (2025)

The Chair: Thank you, Dr. Gordon. That's our time for this round.

Next I recognize Mr. Davies, please, for six minutes.

Mr. Don Davies: Thank you, Mr. Chair.

Thank you to all the witnesses for being here.

Dr. Gordon, I'd like you to elaborate, please, on why breast screening guidelines, in your view, need to use inclusive and more modern evidence.

Dr. Paula Gordon: As you heard from Dr. Wilkinson, the Canadian task force procedures, to this point, have focused on rating the quality of evidence, if you will, and randomized control trials are always ranked the highest. The problem is that the randomized trials were all done between the 1960s and the 1980s, at a time when mammograms where done on X-ray film that you put on the light box. They are now done digitally, and we look at the images on a computer screen. They're much more accurate. We can use software, in fact, to help us decide whether a woman has dense breasts or not.

The old trials were done, as you heard, in white populations, so the guidelines discriminate against racialized women. Now, some people say, “Why don't you just do another randomized trial?” Because those old trials, even the flawed trials, prove that mammograms save lives, it would be unethical to repeat them and expect women to go in a control group that is not having any screening.

The newer observational studies.... The one this committee needs to hear about is one called the pan-Canadian study. It was published in 2014 and ignored by our task force. It looked at 2.8 million women having screening mammograms in our provincial screening programs, and it showed that, overall, women who have mammograms are 40% less likely to die than women who don't. It's even better for women in their forties; they're 44% less likely to die. However, the task force continues to use this old data, claiming that the randomized trials trump this new, modern observational data.

We have a natural experiment in the country, which you heard about from Dr. Wilkinson. Women who live in provinces that start screening at 40 are more likely to be diagnosed with early-stage breast cancer than women who live in provinces that start at age 50, and they have better survival. In provinces that don't screen until 50, the women in their forties are diagnosed more often with late-stage cancers than women in their fifties in the same province.

This is the outcome, and our task force has never audited the outcome of the current guidelines. The current guidelines are from 2018, but they are essentially unchanged since 2011. Dr. Wilkinson and colleagues, with Statistics Canada, were able to show the damage done by those guidelines. However, from what we can see, the current review under way is likely to come up with a recommendation for no change in those guidelines.

● (2030)

Mr. Don Davies: Dr. Gordon, one concern I've heard expressed is one of potential bias.

In May 2023, before the expedited review of the current guidelines had even started, Dr. Guylène Thériault, co-chair of the Canadian Task Force on Preventative Health Care, told the Toronto Star that she does not see any reason to change the task force's guidelines on breast screening, which means to keep it at the current age of 50. In addition, just this month, Dr. Thériault co-authored a journal article called “Debunking myths about screening”.

As a scientist, researcher and someone involved in this, what kind of confidence or lack of confidence does this give you that Dr. Thériault is able to fairly adjudicate based on the evidence?

Dr. Paula Gordon: She's clearly declared her bias and her conclusion.

You might be interested to hear that in that article called “Debunking myths about screening”, she claimed that earlier detection does not result in better outcomes. She said that's a myth. She said it's a myth that “newer technology produces more benefit”, and that it's a myth that screening saves lives.

I just told you that, from the pan-Canadian study, we know there are 40% fewer deaths in women who have mammograms.

Mr. Don Davies: Thank you. I understand that the United States has recently lowered the screening age to 40.

Is that right?

Dr. Paula Gordon: Yes. That's what's prompted this conversation. Normally the task force reissues its guidelines. The last couple have been every seven years. This has to be something....

Research is being churned out very quickly, and these guidelines have to be more nimble. They have to be able to be changed more frequently when more research is done.

Mr. Don Davies: Dr. Wilkinson, to your understanding, why did the U.S. change its guideline and lower the screening age from 50 to 40?

Dr. Anna Wilkinson: The U.S. assumed a benefit of screening, so they did not review evidence before 2016. They moved on. They found no new randomized control trials, much like we spoke to. These trials were all or primarily done a long time ago.

They assumed benefit and they had to look at other things. They looked at some non-randomized trials. They also looked at some modelling data, because we know that we cannot rely on the old trials. The old trials were done before digital mammography. They were done even before tamoxifen existed. We are talking about very rudimentary treatment.

These old trials only show a mortality benefit of 15%, compared to the 40% or 44% that we're hearing.

The other thing the U.S. looked at was the impact on minority groups and the younger age at diagnosis for Black and Asian women. The increasing incidence, the change in the different age of diagnosis and the modelling data are what prompted the change.

The Chair: Thank you, Dr. Wilkinson.

I'm sorry, Mr. Davies. That's your time.

Mrs. Roberts, go ahead, please, for five minutes.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you, Mr. Chair.

I want to state a quote I found at the Public Health Agency of Canada. The “breast cancer death rate peaked in 1986 and has [declined] since.” However, there has been a reduction in death rates due to “the impact of screening and improvements in treatment for breast cancer”. That's according to the Public Health Agency of Canada.

My question is going to be for you, Dr. Anna. I love your name.

You have been a supporter of organized screening for women under the age of 50. You have noted that, “There is a significant increase in survival for women if they live in a province with an organized screening program with self-referral and annual recall for women in their 40s”. You also mention that 16% of breast cancer occurs in women between 40 and 50 years of age.

Can you please help us understand the importance of screening? I know that you're an advocate of it. I really appreciate that as a woman, because I think we need to make sure that women deserve to live and deserve to have the screening. Without us, they wouldn't be here. Let's be honest.

I really love what you're saying and I love what Dr. Gordon is saying. I think you guys are on the same path. Could you please elaborate on why we can save more women if we implement more screening at an earlier age?

● (2035)

Dr. Anna Wilkinson: What screening does is it diagnoses cancers earlier. Screen-detected cancers are often only four millimetres wide. They're cancers that are detected before you can feel them. Smaller cancers, by definition, are at an earlier stage. Earlier-stage cancers, by definition, have better outcomes and less-intensive treatments.

In terms of why you should have an organized program, if that screening happens within an organized program, that means that a woman can self-refer. This is key in this day and age, where a lot of women do not have access to a family doctor or where a family doctor may be a barrier to screening. The family doctor is hearing that the task force says, “Don't screen.” The woman comes and says, “Can I be screened?” and the doctor says, “You don't need to be.”

Women in organized programs get recalls. We're all busy. Life gets a hold of you. The program sends you a letter and says to remember to come for your mammogram this year.

There are quality controls within organized screening programs as well. There are metrics that are followed in terms of the quality of mammograms, reading, follow-up and all of those issues. That's why organized programs are so key. With our current national guidelines, there are no organized programs for women in their forties across the country. It is completely dependent on the province you live in.

Mrs. Anna Roberts: I forgot to mention this earlier. I want to thank you for sitting with patients. I've done it as a volunteer in the long-term care home. It really makes a difference to the patient. Thank you for doing that.

My other question is for you or Dr. Gordon.

Do we need to do a study on the creation of guidelines by the Canadian Task Force on Preventive Health Care for women, so that we can start fresh by discovering that we can save more women? Maybe we need to start now and start doing it for all women, regardless of race.

Dr. Anna Wilkinson: Our task force has been looked at as the gold standard. Why is it the gold standard if experts don't agree with the guidelines? Why is it the gold standard if provinces are doing their own thing and not doing what the guidelines are saying?

The reach of the task force and their guidelines is very broad and hits many points of women's health. It includes lung cancer screening and cervical screening. The last time the cervical guidelines were updated was 10 years ago. In the interim, the whole world has moved to HPV-based screening. That's where we should be. We are handcuffed back to 10 years ago with the old guidelines.

There are other examples of guidelines. Our guidelines tell us not to screen for postpartum depression. We are one of the only countries in the world that suggests that. There are many issues with guidelines across—

Mrs. Anna Roberts: I just quickly want to thank you and Dr. Gordon. I think that you do women justice. Thank you for making sure you protect us. There aren't too many people—

Dr. Paula Gordon: Can I jump in and build on what—

Mrs. Anna Roberts: Absolutely, go right ahead.

The Chair: No, I'm afraid you can't, Dr. Gordon. We're at time.

If Mrs. Atwin wants to give you some of her time, that's up to her. The floor is for Mrs. Atwin for the next five minutes.

Mrs. Jenica Atwin: Thank you, Mr. Chair.

Thank you very much to our witnesses for being with us this evening.

Even just this evening I've learned so much, to be honest. I didn't realize how many different veins my mind would be going in with this kind of a conversation. I think about conversations I've had with my mother about getting tested and the unpleasantness around getting a mammogram but also how important it is. Also there's the general sentiment in my circle of friends. We're all entering that stage where we should be looking at getting screenings.

There's the importance of self-checking. I see in the 2018 guidelines that they're actually recommending against the practice of breast self-examination for screening for breast cancer. There are a few other concerning things in the 2018 guidelines. There are also pieces about the potential for false positives or overdiagnosis, which has very much piqued my curiosity. I've never been warned about the potentials or risks there.

To any one of our witnesses, would you like to jump in on that piece? Could you just clarify for me what the risks are for overdiagnosis or false positives?

Dr. Anna Wilkinson: Paula, maybe you'd like to go?

Dr. Paula Gordon: I'm happy to do that.

First of all, even the term “false positive” is pejorative. It's really fearmongering, because we're not telling women they have cancer when they don't. What they use the term “false positive” to mean is a false alarm, where something showed up on your mammogram and at the end of the day it's probably not going to be cancer, but it deserves another look. For women who have anything that's out of place or that needs more testing—sometimes it's just another couple of mammogram pictures—they are recalled.

That's what it should be: a recall or a false alarm. With the majority of women, we can sort it out with ultrasounds or mammograms. If you take the real numbers in this country, out of every thousand women who are screened, 70 will be recalled, and of those 70, 11 of them—so now we're talking about 11 out of the thousand—will be told that they should have a needle biopsy.

I must tell you that a needle biopsy is done with adequate local freezing, and most women say it's no more uncomfortable than a blood test from the arm. I know that no one believes me when I say that, but the best comment I ever heard from a patient was, “Dr. Gordon, I have shoes that are more uncomfortable than this test.”

In any case, out of the 11 who have a needle biopsy, four of them are told that they have cancer. For the 11 women going through this test, the task force calls them “unnecessary” tests. Well, it's not an unnecessary test until you find the answer. Most women would rather go through something relatively painless to be more sure that they don't have cancer.

That's the false alarm story.

Overdiagnosis is a little tougher to explain. Overdiagnosis is when we find a cancer and it's a real cancer, but that cancer would not have killed the patient had it been left untreated. The typical scenario is that, if we're dealing with an elderly woman and we find a small cancer, it may not be problematic for five or 10 years, but she's also got lung cancer because she's older and she's at higher risk for lung cancer. That lung cancer is going to kill her before her breast cancer would.

Here's another example. A woman gets diagnosed with cancer, she gets treated, she finishes all her treatment and two weeks later she gets hit by a car and dies. That's actually overdiagnosis, because that cancer wasn't going to kill her, but unless you have a crystal ball and you know that you're not going to have a fatal heart attack or be hit by a car, every woman with a new diagnosis of cancer is offered treatment.

It's estimating overdiagnosis that's tricky. The task force used an estimate of 48%. They said that almost half of cancers are overdiagnosed, meaning that they shouldn't have been found or treated. That's because they got that data from that flawed Canadian trial that we heard about from Dr. Narod, and that's why there was no difference in the death rate and all their stats are off. International experts believe that overdiagnosis occurs in about 1% to 10% of women, and probably at the lower end of that range. Now remember that these are real cancers. It's just a question of whether that cancer is going to kill the woman.

Most importantly, our task force is using overdiagnosis as a reason to not screen women in their forties. Women in their forties are much less likely to have a competing cause of death and overdiagnosis in that age group is negligible, so it's absolutely not a reason to not screen women. When it comes to false alarms, we should not only be telling women about overdiagnosis and false alarms but also letting them know there's a possibility that they'll be recalled and mostly it turns out to be nothing.

It's condescending for the task force to decide on behalf of women that they're too fragile to handle a little transient anxiety. Women should be able to decide for themselves. If they say, “No, it would ruin my life and I'd rather risk getting cancer”, that's a woman's choice. Most women, when they understand the principles of overdiagnosis and false alarms, would like to be screened.

● (2040)

The Chair: Thank you, Dr. Gordon.

[*Translation*]

Ms. Larouche, you now have the floor for two and a half minutes.

Ms. Andréanne Larouche: Thank you very much, Mr. Chair.

I'm going to continue along the same lines as my colleague Ms. Atwin.

Since the beginning of the meeting, we've been asking a lot of questions about the prevention of these cancers. One of the counter-arguments is that there are false positives or overdiagnosis.

Dr. Gordon, you explained the difference between a false positive and overdiagnosis. What are the real risks of overdiagnosis? Is it the mental health effects on women or the side effects of treatment? Is it because doctors, specialists or rooms are being removed from other prevention cases and other treatments? What are the real criticisms of overdiagnosis and what are the real risks for women, other than mental health? That said, if you want to address the issue of mental health, please go ahead.

● (2045)

[*English*]

Dr. Paula Gordon: The problem is that we don't know at the time we diagnose a cancer whether it is overdiagnosed, because we don't know yet when that woman is going to die. Now, you could argue for example—you heard this earlier—that if a woman is in good health and she has a life expectancy of at least seven to 10 years, then we should keep screening her. It's when women are ill with other potentially deadly illnesses that they can stop having mammograms. If they have end-stage heart disease or end-stage renal failure and they're not likely to live 10 more years, then let's not go looking for a cancer that will not be threatening to them before their other illness will kill them.

It's a question of judgment. There's no harm in diagnosis. We don't know and that woman deserves treatment, because she might live another 20 or 30 years. It's more a question of judgment as to when to stop screening.

Many of the screening programs stop at age 74. If a woman wants to continue screening then she needs a requisition from her doctor. There are several provinces that allow women to keep self-referring. That assumes that they're in good health with a reasonable life expectancy.

The Chair: Thank you, Dr. Gordon.

Next is Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Dr. Gordon, I want to make sure I have this right. The current task force has recommended against screening until women are 50 for about the last 10 years. If I am hearing the evidence right, the criticisms of this are the following: They're basing that on outdated evidence being used, the diminishment or ignoring of current evidence, a lack of expert input or subject matter expertise, and the potential bias of task force members.

Would that be an accurate summary of the concerns?

Dr. Paula Gordon: That sums it up.

Mr. Don Davies: Dr. Wilkinson, you've mentioned the need for transparent processes. Can you elaborate on your experience as a member of the evidence review committee?

Dr. Anna Wilkinson: I can only elaborate on what I've experienced. Certainly, I've not seen transparency to date.

Our recommendation was to not use old data as the expert. However, during the time that we were trying to establish the evidence base, it seems that the working group was already working on evidence—although I don't know where it came from, since we had not completed our review. When we went to finalize things and there was all of the old data included in the evidence, we were told this was because the task force had demanded that this evidence be included.

I asked where the overdiagnosis number was coming from, because this is a key number. If you say, as we said earlier, that the overdiagnosis rate is 50%, what that means is that, if you're using an old trial with the benefit of 15% and you say that 50% of those don't matter, then you're down to 7%. If you take the newer trials at 40% benefit and you say there's zero overdiagnosis, then you have a 40% benefit. The evidence review panel did not know where that number came from. That is not a number that they were supplying to the task force working group.

Mr. Don Davies: Thanks.

Ms. Dale, I just want you to jump in a little bit.

You have talked about the current patchwork of breast screening practices across the country. How does that impact Canadian women's abilities to get the care they need?

Ms. Jennie Dale: It impacts it significantly.

We look at provinces. Dense Breasts Canada compares all of the provinces in terms of optimal breast cancer practices. We looked at five different key practices. You have a province like Quebec that scores zero out of five. Then you have a province like Nova Scotia that scores five. Most of them score two out of five. That means that women in a province like Quebec do not have equal access to finding cancer early. It's a postal code lottery. We want to see all women in Canada have the same access for that.

We found that, even in provinces that do self-refer at 40, the family doctors are still dissuading women from getting screened. The task force guidelines are still playing a key role, regardless of self-referral. We're also finding with this inequality that there's confusion across the country. We did a survey of 2,500 women and 42% of them did not know what age screening began in their province.

Beyond the confusion, we also have women on social media all of the time—

● (2050)

The Chair: Thank you, Ms. Dale. I let you go a little longer because it was the first question you got on this panel. We are well over time.

Dr. Kitchen is next for five minutes, please.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

I want to thank all of you for being here, and the people in the audience as well. I commend them for being here.

Part of my discussion and my concern is that there are people watching. There are women watching this conversation, and they are concerned. They are very concerned about what's going on, about themselves and about the future for women in this country. It's great to hear many different aspects of this. I recognize the challenges we've had. I've been all over the map with questions I want to ask.

Ultimately, I recognize the challenges we have in doing RCTs in this subject area and the potential that could be there in someone designing that. Dr. Wilkinson, your comments about working with patients, I think, are tremendous, and dealing with women and understanding that.

In my years of practice.... I'm from a rural part of Canada, where I had many women come to me with signs and symptoms that were outside my scope of practice. They came to me because they realized that I would at least refer them to where I felt it was appropriate, to at least be assessed. My home is 14 miles from North Dakota. In North Dakota, they basically have 18-wheelers with mammography units, and they travel all over the state to do testing.

When I see recommendations from the U.S., where they recommend biannual testing for women between 40 and 74, I see that as a concern as to the research and the science they would have used to get that.

Dr. Wilkinson, what are your thoughts on that? If they had some research to support that, why don't we?

Dr. Anna Wilkinson: That's a very good question. That's the crux of the matter, I think. We need to move beyond the old data. We need to move beyond 60-year-old data. We cannot use data from before we landed on the moon to determine our breast cancer guidelines now. We are moving into uncharted territory.

I'm not a methodologist. I'm not a guideline expert. I'm not going to pretend I know how to do this, but I do think we need to think about different methodologies and to involve different kinds of data. Right now, although different data is involved, if it's an RCT, even if it's a really old, crappy RCT, it still trumps a non-randomized study. Those numbers from those randomized studies are still driving.

We need to look at what the U.S. is doing. I think we need to use modelling data. There's a new paper just out that shows screening women in their forties saves 3.3 deaths per thousand women screened. Move to modelling and use a lot of the epidemiological data, because our society is changing, the incidence is changing and the ethnic makeup of our society is changing. We have to do more of a holistic investigation to do that.

Mr. Robert Kitchen: Thank you. I appreciate that.

When we hear about guidelines that are basically suggesting they are against self-screening, that's a concern to me, especially in rural areas—not just rural but urban as well—where there are concerns that you can't access a practitioner to even get that done. At least the self-screening would provide some form of understanding. I think that's information women need to understand. They need to be prepared to learn how to do it and do it, so that they at least understand when they need to see that practitioner.

On that note, the concern I have, having been a regulator in the profession and having dealt with things, is that there is a difference between guidelines and standards. When we talk about guidelines that are presented, where practitioners see those guidelines, they don't necessarily look at it the same way as they might look at standards. I'm just wondering about comments you might have that maybe these things should go even further than guidelines and become standards.

Dr. Anna Wilkinson: Guidelines would be a really good start. We need something. We have an opportunity, and I think the national guidelines are a federal issue, because they are impacting all the outcomes in the province. We have an opportunity to do this differently, to be creative and to think about the impact of what we're doing.

For example, in the U.S., when they recommended against prostate screening, or PSA screening, they looked at their mortality rates, found they were going up and reinstituted it. Whereas, we made that recommendation 10 years ago, and I don't think we have ever looked back at that. It's not a women's health issue, but it's an example of the broader reach. Although standards would be lovely, I think we need to start first with really grounded guidelines. We really need to have regular updates of guidelines, given the quick pace of medical literature change these days.

● (2055)

The Chair: Thank you, Dr. Wilkinson.

Next, we have Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I hate to bring this up and get into this controversy, but Dr. Gordon, I think you suggested that the current task force recommendations on screening were largely based on Dr. Narod's randomized control trial, which I think you've said is flawed.

As I recall, having discussed this with you before, the basis of the flaw was the improper randomization, in that at least some of the nurse practitioners who were involved and doing the randomizing, when they felt a lump in the screening exam, put them in the mammography group. Therefore, yes, at the end, you are going to have more deaths in that group because you have a lot of people in that group who are in there because they had cancer to begin with. That gave a skewed outcome.

Am I right in that this is what you're saying? What evidence do you have that it is, in fact, what happened?

Dr. Paula Gordon: That is what we're saying. In fact, there were 28 former staff who came forward with evidence of protocol deviations. That's what they're called. That wasn't the only problem with the Canadian trial. In fact, they allowed women to be participants even if they had a known breast lump. Screening is for women with no lumps.

First of all, they allowed these women to participate. They were having trouble recruiting enough women for the study, and they actually approached breast surgeons to send patients to be in the study. The reason a woman goes to a breast surgeon is that she has a lump or a symptom.

First of all, they allowed these women to participate. What was supposed to happen was that every woman who came to participate—they were volunteers—got a clinical breast exam by a highly trained nurse, and then they would go to the coordinator, who would decide to put her in either the study group, where they got a mammogram, or the control group, where they didn't.

Nowadays, when we do these studies, the randomization is done by a central office, by a computer. In those days, the coordinators had a piece of paper in front of them with lines. The lines would say, “mammogram, control, mammogram, mammogram, mammogram, control, control”, and at the end of the sheet, you'd have an equal number of women in both arms.

What we know happened, because witnesses came forward and told us—and these are in three peer-reviewed published papers, by the way—is that the nurses would say, “This lady has to be in the mammogram group,” so the coordinator could write her name on the next available mammogram line, and then other women who came in later in the day could go in any blank lines that she had left. They didn't even have to make any erasures.

This was actually picked up in 1992, which was the first publication of the Canadian national breast screening study, because there was a significant imbalance of advanced cancers. In the very first year of the study, there were 25 advanced cancers, which they defined as a cancer with more positive lymph nodes in the armpit. There were 19 of them in the mammogram group and only five in the control group.

This was raised decades ago, and the principal investigators at the trial have denied it to this day. They claim that there was nothing wrong with the randomization. There was even a forensic—

Mr. Marcus Powlowski: Dr. Gordon, I'm sorry. Can I cut you off?

In fairness, I want to give Dr. Narod an opportunity to respond to this.

Dr. Steven Narod: You give my study.... You gave all the time for your question to Dr. Gordon, who.... I have 30 seconds now.

Okay. Let me—

● (2100)

Mr. Marcus Powlowski: I'm giving you time, and other people can give you time as well, but I want to hear from you in response to that accusation.

Dr. Steven Narod: This is my study. The data is on my computer.

Dr. Gordon and others made a claim of scientific misconduct at the University of Toronto last year, at which point I prepared a report on exactly what she's claiming. That report was submitted to the dean of public health sciences and was submitted to an international committee that reviewed the study and came out entirely on my side.

Let me tell you a couple facts. In the first round of screening, there were 270 palpable cancers on the mammography side, and 274 palpable cancers in the control group. If we had shunted women to the mammogram group who had a palpable cancer, that number would be different. There were 270 in the mammogram group, and 274 in the non-mammogram group.

Second, I removed all those women from the first round. I removed all the women with a palpable cancer from the analysis and reran it. The hazard ratio is 1.01.

Third, if what they are saying is true, then death from the cancer excessive in the mammogram group should have occurred in the first five years. This is a 30-year study. When I looked at the annual rates of mortality in the 30 years of follow-up, there was no difference in year one, year two, year three, year four and year five.

What Dr. Gordon is alleging is that I should see an excess of breast cancer deaths from the people who had prevalent breast cancer in the first round of screening, at which point we should see a high rate in the first group.

If I remove all the palpable cancers, which you can do, then I can get a hazard ratio of one. Second, the concept of a palpable cancer being excluded is ridiculous. Let's put it this way. In the studies that Dr. Gordon claims are the ones that provide evidence in favour of mammography was a Swedish two-county study. That was a study where the randomization was in 16 blocks of counties in Gothenburg and Östergötland, Sweden.

What did they do? The invited half the women to have a mammogram, and they didn't invite the others. They were just followed. Following the cancer rates—

The Chair: Dr. Narod, Dr. Ellis may elect to have you continue, but we're over time.

Dr. Ellis has the floor next for five minutes.

Mr. Stephen Ellis: Thanks very much, Chair.

Obviously there are some significant feelings on both sides of this argument that we are experiencing.

Dr. Narod, maybe you could sum up. I think it's only fair to allow you to have your say. You've been at this a long time.

Dr. Steven Narod: Thank you.

In the Swedish trial, they invited women to come for a mammogram, and half the women were not invited.

How do you know that they didn't have a palpable cancer? The ones who came they could have excluded with a palpable cancer, but the controls were never examined. They don't know if they had a palpable cancer or no cancer. That trial, the Swedish trial, is considered the gold standard. I have reviewed it very closely and found many things that I consider to be inadequate.

Dr. Gordon claims that there are eight trials, of which only the Canadian trial is an outlier. I would love to see the other seven. The only two I know of are the Swedish trials. I would love to see the references to the other six trials that I'm not aware of. I'm only aware of the U.K. age trial, which showed no effect.

I'm aware of the HIP trial, which showed no effect after 15 years of follow-up, and the Edinburgh trial.

To come to this committee and say that there are eight trials that show an effect for randomized trials and one that doesn't is something that.... If I were on this committee, I wouldn't wish to have that evidence.

Trust me—it's not there. There are not eight trials that show a benefit. If there are, I'll be very willing to apologize to Dr. Gordon and the others.

Mr. Stephen Ellis: Thanks, Dr. Narod.

Dr. Paula Gordon: I'm happy to supply that evidence later. We'll supply that evidence.

Dr. Steven Narod: Yes, I'd love that.

Mr. Stephen Ellis: Dr. Gordon, if you could table that with the committee, we'd be ever so grateful.

Dr. Simard, you haven't had a chance to weigh in.

If I might summarize, I think we've heard that Dr. Wilkinson and Dr. Gordon would suggest that moving the age for screening for asymptomatic women to age 40 would be appropriate and supported by the science. Dr. Narod, I would suggest, is not supportive of that change. Again, I'm not one to put words in people's mouths.

Dr. Simard, I know your focus is slightly different and is—if I could use a term—talking more about precision diagnostics. I think that's obviously the way of the future.

If you have an opinion, sir, could weigh in on what you think the Canadian task force should be doing? I think that would be beneficial.

● (2105)

Mr. Jacques Simard: What we proposed is to have a risk assessment, for example, at 40 years old. Based on their risk category—it's a risk stratification—those women who have a risk equivalent to the population can start later. However, the 20% of women having an intermediate or high risk should start at 40 years old. I think it's important to have a comprehensive risk assessment.

By the way, it's not so futuristic. We need the political will. We released the comprehensive risk prediction tool—by my colleague at the University of Cambridge in the U.K. Since 2020, already it has been used 1.7 million times in 120 countries.

This is the real world. Of course, if it's not currently available, the polygenic risk score, it will cost the same amount of money as a mammogram—around $100. It can be done once in a lifetime. It just needs political will to introduce this test. Any good genomic lab in Canada—because we have a very good platform and we have clinical labs—can perform maybe 5,000 to 10,000 tests per week. It's not so futuristic. We need political will to introduce innovation. The goal of our research is to provide innovation.

Two weeks ago, the Ministry of Health, during the annual meeting of the Quebec cancer program, gave us the award for our project for health promotion and prevention of cancer.

Mr. Stephen Ellis: I'm sorry. Dr. Simard, can I just interrupt you for one second?

When we're talking about the Canadian guidelines, would you suggest, then, that there would be an addition to say that the polygenic screening that you have researched should be a part of those guidelines as well?

Mr. Jacques Simard: A comprehensive risk assessment...yes.

Mr. Stephen Ellis: Can you table that research with the committee, Dr. Simard?

Mr. Jacques Simard: I provided a slide deck. They should provide you.... They are just looking for the translation, I think.

Mr. Stephen Ellis: That's perfect. Thank you, sir.

The Chair: Thank you, Dr. Simard.

Thank you, Dr. Ellis.

Next we have Mr. Jowhari, please, for five minutes.

Mr. Majid Jowhari: Thank you, Mr. Chair.

Welcome to all the witnesses.

Yesterday I had the opportunity to meet with the Cancer Action Now association. It was a very interesting meeting. It was quite informative.

They talked about a lack of Canada-wide standards around early detection programs that cover a spectrum of services on what we call the technology side. They talked about biomarkers or genetic testing. They talked about various tests that are available, such as CT scans, MRIs, ultrasounds and mammograms.

They also talked about the need to access support and the reduction of long wait times and access to oncologists. What became very clear is that they felt we don't have an early detection program that addresses a variety of considerations. They talked about some of the jurisdictions, and the fact that ethnicity, age and demographics—all of those—play a role in that early detection.

My question is for any of the witnesses who are comfortable responding to this. Is there any jurisdiction that we could look to around best practices for early detection programs that are supported by data and modelling and cover a spectrum of aspects of cancer detection?

Would anyone like to comment?

Dr. Wilkinson, you're here in the room.

Dr. Anna Wilkinson: Are you talking about a jurisdiction in Canada?

● (2110)

Mr. Majid Jowhari: I'm talking about an early detection program that is standardized across Canada. Is there any country in the world that is leading in using data and modelling as well as all those other various elements to make sure they have the best early detection program, which we could model?

Dr. Anna Wilkinson: Our early detection programs are in essence task force guidelines. Those guidelines tell family doctors what to be doing for their patients and what test to be ordering.

Mr. Majid Jowhari: How does that compare to other countries who are leading on this?

Dr. Anna Wilkinson: I would say that our closest counterpart is the U.S. They seem to be more open to looking at newer data that's not standardized randomized control trials. They seem to be more proactive. We tend to be very reactive with our guidelines. I think they are more innovative in terms of looking towards changes that could be made. I think they would be—

Mr. Majid Jowhari: I'm sorry. I'm interrupting.

You're saying, if we model our early detection program after the U.S. model, then it is a good start.

Dr. Anna Wilkinson: I think that openness to different methodological processes would be good. When we say early detection we're talking screening, in essence. Although, you're talking about some other.... There are many things that are coming down the pipeline. One day we may be able to do a single blood test that does a screen, but we are not there yet.

Mr. Majid Jowhari: Is there any country that is really leading on an early detection program?

Are you saying the U.S. is the only one leading?

Dr. Anna Wilkinson: I would think the U.S. would be up there. Some of the European countries are quite proactive in terms of breast screening. I would go with the U.S. probably.

Mr. Majid Jowhari: Okay.

Are there any other witnesses who want to make a comment?

Dr. Paula Gordon: I don't think any one country does it all right. We do see, for example, in France and Austria, women with dense breasts are automatically recalled for supplemental screening. We have that now in British Columbia. Women who have category C and D breast density, can have supplemental breast ultrasound screening covered by their provincial health insurance.

We see in Europe, for example, the recognition that MRIs for women with very dense breasts, in the extremely dense breast category, has now been recommended for all women, ideally every two to three years but no less often than four years.

The U.S. just lowered its age to 40, but it's not perfect because women should be having annual mammograms in their forties and they are only doing biennial.

We have a mishmash of guidelines all over the world. I don't think any one country is an example. I think Canada can be a leader here. We can take the best of each of them.

The Chair: Thank you, Dr. Gordon.

[*Translation*]

I now give the floor to Ms. Larouche for two and a half minutes.

Ms. Andréanne Larouche: Thank you very much, Mr. Chair.

During this meeting, which is coming to a close, we talked a lot about the importance of early diagnosis. I think we now agree that for many types of cancer, the key is early diagnosis to try to act as quickly as possible. The witnesses are saying that this is what family doctors do a lot, that is, they try to intervene as soon as possible.

Dr. Wilkinson, you talked about costs in your opening remarks. You said that a mammogram costs about $68, whereas treating breast cancer can cost about $500,000. In terms of efficiency for the system, how much less will earlier intervention ultimately cost the system than treatment at a later stage?

[*English*]

Dr. Anna Wilkinson: Absolutely.

Our study showed that if you treat DCIS, which is sort of a carcinoma in situ, that's about $15,000. Stage 1 is around $20,000. By the time you get to stage 3, you're up to around $100,000, and stage 4 is over half a million dollars.

If you think that the women in their forties are going to present at some point with their cancers, they're going to just present with later-stage cancers or, like we saw in our study, they're going to be fifty years olds with later-stage cancers or they are going to have more cancers in their fifties because we didn't treat the precancers in the forties. That all adds up to significantly more cost.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much for that.

Finally, I'd also like to thank you, Mr. Simard. You spoke briefly about the award you won, but you were being modest. The Wilder-Penfield Award, in the scientific category, is awarded to individuals who have had an outstanding career in biomedical research. You received it for your contribution to the discovery of the BRCA2 gene. Congratulations on your work at Université Laval.

Lastly, is there anything you would like to add about this award and what it can bring to the future of research?

● (2115)

Mr. Jacques Simard: In fact, when I participated in the co-discovery of the BRCA1 gene and, more importantly, the BRCA2 gene, it looked like it was futuristic to test women for predispositions. We know that millions of women have been tested, and that has probably saved hundreds of thousands of lives.

I think we have to rely on the evidence and the best science possible. Right now, the best science gives us an opportunity to look at all the risk factors. Breast density is one of the significant risk factors, but sometimes when you combine that risk with other risk factors, you can see that there can be a mitigation of risk.

I would also like to mention a fact that we haven't discussed much, but that Dr. Wilkinson mentioned earlier: We must not forget that the natural history of breast cancer differs according to ethnic groups. Among women of African or Asian descent, we know that breast cancer will appear almost 10 years earlier than among European women, hence the interest or relevance of always taking women's ethnic origin into account and providing them with appropriate screening.

The Chair: Thank you, Mr. Simard.

[*English*]

Next is Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

Dr. Narod, did the study you did include a diverse population of ethnicities that would reflect the current Canadian population?

Dr. Steven Narod: They were recruited in 1983.

Mr. Don Davies: Was it controlled for multiple ethnicities?

Dr. Steven Narod: As far as I recall, we did not use race or ethnicity, as a covariant.

Mr. Don Davies: Thanks.

Dr. Steven Narod: They were 98% white.

Mr. Don Davies: They were 98% white—were they?

Dr. Steven Narod: Probably.

Mr. Don Davies: Okay. Thanks.

Dr. Gordon, can you name the eight studies you were referring to?

Dr. Paula Gordon: There were, in fact, 11 randomized controlled trials. The first one was done in 1963. It was in New York, and it was called the HIP, which stood for their health insurance plan. Then there were several in Sweden. There were Malmö 1 and Malmö 2, Kopparberg and Östergötland, and then Edinburgh had a trial. Two of them were the CNBSS trials. CNBSS 1 was for women aged 40 to 49, and CNBSS 2 was for women aged 50 to 59. They were completely different trials with different methods. Then there was Stockholm, Gothenburg and Finland. Of all the randomized trials, the Canadians were the only ones that didn't show reduced deaths in the mammogram arm.

Mr. Don Davies: Thank you.

Just to get to the bottom of this, I have a couple of things. Is there evidence to show that, by delaying screening until 50, this has cost Canadian women's lives, by not being screened earlier at 40?

Dr. Paula Gordon: Absolutely. Dr. Wilkinson's data shows that, and modelling shows that upwards of 400 lives per year of women in their forties were avoidable deaths from not screening women from 40 to 49.

Mr. Don Davies: The last word is for you, Ms. Dale.

We've heard Dr. Gordon suggesting that women with dense breast tissue should be offered annual mammograms.

I understand that the Canadian task force has claimed that there is no evidence to support supplemental screening for women with dense breasts. Can you outline why you disagree with that assessment?

Ms. Jennie Dale: First of all, I'd like to say that women with dense breasts are not of average risk, and the task force has lumped them in with women with average risk. Then they are saying that there is no evidence to support supplemental screening, and we know that there is 50 years of evidence—please don't ask me to list that—and we have that evidence, and we can certainly forward that to you as well.

The task force chair has come out and said that the U.S. said there is no evidence; therefore, there is no evidence. It doesn't appear that they want to even investigate supplemental screening for women with dense breasts, but we know the benefits of supplemental screening for women with dense breasts.

● (2120)

The Chair: Thank you, Ms. Dale.

Thank you, Mr. Davies.

There will be two more rounds of questions.

Next up is Dr. Ellis for five minutes.

Mr. Stephen Ellis: Thanks very much, Chair.

Thanks, everyone, for being here.

Certainly we've heard a bit of the controversy as to why this is difficult. I'd like to ask each of you what your thoughts for the future might be with respect to breast screening.

Maybe, Dr. Simard, I'll start with you. What do you think is your future? If you could be brief, then we could get all four of you.

Mr. Jacques Simard: Start maybe at 35 or 40 years old by having a comprehensive risk assessment. Adapt the starting age and the ending age. Adapt the modalities. That means a mammography plus MRI. I think that's the approach. That's what we call the risk-stratified screening approach.

Mr. Stephen Ellis: Thank you, sir.

Dr. Gordon, go ahead, please.

Dr. Paula Gordon: I agree that risk assessment is important. I think AI is going to play an increasing role. AI can find things in the mammograms that human eyes can't see, which can help us predict risk.

There are the usual questionnaire kinds of things about family history and so on. Everyone should have a risk assessment, ideally around 30. Average-risk women should start a screening mammography at 40 and be able to attend annually. All women should be told their breast density. Women with dense breasts should have supplemental screening.

There are new modalities coming online all the time. The newest one is called contrast-enhanced mammography. It's going be much less expensive than MRI. It's very close in sensitivity. That will make a huge difference. Only 30 places in Canada have purchased that.

Mr. Stephen Ellis: Thanks, Dr. Gordon. I hope you don't work yourself out of a job with AI there. You never know.

Voices: Oh, oh!

Mr. Stephen Ellis: Dr. Wilkinson, can I have your thoughts, please?

Dr. Anna Wilkinson: I agree with Dr. Gordon.

I think we need risk assessment. The Mirai is the new technology looking at using AI to predict, based on a women's baseline mammogram, what her future risk would be and to help establish a screening interval.

What I hear mostly here is that there are so many new technologies coming up and things changing that we need experts who know all this stuff on the bodies that are making these decisions.

Mr. Stephen Ellis: Dr. Narod, would you go ahead, please, sir?

Dr. Steven Narod: The future of screening...? That's a good question.

I have a paper coming out in the early 2024 in JAMA Oncology that evaluates screening. I think that will change everything. It's embargoed, so I can't tell you more.

Voices: Oh, oh!

Dr. Steven Narod: We hear about experts a lot here today. I would never claim to be an expert. I think it's important that other people give you that designation. It's not something we self-proclaim. I may say that I won the McLaughlin Medal this year from the Royal Society for the top medical scientist in Canada. I can say I won the Killam Prize for the top medical scientist in Canada in 2016. I can say I won the Lifetime Achievement Award from the Canadian Society for Epidemiology and Biostatistics in 2019. It's up to the committee to decide who's.... There are always people who have contrasting opinions. I hear them every day. I just want to make you guys aware that people have different levels of expertise.

Mr. Stephen Ellis: Thanks, Dr. Narod. I think it's important to talk about the scientific method, and differences of opinion, of course, are important.

Ms. Dale, often, we think about absolutes. As a former family doctor, I would say that our job is to educate—in this case, women—about the risks and benefits and help them make good decisions. As a patient, you might want to have some comments around that, if you would, please.

Ms. Jennie Dale: Yes, there are tremendous gaps in education for women but also for family physicians as well. That's in part due to misinformation and disinformation that is being spread. We are doing our best to dispel that information, but a lot of it really comes from the task force. That's where everything stems from.

You're asking about the future, but we're very much focused on today. We can't think about the future when we have so many women dying today, especially with rising incidence amongst women aged 30 to 39. It's risen about 18% since 1984, so we need to find solutions for women today.

● (2125)

The Chair: Thank you.

Go ahead, Dr. Wilkinson, briefly.

Dr. Anna Wilkinson: Could I speak to the education of family doctors?

I would just like to make it clear that the task force is a venerable institution, and there is an institutional bias that is created. I was the chair of the cancer care committee for the College of Family Physicians. I approached the college to ask if I could do some education for family doctors on breast cancer risk for women in their forties, after completing our research. I was told that I could not do that, because it was not in line with what the guidelines were saying.

I submitted a commentary to Canadian Family Physician about this research and impacts, again, to educate family physicians. This commentary was not even sent for peer review, and I've had many articles published with them. Because what I'm saying is different from what the guidelines are quoting, it's not something that can be put out there to educate family doctors.

The Chair: Thank you.

The last round of questions will come from Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley: Since I'm the last speaker, I want to thank each of you for your testimony. This has been a really incredibly interesting and rich couple of hours. You've each added a really important perspective. I don't think we're going to solve all the controversies in this study, but it does show some of the controversies and also the complexities of navigating a way forward.

I will say that I'm from one of those jurisdictions—all the smaller jurisdictions—that have been more permissive about breast cancer screening in that age range of 40 to 50, and where we've encouraged that conversation also with primary care providers.

Dr. Wilkinson, I'll start with you. I'm really interested in your study, which I haven't seen, on what you called a “natural experiment” between jurisdictions. Would you describe it? I presume that's not a longitudinal study but more of an ecological study. Is that how you would describe it?

Dr. Anna Wilkinson: We basically looked at stage distribution at diagnosis for the women who lived in these jurisdictions that had organized programs and those that didn't. What we saw was significantly more stage 1, less stage 2, less stage 3 and less stage 4 for women in their forties if there was screening. They had more earlier breast cancer and less advanced cancer. In their fifties we saw a knock-on effect. Stage 2 and stage 3 were significantly greater if there was no screening in their forties.

Mr. Brendan Hanley: Thanks.

Dr. Narod, you said that you read all the scientific literature. Are you familiar with that study?

Dr. Steven Narod: Yes, I am.

Mr. Brendan Hanley: Would you have any comment on it? I'm just wondering if there's any possibility of selection bias in that study.

Dr. Steven Narod: There are a lot of studies like that study. Let me put it this way. In the Canadian national breast cancer screening study, the women who had their cancers detected in the mammogram arm that were smaller and less likely to be node-positive had better survival, but the number of deaths was the same. You can't use that to....

Early detection works. It finds them when they're smaller and more likely to be node-negative. The survival of the mammogram-detected cancers was two years longer than the survival of the palpable cancers, but unless you have clear data that shows there's a difference in death—

Dr. Anna Wilkinson: We do.

Dr. Steven Narod: Go ahead.

Dr. Anna Wilkinson: In our survival study we looked at survival, but we also looked at incidence-based mortality to make sure we weren't looking at just lead time and—

Mr. Brendan Hanley: Thank you. I have only two minutes left.

I'd love for you to submit that study and perhaps what you tried to submit as commentary as well but that was not accepted, from what you said.

Dr. Narod, I'm looking forward to your book as well as the JAMA article in 2024.

I want to shift a little bit and talk about access.

Dr. Wilkinson, I think you have a program about access to breast screening in women who do not have a primary care provider. Obviously, you've identified an area. I worry about women who, regardless of age, both in my territory but elsewhere, are not aware of screening guidelines at all, are often remote and are not accessing the available mammography programs. It's not just about geography. Sometimes it's about social access, fear, trauma or psychological access.

I wonder if you could comment on that and how we tackle that area.

● (2130)

Dr. Anna Wilkinson: For those of you who aren't familiar, we started a new program in Champlain region, the Champlain screening outreach program, which allows anyone without a family doctor to access cancer screening. More than that, it also is a proactive program. We go out and we link with different community organizations. For example, we used the COVID vaccination networks to repurpose those for cancer screening. We do a lot of education.

I think that's the model we need to move to. It's more outreach, education and finding those people who aren't accessing screening.

The Chair: Thank you, Dr. Wilkinson.

Thanks to all of our panel.

Go ahead, Dr. Powlowski.

Mr. Marcus Powlowski: Dr. Narod, you had a response to U of T about the accusations made about the RCT you were involved with. Would you mind submitting that to the committee?

Would Dr. Gordon also mind submitting—

Dr. Steven Narod: I'll give it to you, but I would rather not give it to the committee. Is that appropriate?

Mr. Marcus Powlowski: Maybe give it to the clerk.

Dr. Steven Narod: I'd like to give it to Dr. Hanley and to you, too. I would rather the rest of the committee not see it.

Is that appropriate?

Mr. Marcus Powlowski: I think it would probably have to go to the rest of the committee.

We can distribute it, though.

Dr. Steven Narod: I would rather you didn't distribute it.

Mr. Marcus Powlowski: Okay.

You can privately do whatever you want after the meeting.

The Chair: We're going to try to wrap this up, please.

Dr. Hanley gave a very eloquent thanks to all of our witnesses. You can take that as coming from the full committee.

I can also say to you that you are welcome—and we encourage you—to provide any additional information to the committee, separate and apart from what's been specifically requested and what's been referred to. It will all be taken into consideration in the study.

Dr. Narod, we would love to see that embargoed report when it's no longer embargoed, for example.

By all means, what you submit to the committee will be taken as part of the evidence of the study. This has been a fascinating discussion and there have clearly been times when I've interrupted you when you've had something further to say. Feel free to say it in writing.

Thank you so much for being here. Your expertise and your patience are greatly appreciated.

Colleagues, our next meeting is on Monday. We had scheduled three hours, but we're only going to need two hours, because we haven't been able to secure the attendance of Minister Champagne. We'll be meeting from 11 to one, with the first hour on the opioid study and the second hour on the Medicago issues.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: The meeting is adjourned. Thank you.