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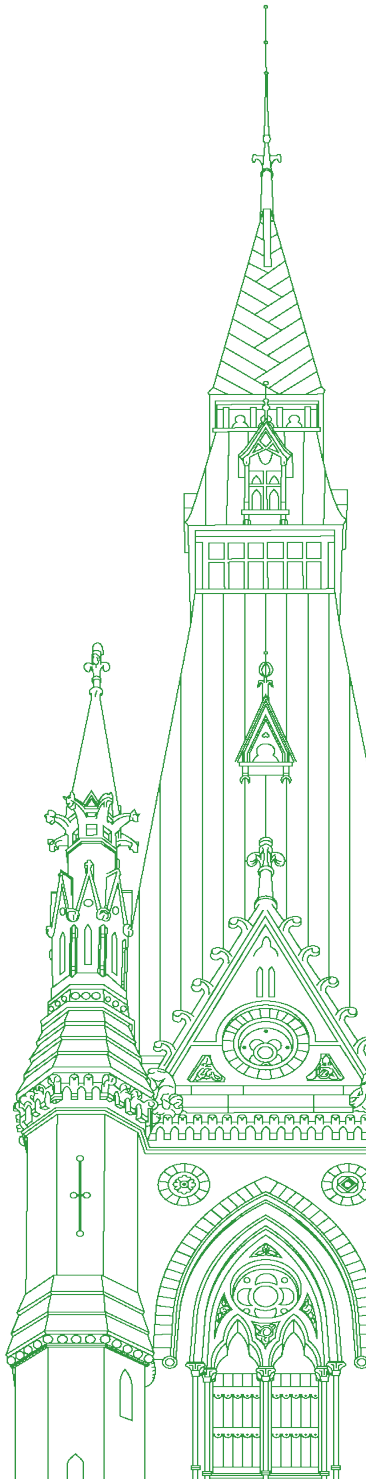

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, February 15, 2024

● (1105)

[*English*]

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

Welcome to meeting 103 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

We have a couple of witnesses on Zoom today, so I just want to let them know that they have interpretation available to them on Zoom. There is the choice, at the bottom of the screen, of floor, English or French. Please don't take any screenshots or photographs of your screen.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on May 16, 2022, the committee is resuming its study of women's health. I'd like to welcome our panel of witnesses. As individuals, we have Dr. Ghadeer Anan, medical oncologist, who is joining us by video conference; Dr. Ambreen Sayani, scientist; and Dr. Andrea Simpson, obstetrician gynecologist, St. Michael's Hospital, Toronto, who is joining us by video conference. Representing the Canadian Cancer Society, we have Helena Sonea, director, advocacy; and Ciana Van Dusen, advocacy manager, prevention.

We thank all of our witnesses for being here today. You will have up to five minutes for your opening statements, and we will begin with Dr. Anan.

Dr. Anan, welcome to the committee. You have the floor.

Dr. Ghadeer Anan (Medical Oncologist, As an Individual): Thank you, Mr. Chairman. Good morning.

Good morning, members of the committee.

Thank you for giving me the opportunity to be here today.

I should mention that, when I received the invitation, I was only asked to speak about women and cancer and was not given any further details about what specific area was of interest. I have prepared my notes on my own experience in my own practice, but I'm more than happy to answer any questions.

I'm a medical oncologist, practising in Fredericton, New Brunswick. I have been in practice for more than 13 years. Patients with breast cancer represent most of my practice.

Fredericton is a city with a population of more than 60,000 people. However, the catchment area that we look after has a population of more than 170,000, so the majority of the population in my catchment area live in a rural setting. The annual population growth rate in my area is 6.2%, per Statistics Canada. However, our local data shows that the increase in cancer patients is 8.2%. New Brunswick has seen an unprecedented increase in population since the COVID pandemic.

I would like to share with you today the differences in the journey of women who get diagnosed with breast cancer, depending on where they live. As you are aware, breast cancer is common and can affect one in eight Canadian women. When a woman is diagnosed with breast cancer, she usually undergoes surgery, with or without radiation, with or without chemotherapy, and it may or may not be followed by endocrine therapy in the form of pills. The problem is not having access to surgery, chemotherapy or radiation. The problem is having access to extra supports, which are just as important. Luckily, the cure rate is high, but it comes with a price. That's where your place or residence can make a difference. That's when it matters whether you live in an urban or a rural setting.

After such a diagnosis, a woman may require physiotherapy following her surgery. If she doesn't, she might end up with long-term limitations to arm and shoulder movements, which would obviously affect her quality of life. Some women might develop lymphedema, which can be a complication following surgery and radiation that may cause pain, swelling and even disfiguration of the chest and arm on the affected side. Having access to a physiotherapist with special training in the treatment of lymphedema is crucial to help mitigate that. A physiotherapist with such training can provide treatment, fit the affected woman with the proper compression sleeve or glove, or even make it to order. Women living in rural New Brunswick have limited access to such services.

A breast cancer diagnosis and all the treatments that come with it, including the endocrine treatments that a woman can be on for five to 10 years, can have a significant toll on mental health. Having access to mental health services can make a huge difference. Again, women living in rural New Brunswick have limited access to such services.

Unlike surgery, which is required once or twice, radiation, which is usually prescribed anywhere from three to six weeks, or even chemotherapy, which is prescribed for anywhere from three to six months, physiotherapy or mental health support is usually required for a much longer duration and has a maintenance component to it.

What makes this even more challenging is that not only are we seeing an increase in the numbers of women being diagnosed with cancer in general, but we are also noticing that they are being diagnosed younger. The average age for a woman to be diagnosed with breast cancer is 60 to 65, but we are seeing more women being diagnosed in their forties and even in their thirties, when they have jobs and young families to look after and have to live with the complications of the treatments longer.

I am seeing an increasing number of women who are unable to go back to their jobs and normal lives after the completion of their treatments, and even having to go on disability due to treatment long-term effects that are not managed properly due to the lack of resources in rural areas.

In summary, I believe that women living in rural New Brunswick have good access to treatment once diagnosed with breast cancer, equal to women living in urban centres. They should have equal access to supportive services during and after completion of treatment.

Thank you.

The Chair: Thank you, Dr. Anan.

Next, we're going to hear from Dr. Sayani, please, for five minutes.

Welcome to the committee. You have the floor.

Dr. Ambreen Sayani (Scientist, As an Individual): Thank you.

Good morning, Mr. Chairman, committee members and fellow witnesses. I am Dr. Ambreen Sayani. I am a scientist at Women's College Hospital and an assistant professor at the University of Toronto.

I lead a person-centred research program focused on promoting cancer prevention, early detection and access to high-quality care for all. I supervise our next generation of learners, including graduate and medical students. In my role as health equity expert adviser to the Canadian Partnership Against Cancer, I guide the partnership's efforts to achieve equitable access to quality cancer care for all people in Canada. In 2020, I co-founded a group called EMPaCT, which engages directly with members of the community from underserved populations to give them direct influence on health care decisions. I am also an international medical graduate. I practised surgical oncology before moving to Canada.

From my community-engaged work, I want to give you some insight into the lived experiences of three women with cancer in Canada.

The first is a 65-year-old woman with colon cancer. Let's call her Audrey for the purposes of today. She said, “You have no idea how time consuming it is to be poor. You spend so much time proving you are poor, by getting photocopies of things. Plus, I am dealing with the fact that I am dying. It is so terrible”.

The second is a young adult bone and lung cancer survivor. We will call her Fatima for today. She said, “As newcomers to Canada, my parents did not know anyone or the system. Our primary care doctor didn't take my symptoms seriously and we did not know how to advocate for ourselves”.

The third, Maria, is a 71-year-old woman who has since died of cervical cancer. She said, “I went into the hospital, and I got treated so badly. I don't want to go back. I don't want to go through that ever again.”

Mr. Chairman and committee members, in Canada we are supposed to have universal access to cancer care, yet cancer care is not universally accessible to all. One out of every five women diagnosed with cancer will die from the disease. Last year 40,200 women died of cancer in Canada. That is on average 110 women a day, but not all women have the same risk of dying from cancer. Such factors as racism, sexism, ableism, classism and ageism can be the difference between life and death from cancer.

For women, biological sex influences susceptibility to certain types of cancer, while socially and culturally constructed gender roles impact women's cancer outcomes by influencing their health literacy, their health care-seeking behaviours and access to health care. Issues related to financial hurdles, geographic challenges, lack of transportation and limited availability of culturally and linguistically appropriate services directly contribute to delays in cancer diagnosis, inadequate treatment and poor quality of care.

For indigenous peoples, racialized communities, people living with low income and gender-diverse individuals, issues of systemic racism and discrimination lead to poor care experiences, avoidance of care and missed diagnosis. This can occur in part because of a lack of competencies to deliver equity-oriented health care in the workforce and services that are not designed to respond to their needs.

As a country, we've made strides in cancer prevention, detection and survivorship. These efforts include the implementation and coordination of preventative measures, organized cancer screening and design of innovative models of care. However, as I have shared with you today, care gaps are evident. They will require concerted and multipronged efforts across all sectors to address the root causes of social inequalities so that we can improve health outcomes for all women by elevating their living and working conditions.

In conclusion, I want to recommend three areas for action based on the lived experiences that I have shared with you today.

For women like Audrey, who are experiencing financial toxicity, we need to reduce the administrative burden of accessing the resources required to support cancer care. More broadly, this implies that we must invest resources to understand and respond to the real-life experiences of patients, with a focus on engaging those who are marginalized and underserved.

Second, for women like Fatima, who experience multiple barriers to care, we need culturally and linguistically accessible care pathways. To achieve this more broadly, we must strengthen community-based care and focus on diversifying the health care workforce so that it is representative of the populations it serves.

● (1110)

Last, for women like Maria who experience discrimination, we need to train and raise awareness across the health and social sector on the historical and systemic factors that shape health. Responsive care can lead to better health outcomes.

Thank you for inviting me to share my perspective.

The Chair: Thank you, Dr. Sayani.

Next, we're going to hear from Dr. Simpson.

For the next five minutes, the floor is yours. Welcome.

Dr. Andrea Simpson (Obstetrician Gynaecologist, St. Michael's Hospital, Toronto, As an Individual): Thank you very much.

I'd like to thank the members of the House of Commons Standing Committee on Health for the opportunity to speak today about women and cancer for the women's health study.

I'm here to advocate for the prevention of endometrial cancer, which is the most common type of cancer of the uterus, to suggest simple strategies that can be instituted by the government for early diagnosis, and to ensure equitable access to treatment for all Canadian women with endometrial cancer.

My name is Dr. Andrea Simpson. I'm an OB/GYN and minimally invasive gynecological surgeon at St. Michael's Hospital in Toronto. I am an assistant professor at the University of Toronto. I am also a researcher with a focus on equitable health care access.

One of my areas of clinical and research expertise is the surgical care of women with endometrial cancer, including those with obesity, who experience barriers in accessing health care and surgery. I am one of four gynecological surgeons at St. Michael's Hospital who run a specialized clinic for women with early endometrial cancer, enabling streamlined care and providing laparoscopic and robotic surgery for treatment—rather than a large abdominal incision—which affords them the best possible outcomes.

Our mission is to ensure that women with obesity or a high body mass index receive the same excellent care as women with a body mass index in the normal range. We endeavour to remove geographic barriers to care. We receive referrals from all over Ontario.

Endometrial cancer is the fourth-most common cancer in women. About 8,500 Canadian women will be diagnosed each year. The incidence of endometrial cancer has been on the rise for over 10 years. Endometrial cancer can be prevented through education of the public about risk factors such as obesity, polycystic ovarian syndrome and genetics, and the availability of funded hormonal therapies, such as those that are available in British Columbia.

Early signs of endometrial cancer are often not well known by the public. They include abnormal uterine bleeding, such as heavy or irregular menstrual periods, or any vaginal bleeding after menopause. The diagnosis can be made by performing an endometrial biopsy, which is a small procedure that can be performed in an outpatient office.

Our national guidelines recommend biopsy for any woman over the age of 40 with abnormal bleeding and in younger women who have risk factors for endometrial cancer. In recent years, we've seen younger and younger women diagnosed with endometrial cancer. A major contributing factor to this rise in incidence is the rise in obesity, which is a major risk factor.

Unfortunately, our research has shown that women with obesity experience discrimination in health care settings, which can often lead to avoidance of health care. This can result in a delay in diagnosis. When they're diagnosed with endometrial cancer, due to the complexity of the surgery, they also experience delays in access to surgical care. Not every hospital or surgeon is comfortable managing patients with obesity. These systemic delays render Canadian women with obesity a marginalized group that cannot access equitable health care.

The surgical treatment for endometrial cancer is removal of the uterus, cervix, ovaries and fallopian tubes. Minimally invasive surgery or keyhole surgery is the standard of care. It results in the best possible patient outcomes, but it is more challenging in people with obesity. Robotic-assisted technology can help overcome many of the surgical challenges for women with obesity who are undergoing endometrial cancer surgery.

I would like to acknowledge and applaud Ontario Health for recently providing funding for robotic surgery for women with endometrial cancer and obesity, which was a huge step forward in providing equitable access to surgery for women with obesity. Ensuring that surgeons and hospitals are incentivized to provide the surgery would be the next step.

I would suggest that the following actions be taken to ensure timely and equitable access to cancer care for women with endometrial cancer.

First, create initiatives to increase public awareness about the risk factors for and early signs of endometrial cancer. Public awareness initiatives include routine screening for menstrual abnormalities and post-menopausal bleeding through primary care and public messaging to seek medical attention if these abnormalities are experienced.

As part of this women's health study, several witnesses have suggested national education programs, including a standardized high school curriculum on menstrual disorders. An inclusion of abnormal bleeding in this curriculum may also help increase public awareness.

Second, encourage all provinces to fund hormonal therapy that prevents endometrial cancer, as is available in British Columbia.

Third, improve availability of endometrial biopsies for women with abnormal uterine bleeding. In addition to incentivizing primary care physicians to offer this in their practices, the creation of rapid access clinics for abnormal uterine bleeding would also increase timely diagnosis.

● (1115)

Fourth, improve access to robotic surgery in Canada. Robotic surgery overcomes many of the surgical challenges we experience when we operate on women with obesity. Expansion of training, facilities with this technology, funding across Canada for the provision of this technology and increased remuneration to hospitals and surgeons who perform these complex surgeries would improve equitable access for patients.

Enacting these strategies should result in the prevention of endometrial cancer, earlier diagnosis of cancer, shorter wait times and better outcomes for patients. If diagnosed early, endometrial cancer can be cured with surgery alone in many cases. Based on our research, improved access to robotic surgery in patients with obesity would result in a higher proportion of patients who undergo minimally invasive cancer surgery rather than a large abdominal incision, which would shorten their hospital stay, recovery time and return to work.

It is only fair that all Canadian women, no matter what province they live in and what body type they have, should have the same access to preventative measures for endometrial cancer, early diagnosis and treatment.

I would like to again thank the committee for allowing me to highlight these very important and actionable issues.

● (1120)

The Chair: Thank you very much, Dr. Simpson.

Next is the Canadian Cancer Society.

I understand you have a joint statement, Ms. Sonea and Ms. Van Dusen. We'll go over to you.

You have the floor for the next five minutes.

Ms. Helena Sonea (Director, Advocacy, Canadian Cancer Society): Thank you very much.

Hello. My name is Helena Sonea, director of advocacy at the Canadian Cancer Society. With me today is Ciana Van Dusen, manager of prevention, and our colleague Rob Cunningham, senior advocacy adviser.

Cancer is the leading cause of death in Canada and is responsible for 26% of all deaths. In 2023, researchers estimated that there would be over 200,000 new cancer cases and nearly 87,000 cancer deaths in Canada, about half of which are expected to occur in women.

Lung cancer is the leading cause of death in women. About 72% of lung cancer cases in Canada and 30% of all cancer deaths are due to smoking tobacco. A comprehensive strategy is needed to reduce tobacco use among women and girls to achieve Canada's objective of under 5% tobacco use by 2035.

We recommend that tobacco taxes be increased by six dollars per carton; that Bill C-59's legislative measures for a cost-recovery fee be adopted with strengthening amendments and subsequent regulations to cover the full cost of the initiatives in Canada's tobacco strategy from tobacco and vaping companies; that tobacco legislation be strengthened by banning all remaining tobacco promotion and banning flavours in all tobacco products; that measures be adopted to reduce youth vaping, including banning flavours in e-cigarettes; that cessation and other programs be enhanced; and, finally, that action be taken on nicotine pouches, which can be sold to children of any age and are advertised in places where youth are exposed to them.

Cancer does not solely touch the person who lives with it. It takes a community and a society to care for them, and no one understands that better than caregivers. Caregivers provide vital, unpaid, practical, physical and emotional support to loved ones with complex health conditions, including cancer. Half of the people in Canada will be caregivers in their lifetimes.

In 2018, caregivers provided 5.7 billion hours of care work, the value of which is estimated to be between $97 billion and $112 billion annually. Women disproportionately bear the challenges of this work.

The Government of Canada has tried to recognize the tremendous role of caregivers; however, substantial unmet needs remain. We recommend the federal government improve support for current and future caregivers by implementing or enhancing accessible, refundable federal tax credits to compensate these families.

I will now turn it over to Ciana to speak to cervical cancer.

[*Translation*]

Ms. Ciana Van Dusen (Advocacy Manager, Prevention, Canadian Cancer Society): After a 30-year decline, cervical cancer is now the fastest increasing cancer in females, with most cases occurring in women under 50. This rise is explained by lower uptake in screening and vaccination against the human papilloma virus, or HPV.

Because virtually all cervical cancers are caused by HPV infection, we can reverse this trend and achieve the Canadian Partnership Against Cancer's goal of eliminating cervical cancer by 2040 through prevention and early detection.

For example, replacing the Pap test with HPV testing as the primary method of screening for cervical cancer, with the option to self-test, can better detect cervical cancer and reduce barriers related to socio-economic factors or lack of access to health care providers.

While many provinces and territories are preparing for this change, the swabs used for HPV tests currently have an indication that they must be conducted by a health care professional. Health Canada has an opportunity to update this indication and remove this barrier in providing at-home tests. We recommend that Health Canada proceed with this update promptly.

● (1125)

[*English*]

Lastly, when talking about cancer prevention and women's health we must acknowledge that alcohol is a cancer-causing substance and is estimated to be one of the top three causes of cancer deaths worldwide. However, over 40% of people in Canada are not aware that alcohol consumption, even at low levels, increases cancer risk.

In 2019, almost 20% of women between the ages of 15 and 54 reported consuming over six standard drinks of alcohol per week. Because of biological factors, this high-risk level of alcohol consumption has long-term health impacts, including breast cancer.

We recommend the federal government implement mandatory labels on all alcoholic products sold in Canada to ensure more people can make informed decisions for their health. Additionally, honouring the scheduled 4.7% federal alcohol excise duty increase slated for April 2024 would maintain the alcohol industry's contribution to our economy, which, as is, only partially offsets the social costs and harms directly caused by their products.

We thank you all for your attention today and look forward to your questions.

The Chair: Thank you to all of our presenters today. We're now going to begin with rounds of questions, starting with the Conservatives.

Mrs. Vecchio, you have six minutes.

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

I'd really like to thank all of the panellists for being here today as we talk about this really important topic.

When you're talking about the HPV self-testing, I'm thinking of my own schedule and the schedules of so many women. Trying to get into a doctor's office can be very complicated. I'm thinking of the COVID test and the fact that I hated putting that thing up my nose.

What are some of the concerns that people would have with self-testing and why at this time is it only in doctors' facilities? What is the concern of expanding it to home care?

Ms. Ciana Van Dusen: It's really the process that's going to be the biggest change. As far as doing it ourselves is concerned, it's less invasive than the Pap test and it's fairly easy. It's actually a huge opportunity for women who, like you said, may not have access to a health care provider or may not feel comfortable due to all sorts of barriers, whether it's language or past experience with trauma. We're really excited by the opportunity to give the option. This is not to say that it would be mandatory. Women who prefer to go to their health care providers to receive this test could still have the ability to do so.

Mrs. Karen Vecchio: I'm thinking of the FIT test that you actually just pop in the mail. Could this not be a similar way of processing this?

Ms. Ciana Van Dusen: It would be.

Mrs. Karen Vecchio: Dr. Andrea Simpson, thank you very much for your testimony. I think it's really important when we're talking about the diversity of women. One thing you talked about was obesity. I'm not a physician. I've never done surgery. I've been in people's mouths doing dental surgery, but never in the body.

When you're talking about the issues, is it just because of the additional layers that they don't feel comfortable doing that or other concerns...or with the robotics? Can you share a little more on why, when dealing with obesity, there is concern?

I wouldn't know, so can you share that with me?

Dr. Andrea Simpson: When we are doing these surgeries we actually have to tilt patients' heads down in order to access their pelvis. The anesthesiologist is trying to ventilate the patients lungs, we're trying to expand their belly with gas so that we can see into their pelvis. When someone has obesity this can add a whole lot of extra weight or pressure on what the anesthesiologist is trying to do.

With robotic surgery, the robot has the ability to actually lift up the abdominal wall so that we can lower our gas pressure inside the abdomen to take a lot of pressure off the lungs. Compared to conventional laparoscopy, robotics is 3-D rather than 2-D, so we have much better visualization at the time of surgery. The robot also has articulating arms, so instead of only being able to move your instrument in two directions, you actually have a full 360° of rotation. This can be especially helpful when working deep in the pelvis.

These are some of the things that make robotic surgery better for patients with obesity. We did a study looking at the literature and found that conversion to the big up-and-down incision was lower for obesity-related reasons when the robot was used compared to conventional laparoscopy.

Mrs. Karen Vecchio: Thank you very much. I really appreciate that.

I want to go on to Dr. Ghadeer.

You were talking about New Brunswick and looking at mental health. I think any time we're looking at anyone postsurgery specifically and the isolation, the fact that—I'm thinking of someone I know personally—when you're trying to get better faster and you just don't seem to be getting better faster, mental health supports are really an important part of that. There's that absolute rural-urban divide.

I'm very fortunate because I'm 20 minutes away from the London Health Sciences Centre, where we have great things.

What happens if you're in a community where there might not be a psychologist or social worker, and sometimes not even a nurse?

What types of things are available in New Brunswick to people who are living in rural areas to be able to get those mental health supports?

● (1130)

Dr. Ghadeer Anan: Thank you for that question. Unfortunately, it really ends up depending on what type of insurance plan you have. The majority of New Brunswickers unfortunately have access to the provincial drug plan, which is good when it comes to drug coverage. It doesn't cover private practice when it comes to access to mental health, so you have to access—

Mrs. Karen Vecchio: I want to interrupt you there, as you're continuing with that, because with the mental health services, we have that insurance, but could you talk about trying to find those providers in those rural settings?

Dr. Ghadeer Anan: There are a good number of private providers, but the problem is the patients not having the financial ability to go and seek help from them. If you have private insurance, your private insurance will pay for your mental health services. If you are under the provincial drug plan, that is not a possibility. You always have to go to the hospital-based mental health care providers, which adds to the pressure on the system.

Mrs. Karen Vecchio: Thank you.

Dr. Ghadeer Anan: I don't know if that answers your question.

Mrs. Karen Vecchio: That's fantastic. Thank you so much.

I'm going to go on to Helena.

Helena and Ciana, thank you very much for being here.

We're talking about cervical cancer. What can we do to ensure that women and young girls get the HPV vaccine?

Ms. Ciana Van Dusen: I think a lot of it is coming out of this awareness piece. Especially after COVID, we saw a decrease in vaccination, so we remind people that this remains one of the two best ways to prevent cervical cancer along with our screening. Whether it's awareness campaigns or conversations with our doctors, we encourage that for both boys and girls of the appropriate age, based on the provinces.

Mrs. Karen Vecchio: Thank you so much.

The Chair: Thank you, Ms. Vecchio.

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

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

Welcome to all of our witnesses.

I'll be focusing my line of questioning today on screening and early detection using genetic profiling technologies and biomarkers, with a special focus on research. What are we are doing? How we are fairing against other countries, for example, in the OECD? I will open it up to any of our witnesses who are comfortable talking about where we are on research and development, specifically around genetic profiling technology, the use of biomarkers and where we should be. How far are we from a solution, and how are we comparing to other countries?

Anyone, go ahead.

Ms. Ciana Van Dusen: I can jump in. I know that at the Canadian Cancer Society we're really interested in this, and we are investing in research to better understand the opportunities and limitations of such screening. I'm not sure we're at a point to necessarily bring it forward, but as I said, we're continuing to invest in seeing where this could go, because it is quite exciting.

Maybe you have something to add?

Ms. Helena Sonea: I think what we would really just like to highlight as well is that we really support anybody who would like to advocate for themselves to receive that additional testing. We absolutely support that in terms of the mechanisms through which they can accomplish that.

Mr. Majid Jowhari: What kind of research are we doing across all the different types of cancer using genetic profiling or biomarkers in Canada? Are we doing enough research? Are we leading in research? Do we have the technology?

Ms. Helena Sonea: There is certainly more to be done on the research front, just with respect to overall investment in the research ecosystem. The Canadian Cancer Society is the second-largest funder of cancer research outside of the federal government, and that's the role of the charity.

We hope that, as we can connect with you and with other levels of government, we can all prioritize investments in research, because we really do know that this is the way forward for people living with cancer and their loved ones.

I'm sorry. We're not specifically answering the question.

● (1135)

Mr. Majid Jowhari: Go ahead, Dr. Anan. I was actually hoping you... Go ahead.

Dr. Ghadeer Anan: Actually, I just wanted to mention something. It's not only about research; it's about access to genetic testing. There are two different kinds of genetic testing if you're talking about prevention. If you have either a personal history or a family history, a family member who has had cancer....

I'll talk about Atlantic Canada. Our main hub for testing is the IWK in Halifax, and their wait time is anywhere from 18 months to two years. That is huge when it comes to prevention.

When it comes to genetic testing that can dictate your treatment, the type of treatment you need, that could be easier and faster to get access to. I just wanted to mention that, unfortunately, even when we know exactly what works, access is still an issue.

Mr. Majid Jowhari: Thank you. That's, I think, a complementary point of view.

I'm still trying to get a sense of where we are in Canada around the research. I have a company in my riding that has patented a technology that can use the plasma off of the blood to detect different cancer types and the stages they are at. I'm trying to get an understanding of where we are. Does anyone else want to comment?

Dr. Simpson, you might want to comment on that.

Dr. Andrea Simpson: Yes. I think that earlier this week the committee heard from Dr. Shannon Salvador, the president-elect for GOC. I do think that research in general for women's cancers in Canada is lagging behind and is under-resourced.

Speaking to endometrial cancer specifically, often in younger women this is actually the first obesity-related diagnosis they will receive. A good number of those patients will actually have Lynch syndrome, which puts them at risk of other types of cancer, such as colorectal and ovarian cancer.

I do think that there are some good steps forward in terms of better characterization of early endometrial cancer, identifying those patients and routinely looking for Lynch syndrome in those patients, and better characterization of who is at a higher risk of occurrence for endometrial cancer as well.

Mr. Majid Jowhari: Thank you.

Dr. Ambreen Sayani, do you want to comment on that?

Dr. Ambreen Sayani: I would just say that all research, particularly if it is precision medicine based, needs to include the patient perspective, because we can create as many interventions, products, devices and plasma testing that exist under the sun, but if they're not acceptable to patients and they're not accessible to patients, then we've lost the plot. The investment in research needs to ensure that there is a patient-driven perspective that's woven into the discovery journey.

Mr. Majid Jowhari: Thank you.

I think that concludes my time, sir.

The Chair: It does. Thank you.

[*Translation*]

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

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

Thank you to all the witnesses for their opening remarks. It's always very inspiring, even though this is an extremely delicate subject. I'd like to come back to what stood out for me from what each of you said.

Ms. Sayani, you talked about the financial issue, the administrative burden, but beyond the administrative burden, we know that it takes time to heal. This has financial implications.

I'd like to talk about employment insurance, and why the number of weeks currently allowed is not enough for people with cancer to recover. The Bloc Québécois has already introduced a bill on this. Given that 26 weeks isn't enough, we talked about 50 weeks to give people real time to recover in the event of a serious illness.

Can you expand on the importance of removing this mental burden and stress from people who are suffering?

● (1140)

[*English*]

Dr. Ambreen Sayani: Financial toxicity is a huge burden that anyone already going through a cancer diagnosis shouldn't have to face. For women, I think it's particularly important. Because of socially constructed roles, they may already be at higher risk of losing their livelihoods, of being underpaid and of being unemployed.

Deep consideration is needed into what their financial situation is already, and then, if we top that up with a cancer diagnosis, what does it look like? We have experiences of cancer patients who have shared that “we're precariously employed” or “we have contract jobs”, and I think the contingent labour market is one that is on the rise. That disproportionately affects women.

It's about due consideration in terms of how the employment structures are set up and the financial implications for women when they are faced with a cancer diagnosis. Does that mean they are left unemployed? Does that mean they do not have benefits, which, as we discussed earlier, are needed to access the support services they need for a good quality of care, treatment and survival?

The employment insurance sickness benefit is one that I have studied particularly. In terms of the 15 weeks, if I can quote one of the patients in the study, “It's like a slap in my face.” It does an absolute disservice to their quality of life given that cancer treatment is not for 15 weeks. It is at least 26 weeks of treatment followed by a year of recovery. That means supporting them through that journey with financial means so that they are not having to pick and choose between medicine, gas and food, or making sure that they have a good pathway to return to good employment that supports them financially—and with benefits—as they recover.

[*Translation*]

Ms. Andréanne Larouche: Studies show that even 26 weeks isn't enough. That's why we were talking about 50 weeks. We wanted to give people time to fully recover.

I am the status of women critic.

Ms. Sonea, you raised the issue of unpaid work and what it means for family caregivers. You mentioned a refundable tax credit. Besides that, a women's group is calling for a day to recognize invisible work in order to reflect on this issue. As we all know, cancer has a huge impact on the patient's loved ones. Caregivers must be involved. One cannot go through an ordeal like cancer all alone. The consequences are enormous. Women are particularly and disproportionately affected.

By designating a day to recognize this invisible work, we could also reflect on all the ways in which invisible work could be appreciated more. This could have an impact on cancer caregivers.

[*English*]

Ms. Helena Sonea: Thank you very much for the question.

We really appreciate the opportunity to be able to highlight this, because it is such a women's health issue. Caregiving disproportionately impacts women, and I really appreciate the opportunity to elevate that here to this group today.

We know that financial support is the most significant need identified by caregivers. Our recommendation around making the federal caregiver tax credit refundable is one step to accomplish that. However, there is much more that we can do.

At the Canadian Cancer Society, we have the privilege of being able to engage on an ongoing basis with people with lived experience and with their loved ones. A survey we conducted last fall demonstrated to us that the number one need identified by caregivers was mental health supports, in addition to that financial need. Very often, you have individuals who don't have access to that, and very often when individuals are in the role of caregiving, they are on a fixed income—or no income.

There are so many things we can do. I'm really thrilled that you brought up the employment insurance system, because there are lots of opportunities and strides that we can continue to take in this space, including expanding the sickness benefit further and making compassionate care leave more accessible for caregivers as well. Even eliminating the mandatory one-week waiting period to receive an employment insurance benefit is a very practical thing that could happen.

We also would really recommend developing national standards. You might hear that woven into various answers, because we do lack a significant amount of just oversight and understanding of where the gaps continue to be in order to keep informing our policy decisions. In particular, as it relates to the caregiver tax credit, we recommend developing national standards that both the government and the employers can use to measure and evaluate the overall success of programs, services and supports to meet the needs of working caregivers.

For example, right now, we were very pleased to see the sickness benefit expanded last year. We look forward to hearing a little more in the coming weeks and months about how this program change has been taken up across the country, by people living in this country, and—

● (1145)

The Chair: Thank you, Ms. Sonea. We're out of time.

Ms. Helena Sonea: We can chat more.

The Chair: Ms. McPherson, please, you have six minutes.

Ms. Heather McPherson (Edmonton Strathcona, NDP): Thank you very much to all of you for being here today.

I'm new to this committee. I haven't sat on this committee before. Thank you for letting me come and participate, everyone. You're a very well-behaved committee so far today—much better than foreign affairs.

The Chair: Don't jinx it.

Voices: Oh, oh!

The Chair: Don't jinx it, please, Ms. McPherson.

Ms. Heather McPherson: Knock on wood....

In fact, I am here because I am a cancer survivor. That's why I'm here. Frankly, so much of the testimony we've heard so far has echoed what I went through as somebody who had colon cancer diagnosed at 45.

For me.... I mean, you talked about early detection and you talked about access and being to able to identify and to treat. I think the entire conversation here is about access. I was very lucky: huge shout-out to my doctor. She believed in me when I told her something was wrong. She got me tested. I got the treatment that I required and am now cancer free.

Dr. Sayani, I listened to you when you talked about access and how that is very different for women in different parts of our country. We don't have national standards, as you mentioned. Rural, indigenous and marginalized groups don't have the same access to cancer care. As recommendations for this committee, Dr. Sayani, what are those pieces that need to be done to do that?

Also, how do we balance the fact that health care is very expensive and we can't have the same health care access in different parts of the country because we simply can't afford to do that? How do we bridge that gap? How do we work with the resources we have to make sure that women across the country have access to health care?

I'll start with you, Dr. Sayani, and then I'll it pass it on to others if that's all right.

Dr. Ambreen Sayani: Thank you for that question.

I want to start by acknowledging the incredible frontline workers who are in a crisis. There are many very well-intentioned people who are trying to do their best with limited resources, and they do need support in a variety of ways to build capacity, but I think we can also be creative in terms of how we build on the strengths of our country. Those strengths may differ from region to region.

I am a person who works out of Toronto, where approximately 50% of the population has a first language that is not English or French, 50% of the population was not born in Canada, 20% of the population lives with disabilities and around 15% are living with lower incomes, but there are community-based strengths that we can build on.

We know the community health care centres. They have a wraparound model that doesn't just focus on family physicians. I've heard time and again from patients who say that their family physician is not their point of care. There are other people within the community whom they go to for knowledge, for resources, for information, so let's build out those community champions. Who are they? There was a very successful community ambassador program linked to COVID-19 vaccination. How can we leverage some of those examples? The health care system is already strained. How do we support it to function better, and how do we build capacity around it and in the community so that it is catering to the localized needs of the populations that are being served?

Invest in community health centres. Look at other models of care such as the community ambassador program. Build community champions so that people have alternative ways to access information and care pathways that come straight from the roots of the community into the health care system.

Ms. Heather McPherson: Yes, it's a complicated balance because of course we have to use the strengths of each community, but we want some equality and some equity across those communities.

Dr. Anan, would you have something to add on this?

● (1150)

Dr. Ghadeer Anan: I'm glad that Dr. Sayani got to speak first because this was exactly what I was thinking. Again, going back to rural settings, it takes a village to get somebody through a cancer diagnosis and treatment, and that's what I find my patients mostly rely on. It's obviously out of the goodness of peoples' hearts, but we can build on that. We can put in place programs that support people who are willing to offer, say, drives to people who do not have access to a vehicle or cannot afford a vehicle, and compensate them for that, compensate them for their time.

The same thing applies to, say, meals for somebody who's getting treatment and having a program in place to make sure that they have enough nourishment, especially when we're talking about seniors. As we all know, cancer is a diagnosis of the elderly.

I agree with what Dr. Sayani said. We need to think outside the box and build more on the strength that comes from our community.

Ms. Heather McPherson: Dr. Simpson, I'll go to you, but I'd also like to just ask you this really quickly.

We just heard that cancer is a disease of the elderly, but we know as well that there's an increase in the number of diagnoses happening with younger women—women like me, who are getting colon cancer in their forties, not in their eighties. Could you address that as well, please?

Dr. Andrea Simpson: Yes. As I mentioned, for endometrial cancer, we are seeing a shift to younger and younger women being diagnosed. Relating back to issues around access, I think access to hormonal treatments that could be preventative, especially in patients you can identify are at risk.... Women with polycystic ovary syndrome, for example, are at a higher risk, and hormonal treatment could help mitigate that. A lot of patients, however, are not able to afford the hormonal treatments if they don't have private insurance.

I think this does call for more public access and funded hormonal treatments in every province.

I think also that there should be more access to weight loss interventions such as clinics that can offer weight loss counselling, medications and, in some cases, bariatric surgery as well.

The Chair: Thank you, Dr. Simpson.

Ms. Heather McPherson: I think I'm done my time, but thank you.

The Chair: Mrs. Goodridge, please proceed for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Chair.

Thank you to all of the witnesses for being here. I'm going to start with Dr. Anan.

You specifically touched on the supports in rural areas. You made it very clear. I was born and raised in Fort McMurray. I very much am a rural member of Parliament. Both my parents had to get their cancer treatments five hours away in Edmonton, and I remember how much more complicated it was because you don't do a 10-hour day trip typically. We do, but we're kind of crazy.

I say this because that's the reality for many people living in rural communities. I was just wondering if you could talk about some of the best practices you've seen, whether in the Atlantic region or across the country, to support rural patients who are getting very specialized cancer care in urban centres.

Dr. Ghadeer Anan: One of the big things we need to work on is providing free accommodation—free housing. Just as you mentioned, a lot of people can't afford to do that 10-hour round trip. They can't afford to stay overnight to get their five- or six-hour treatment. Having accommodation available, attached or very close to cancer centres or cancer clinics would help mitigate a lot of that, with all the supports that come with it, such as a social worker to help with the financial part, as I mentioned before, and a psychologist to help with that.

I'll give you an example. In the two centres here in New Brunswick that give radiation therapy, they have free hostels where the patient can stay, because radiation can go on for weeks, Monday to Friday. It's a five-minute treatment, but people cannot keep on going back and forth every day, five days a week for five or six weeks, so they are offered free stays during the week, but they're not open on weekends.

The same thing should apply to other treatments—

Mrs. Laila Goodridge: Thank you. I appreciate that.

In fact, in Edmonton there is Sorrentino's Compassion House. It's a really cool program. It really does cater to women going through treatment, primarily for breast cancer but also for a variety of different cancers. It's kind of like the Ronald McDonald House, but it's for women. It's such a spectacular place. If anyone hasn't heard of it, I would highly recommend checking it out. They make magic happen.

We were really lucky when my mom was diagnosed. I was still in university, so she came and stayed with me.

To streamline a little bit, Dr. Simpson, you talked about robotic care. Could you perhaps highlight where exactly robotic surgeries are currently being performed in Canada? Do you see any opportunity to expand that?

● (1155)

Dr. Andrea Simpson: Thanks for that question.

They are few and far between right now. I believe Alberta was the first province to have access to robotic surgery. It's in B.C. and a few centres in Ontario, and I believe it is starting to expand more across Ontario ever since Ontario Health started to fund robotic surgery.

Mrs. Laila Goodridge: That's wonderful.

I saw an article that appeared this week in which you were quoted. It talked about some of the pay discrepancies for women's surgeries versus men's surgeries. Could you perhaps expand on that a little bit? I was hoping you were going to say something about that in your opening statement. I think it would be very valuable to hear about that in the context of this committee.

Dr. Andrea Simpson: Unfortunately, there has been a lot of work demonstrating that procedures performed on female patients are not remunerated at the same level as procedures performed on male patients, even for relatively similar procedures.

There are a lot of factors that go into this. One of them is that most gynecologists are women, so as our specialty has become more female-dominated, we have not, unfortunately, been remunerated at the same rate as have male surgeons in other specialties. There is a gender pay gap, and it is affecting the way that care is delivered to women patients.

Thank you for bringing that up. I do think this is a big part of the conversation on women and cancer.

Mrs. Laila Goodridge: To make it very clear, would you recommend that we institute more pay equity when it comes to things like this? We are going to be having a report on this at some point, so I would really love to hear what your recommendation would be to solve this problem.

Dr. Andrea Simpson: I think, as a starting point, you should look at the procedures in the schedule of benefits across provinces and compare them to comparable procedures on male patients and look at pay equity with respect to those procedures. There is a lot of consistent research now showing that this issue spans provinces. There's an undeniable pay gap at this point, so, yes, I would appreciate that being included in the report as well.

It has to do with remuneration to the surgeons who perform these procedures but also with the way hospitals value which procedures are being performed, so really it's about elevating women's health in that area as well.

The Chair: Thank you, Dr. Simpson.

Mrs. Laila Goodridge: Thank you.

The Chair: Next we have Ms. Sidhu.

Go ahead, please, for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Before I start with questions for the witnesses, I want to say that we know that this week is sexual health week in Canada. I believe it is appropriate for me to put the following motion on notice:

> That the Standing Committee on Health affirm its support for reproductive and sexual health rights across Canada, recognize that the right to safe and legal reproductive and sexual care is a right to health care; condemn any effort to limit or remove sexual and reproductive rights from Canadians; and emphasize the importance of protecting and expanding access to reproductive and sexual health care, including abortions and contraceptives.

Now I want to move to the questions, Mr. Chair. My question is for Dr. Simpson.

Dr. Simpson, you talked about the standard high school programs for awareness so that young girls know that early detection is the key. Also, I want to talk about ovarian cancer and how BRCA1 is helping to detect the next generation and how the mutations change. Perhaps you can answer that.

Dr. Andrea Simpson: Thank you very much.

With regard to a national health education program, I believe it was brought up as part of this women's health study relating to endometriosis and pelvic pain. Unfortunately, right now a lot of young girls have either painful, heavy or irregular periods, and they don't realize that it's something that can be treated to improve their quality of life. I think introducing these concepts early is important, especially among young girls who are probably missing out on a lot of days of school every month because of their periods.

With respect to ovarian cancer, I'm not a cancer surgeon and I'm not an oncologist, so I can't answer your question about the BRCA1 mutation. I don't know if one of my co-panellists would like to address that.

● (1200)

Ms. Sonia Sidhu: Dr. Sayani, do you want to chime in about how the BRCA1 mutation is helping to detect the early cancer stages?

Dr. Ambreen Sayani: All I can say is that I've looked into the accessibility of genetic testing, and what it really boils down to is the awareness level within communities about the fact that genetic testing exists. To quote a community member, “When I look at ads for genetic testing, I don't see myself represented, so I didn't even know that was applicable to me.”

The awareness doesn't exist within communities. Furthermore, when they do go to access care pathways, those conversations may not be culturally appropriate.

We also need to consider how we can.... It's not just about getting the result but about supporting people if they are positive. What do those care support pathways look like? Those are the pieces of work that I have studied, but I don't study genetic markers. I study access to different care pathways.

Ms. Sonia Sidhu: Dr. Anan, do you want to chime in?

Dr. Ghadeer Anan: Thank you.

What I can add is that, even when women come to ask for the testing, as I mentioned, my experience here in Atlantic Canada is that there aren't enough genetic counsellors. Even when I send a referral for genetic counselling, the wait-list is about 18 to 24 months.

Ms. Sonia Sidhu: You also talked about the lack of resources in rural areas for rural access. What is your recommendation to this committee?

Dr. Ghadeer Anan: There should be funding for more genetic counsellors to represent the increase in population.

Unfortunately, right now the obstacle and the reason for the long wait is that there are not enough genetic counsellors.

Ms. Sonia Sidhu: Do you have any other recommendations, Dr. Simpson?

You gave three very good recommendations. Do you want to talk about that?

What is your recommendation to the committee on how we can get early detection of any cancer? We know that when cancer is in the third or fourth stage, it is hard to manage. Also, can you provide any recommendations on how to manage the psychological effects?

Dr. Andrea Simpson: Thank you for that question.

In terms of early diagnosis, I think it's really around access to endometrial biopsy. We need public awareness first. Patients need to know that they should go in and see their health care provider if they are having menstrual abnormalities.

In terms of access to biopsy, it's not a complicated procedure to do in the office, but I do recognize that a lot of primary care providers are not comfortable providing this or experience other financial barriers, perhaps, to providing this test. I think we should examine those barriers to understand how we can make biopsy more available to patients so that they don't necessarily have to wait for a referral to a gynecologist to have the test done.

Rapid access clinics.... We don't have an organized program for getting these patients in quickly to biopsy them and determine if they have endometrial cancer. I think we should look to other cancer types—perhaps breast cancer—and the way that care has been streamlined to allow more rapid access to diagnosis for these patients.

With respect to the psychosocial, psychological aspects of recovery, I do see it a lot in my practice. Patients really do struggle with their diagnosis in the context of its being related to their obesity, because I think that there is a lot of guilt that comes along with this diagnosis and the feeling that they perhaps should have done something to prevent it sooner.

I usually don't address obesity with my patients prior to surgery. We get them treated first, and then a lot of them ask me about it later and ask about access to weight loss resources to prevent other complications of obesity and improve their quality of life overall. Improving access to weight loss treatments would be another area where I think we can do better.

● (1205)

The Chair: Thank you, Dr. Simpson.

Thank you, Ms. Sidhu.

[*Translation*]

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

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

I'll continue with my questions for each of the witnesses.

Ms. Van Dusen, you talked about cervical cancer. Vaccination is now available. I'm part of that generation that was made aware of the HPV vaccine and was able to benefit from it. The World Health Organization has also called for the global elimination of cervical cancer, in part because we can now prevent it largely through vaccination.

Is Canada on track to meet the targets set by the World Health Organization by 2030?

I already put this question to another panel of witnesses, but I'd like to hear your answer to this question.

[*English*]

Ms. Ciana Van Dusen: As I mentioned in our remarks, following a 30-year decline in the incidence rate for cervical cancer, that has now increased by 3.7% since 2015.

Cancer of the cervix is now the cancer in females that is increasing at the highest rate, so that's really concerning, especially given that we've acknowledged that it's incredibly preventable for the most part with vaccination and with screening.

That's why we're coming to you today—in the hope that we can increase the ease of transferring our screening from the Pap test to the HPV test and encourage that kids who are eligible in their province receive vaccinations—both boys and girls.

As you said, we've had incredible progress in delivering that up until now, so we need to keep that momentum going so we can reverse this trend.

[*Translation*]

Ms. Andréanne Larouche: As you say, there are Pap tests, but there are also tests that can be done at home, so there are other ways.

All in all, despite the increase in the number of cases, your tone was still very positive in terms of solutions. Although we have some very positive solutions for this type of cancer, what are some of the obstacles we need to overcome so that this number....

You mentioned self-testing, but do you have any other suggestions?

[*English*]

Ms. Ciana Van Dusen: Right now we're really calling on Health Canada to approve self-testing.

We know there are provinces—B.C. and P.E.I.—that are going forward with or without this approval. However, other provinces and territories have said that this is a barrier to their ability to bring this test home to Canadians, so that is something very tangible that we can do something about today to make it more accessible.

The Chair: Thank you, Ms. Van Dusen.

[*Translation*]

Thank you, Ms. Larouche.

[*English*]

Next we'll have Ms. McPherson.

Go ahead, please, for two and a half minutes.

Ms. Heather McPherson: Thank you.

Again, thank you for the testimony you shared with us today.

Obviously, Canada's New Democratic Party is pushing very hard for pharmacare to be part of our medicare program.

As we talk about access and we talk about testing outside of doctors' offices and whatnot, I'm wondering what access to pharmaceuticals is like and how we could improve that. What would that look like for cancer patients?

I'll start with you, Dr. Sayani.

Dr. Ambreen Sayani: More and more cancer treatments are being delivered outside the health care setting. When it's within the hospital setting, the medications are covered, but when we have take-home medications, particularly those that are the supportive medications that improve quality of life, those are covered by drug plans or the patient pays out of pocket.

When we look at it through an equity lens, women are less likely to have those health benefit plans, and they're also less likely to have that cash in their pocket. It really is about who is being hurt the most when there isn't a pharmacare policy. It would improve access for all people and improve their ability to be treated for and survive cancer if they didn't have the stress related to access.

Ms. Heather McPherson: As you mentioned, women are less likely to have those drug plans that would cover those medications, and they're also less likely to have the income. If you layer that onto marginalized women, women in remote northern communities and women who are experiencing poverty, then the numbers would increase.

I notice that you're nodding. Can I ask for your thoughts on that as well?

● (1210)

Ms. Helena Sonea: Absolutely. We really appreciate the opportunity to talk about this important issue, because there is an incredible opportunity in front of us.

We really want to ensure that any program put forward has safeguards in existing access and that there are no additional administrative barriers that people with cancer and their loved ones face when accessing the very large patchwork that already exists. For us, it is very centred around not increasing that for that threshold.

Ms. Heather McPherson: Thank you.

The Chair: Dr. Kitchen, please, you have five minutes.

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

Thanks to all of you for being here. It's greatly appreciated.

It's interesting, especially with having the Canadian Cancer Society here with us, and with your conversations. I appreciate that. We've talked about swabs and, in particular, the option of self-testing and the challenges you have with swabs and how it's dictated that the swab has to be used by a medical professional, although I guess that can be changed.

If we look back at COVID and when it happened, all of a sudden we were all so short of PPE, swabs, etc. It was a huge challenge. The government stepped up and said they were going to give out a whole bunch of money to a whole bunch of businesses in this country to ramp up what they were doing, to build this and to bring it.... Now, we find out that we're having a lawsuit brought forward where that actually didn't transpire.

On this issue, what I want to touch on is the aspect of that swab. You say that it should be something that Health Canada does. Have you talked with Health Canada on this issue?

Ms. Ciana Van Dusen: I have not personally had the opportunity. I'm not sure if anyone else at our organization has.

Ms. Helena Sonea: We are very fortunate to be part of a large community through the Canadian Partnership Against Cancer. They have individual screening network meetings that bring together a variety of government stakeholders and organizations such as ours. It was through these various conversations that it was brought to our attention that this was a gap. We have not specifically addressed this with Health Canada at this point in time, but certainly after today we will be prioritizing it more.

Mr. Robert Kitchen: Thank you.

I would encourage you to do that, because I think it's something that needs to be brought to their attention such that it can be quickly remedied and is providing for those self.... As you said, someone who's vulnerable all of a sudden gets a form and says, “Oh, this has got to be.... Now I'm not going to use it.” It puts fear in those individuals. That adds further to delays and to not getting those self-tests done when they can be done. It's going to protect women by doing that aspect of things. I do encourage that. Perhaps that might be a recommendation that we have as we move forward.

On that aspect of things, as we look at the issue of providing those self-tests, one of the things that I have seen a lot as a practitioner is a lot of fear amongst patients. It's about educating them. How do we educate women for a simple thing—perhaps Dr. Simpson might want to touch on this too—like the issue of robotic surgery? All of a sudden it's all new. People see it on TV and they watch these movies, etc., but they're fearful of it. There are populations that will be. What are your thoughts on that? How do we get that across to people to get that fear out of there?

I'll go with Dr. Simpson first.

Dr. Andrea Simpson: Specific to robotic surgery, it's a technology that's widely available in the U.S., but there have been barriers to bringing it to Canada, mainly related to cost. I do think that we need to be somewhat judicious with the use of robotics in Canada. I'm not recommending that it be used for every single patient. I think it's for the patients who would benefit most from it.

I haven't encountered too much in the way of fear related to robotic surgery in my practice when I talk to patients. I do think that it's a a very well-studied technology. It's the limitations that we've had in Canada so far.

I'm not sure if that answers your question.

● (1215)

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

Dr. Anan, I appreciate your comments, especially from a rural point of view. I come from a very rural area. The biggest community in my riding, which is 43,000 square kilometres in size, has basically about 12,000 people. For my constituents, when they're dealing with things.... For females, when they're going to their practitioners, number one, they have practitioners who, while they're educated, are not specialized in that area. It's a huge challenge for them when it gets diagnosed or, as we heard from Dr. Sayani, there might be a patient where the doctor sloughs it off and doesn't pay attention to it or think it's a big deal.

Those challenges are big, not only from a doctor's point of view but also from a rehab point of view, as you've indicated. It's about making certain that you have that rehab physiotherapist that you might need in certain situations or for breast cancer, etc.

If you would, what are your comments?

The Chair: Give a brief response, if possible, please.

Dr. Ghadeer Anan: Yes, certainly.

The restrictions are not just because a patient is dismissed or whatnot. Sometimes they don't even seek medical advice—especially in rural areas, as mentioned earlier—because they are caregivers, because they cannot afford to, because they need, say, a son or a daughter to take the day off work to take them to see the doctor and then the specialist, and so on and so forth. Unfortunately, there are a lot of financial restrictions, plus, of course, the stigma that comes with it and women being care providers.

I don't know if that's short enough.

The Chair: I didn't interrupt you, so it is.

Dr. Powlowski, you have five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): This is for the Canadian Cancer Society.

What is the percentage of cancer deaths that are attributable to smoking, and when is that number from?

Ms. Helena Sonea: If it's okay, we would love to invite Rob Cunningham to answer that question, if possible.

Mr. Rob Cunningham (Senior Policy Analyst, Canadian Cancer Society): Thirty per cent of cancer deaths are caused by smoking. Among women, it's not just lung cancer and colorectal cancer but also cervical cancer and ovarian cancer. There are 16 types of cancer altogether that are caused by smoking.

Mr. Marcus Powlowski: Are those numbers going up or down? I would have thought that they've been going down, but are we now seeing an increase in the amount of smoking, particularly by young people?

Mr. Rob Cunningham: The good news is that we are seeing a decrease in smoking among both women and girls, so the overall lung cancer death rates are now decreasing among women. They've been decreasing among men for a very long time. It's a tragedy in terms of the increase in smoking and the increase in lung cancer and other smoking-related cancers, but the trends are good.

Mr. Marcus Powlowski: Let me shift gears.

Can somebody tell me how much we spend in Canada on research related to doing better at cancer detection and treatment? Let me preface that by saying that there recently was an article in La Presse that looked at the percentage of GDP that's spent for research and development, comparing Canada to other countries. We're not doing very well. We're well below the OECD average. We're below China. We spend less than half of what the United States spends and about a quarter of what South Korea spends. We're spending 1.5%—it used to be 2%—on research and development.

How much are we spending on research and development related to cancer, and should that be increased? The Biden administration has announced a moon shot to try to prevent four million cancer deaths by 2047. Should Canada make a commitment to do something similar and put more money into research and development?

Whatever I say can't end up on the record, but what you say can, so I'd like to hear from all of you. Hopefully, you're all going to say "yes".

Ms. Helena Sonea: We would absolutely support a similar initiative in this country, for sure. The Canadian Cancer Society invests over $50 million on an annual basis. That's a charity, and there's a lot of opportunity and room for improvement for the federal government to be increasing investment in cancer research.

Mr. Marcus Powlowski: Do you know much Canada puts in at the moment?

Ms. Helena Sonea: Off the top of my head, no, but I would be happy to follow up later today with some specific figures for you, for sure.

● (1220)

Mr. Marcus Powlowski: I'd like to hear quickly from the other doctors on the panel, both online and Dr. Sayani.

Dr. Ambreen Sayani: It's important to focus on prevention and early detection because that's where the most gains can be made. It is currently less funded than other aspects of the cancer care continuum. Therefore, we do need consistent effort and investment in this area.

Mr. Marcus Powlowski: Go ahead, Dr. Simpson and Dr. Anan.

Dr. Andrea Simpson: I agree. Particularly on cases where there are very identifiable risk factors and on those cancers, such as endometrial and cervical, where we are seeing, unfortunately, an increase in incidence, that's where our attention should be.

Dr. Ghadeer Anan: I know that I'm starting to sound like a broken record, but if you have challenges accessing medical advice and supports, you are less likely to participate in research and clinical trials, even when they are available.

Mr. Marcus Powlowski: Let me briefly ask about support for families and for caregivers. I think Ms. Sonea talked about the particular burden on women who are caregivers. If someone in the family has cancer, somebody else probably has to stay home and look after them. I looked up the federal caregiver tax credit, and it looks like it's $10,500, which isn't nothing, but on the other hand, that's a tax credit. Is that enough, and should that be increased?

Ms. Helena Sonea: That's a great question. Thank you very much for bringing your attention to it.

At the end of the day, making it refundable, regardless of your tax bracket, means that you would get the money back, not just reduce what you would owe. That very particular nuance would really impact people who are already having to either take time off or go on short-term disability or the compassionate care benefit.

Mr. Marcus Powlowski: Before, under the Conservatives, it was a tax credit, but then we made it a benefit where we actually paid people.

You're proposing that, instead of $10,500 as a tax credit, that gets paid directly to people.

Ms. Helena Sonea: There's the compassionate care benefit, which we were thrilled to see extended from six weeks to 26 weeks, I believe, in 2016. It was fantastic because it was where we sought that alignment with the sickness benefit to make sure that caregivers and patients have the same amount of time.

There's room for improvement in that discussion as well, but what we're looking for is to ensure that $1,100 is about the amount that an adult can take back if they are looking after a dependent, mainly an adult—it's approximately $2,300 if it's a child.

The Chair: Thank you.

Ms. Helena Sonea: There are a lot of nuances with it, but I'm happy to chat more about it.

The Chair: Thank you.

We'll have Dr. Ellis, please, for five minutes.

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

Thank you, everyone, for being here. There are a bunch of wide-ranging questions here.

Dr. Anan, if I could start with you, Dr. Simpson highlighted robotic surgery around the rest of the country but left out the most important part of the country which is Atlantic Canada, of course. I'm from Nova Scotia.

If you're aware, could you highlight the robotic surgery programs in Atlantic Canada?

Dr. Ghadeer Anan: Unfortunately, I'm not. I don't treat gynecologic cancers, so I have to admit I'm not aware of what's available right now.

Mr. Stephen Ellis: Thank you.

Dr. Simpson, did you have a comment on that, not just to say you're sorry but to highlight the programs?

Dr. Andrea Simpson: I actually don't believe that it is currently available in Atlantic Canada, but it should be.

Mr. Stephen Ellis: I think it is in Halifax, but that's okay.

To you, Dr. Simpson, if I could, for the benefit of the analysts and Canadians watching, could you give a few examples of the disparities between male-related and female-related surgeries and the pay inequities? I think that would be very helpful.

Dr. Andrea Simpson: Sure. Building on some research that we had done previously, a group recently looked at procedures across Canada and the remuneration for procedures that are more commonly performed on male patients compared to female patients. These would be things like a hysterectomy compared to the removal of a prostate, for example.

It was pretty consistent across all provinces and across all of these procedures that procedures on women are remunerating at a much lower level. This is payment to the surgeon for these procedures.

What we can do, in terms of trying to promote more pay equity for surgeons and also ensuring that we're delivering the best care to our patients, would be to look at these procedures and promote pay equity across provinces to ensure that the sex of the patient does not matter when making these remuneration decisions. It's a very complicated issue, but I think that's a very simple thing that could be done as a first step to promote pay equity.

● (1225)

Mr. Stephen Ellis: Thank you, Dr. Simpson.

You've done some research on that. Could you send that and table it with the committee, please?

Dr. Andrea Simpson: Yes, I'm happy to send it along.

We have research looking at the gender pay gap between male and female surgeons across Ontario, and also referral patterns, which can be partly attributable for these differences in pay. I'm happy to share those papers with you.

Mr. Stephen Ellis: Thank you for that.

Dr. Anan, I'll go back to you.

We talked a fair bit about the availability of services in rural and remote parts of the Maritimes. One of the things you didn't highlight was talking a bit about reconstruction, which is often an important part of breast cancer recovery.

Can you talk a bit about the availability of that?

Dr. Ghadeer Anan: Yes, certainly.

The first obstacle is not having enough plastic surgeons to begin with. Part of a plastic surgeon's practice would be a private practice and cosmetic surgery, and in rural areas, that is not something that is in high demand, basically. What has been happening and what my patients are facing are due to the lack of enough plastic surgeons.

Ideally, you should plan for the actual surgery, with the general surgeon performing the mastectomy, to happen at the same time as the reconstructive surgery to get the best cosmetic outcomes and minimize the downtime for the patient. It should be the standard of care, but unfortunately, it's not right now due to the lack of enough plastic surgeons, which, unfortunately, adds to the negative mental effects of having to deal with a mastectomy and having a flat chest for God knows how long until you have your plastic surgery.

Mr. Stephen Ellis: Thank you.

I have just one quick question for the folks from the Canadian Cancer Society.

Nicotine pouches have become easily available in Canada and are legally available to minors and, of course, to women, and that's been since the summer. The Minister of Health promised to reverse that decision and make it right.

What's the progress on behalf of Canadians with respect to that decision?

Mr. Rob Cunningham: Thank you, Dr. Ellis and Mrs. Goodridge, for your public statements on this. You were very concerned.

B.C. and Quebec now only allow them to be sold in pharmacies behind the counter. We need national action, essentially, throughout Canada. In those two provinces, they can be sold to kids underage.

We're concerned by the delays. There should be action as soon as possible so that these tropic breeze and berry blast products, which are very popular and attractive to girls and boys, are not sold in that way.

Mr. Stephen Ellis: Thank you.

The Chair: Thank you.

[*Translation*]

Mrs. Brière, you have the floor.

[*English*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

[*Translation*]

I want to welcome all our witnesses and thank them for joining us for this important study.

An article published in *La Presse* on February 8 raised the concerns of women waiting for a diagnosis. We know that things don't start to happen until a diagnosis has been made. An action plan and treatment are then put in place.

However, when the tests have been done and the results are not forthcoming, it raises a lot of questions. What would be the impact of a cancer diagnosis? Could the cancer get worse while awaiting diagnosis? Will it be too late? Who will be able to help?

Do you find that these women are being left on their own? What about the time period between testing and diagnosis?

[*English*]

Ms. Helena Sonea: That's a very good question. Thank you.

I think it really speaks to that mental health component, because we know that when you hear the word “cancer”, it can completely change your life and your family's life. We need greater mental health supports and for individuals to not fall through the cracks while they are in this very delicate time, waiting to receive whatever the next step of their journey is. It's a role that we all can play together, whether it's the different levels of government or community organizations such as ours.

We're very fortunate at the Canadian Cancer Society to be able to provide a cancer information helpline. That is a lovely phone line for you to call and speak with, usually, a previous oncology nurse or social worker. They'll be able to talk you through all of these things and help direct you to various support services that might be available in your community, because we've had a lovely conversation here about how important receiving care in your community is. The service is available in over 200 languages.

That's just a practical example of the ways in which we can all work together, because that mental health component is absolutely paramount, as you've clearly identified. It's absolutely an area that we need to keep talking about and keep bringing up over and over again, because it does not just go away.

Even if you are through your care journey, there's still always that “what if?” in the back of your mind: What does that mean for me five years from now or 10 years from now? How does it impact my children and their potential complications? There's a lot we can be doing together.

● (1230)

Mrs. Élisabeth Brière: Thank you very much.

[*Translation*]

I was involved for several years on the board of directors of a hospice in my riding, in Sherbrooke, called La Maison Aube-Lumière.

The hospice has cared for young mothers whose life expectancy was less than three months. It provides support for the family, particularly for young children who may find themselves orphaned.

I'd like to hear your thoughts on the importance of supporting families after the death of a loved one.

[*English*]

Ms. Helena Sonea: Thank you very much for highlighting this incredibly important part of the care trajectory. The cancer continuum is so vast. I think that mental health piece includes grief and bereavement.

We know that Canadians with cancer are three times more likely to receive palliative care. There's so much more that we can be doing.

I really appreciate the opportunity to talk about hospice beds. There are not enough hospice beds in facilities across the country. The Canadian Cancer Society in October released a report that really distinguished the gaps across jurisdictions.

The best practice, as identified by the auditor general in Ontario and others, suggests that we should have seven hospice beds per 100,000 people. By our count, which was at the end of May 2022, there are only approximately four beds per 100,000 people. That does not take into account at all the challenges that are faced in rural and remote communities and in community care provided in one's setting of choice. I should say, to be fair to British Columbia, its numbers are much better.

We were so pleased that Health Canada did have that report back in December on the progress that we are making in palliative care in this country. There's a lot more that can be done, though, specifically around grief and bereavement.

We are asking the federal government to dedicate $7.5 million over three years to improve national data and standards for palliative care; to develop a national atlas that maps out where services are located across the country; and to invest in research, education and training as it relates to palliative care delivery.

The Chair: Thank you both.

[*Translation*]

We will continue with Ms. Larouche.

You have the floor for two and a half minutes.

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

The questions that were asked earlier about research made me think of a news story that came out this morning.

My question is first for you, Ms. Simpson, because you talked a lot about research, polycystic ovarian syndrome, robotic surgery and hormone therapy. This is all based on scientific research. We agree on that.

This morning, Radio-Canada published an article under the headline “A generation of researchers lost due to lack of funding”.

It reads, in part:

> A hundred or so researchers from all walks of life joined forces in a letter sent to federal minister François-Philippe Champagne, calling on him to take immediate action to restore Canada's place among the world's scientific research leaders.

A hundred or so researchers is a significant number. Among the researchers are people in the health field, including a neurosurgeon whose testimony is included in the letter.

Today, we are talking about women's health. We know that research is crucial and that some cancers, particularly ovarian cancer, are still far too deadly. In short, research is essential.

Ms. Simpson, what is your opinion on this open letter and this call to the Minister of Innovation, Science and Industry, François-Philippe Champagne?

I'll start with Ms. Simpson because she touched on the issue of new technologies, but if anyone else would like to answer my question, I invite them to do so.

● (1235)

[*English*]

Dr. Andrea Simpson: Thank you for that question. I would love to hear from my co-panellists on this as well.

Yes, there have been significant reductions to research funding. I think if we're really going to stay competitive with research on an international level, then we need to restore this funding for all cancer types. Today, the focus has been largely on the disparities in the study of cancers for women's cancers. It's really making up for the historical gaps that we've experienced in research in women's cancers by increasing funding in this specific area.

I don't know if anybody else wants to comment.

Ms. Helena Sonea: I can comment.

We were fortunate to meet with some stakeholders last week around this concept of postgraduate students who are choosing to leave the country because there is not enough support for them to develop their research further. A lot of those decisions are being made because there is no financial support for them to stay, or, if there is support, it's not much. How does that impact their career trajectories?

We really need to be making larger investments in terms of early-career researchers. We absolutely would support an investment of that type.

The Chair: Thank you.

Ms. McPherson, you have two and a half minutes, please.

Ms. Heather McPherson: Thank you, Mr. Chair.

I was very interested in what you were saying about hospice beds and access. I know you provided an answer, but I'm wondering if you could share that report with the analysts so that they could include that. I would love to know where Alberta stands on that.

Could you perhaps tell me where Alberta stands on that?

Ms. Helena Sonea: They're not bad.

Ms. Heather McPherson: It would be great if you could submit that.

Ms. Helena Sonea: Absolutely. I'd be happy to.

Ms. Heather McPherson: I was also struck by the comments I heard from all of the witnesses on testing and the implications for children. I know that, for me, colon cancer is hereditary, so there are impacts of being able to do that.

Perhaps I'll start with you again, Ms. Sayani. Right now the health care system—we are hearing—from coast to coast to coast, is in free fall. Frontline workers are overworked. The system is very at risk at the moment, yet we know how important the identification of cancer is. I know that in Alberta, it's very difficult to get a colonoscopy. You wait a very long time.

What are the implications of this collapsing health care system on cancer treatment for women?

Dr. Ambreen Sayani: If we look at it from an equity lens and consider who's falling straight through the cracks and who's being left out the most, it will be precisely those women who are not aware, who speak different languages and who don't have the cultural resources in their community.

The way I like to think about access is that, in terms of having your health care needs met, that's access, but access really does have five dimensions. The first is approachability. You know that care services exist. The second is acceptability. It's acceptable to you in a culturally appropriate way. It's affordable. Direct and indirect costs are covered. It's available at a time that works for you. If it's only available nine to five, that certainly won't be available for other people. Ultimately, it serves the needs it is supposed to serve. You have health care needs met at the end of all those things.

I think breaking down access into those five different dimensions and seeing how we can improve it all across those dimensions will allow us to work on each of them in a multipronged way.

Ms. Heather McPherson: Thank you very much.

I have four seconds left, I believe.

The Chair: Thank you.

Mrs. Goodridge, you have five minutes, please.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Again, thank you to the witnesses.

Helena, you talked about caregivers. We've talked about caregivers a lot. Do you have any stats on what the caregiver typically looks like? What is the female-male split on caregivers?

● (1240)

Ms. Helena Sonea: That's a great question. Caregivers make up approximately 35% of the total Canadian workforce, representing approximately one in three employees. Half of all caregivers are between the ages of 45 and 65. These are some of our peak earning years.

Mrs. Laila Goodridge: Understood. Do you have a gender split of male to female?

Ms. Helena Sonea: Women account for 50% of all caregivers, and 64% of those provide 20 hours or more of care per week.

Mrs. Laila Goodridge: Fantastic. I appreciate that. I think that's worth highlighting for this committee.

I'll go back to you, Dr. Anan, on some of the questions around reconstruction. We've been talking about breast cancer happening more and more often in younger and younger women. They'll often have families and young children at home. The requirement to now have two separate surgeries becomes that much more difficult for them, especially if they have young children. I can't imagine trying to keep a two-and-a-half-year-old from jumping on you after surgery, yet I know so many moms who have to do this exact same thing all the time.

I'm wondering if you could speak to that a little bit and what your suggestion would be to improve it.

Dr. Ghadeer Anan: Thank you.

In fact, I have had to deal with that in my own practice several times. A woman would have to go through treatment, surgery, reconstruction and radiation with kids at home and couldn't even afford child care. I think there should be policies in place with extra support for women who are undergoing treatment—any kind of cancer-related treatment, be it surgery, systemic treatment or radiation. They should have access to free child care. I've had women declining different types of treatments because of that particular reason, unfortunately.

Mrs. Laila Goodridge: I think it's worth also highlighting that a Monday to Friday, nine-to-five child care program probably wouldn't be sufficient for someone who is undergoing treatments like this.

Dr. Ghadeer Anan: That's correct. It's for respites as well, respites on evenings, weekends and that sort of thing—absolutely.

Mrs. Laila Goodridge: Exactly. Every mom can tell you that being a mom is a 24-7 job. The kids will climb on you even in the middle of the night—especially in the middle of the night.

Quickly, I want to go back to the Canadian cancer association around your recommendations. If we were to put a recommendation in this study regarding nicotine, and specifically nicotine pouches, what would you like us to have as a recommendation?

Mr. Rob Cunningham: Thank you.

We're urging in the short term that the health minister require that nicotine pouches be prescription only so that they will still be available for sale, or temporarily suspend their sale until federal and provincial regulatory legislative frameworks are in place. That's what we've asked the minister for.

Mrs. Laila Goodridge: Thank you. I really appreciate this, and I appreciate the leadership you guys have taken in bringing this to light. I know that many parents reached out to me after you guys put out your initial statement. They simply weren't aware. They were very scared that their child could then access something like this and potentially end up developing an addiction to nicotine, which we know has long-term consequences.

Dr. Sayani, you talked quite a bit about access to care. In my home province of Alberta, Alberta Health Services has actually done a lot of work on providing the translation of many different health services directly on the Alberta Health website, so that patients can access and understand better in their home language what that looks like. Is that one of the potential options that you would see as a success? Can you point to any other jurisdictions that are perhaps doing well when it comes to things like that?

Dr. Ambreen Sayani: Having materials available in multiple different languages is important. It's also important that people see themselves represented within the materials in a culturally appropriate way. They see their gender identity. They see their racial and their ethnic—

Mrs. Laila Goodridge: I think I've run out of time. I'm sorry. Thank you.

● (1245)

The Chair: Thank you, Mrs. Goodridge.

The last round of questions for this panel will come from Dr. Hanley for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

Thanks, everyone. This is a great panel with representation on really the whole spectrum of care.

With the Canadian Cancer Society, I want to focus on prevention. Thank you for coming.

First of all, Mr. Cunningham, on the fall economic statement and the tobacco cost recovery framework, could you comment on the significance of that and the need to actually carry that out?

Mr. Rob Cunningham: Yes. That is something that we've been urging for over many years. In the last federal election, it was in the platforms of the Liberal and Conservative parties and the NDP. It's a way to hold the tobacco industry accountable.

The $66 million for the federal tobacco strategy would be recovered from both the tobacco companies and the vaping companies. The sooner those regulations can be done, the sooner we'll have that accountability. We strongly support that.

Mr. Brendan Hanley: Thanks.

We've talked about nicotine pouches. What else legislatively at the federal level should we or could we be doing, especially with regard to vaping and tobacco?

Mr. Rob Cunningham: With respect to vaping, while smoking among boys and girls has been going down, we've had a dramatic increase in youth vaping. What could be done by the minister is to finalize regulations to ban flavours in e-cigarettes other than tobacco flavour. There's a draft regulation that was published more than two and a half years ago.

I have some examples with me. There are flavours such as “Confusion” or “Love Pink.” These are things that are not even flavours. Here's an example: “Tutti Frutti Pineapple Strawberry” or “Mango Pineapple”. They're styled as potential flavours. They're attractive to kids. Banning those flavours will help to reduce youth vaping among girls and boys.

Mr. Brendan Hanley: Yes, there's quite the collection.

Is there anything else you want to show off in terms of...?

Mr. Rob Cunningham: I do want to point out that there is a federal tax on e-cigarettes that helps reduce vaping among kids. The companies are undermining that with these disposable e-cigarettes that started out with 500 puffs. Then they brought forward 1,500 puffs, and then they brought forward 5,000 puffs. The price per week or per month goes down and undermines the tax objective. More recently, there are 9,000 and 10,000 puffs. That is an issue.

The flavours go on and on. Monster E or Caribbean Breeze are not even flavours, and that's a real concern. That's an easy action for the government to take.

Mr. Brendan Hanley: Thank you.

I'm going to switch from tobacco to alcohol. I'm pleased that you mentioned that in your opening remarks. Could you talk about, maybe, the relationship between alcohol accessibility and drinking behaviour? Are we aware enough of the link to the harms, especially with some increasing efforts to make alcohol more accessible in some parts of the country?

Ms. Ciana Van Dusen: We know that about 75% of Canadians 15 years old and over consume alcohol, and 40% of Canadians have no idea that there's any link between alcohol and cancer. Alcohol is related to over 200 different chronic diseases, illnesses and injuries, and it's contributing to a lot of costs and social harms in Canada. It is a concern that as we continue to increase its accessibility.... There's plenty of research to demonstrate a link between more availability, more accessibility, more consumption and more harm. We think that it's really important that people have the availability of information to make informed decisions for their health.

Not having this information widely spread, for example, on labels is a failure to give people the chance to make that choice for themselves as to whether it's something that they're willing to take on.

Mr. Brendan Hanley: Speaking of labels, in my former role, I was involved in the Yukon Territory, in collaboration with Public Health Ontario and the University of Victoria, in a study that, despite some push-back from industry, did show some promising results.

Can you comment on what the evidence tells us about the effect of alcohol warning labels and the information that consumers may want or need to modify their drinking habits?

Ms. Ciana Van Dusen: That study was tremendous in bringing us forward. It did demonstrate a reduction by, I believe, almost 7% in alcohol consumption. It meant that people were far more aware of the potential harms and risks. It also meant that, with increased awareness of alcohol costs and harms, people were more likely to support other legislation that would also aim to raise awareness or reduce consumption. It's a great first step in bringing us to a point where we are able to have more serious conversations.

● (1250)

The Chair: Thank you, Dr. Hanley and Ms. Van Dusen.

First of all, I want to thank all of our witnesses for being with us.

That concludes the rounds of questions. The MPs in the room should not go anywhere. We still have some committee business that we need to deal with.

To all of our witnesses, we very much appreciate your being here. We very much appreciate the degree of specificity that you put into the recommendations you provided. It will be of great assistance to us in the development of our report to the House. We very much appreciate your being here. Thank you so much.

Colleagues, we're going to suspend to allow us to switch the technology over to go in camera and for the witnesses to take their leave.

We are suspended.

[*Proceedings continue in camera*]