HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

SAVING MORE LIVES: IMPROVING GUIDANCE, INCREASING ACCESS AND ACHIEVING BETTER OUTCOMES IN BREAST CANCER SCREENING

Report of the Standing Committee on Health

Sean Casey, Chair

DECEMBER 2024
44th PARLIAMENT, 1st SESSION

SAVING MORE LIVES: IMPROVING GUIDANCE, INCREASING ACCESS AND ACHIEVING BETTER OUTCOMES IN BREAST CANCER SCREENING

Report of the Standing Committee on Health

Sean Casey
Chair

DECEMBER 2024

44th PARLIAMENT, 1st SESSION

NOTICE TO READER

Reports from committees presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

STANDING COMMITTEE ON HEALTH

CHAIR

Sean Casey

VICE-CHAIRS

Stephen Ellis
Luc Thériault

MEMBERS

Todd Doherty
Laila Goodridge
Brendan Hanley
Peter Julian
Arielle Kayabaga
Hon. Rob Moore
Yasir Naqvi
Marcus Powlowski
Sonia Sidhu

OTHER MEMBERS OF PARLIAMENT WHO PARTICIPATED

Élisabeth Brière
Michelle Ferreri
Anna Gainey
Gord Johns
Robert Kitchen
Shelby Kramp-Neuman
Damien C. Kurek
Andréanne Larouche
Leslynn Lewis
Ron Liepert
Larry Maguire
Jeremy Patzer
Anna Roberts

Peter Schiefke
Martin Shields
Karen Vecchio
Bonita Zarrillo

CLERKS OF THE COMMITTEE

Aimée Belmore
Catherine Ngando Edimo

LIBRARY OF PARLIAMENT

Research and Education

Kelly Farrah, Analyst
Tu-Quynh Trinh, Analyst

THE STANDING COMMITTEE ON HEALTH

has the honour to present its

TWENTY-THIRD REPORT

Pursuant to its mandate under Standing Order 108(2), the committee has studied breast cancer screening guidelines and has agreed to report the following:

TABLE OF CONTENTS

SUMMARY 1

LIST OF RECOMMENDATIONS 3

SAVING MORE LIVES: IMPROVING GUIDANCE, INCREASING ACCESS AND ACHIEVING BETTER OUTCOMES IN BREAST CANCER SCREENING 7

- Introduction 7
- Breast Cancer in Canada 9
- Provincial and Territorial Breast Cancer Screening Programs 13
- Canadian Task Force on Preventive Health Care 15
  - Update of the Breast Cancer Screening Guideline 16
- Evidence on the Draft Recommendations of the Canadian Task Force on Preventive Health Care 18
  - Selection of Evidence 20
  - Interpretation of Evidence 22
  - Diversity, Equity and Inclusion 25
  - Bias 26
  - Shared Decision-Making 26
  - Expert Input 27
  - Timeliness, Accountability and Transparency 28
  - Reforms 29
- Barriers to Screening 30
  - Screening Capacity 30
  - Awareness and Access 31
  - Data Collection and Research 31
- Conclusion and Recommendations 32

APPENDIX A: BREAST CANCER SCREENING GUIDELINES, TWENTIETH REPORT, STANDING COMMITTEE ON HEALTH, 1ST SESSION, 44TH PARLIAMENT .. 37

APPENDIX B: RECOMMENDATIONS FROM THE 2022 EVALUATION OF THE CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE 39

APPENDIX C: STATEMENT FROM THE MINISTER OF HEALTH IN RESPONSE TO THE CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE 41

APPENDIX D: RESPONSE OF THE PUBLIC HEALTH AGENCY OF CANADA TO THE MOTION DATED 13 JUNE 2024 OF THE HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH 43

APPENDIX E: LIST OF WITNESSES 45

APPENDIX F: LIST OF WITNESSES (WOMEN'S HEALTH) 47

APPENDIX G: LIST OF BRIEFS 51

APPENDIX H: LIST OF BRIEFS (WOMEN'S HEALTH) 53

REQUEST FOR GOVERNMENT RESPONSE 57

SUMMARY

The national breast cancer screening guideline developed by the Canadian Task Force on Preventive Health Care (Task Force) has been sharply criticized, in particular for its continued recommendation against routine breast cancer screening for women aged 40 to 49. Critics argue that this recommendation is founded on outdated evidence, underestimates the benefits while overstating the harms of such screening and may discourage the use of a potentially life-sparing secondary prevention measure. Evidence indicates a rising incidence of breast cancer among women under the age of 50. Additionally, a Canadian study has found that, compared to white women, women of other race and ethnicity groups are more likely to develop breast cancer at a younger age and to have higher proportions of cases diagnosed under the age of 50. To help ensure that Canada's breast cancer screening guideline is based on best evidence and practice and that women have optimal access to preventive care, the House of Commons Standing Committee on Health (Committee) undertook a study on breast cancer screening guidelines in Canada. Following that study, the Committee unanimously adopted a motion urging the Task Force to revisit its draft recommendations on breast cancer screening.

This report summarizes the evidence gathered for the study, centring around significant concerns over the Task Force's draft recommendations and barriers to breast cancer screening across Canada. To address these concerns, the Committee puts forward 13 recommendations to the Government of Canada, notably:

- accelerating an external expert review of the Task Force's breast cancer screening guidelines;
- initiating the development of guidelines for women who are at higher-than-average risk for developing breast cancer;
- ensuring appropriate levels of funding for optimized breast cancer screening programs;
- enhancing data collection on breast cancer and, in particular, disaggregated data by race, ethnicity and breast density;
- implementing public health awareness campaigns on breast cancer screening, including those targeted at younger women and Indigenous and racialized communities; and

- investing in research on breast cancer.

More broadly, the Committee recommends that the Task Force be rebuilt, with appropriate governance, accountability, transparency and ethics oversight.

LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

Recommendation 1: Rebuilding the Task Force

That the Government of Canada, in consultation and collaboration with specialty societies, specialist physicians, primary care providers, patients and allied scientists, as needed, work toward rebuilding a Canadian Task Force on Preventive Health Care that has:

- **an appropriate governance and accountability structure;**
- **full and appropriate transparency;**
- **ethics oversight;**
- **content-expert leadership with methodologist assistance; and**
- **respect for academic freedom. 32**

Recommendation 2: External Expert Review of the Task Force

That the Public Health Agency of Canada accelerate the External Expert Review that will examine the processes and parameters of the Canadian Task Force on Preventive Health Care and provide recommendations to improve the Task Force to ensure a timely response to emerging needs and expectations of Canadians. 33

Recommendation 3: Consultation on the Task Force

That the Government of Canada consult with the medical community and other stakeholders on:

- **the selection of the members of the Canadian Task Force on Preventive Health Care;**

- **the integration of specialists into the Canadian Task Force on Preventive Health Care;**

- **increased transparency in the process for developing recommendations; and**

- **enhanced accountability to the Canadian public;**

and that the recommendations flowing from this consultation be presented to the House of Commons Standing Committee on Health and to Parliament within one year of the close of the consultation. 33

Recommendation 4: Expert Review of Guidelines

That the Chief Public Health Officer convene with senior provincial and territorial officials and key experts to review the breast cancer screening guidelines of the Canadian Task Force on Preventive Health Care and to share their best practices. 33

Recommendation 5: Monitoring Outcomes of Guidelines

That the Government of Canada work with Statistics Canada and the relevant content experts to implement measures to audit outcomes associated with the recommendations of the Canadian Task Force on Preventive Health Care. 33

Recommendation 6: Responsiveness

That the Government of Canada implement a process for developing more frequent updates to guidelines that would be responsive to the rapid evolution of the areas of breast cancer detection and treatment. 34

Recommendation 7: Up-to-Date Modelling

That the Government of Canada immediately work with Statistics Canada and the Canadian Partnership Against Cancer to ensure that the OncoSim cancer models are updated with respect to accuracy and relevance. 34

Recommendation 8: High-Risk Programs

That the Government of Canada, in consultation and collaboration with specialty societies, specialist physicians, primary care providers, patients and allied scientists, work with provinces and territories to implement at the soonest possible date a process for developing guideline recommendations for women who are at higher-than-average risk for developing breast cancer and provide funding for high-risk programs. 34

Recommendation 9: Data Collection

That the Government of Canada work with Statistics Canada and/or provincial and territorial agencies to provide resources to ensure that data on breast cancer are collected on a more granular basis with respect to ethnic and racial factors, breast density, mode of detection of breast cancer, stage, characteristics of disease and recurrences. 34

Recommendation 10: Public Health Awareness Campaigns

That the Government of Canada, in consultation and collaboration with the provinces, territories and Indigenous peoples, work with the Public Health Agency of Canada:

- **to rapidly develop and swiftly implement public health awareness campaigns promoting the value of screening and providing accurate, accessible information to physicians and the public on both the benefits and limitations of breast cancer screening; and**

- **to rapidly develop and swiftly implement public health awareness and education strategies specifically targeting adolescent and young adult women, Indigenous and racialized communities, as well as the health care professionals who serve them, to address knowledge barriers regarding early detection and reduce disparities in the stage at which breast cancer is diagnosed in women. 34**

Recommendation 11: Research Investments

That the Government of Canada invest funding to improve breast cancer research. 35

Recommendation 12: Appropriate Funding

That the Government of Canada ensure that the provinces and territories receive appropriate levels of funding, through increases in Canada Health Transfer payments and/or by other means, to enable them to:

- **enhance breast cancer screening programs;**
- **allow women who are 75 or older to continue screening for breast cancer where clinically appropriate;**
- **ensure adequate capacity for breast screening and diagnostic programs and support supplemental screening, which may include MRI, ultrasound, tomosynthesis and contrast-enhanced mammography for people with dense breasts;**
- **provide solutions to access health care providers through screening programs and offer support to people without a regular health care provider; and**
- **reach communities that are underserved. 35**

Recommendation 13: Investment in Health Human Resources

That the Government of Canada ensure appropriate funding to the provinces and territories through increases in Canada Health Transfer payments to enable them to invest in health human resources. 35

SAVING MORE LIVES: IMPROVING GUIDANCE, INCREASING ACCESS AND ACHIEVING BETTER OUTCOMES IN BREAST CANCER SCREENING

INTRODUCTION

Among Canadian women, breast cancer is the most diagnosed cancer[1] and second leading cause of cancer death.[2] Breast cancer screening programs aim to detect the cancer early, before symptoms develop, to reduce mortality and morbidity. However, in Canada, the best approach to breast cancer screening has been subject to debate, particularly regarding the starting age for routine screening. Evidence indicates a rising incidence of breast cancer among women under the age of 50.[3] Additionally, data indicate that, compared to white women, women from certain racialized groups are more often diagnosed with breast cancer under the age of 50 and more frequently diagnosed at a later stage.[4] Over the past few years, certain provincial breast cancer screening programs have lowered the age of eligibility for routine screening from 50 to 40. Some experts, patients and advocacy groups have criticized the national breast cancer screening guideline developed by the Canadian Task Force on Preventive Health Care (Task Force) in 2018, notably because it did not recommend that women aged 40 to 49 be routinely screened for breast cancer. In May 2024, the Task Force released a draft guideline update,[5] continuing to recommend against routine screening for women in their 40s. Critics argue that this recommendation is founded on outdated evidence, underestimates benefits while overstating harms and may discourage the use of a potentially life-sparing secondary prevention measure.

1 Excluding non-melanoma skin cancer.

2 Canadian Cancer Statistics Advisory Committee, in collaboration with the Canadian Cancer Society, Statistics Canada and the Public Health Agency of Canada, *Canadian Cancer Statistics 2023*, November 2023.

3 HESA, *Evidence*, 6 December 2023, 1955 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual).

4 HESA, *Evidence*, 13 June 2024, 1110 (Kelly Wilson Cull, Director, Advocacy, Canadian Cancer Society); and HESA, *Evidence*, 13 June 2024, 1145 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

5 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*.

To help ensure that Canada's breast cancer screening guideline is based on best evidence and practice and that women[6] have optimal access to preventive care, the House of Commons Standing Committee on Health (Committee) committed to studying that guideline, adopting the following motion on 11 April 2024:

> That, pursuant to Standing Order 108(2), the committee undertake a two meeting study on breast cancer screening guidelines in Canada, including but not limited to, an examination of (a) current breast cancer screening guidelines, (b) Breast Cancer Canada's recommendation to lower breast cancer screening guidelines to begin at age 40, (c) Breast Cancer Canada's recommendation that Canadian guidelines for the screening, detection, and treatment for breast cancer be updated every two years, (d) best practices in treatment and options to improve health outcomes; that the committee report its findings and recommendations to the House; and that, pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.[7]

The Committee held two meetings for this study, on 10 and 13 June 2024, during which it heard from nine witnesses, including advocacy groups, health care professionals and researchers. In addition, 15 briefs were submitted to the Committee. The Committee did not receive evidence from any member of the Task Force, although one of the witnesses had served as a non-voting content expert on the Task Force's breast cancer screening working group. In addition, Task Force members submitted a brief as part of the Committee's study on women's health. The Committee adopted a motion on 18 April 2024 stating "that the evidence and documents received as part of the women's health study be also considered in the Committee's study of breast cancer screening."[8]

After its meetings in June 2024, the Committee agreed unanimously to a motion that, among other things, urged the Task Force to revisit its draft recommendations on breast cancer screening. The motion read as follows:

> That, given that the federally created Canadian Task Force on Preventive Health Care decided not to lower the breast cancer screening age guidelines, and that, Breast Cancer Canada said it was "deeply concerned" by the task force's guidelines, and so were the majority of

6 Transgender men and gender-diverse people can also be candidates for screening: see Canadian Cancer Society, *Screening in 2SLGBTQI+ communities*.

7 House of Commons, Standing Committee on Health (HESA), *Minutes of Proceedings*, 11 April 2024.

8 HESA, *Minutes of Proceedings*, 18 April 2024.

> witnesses, the committee report to the House that the decision by the Canadian Task Force on Preventive Health Care should be immediately reversed and breast cancer screening should be extended to women in their 40s, as this will help save lives; that the Minister of Health urge the task force to go back to the drawing board and revisit the guidelines based on the latest science; and that the Public Health Agency of Canada table to this committee the parameters given to the task force to update breast cancer screening guidelines.[9]

On 19 June 2024, the Committee presented a report based on that motion to the House of Commons.[10] That report is reproduced in Appendix A.

This second, more in-depth report on the breast cancer screening guideline begins by providing background information on breast cancer in Canada, provincial and territorial screening programs, and the Task Force's guidelines. It then summarizes the evidence gathered for the study, focusing on concerns regarding those guidelines as well as barriers to breast cancer screening. Finally, it offers recommendations to the Government of Canada on improving both the Task Force's guideline development process and access to breast cancer screening in Canada.

BREAST CANCER IN CANADA

Breast cancer has a profound impact on the health and well-being of tens of thousands of women[11] in Canada each year. The Canadian Cancer Society estimates that 1 in 8 Canadian women will develop breast cancer during their lifetimes and that 1 in 36 will die from it. In 2024, an estimated 30,500 Canadian women will be diagnosed with breast cancer (representing 25% of cancer cases among women), and around 5,500 will die from the disease (representing 13% of all cancer deaths among women).[12] Figure 1 shows key facts and figures on breast cancer in Canada.

---

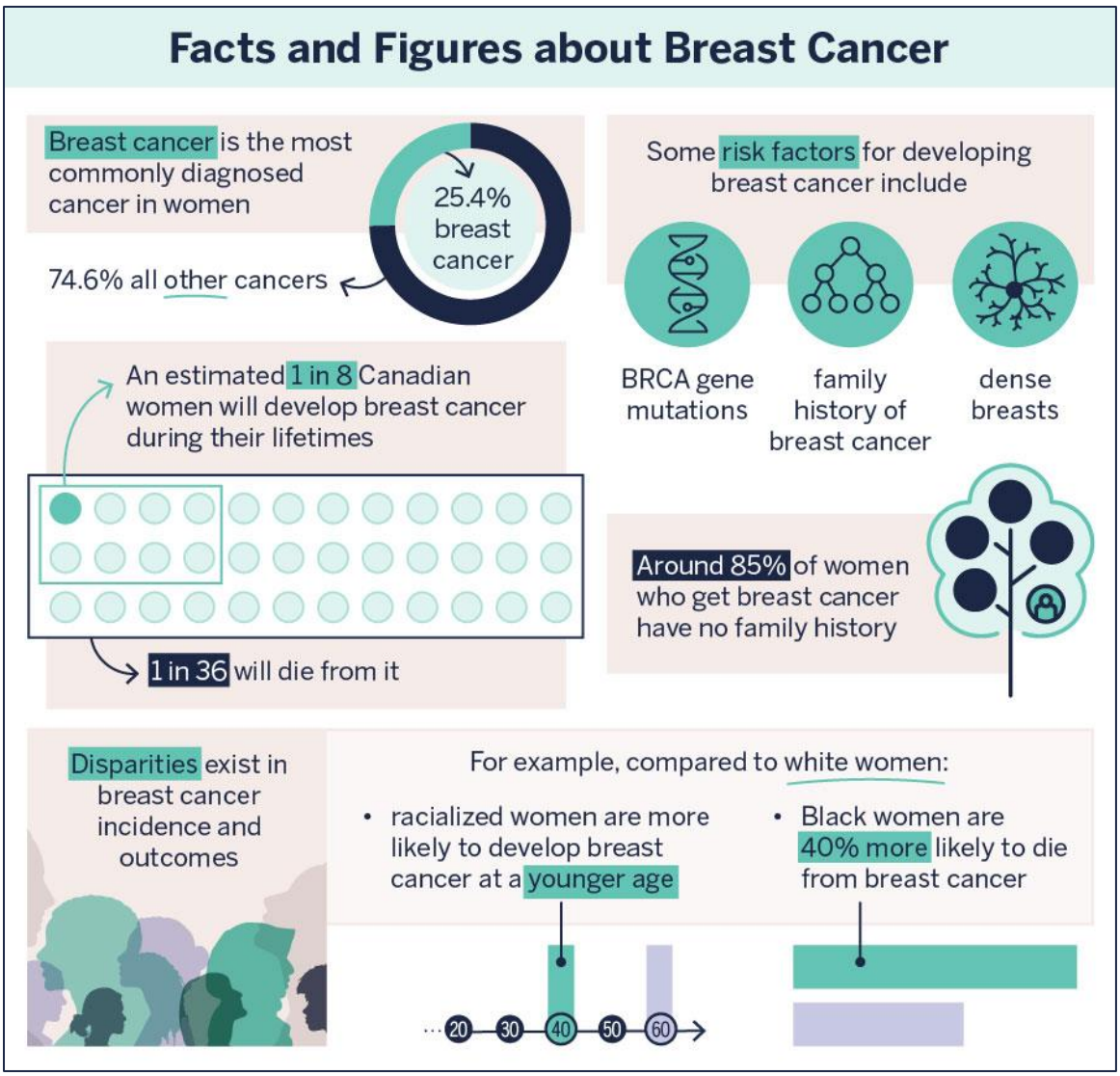
9 HESA, *Minutes of Proceedings*, 13 June 2024.

10 HESA, *Breast Cancer Screening Guidelines*, Twentieth Report, 1st Session, 44th Parliament, June 2024.

11 Men can also develop breast cancer. In 2024, an estimated 290 males will be diagnosed with breast cancer. See Darren R. Brenner et al., for the Canadian Cancer Statistics Advisory Committee, "Projected estimates of cancer in Canada in 2024," *Canadian Medical Association Journal*, Vol. 196, No. 18, 13 May 2024.

12 Canadian Cancer Society, *Breast Cancer Statistics*, May 2024.

Figure 1—Facts and Figures about Breast Cancer



Source: Prepared by the Library of Parliament using information from the evidence.

Since 1986, the breast cancer death rate has been declining. The Canadian Cancer Society states that this reduction likely reflects the impact of screening and improvements in treatment.[13] The rate of new cases of breast cancer has remained mostly stable since the early 1990s.[14] However, overall trends in incidence can mask

13 Ibid.

14 Ibid.

age-specific changes. A 2024 study observed trends of increasing incidence of breast cancer in Canada among women in their 20s, 30s, 40s and early 50s.[15]

There are over 50 types of breast cancer.[16] Breast cancer can be categorized by stage, from zero to four, depending on the extent of the cancer in the body. In general, higher stages indicate a larger cancer or more spread throughout the body. According to the Canadian Cancer Society,[17] the following factors are commonly used to determine stage:

- the size of the tumour and whether it has grown into nearby tissues;
- whether the cancer has spread to the lymph nodes;
- whether the cancer has spread to distant sites (metastasis);
- the hormone receptor status;[18]
- the HER2 status;[19] and
- the grade.[20]

---

15 Jean M. Seely et al., "Incidence of Breast Cancer in Younger Women: A Canadian Trend Analysis," *Canadian Association of Radiologists Journal*, 25 April 2024.

16 Breast Cancer Canada, *Progress CONNECT*.

17 Canadian Cancer Society, *Stages of Breast Cancer*, June 2023.

18 The Canadian Cancer Society explains "hormone receptor status" in the following manner:

> Some types of breast cancer cells have estrogen receptors (ERs) and progesterone receptors (PRs) on their surface or inside them. …
>
> …
>
> Hormone receptor-positive tumours have ERs, PRs or both. They are usually less aggressive than hormone receptor-negative tumours (which don't have ERs or PRs). [Canadian Cancer Society, Prognosis and survival for breast cancer, March 2023].

19 "The HER2 gene controls a protein on the surface of cells that promotes their growth. HER2-positive breast cancer means that the cancer cells make too many copies of, or overexpress, the HER2 gene": Canadian Cancer Society, *Prognosis and survival for breast cancer*, March 2023.

20 The Canadian Cancer Society describes "grade" as follows:

> The grade is a description of how the cancer cells look compared to normal cells. Low grade means the cancer cells look a lot like normal cells. High grade means the cancer cells look more abnormal.
>
> Low-grade tumours have a better prognosis because they grow slower and are less likely to spread than high-grade tumours. [Canadian Cancer Society, *Prognosis and survival for breast cancer*, March 2023].

The prognosis and survival rate for breast cancer depends on factors such as those listed above and age at diagnosis. For example, early-stage breast cancers have a more favourable prognosis, and young women are more likely to be diagnosed with aggressive breast cancers.[21] Triple-negative breast cancer is an aggressive type of breast cancer that is more likely to grow and spread quickly. This type of breast cancer does not have estrogen or progesterone receptors and does not overexpress the HER2 gene.

Breast cancer incidence and outcomes vary by race and ethnicity. An analysis that used data from Statistics Canada found that, compared to white women, women of other race and ethnicity groups are more likely to develop breast cancer at a younger age (with a peak age of diagnosis ranging from 42 to 60, versus 65 for white women).[22] Additionally, compared to white women, Black women are more likely to be diagnosed with triple-negative breast cancer and are 40% more likely to die from breast cancer.[23]

Various factors are associated with an elevated risk of developing breast cancer. According to the Public Health Agency of Canada (PHAC), these factors include increased age, family history, BRCA gene mutation, earlier starting age of menstruation, later starting age of menopause and alcohol use, as well as post-menopausal obesity and physical inactivity.[24] Genetic testing can be used to identify gene mutations associated with an elevated risk of breast cancer, such as BRCA1 and BRCA2. Carriers of such gene variants are considered at high risk for developing breast cancer. Around 85% of women diagnosed with breast cancer have no family history.[25]

Having dense breasts can increase a person's risk for developing breast cancer. It can also make it difficult for breast cancer to be seen on a mammogram. Mammography is a low-dose x-ray of the breast. Dense breast tissue and cancerous tumours both display as white on a mammogram, making it difficult for radiologists to read. Breast density is a measure of the amount of dense tissue (glandular or fibrous tissue) that a person has compared to non-dense tissue (fatty tissue). It is measured on a scale from A to D, going

21 Canadian Cancer Society, *Prognosis and survival for breast cancer*, March 2023.

22 HESA, *Evidence*, 6 December 2023, 1955 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual). See also Anna N. Wilkinson et al., "Breast cancer incidence and mortality, by age, stage and molecular subtypes, by race/ethnicity in Canada," *The Oncologist*, 2 November 2024; and Paul Logothetis, University of Ottawa, "New study reveals racial disparities in breast cancer diagnosis and outcomes in Canada," *Research and Innovation*, 1 November 2024.

23 HESA, *Evidence*, 10 June 2024, 1735 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

24 Public Health Agency of Canada, *Breast Cancer*.

25 HESA, *Evidence*, 10 June 2024, 1735 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

from least to most dense. It is common for women to have dense breasts, particularly younger women and older women who take hormone replacement therapy.[26]

Given the increased risk of breast cancer among women with dense breasts, Dense Breasts Canada advocates for all women to be informed of their breast density following screening mammography and for those with dense breasts to receive supplemental breast cancer screening, for example with ultrasound or magnetic resonance imaging (MRI).[27] Prior to 2018, women in Canada were typically not told their breast density;[28] as of fall 2024, all provinces and territories with an organized screening program inform clients of their breast density.[29] However, the availability of supplemental screening varies across the country.

PROVINCIAL AND TERRITORIAL BREAST CANCER SCREENING PROGRAMS

Screening can be used to detect cases of breast cancer before symptoms develop. Mammography is a commonly used screening method. Compared to palpable cancers, cancers detected by screening mammography are more likely to be smaller, earlier-stage cancers.[30] According to the Canadian Cancer Society, early detection of breast cancer increases the chances of successful treatment.[31] Screening mammograms are conducted in the absence of symptoms. By contrast, diagnostic mammograms are used to help make a diagnosis when symptoms, such as a lump or swelling in the breast, are present or when an abnormality is found during screening mammography. Diagnostic mammograms generally take images in greater detail and from multiple angles.[32]

Every province and territory, except Nunavut, runs a breast cancer screening program. These programs all generally offer biennial screening for women aged 50 to 74.

---

26 Canadian Cancer Society, *Breast Density*, January 2024.

27 HESA, *Evidence*, 6 December 2023, 2120 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); and HESA, *Evidence*, 10 June 2024, 1815 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

28 HESA, *Evidence*, 10 June 2024, 1815 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

29 Dense Breasts Canada, "3.10 Provincial comparison chart," *Your Comprehensive Guide to Breast Cancer Screening in Canada*, 2024, p. 19.

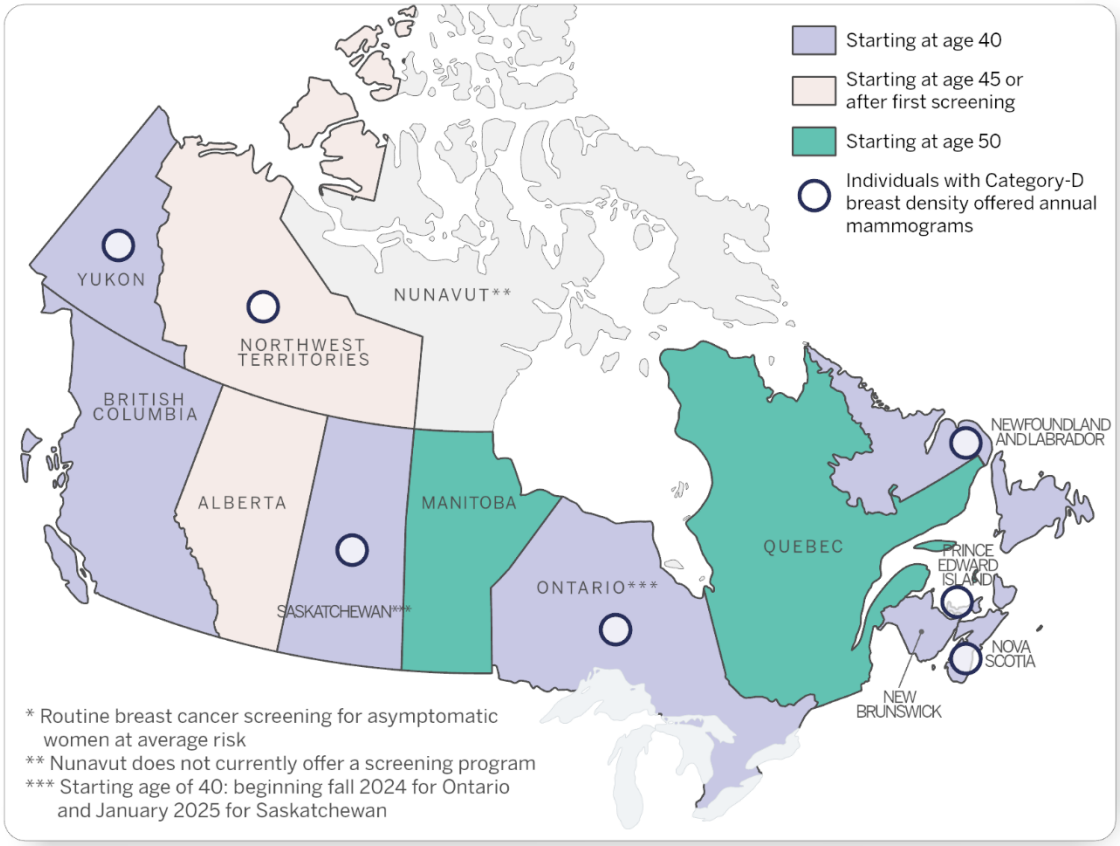
30 HESA, *Evidence*, 6 December 2023, 2035 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual).

31 Canadian Cancer Society, *Screening for Breast Cancer*, April 2024.

32 Canadian Cancer Society, *Mammography*, January 2024.

However, they vary in other aspects, such as whether they routinely screen women in their 40s, whether they offer supplemental screening to people with dense breasts and whether women can self-refer after age 74 (instead of needing a doctor's requisition).[33] Figure 2 shows some key differences between programs.

Figure 2—Provincial and Territorial Breast Screening Programs*: Starting Ages and Supplemental Screening for Dense Breasts



Note: In September 2024, the province of Manitoba announced its intention to "lower the age for self-referrals to 40 from 50, beginning with a commitment to get to age 45 by the end of next year": Government of Manitoba, *Manitoba Government Helping More Women Get Screened for Breast Cancer*, News release, 24 September 2024.

Source: Figure prepared by the Library of Parliament using data from Dense Breasts Canada, *Your Comprehensive Guide to Breast Cancer Screening in Canada*, 2024.

33 Dense Breasts Canada, *Your Comprehensive Guide to Breast Cancer Screening in Canada*, 2024.

Inequities in access to breast cancer screening across Canada was a theme in the testimony. Some witnesses viewed the Task Force's recommendations as causing or amplifying such inequities.[34] Although provinces and territories may implement their respective guidelines for breast cancer screening, national recommendations help inform policies and practices across the country. According to physician Dr. Anna Wilkinson, the Task Force's guidelines "really drive what the provinces do."[35] Further, the Task Force's guidelines are influential among family physicians and are promoted by the College of Family Physicians of Canada (CFPC). In the words of Dr. Wilkinson, "when the task force says, 'Don't screen', family doctors really listen."[36]

CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE

The Task Force is an independent body established by PHAC to develop national guidelines to support primary care providers in delivering preventive health care.[37] It comprises 15 experts in primary care and prevention, including, for example, family physicians, mental health experts, pediatricians and other physician specialists. Task Force members are not paid for their contributions. Current and prospective members are subject to the Task Force's policy on conflicts of interest.[38] Members are jointly appointed by the Chief Public Health Officer of Canada and the Executive Director, Professional Development and Practice Support, of the CFPC. These appointments are based on the recommendations of a selection committee composed of:

- the Task Force Chair and Vice-Chair;
- two Task Force members;
- one PHAC representative; and
- the Executive Director, Professional Development and Practice Support, of the CFPC (or a delegate thereof).

---

34 HESA, *Evidence*, 13 June 2024, 1125 (Kelly Wilson Cull, Director, Advocacy, Canadian Cancer Society); Dense Breasts Canada, *Breast Cancer Screening Guidelines Study*, Brief submitted to HESA, 5 July 2024; HESA, *Evidence*, 6 December 2023, 2000 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); and HESA, *Evidence*, 6 December 2023, 2005 (Dr. Anna Wilkinson, Doctor of Medicine, as an individual).

35 HESA, *Evidence*, 6 December 2023, 2005 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual).

36 Ibid.

37 Canadian Task Force on Preventive Health Care, *About us*.

38 Canadian Task Force on Preventive Health Care, *Conflict of Interest Policy*.

The procedures that the Task Force uses to develop its recommendations are documented in its methods manual.[39] Among other things, the manual outlines the membership appointment process, including qualifications for appointment. It also details the Task Force's guideline development process. Broadly, this process involves four stages: topic selection, evidence synthesis, guideline development and dissemination. When developing guidelines, the Task Force engages independent evidence review and synthesis centres to prepare summaries of scientific evidence. It also brings in specialists and experts in other disciplines to serve on guideline working groups.

The Task Force publishes and periodically updates a national guideline on breast cancer screening. This guideline contains recommendations on screening for women with average risk of breast cancer, not those with genetic risk factors or symptoms.

In 2022, PHAC published a five-year evaluation of the Task Force that made several recommendations. One of these recommendations was to "explore ways to improve the timeliness of the guideline development process," as the Task Force had been unable to meet its commitment to producing three guidelines per year since 2018.[40] The full recommendations from this evaluation are reproduced in Appendix B.

Update of the Breast Cancer Screening Guideline

On 8 June 2023, the Minister of Health announced $500,000 in additional funding to the Task Force to help expedite the update of its 2018 breast cancer screening guideline, stating that "having breast cancer screening guidelines that are based on the latest science is essential."[41] A month earlier, the United States Preventive Services Task Force (USPSTF) had released a draft recommendation on breast cancer screening, updating its 2016 guideline and recommending that screening start at age 40 (instead of 50). The

39 Canadian Task Force on Preventive Health Care, *Methodology*.

40 Office of Audit and Evaluation, Public Health Agency of Canada, *Evaluation of Canadian Task Force on Preventive Health Care*, December 2022.

41 Public Health Agency of Canada, *Government of Canada to help advance work on breast cancer screening*, 8 June 2023.

change was based on "new and more inclusive science."[42] The USPSTF published its final recommendation in April 2024.[43]

On 30 May 2024, the Task Force published draft recommendations on breast cancer screening, a preliminary update of its 2018 guideline.[44] According to the Task Force, the recommendations were informed by a comprehensive evidence review on breast cancer screening, including recent observational studies, randomized controlled trials (RCTs), modelling, a review of patient values and preferences, Statistics Canada data and the USPSTF's evidence review. The Task Force published several documents alongside the draft recommendations, such as its research plan, discussion tools, evidence reviews and response to stakeholder peer-review comments. The final recommendations and guideline are to be released at a later date, following a public consultation period.

The Task Force's 2024 draft recommendations are consistent with its 2018 guideline regarding the age at which to start and stop routine screening:

> For women aged 40 to 49, based on the current evidence (trials, observational studies, modelling and a review on values and preferences), we suggest not to systematically screen with mammography. Because individual values and preferences may differ, those who want to be screened after being informed of the benefits and harms should be offered screening every 2 to 3 years (conditional recommendation, very low certainty).
>
> …
>
> For women aged 50 to 74, based on the current evidence (trials, observational studies modelling and a review on values and preferences), we suggest screening with mammography every 2 to 3 years. Because individual values and preferences may differ, it is important that women aged 50 to 74 have information about the benefits and harms of screening to make their decision (conditional recommendation, very low certainty).
>
> …

42 United States Preventive Services Task Force, *Task Force Issues Draft Recommendation Statement on Screening for Breast Cancer*, 9 May 2023.

43 United States Preventive Services Task Force, *Final Recommendation Statement, Breast Cancer: Screening*, 30 April 2024.

44 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*.

> For women aged 75 and above, based on the current evidence (observational studies and modelling; no trials available), we suggest not to screen with mammography (conditional recommendation, very low certainty).[45]

Citing a lack of evidence, the Task Force advises against the use of MRI or ultrasound as supplemental screening tests for people with dense breasts or for women with a moderately increased risk due to a family history of breast cancer.[46]

Shortly after these draft recommendations were released, certain advocacy groups such as Dense Breasts Canada and the Canadian Cancer Society voiced criticisms.[47] On 30 May 2024, the Minister of Health published a statement in response to the Task Force's draft recommendations.[48] The Minister expressed concerns and announced that he was taking a number of actions, including calling for an extension to the consultation period, addressing knowledge gaps and accelerating PHAC's external expert review of the Task Force's processes. The full statement is reproduced in Appendix C.

The Committee's motion to study breast cancer screening guidelines predated the publication of the draft recommendations, and its first meeting on this study was held on 10 June 2024.

EVIDENCE ON THE DRAFT RECOMMENDATIONS OF THE CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE

Many witnesses and authors of briefs voiced significant concerns over the Task Force's draft recommendations. The Committee heard from a range of stakeholders who strongly disagreed with the recommendations, including physicians and breast imaging

45 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*. The Task Force's methodology employs the Grading of Recommendations Assessment, Development and Evaluation system (GRADE) to assess the strength of the recommendation (strong versus conditional) and certainty of the evidence (very low, low, moderate and high). For more information, see Canadian Task Force on Preventive Health Care, "Chapter 5: Development of Recommendations," *Methods Manual*.

46 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*.

47 Dense Breasts Canada, *Concerns about the 2024 draft breast screening guidelines*; and Canadian Cancer Society, *New national breast screening guidelines miss the mark*, 30 May 2024.

48 Mark Holland (@markhollandlib), "Statement on breast cancer screening guidelines," X, 30 May 2024, 1:58 p.m.

specialists;[49] advocacy groups, such as the Canadian Cancer Society, Breast Cancer Canada and Dense Breasts Canada;[50] and patients and relatives.[51] A minority of witnesses and briefs challenged this criticism.[52] The various arguments, which are summarized below, centred around issues of evidence selection and interpretation; diversity, equity and inclusion; bias; shared decision-making; incorporation of expert input; timeliness, accountability and transparency; and calls for reform.

In response to the Committee's motion that PHAC table the parameters it had set for the Task Force's update of the breast cancer screening guideline, the agency replied that, given the arms-length and independent nature of the Task Force, PHAC does not provide parameters for the development of clinical screening guidelines, including the update to the breast cancer screening guideline. This response from PHAC is reproduced in Appendix D.

---

49 HESA, *Evidence*, 13 June 2024, 1105 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual); HESA, *Evidence*, 13 June 2024, 1205 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual); HESA, *Evidence*, 13 June 2024, 1210 (Dr. Supriya Kulkarni, President, Canadian Society of Breast Imaging); Dr. Supriya Kulkarni, *The Canadian Society of Breast Imaging Statement in Response to the Canadian Task Force on Preventive Health Care (Draft) guidelines for Breast Cancer Screening*, Brief submitted to HESA; Canadian Association of Radiologists, *Response to the Canadian Task Force on Preventive Healthcare's Draft Guidelines on Breast Imaging*, Brief submitted to HESA; and HESA, *Evidence*, 6 December 2023, 1955 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual).

50 HESA, *Evidence*, 10 June 2024, 1710 (Kimberly Carson, Chief Executive Officer, Breast Cancer Canada); HESA, *Evidence*, 10 June 2024, 1715 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines); HESA, *Evidence*, 10 June 2024, 1720 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); HESA, *Evidence*, 6 December 2023, 2005 (Jennie Dale, Co-founder and Executive Director, Dense Breasts Canada); HESA, *Evidence*, 13 June 2024, 1110 (Kelly Wilson Cull, Director, Advocacy, Canadian Cancer Society); and HESA, *Evidence*, 13 June 2024, 1115 (Ciana Van Dusen, Advocacy Manager, Prevention and Early Detection, Canadian Cancer Society).

51 Natalie Kwadrans, *2024 Draft Breast Screening Guidelines*, Brief submitted to HESA, 9 June 2024; Fiona McIntyre, *My Story on the Impacts of Breast Cancer, and Why the Current Recommendations Need to Change*, Brief submitted to HESA; Kimberly Porter, *Metastatic Breast Cancer; A Million Tiny Deaths*, Brief submitted to HESA; Cheryl White, *Breast Cancer Screening Guideline*s, Brief submitted to HESA; Jennifer Borgfjord, *How Canada's Current Breast Cancer Screening Recommendations "Harmed" Me*, Brief submitted to HESA; and Julie McIntyre, *Breast Cancer Screening Guidelines Study*, Brief submitted to HESA, 19 July 2024.

52 HESA, *Evidence*, 10 June 2024, 1710 (Dr. Michelle Nadler, Breast Medical Oncologist and Implementation Scientist, as an individual); HESA, *Evidence*, 6 December 2023, 1945 (Dr. Steven Narod, Senior Scientist, as an individual); Sharon Batt, *Canadian Task Force on Preventive Health Care's Draft Breast Cancer Screening Guidelines*, Brief submitted to HESA, 17 June 2024; Anne Kearney, *The Canadian Task Force on Preventive Health Care Draft Breast Cancer Screening Recommendations*, Brief submitted to HESA, 27 June 2024; and Renée Pellerin, *Regarding Canadian Task Force on Preventive Health Care Draft Breast Screening Guidelines*, Brief submitted to HESA, 18 July 2024.

Selection of Evidence

> **"The mortality reduction possible with screening depends on what kinds of studies you look at."**
>
> —Dr. Paula Gordon, Volunteer Medical Advisory, Dense Breasts Canada, Clinical Professor at University of British Columbia

Some witnesses found problematic the types of studies used to inform the Task Force's draft recommendations. The RCTs[53] that originally evaluated the efficacy of mammography date back 40 to 60 years and employed technologies that are now obsolete (e.g., film, rather than digital, mammography). According to Dr. Wilkinson and Dr. Jean Seely, Professor of Radiology at the University of Ottawa, experts working with the evidence review group advised against the inclusion of these trials, yet the Task Force "dictated" their inclusion.[54] Further, representatives from Dense Breasts Canada pointed to serious flaws (notably, improper randomization) in one of these trials, the Canadian national breast screening study, which found no evidence of mortality benefit from screening.[55] Dr. Steven Narod, a senior scientist at Women's College Research Institute, disputed this criticism, affirming that the study results are valid.[56]

Several witnesses argued for better incorporation of observational trials and modelling in the evidence review process. According to Dr. Paula Gordon, Volunteer Medical

---

53 The Canadian Institutes of Health Research (CIHR) defines "randomized controlled trial" as follows:

> A randomized controlled trial (RCT) is considered the most unbiased way of assessing the outcome of an intervention. In the simplest case, a relevant population is identified (e.g., patients with the disease the drug is designed to treat). The population is divided by some impartial method of assignment (ideally, random numbers generated by a computer program) into intervention and control groups. … When the trial ends, all data are analyzed to determine if a statistically significant difference exists between the groups. If so, it can be concluded that the difference is due to the intervention. [CIHR, *Jargon Buster*].

54 HESA, *Evidence*, 6 December 2023, 1955 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual); and HESA, *Evidence*, 13 June 2024, 1120 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

55 HESA, *Evidence*, 6 December 2023, 2020 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); and HESA, *Evidence*, 6 December 2023, 2005 (Jennie Dale, Co-founder and Executive Director, Dense Breasts Canada).

56 HESA, *Evidence*, 6 December 2023, 1945 (Dr. Steven Narod, Senior Scientist, as an individual).

Advisor with Dense Breasts Canada, newer observational studies[57] show greater reduction in breast cancer mortality compared to the older RCTs (around 53%, versus 15% to 20%).[58] The Task Force did include observational studies in its updated review. Dr. Gordon nevertheless argued that it still prioritized older RCTs over newer observational studies.[59] Certain witnesses preferred the USPSTF's approach, because it examined data subsequent to 2016 (the date of its last review), without re-evaluating the older RCTs.[60] Dr. Michelle Nadler, who served as a content expert on the Task Force's working group, supported the way evidence was selected, asserting that the Task Force "must look at the evidence in totality."[61] She also noted the importance of acknowledging bias in studies, including sources of bias in observational studies, and evaluating the data "as systematically and as methodically as possible."[62]

According to Mr. Martin Yaffe, Senior Scientist at the University of Toronto's Sunnybrook Research Institute, modelling is valuable, as it can be used to "extrapolate from what we've learned in the randomized and observational studies."[63] The Task Force commissioned a modelling analysis to examine the benefits of screening, finding very low benefits from screening younger women. These results differ from published modelling done by Mr. Yaffe that found improved breast cancer mortality when the starting age for screening is lowered to 40, as well as when the stopping age is increased to 79 and screening is performed annually. The Task Force and Mr. Yaffe both used the OncoSim tool, which was spearheaded by the Canadian Partnership Against Cancer.[64] As

57 Unlike with experimental studies such as RCTs, in observational studies, researchers do not assign participants into groups. According to the CIHR, *Jargon Buster*, "[a]n observational study, as distinguished from a randomized study, is usually undertaken when it is impossible, impractical, or unethical to have a control group. … Their major disadvantage is that there is no assumption that participants are representative of others with that condition."

58 HESA, *Evidence*, 10 June 2024, 1745 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

59 Ibid.

60 HESA, *Evidence*, 13 June 2024, 1225 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual); HESA, *Evidence*, 6 December 2023, 2030 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual); and HESA, *Evidence*, 13 June 2024, 1155 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

61 HESA, *Evidence*, 10 June 2024, 1710 (Dr. Michelle Nadler, Breast Medical Oncologist and Implementation Scientist, as an individual).

62 Ibid., 1825.

63 HESA, *Evidence*, 13 June 2024, 1225 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual).

64 HESA, *Evidence*, 13 June 2024, 1205 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual); Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations*; and Canadian Partnership Against Cancer, *OncoSim*.

of September 2024, the modelling report prepared for the Task Force had not yet been posted.[65]

Dense Breasts Canada contends that the Task Force ignored relevant evidence on supplemental screening for women with dense breasts. The organization states that the Task Force relied on the USPSTF's review on this topic rather than completing an independent review, that the team engaged by the Task Force to review the evidence lacked breast cancer screening experts and that the Task Force diminished the value of RCT evidence on supplemental screening using MRI.[66]

Interpretation of Evidence

> **"The decision to participate in breast cancer screening or not should be up to individuals, but to inform that decision, they need accurate, unbiased and accessible information regarding the benefits, limitations and potential harms associated with screening."**
>
> —Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual

Critics of the draft recommendations argued that the Task Force's interpretation of the evidence on breast cancer screening minimized the benefits of screening while overstating the harms. They pointed, for instance, to the inclusion of older RCTs, which may underestimate the mortality benefits when compared with newer studies. Some witnesses also took issue with the fact that the Task Force's discussion tool presented absolute numbers only without also showing relative risks. The tool illustrates the difference between screening and no screening for people in their 40s. The Committee heard that when the difference is expressed as "1 death for every 1,000 women screened" versus "2 deaths for every 1,000 women not screened," the impact tends to be lessened, whereas a stronger impression is made when the difference is expressed as a relative reduction in mortality of 50%. Dr. Gordon noted that "if you multiply that by the number of women in that age group in the country, you'll find there could be 400 to 600 fewer deaths every year in Canada if women in their forties were allowed to

65 Canadian Task Force on Preventive Health Care, "Additional documents," *Breast cancer (update)—draft recommendations (2024)*.

66 Dense Breasts Canada, *Breast Cancer Screening Guidelines Study*, Brief submitted to HESA, 5 July 2024.

attend."[67] By contrast, Dr. Nadler supported the Task Force's use of absolute numbers instead of relative numbers, saying it reflects best practice in risk communication.[68]

Some witnesses said that the benefits of early breast cancer detection, beyond reduction in mortality, had been insufficiently emphasized. According to Breast Cancer Canada, in addition to saving lives, early detection results in less aggressive and less costly treatments with fewer side effects, all of which improves quality of life and alleviates burdens on the health care system.[69] Several witnesses asserted that screening is cost-effective for the health care system.[70] Dr. Seely noted that the cost of treating breast cancer increases sharply depending on the stage of cancer: $30,000 for stage 1 compared to $500,000 for stage 4, on average.[71] Thus, given that screening identifies cancers at earlier stages, it could reduce health system spending on more intensive and costly treatments.

Many witnesses felt that the Task Force had placed inordinate weight on the potential harms of screening, including recalls and overdiagnosis. According to Dr. Seely, any harms related to abnormal recalls (which the Task Force previously called "false positives") "are vastly exaggerated."[72] In the same vein, Dr. Supriya Kulkarni, President of the Canadian Society of Breast Imaging, declared that "[r]ecalls are not harms."[73] She emphasized that women may experience transient anxiety but are generally relieved and grateful to have undergone the testing.

Similarly, several witnesses stated that the Task Force had overestimated the harms caused by overdiagnosis. Overdiagnosis occurs when screening identifies a cancer that would not have caused harm prior to the person's death from another cause. In

---

67 HESA, *Evidence*, 10 June 2024, 1730 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

68 HESA, *Evidence*, 10 June 2024, 1800 (Dr. Michelle Nadler, Breast Medical Oncologist and Implementation Scientist, as an individual). See also Renée Pellerin, *Regarding Canadian Task Force on Preventive Health Care Draft Breast Screening Guidelines*, Brief submitted to HESA, 18 July 2024.

69 Breast Cancer Canada, *Study on Women's Health*, Brief submitted to HESA, 25 March 2024.

70 HESA, *Evidence*, 6 December 2023, 2030 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual); HESA, *Evidence*, 10 June 2024, 1730 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); and HESA, *Evidence*, 13 June 2024, 1230 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual).

71 HESA, *Evidence*, 13 June 2024, 1105 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

72 Ibid., 1155.

73 HESA, *Evidence*, 13 June 2024, 1210 (Dr. Supriya Kulkarni, President, Canadian Society of Breast Imaging).

Dr. Seely's view, it is "a small, acknowledged risk of screening"[74] but one that is less common among women in their 40s, who typically have a longer life expectancy, compared to older women. Dr. Gordon indicated that "[o]verdiagnosis is only important if it leads to overtreatment."[75]

In its brief, the Task Force explained thus the importance of evaluating the harms of screening:

> [M]any [screening] practices do not lead to benefits, and all screening has some harms. This is why it is critical to identify high-quality evidence on whether screening works. Inviting healthy people to undergo screening tests that don't improve health would not be responsible or ethical.[76]

According to the Task Force, the 2024 draft recommendations were based on "very low certainty" evidence, as determined by Grading of Recommendations, Assessment, Development and Evaluation (GRADE) methodology.[77]

In developing its recommendations, the Task Force considered a systematic evidence review on patient values and preferences, which found that "a majority of patients aged 40 to 49 may not weigh the benefits as greater than the harms."[78] Even so, the Task Force further notes that there was variability in the results and a lack of data for racially and ethnically diverse populations.

74 HESA, *Evidence*, 13 June 2024, 1155 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

75 HESA, *Evidence*, 10 June 2024, 1720 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

76 Canadian Task Force on Preventive Health Care, *Breast cancer screening guideline and screening concepts from the Canadian Task Force on Preventive Health Care*, Brief submitted to HESA, 14 February 2024.

77 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*.

78 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*.

Diversity, Equity and Inclusion

> **"While acknowledging the influence of race, ethnicity, family history and breast density, the task force has minimized these important individualizing issues."**
>
> —Dr. Shiela Appavoo,
> Chair, Coalition for Responsible Healthcare Guidelines

Several witnesses affirmed that the Task Force's draft recommendations fail to sufficiently account for racial or ethnic disparities in breast cancer incidence and outcomes. These witnesses decried such a one-size-fits-all approach, given that non-white women are more likely to be diagnosed with breast cancer before 50 and that Black women in their 40s have a higher mortality rate. In the older RCTs on breast cancer screening, 98% of the participants were white. According to Dr. Shiela Appavoo, Chair of the Coalition for Responsible Healthcare Guidelines, disregard for such racial imbalances in research represents a form of "systemic racism."[79] Dr. Kulkarni also pointed to a perceived failure to consider diversity:

> Canada's evolving ethno-racial landscape has been systematically excluded by task force recommendations, which are still predominantly based on older studies involving white women. The data is not fully representative of our population, leading to recommendations that might not be applicable, beneficial or safe for everyone.[80]

Furthermore, some witnesses criticized the draft recommendations for taking insufficient account of evidence on women with dense breasts or those at elevated or high risk for breast cancer, arguing that these groups should receive separate guidance.[81] Lack of guidance in these areas may contribute to variation in practices across provinces and territories. Jacques Simard, Professor in the Department of Molecular Medicine at Université Laval, observed, for instance, that "[t]here are no national guidelines for screening individuals deemed high risk. Screening protocols vary across jurisdictions, and the definition of high risk of developing breast cancer also varies across Canada."[82] Additionally, Mr. Simard noted that women are generally identified as high-risk based on

79 HESA, *Evidence*, 10 June 2024, 1750 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines).

80 HESA, *Evidence*, 13 June 2024, 1210 (Dr. Supriya Kulkarni, President, Canadian Society of Breast Imaging).

81 HESA, *Evidence*, 13 June 2024, 1150 (Kelly Wilson Cull, Director, Advocacy, Canadian Cancer Society).

82 HESA, *Evidence*, 6 December 2023, 1950 (Jacques Simard, Full Professor, Department of Molecular Medicine, Université Laval, as an individual).

an assessment of family history, followed by testing for BRCA1 and BRCA2 gene mutations. Such an approach, he cautioned, risks overlooking women who have a genetic predisposition to breast cancer without a known family history, as well as those who are at high risk owing to a combination of other factors.[83]

Bias

Certain witnesses alleged that the Task Force is biased against screening. Dr. Appavoo saw the Task Force's stance on screening for women aged 40 to 49 as "seemingly predetermined,"[84] given that its leadership had, before the start of the evidence review, stated in the media that the guideline needed no change. Dr. Seely theorized that this bias might arise from a mistaken belief that treatment can resolve all cancers, regardless of the stage.[85] According to the Task Force, its members "are vetted to ensure neutrality in assessing evidence and developing recommendations; they do not have ties to industry or specialty organizations, nor financial conflicts of interest."[86]

Shared Decision-Making

The Committee heard that the Task Force strongly influences the practices of family physicians and that a recommendation against routine screening of women in their 40s could discourage these physicians from referring a woman for screening, even if she wishes to be screened. The Task Force draft recommendations state that "those who want to be screened after being informed of the benefits and harms should be offered screening every 2 to 3 years."[87] The testimony highlighted problems with such shared decision-making approaches, including the uneven power dynamic between doctors and patients and knowledge gaps among some physicians. Several authors of briefs related their experiences as patients requesting screening from their doctors and being denied or discouraged.[88] Currently, not all provinces allow women to self-refer, and lack of

83 Ibid.

84 HESA, *Evidence*, 10 June 2024, 1715 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines).

85 HESA, *Evidence*, 13 June 2024, 1135 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

86 Canadian Task Force on Preventive Health Care, *Breast cancer screening guideline and screening concepts from the Canadian Task Force on Preventive Health Care*, Brief submitted to HESA, 14 February 2024.

87 Canadian Task Force on Preventive Health Care, *Breast cancer (update)—draft recommendations (2024)*.

88 Natalie Kwadrans, *2024 Draft Breast Screening Guidelines*, Brief submitted to HESA, 9 June 2024; Cheryl White, *Breast Cancer Screening Guidelines*, Brief submitted to HESA; and Jennifer Borgfjord, *How Canada's Current Breast Cancer Screening Recommendations "Harmed" Me*, Brief submitted to HESA.

access to a family physician can pose an additional obstacle to screening. Such barriers can exacerbate disparities experienced by racialized, marginalized or underserved groups, as well as women with dense breasts and carriers of BRCA gene variants.

Expert Input

> **"Our task force has been looked at as the gold standard. Why is it the gold standard if experts don't agree with the guidelines? Why is it the gold standard if provinces are doing their own thing and not doing what the guidelines are saying?"**
>
> —Dr. Anna N. Wilkinson,
> Doctor of Medicine, as an individual

Criticisms were levelled against the Task Force's process for incorporating expert input in its guideline development. Task Force members are experts in primary care and prevention, not breast cancer. Four content experts joined its working group for the breast cancer screening update: a medical oncologist, a radiation oncologist, a radiologist and a surgical oncologist. These experts do not vote on the recommendations and must sign a confidentiality agreement, a requirement that deterred at least one expert from serving on the working group, for fear of being unable to speak freely if he disagreed with the recommendations.[89]

The Task Force noted that it sought external input in numerous ways. In addition to turning to content experts on the working group, it solicited feedback from various sources on key documents and posted the draft recommendations for public consultation.[90] Several witnesses nonetheless voiced concerns over the Task Force's perceived dismissal of expert guidance, such as advice that it should exclude outdated RCTs or consider RCT evidence on the benefits of supplemental screening with MRI for women with dense breasts.

89 HESA, *Evidence*, 13 June 2024, 1230 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual).

90 Canadian Task Force on Preventive Health Care, *Breast cancer screening guideline and screening concepts from the Canadian Task Force on Preventive Health Care*, Brief submitted to HESA, 14 February 2024.

The testimony underscored the differences between what the Task Force has recommended and what experts would advise. Several witnesses recommended the following measures as optimal screening practices:

1) Risk assessment beginning at age 25–30 and revisited every few years.

2) Screening average-risk women 40–49 annually by self-referral.

3) Screening women 50 and older every 1 to 2 years for as long as they are in good general health, with a life expectancy of 10 years [including women over the age of 74].

4) Supplemental screening if an individual has category C or D density.[91]

Timeliness, Accountability and Transparency

The Committee heard that the Task Force guideline development process lacks timeliness, accountability and transparency. With respect to timeliness, the previous two updates of the breast cancer screening guideline occurred every seven years or so. This time interval means that the guideline may not always reflect the latest evidence. Kimberly Carson, Chief Executive Officer of Breast Cancer Canada, recommended that the guideline be updated every two years, to keep pace with new treatments and technological advances.[92]

Some witnesses observed that the Task Force lacks sufficient oversight.[93] In the words of Dr. Appavoo,

> [u]nfortunately, there is no accountability structure. Because it's at arm's length, there's no way to fix the guidelines that are wrong, and there's no way to update any sooner than they feel like updating, so we have guidelines sitting there that are very outdated, dating back to 2012 and 2013.[94]

91 Paula Gordon et al., *Expert Recommendations for Breast Cancer Screening in Canada*, Brief submitted to HESA, 10 June 2024.

92 HESA, *Evidence*, 10 June 2024, 1710 (Kimberly Carson, Chief Executive Officer, Breast Cancer Canada).

93 Dense Breasts Canada, *Breast Cancer Screening Guidelines Study*, Brief submitted to HESA, 5 July 2024; HESA, *Evidence*, 6 December 2023, 2025 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); and HESA, *Evidence*, 10 June 2024, 1810 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines).

94 HESA, *Evidence*, 10 June 2024, 1810 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines).

Additionally, the Committee heard that the Task Force currently has no way of tracking the impact of recommendations and making adjustments. According to Dr. Gordon, "[t]he Canadian task force is an arm's-length body with no accountability and no requirement to monitor the impact of their guidelines."[95]

Speaking from experience, Dr. Wilkinson declared that she had "not seen transparency to date"[96] from the Task Force. She noted that, during her time as an expert with the evidence review group, it was unclear how the Task Force decided generally on what evidence to include as part of its review and specifically how it had obtained the overdiagnosis estimate used in the 2018 guideline. Dense Breasts Canada raised other concerns around transparency, such as the inability of content experts and patient representatives on the working group to vote on the recommendations; the impossibility for expert participants to revoke signatures on nondisclosure agreements, even when they disagree with the recommendations; and the release of the 2024 draft recommendations without a report on the modelling methods used to inform the recommendations.[97]

Reforms

Many witnesses expressed the opinion that, if left unchanged, the Task Force's draft guidance on breast cancer screening would discourage screening for those who might benefit, particularly racialized women in their 40s, leading to delayed diagnoses, more aggressive and costly treatments, diminished quality of life and loss of life.[98] As such, and because serious concerns have also been raised over other Task Force guidelines,

95 HESA, *Evidence*, 6 December 2023, 2000 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada).

96 HESA, *Evidence*, 6 December 2023, 2045 (Dr. Anna N. Wilkinson, Doctor of Medicine, as an individual).

97 Dense Breasts Canada, *Breast Cancer Screening Guidelines Study*, Brief submitted to HESA, 5 July 2024.

98 HESA, *Evidence*, 10 June 2024, 1715 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines); HESA, *Evidence*, 13 June 2024, 1240 (Dr. Supriya Kulkarni, President, Canadian Society of Breast Imaging); HESA, *Evidence*, 13 June 2024, 1220 (Martin Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto, as an individual); HESA, *Evidence*, 10 June 2024, 1720 (Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia, Dense Breasts Canada); and HESA, *Evidence*, 6 December 2023, 2005 (Jennie Dale, Co-founder and Executive Director, Dense Breasts Canada).

notably on prostate, lung and cervical cancer screening,[99] Dr. Appavoo called for the guideline process to be reformed or for the Task Force itself to be rebuilt:

> Ultimately, we can make any fix to any individual guideline we want, but the problem will happen again and again and again, because the problem is fundamental to the structure and the accountability of the task force.[100]

BARRIERS TO SCREENING

Beyond the guideline, some witnesses also touched upon barriers to breast cancer screening in Canada. These barriers are disproportionately experienced by racialized, Indigenous, rural and remote communities. Certain key barriers—namely, lack of capacity, lack of public awareness and access, and a need for further data and research—are outlined below.

Screening Capacity

An expansion of routine breast cancer screening programs would necessitate increased capacity for screening. According to Ciana Van Dusen, advocacy manager at the Canadian Cancer Society, "[i]t is important to increase capacity to meet people's needs in Canada, while taking into account the needs of underserved populations."[101]

Indeed, the Committee heard about current resourcing challenges. Dr. Kulkarni, for example, spoke of "horrendous" wait times in the present system and the impossibility of expanding ultrasound screening, given current capacity issues.[102] To accommodate such a potential increase in demand, the Canadian Association of Radiologists recommends building up the necessary infrastructure, including equipment, technology and radiology human resources.[103]

---

99 HESA, *Evidence*, 10 June 2024, 1810 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines); and HESA, *Evidence*, 13 June 2024, 1200 (Dr. Jean Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa, as an individual).

100 HESA, *Evidence*, 10 June 2024, 1810 (Dr. Shiela Appavoo, Chair, Coalition for Responsible Healthcare Guidelines).

101 HESA, *Evidence*, 13 June 2024, 1115 (Ciana Van Dusen, Advocacy Manager, Prevention and Early Detection, Canadian Cancer Society). See also Canadian Cancer Society, *Breast Cancer Screening*, Brief submitted to HESA, June 2024.

102 HESA, *Evidence*, 13 June 2024, 1245 (Dr. Supriya Kulkarni, President, Canadian Society of Breast Imaging).

103 Canadian Association of Radiologists, *Response to the Canadian Task Force on Preventive Healthcare's Draft Guidelines on Breast Imaging*, Brief submitted to HESA.

Awareness and Access

Not everyone who is eligible participates in breast cancer screening. Data from the Canadian Partnership Against Cancer indicate that, prior to the pandemic, breast cancer screening programs were below the national objective of 70% participation.[104] Lower levels of participation may be related to lack of public awareness and access. In its brief, the Canadian Association of Radiologists highlighted the federal government's role in promoting breast cancer screening.[105] According to Dr. Kulkarni, more funding should go to public education on screening.[106]

Evidence from the Canadian Cancer Society emphasized the importance of meeting the needs of communities who face greater barriers to accessing and participating in breast cancer screening, notably Black, First Nations, Inuit, Métis, racialized, low-income, rural, remote and 2SLGBTQI+ communities.[107]

Data Collection and Research

The Committee heard about the importance of continued investment in data collection and research on breast cancer, to inform screening, diagnosis and care. Witnesses stressed the need to fill gaps in data and research, noting in particular the importance of data disaggregated by ethnicity.[108] According to the Canadian Association of Radiologists, addressing such gaps is essential for informed decision-making.[109] The Task Force's draft recommendations themselves note a lack of evidence in several areas,

104 HESA, *Evidence*, 13 June 2024, 1115 (Ciana Van Dusen, Advocacy Manager, Prevention and Early Detection, Canadian Cancer Society).

105 Canadian Association of Radiologists, *Response to the Canadian Task Force on Preventive Healthcare's Draft Guidelines on Breast Imaging*, Brief submitted to HESA.

106 HESA, *Evidence*, 13 June 2024, 1245 (Dr. Supriya Kulkarni, President, Canadian Society of Breast Imaging).

107 HESA, *Evidence*, 13 June 2024, 1115 (Ciana Van Dusen, Advocacy Manager, Prevention and Early Detection, Canadian Cancer Society); and Canadian Cancer Society, *Breast Cancer Screening*, Brief submitted to HESA, June 2024.

108 HESA, *Evidence*, 13 June 2024, 1115 (Ciana Van Dusen, Advocacy Manager, Prevention and Early Detection, Canadian Cancer Society); HESA, *Evidence*, 10 June 2024, 1735 (Kimberly Carson, Chief Executive Officer, Breast Cancer Canada); HESA, *Evidence*, 10 June 2024; and Canadian Association of Radiologists, *Response to the Canadian Task Force on Preventive Healthcare's Draft Guidelines on Breast Imaging*, Brief submitted to HESA.

109 Canadian Association of Radiologists, *Response to the Canadian Task Force on Preventive Healthcare's Draft Guidelines on Breast Imaging*, Brief submitted to HESA.

including on the benefits of supplemental screening and on outcomes for racialized and ethnically diverse populations.[110]

CONCLUSION AND RECOMMENDATIONS

The Committee recognizes the devastating impact that breast cancer has on those diagnosed with the disease and their loved ones. A national, high-quality guideline for breast cancer screening, based on the most up-to-date evidence, can help provinces and territories develop optimized screening programs, as well as assist primary care physicians and patients in making informed decisions about screening. This guideline should not create confusion or add barriers to screening. The serious concerns raised by the witnesses about the Task Force's 2024 draft recommendations on breast cancer screening must therefore be urgently addressed.

More broadly, it is imperative that any concerns regarding the Task Force's guideline development process be adequately investigated and resolved. Finally, barriers to breast cancer screening in Canada should be eliminated.

Therefore, the Committee reaffirms the report it presented to the House of Commons on 19 June 2024 and makes the following additional recommendations:

Recommendation 1: Rebuilding the Task Force

That the Government of Canada, in consultation and collaboration with specialty societies, specialist physicians, primary care providers, patients and allied scientists, as needed, work toward rebuilding a Canadian Task Force on Preventive Health Care that has:

- **an appropriate governance and accountability structure;**
- **full and appropriate transparency;**
- **ethics oversight;**
- **content-expert leadership with methodologist assistance; and**
- **respect for academic freedom.**

110 Canadian Task Force on Preventive Health Care, *Breast cancer (update) – draft recommendations (2024)*.

Recommendation 2: External Expert Review of the Task Force

That the Public Health Agency of Canada accelerate the External Expert Review that will examine the processes and parameters of the Canadian Task Force on Preventive Health Care and provide recommendations to improve the Task Force to ensure a timely response to emerging needs and expectations of Canadians.

Recommendation 3: Consultation on the Task Force

That the Government of Canada consult with the medical community and other stakeholders on:

- **the selection of the members of the Canadian Task Force on Preventive Health Care;**
- **the integration of specialists into the Canadian Task Force on Preventive Health Care;**
- **increased transparency in the process for developing recommendations; and**
- **enhanced accountability to the Canadian public;**

and that the recommendations flowing from this consultation be presented to the House of Commons Standing Committee on Health and to Parliament within one year of the close of the consultation.

Recommendation 4: Expert Review of Guidelines

That the Chief Public Health Officer convene with senior provincial and territorial officials and key experts to review the breast cancer screening guidelines of the Canadian Task Force on Preventive Health Care and to share their best practices.

Recommendation 5: Monitoring Outcomes of Guidelines

That the Government of Canada work with Statistics Canada and the relevant content experts to implement measures to audit outcomes associated with the recommendations of the Canadian Task Force on Preventive Health Care.

Recommendation 6: Responsiveness

That the Government of Canada implement a process for developing more frequent updates to guidelines that would be responsive to the rapid evolution of the areas of breast cancer detection and treatment.

Recommendation 7: Up-to-Date Modelling

That the Government of Canada immediately work with Statistics Canada and the Canadian Partnership Against Cancer to ensure that the OncoSim cancer models are updated with respect to accuracy and relevance.

Recommendation 8: High-Risk Programs

That the Government of Canada, in consultation and collaboration with specialty societies, specialist physicians, primary care providers, patients and allied scientists, work with provinces and territories to implement at the soonest possible date a process for developing guideline recommendations for women who are at higher-than-average risk for developing breast cancer and provide funding for high-risk programs.

Recommendation 9: Data Collection

That the Government of Canada work with Statistics Canada and/or provincial and territorial agencies to provide resources to ensure that data on breast cancer are collected on a more granular basis with respect to ethnic and racial factors, breast density, mode of detection of breast cancer, stage, characteristics of disease and recurrences.

Recommendation 10: Public Health Awareness Campaigns

That the Government of Canada, in consultation and collaboration with the provinces, territories and Indigenous peoples, work with the Public Health Agency of Canada:

- **to rapidly develop and swiftly implement public health awareness campaigns promoting the value of screening and providing accurate, accessible information to physicians and the public on both the benefits and limitations of breast cancer screening; and**

- **to rapidly develop and swiftly implement public health awareness and education strategies specifically targeting adolescent and young adult women, Indigenous and racialized communities, as well as the health care professionals who serve them, to address knowledge barriers**

regarding early detection and reduce disparities in the stage at which breast cancer is diagnosed in women.

Recommendation 11: Research Investments

That the Government of Canada invest funding to improve breast cancer research.

Recommendation 12: Appropriate Funding

That the Government of Canada ensure that the provinces and territories receive appropriate levels of funding, through increases in Canada Health Transfer payments and/or by other means, to enable them to:

- **enhance breast cancer screening programs;**
- **allow women who are 75 or older to continue screening for breast cancer where clinically appropriate;**
- **ensure adequate capacity for breast screening and diagnostic programs and support supplemental screening, which may include MRI, ultrasound, tomosynthesis and contrast-enhanced mammography for people with dense breasts;**
- **provide solutions to access health care providers through screening programs and offer support to people without a regular health care provider; and**
- **reach communities that are underserved.**

Recommendation 13: Investment in Health Human Resources

That the Government of Canada ensure appropriate funding to the provinces and territories through increases in Canada Health Transfer payments to enable them to invest in health human resources.

APPENDIX A: BREAST CANCER SCREENING GUIDELINES, TWENTIETH REPORT, STANDING COMMITTEE ON HEALTH, 1ST SESSION, 44TH PARLIAMENT

BREAST CANCER SCREENING GUIDELINES

That the committee report to the House that the decision by the Canadian Task Force on Preventive Health Care should be immediately reversed and breast cancer screening should be extended to women in their 40s, as this will help save lives; that the Minister of Health urge the task force to go back to the drawing board and revisit the guidelines based on the latest science; and that the Public Health Agency of Canada table to this committee the parameters given to the task force to update breast cancer screening guidelines.

A copy of the relevant Minutes of Proceedings (Meeting No. 123) is tabled.

Respectfully submitted,

Sean Casey
Chair

Source : House of Commons Standing Committee on Health, *Breast Cancer Screening Guidelines*, Twentieth Report, 1st Session, 44th Parliament, June 2024.

APPENDIX B: RECOMMENDATIONS FROM THE 2022 EVALUATION OF THE CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE

RECOMMENDATIONS

A number of lines of evidence were reviewed as part of the evaluation, including files and documents, performance data and data from interviews with internal and external key informants. As a result, three recommendations emerged.

Recommendation 1: Explore ways to improve the timeliness of the guideline development process.

The Task Force has committed to producing three guidelines per year; however, it has not met this target since 2018. Several factors have affected the Task Force's ability to produce its guidelines, including the sudden death of the incoming Chair, turnover at GHGD [Global Health and Guidelines Division], increased workloads, and Task Force members' and GHGD staff's involvement in the COVID-19 pandemic response. Other factors affecting the timeliness of guidelines included an inability of some Task Force members to volunteer due to a lack of remuneration, too many internal reviews, too many meetings, and the length of time it took to draft scoping questions. PHAC [Public Health Agency of Canada], in consultation with the Task Force, should continue to explore ways to improve the timeliness of the guideline development process to ensure it meets its goal of producing three guidelines a year.

Recommendation 2: Given challenges, explore potential changes to address funding issues and adapt the Task Force funding model appropriately:

- Examine potential compensation for Task Force members, which may help to diversify its current composition.
- Examine ways to prioritize or optimize activities within available funding.

The lack of compensation for members affects the Task Force's ability to recruit new members. Without such compensation, some health care professionals such as rural and remote physicians are unable to participate. The lack of compensation has also limited the amount of time that members can devote to Task Force activities, affecting overall timeliness.

PHAC is the sole funder of Task Force activities and most interviewees felt it should remain so, as it helps to avoid the possibility that outside organizations could compromise the independence of the Task Force. At the same time, funding amounts have remained largely unchanged while salaries and planned activities have increased because of efforts to increase awareness and use of the guidelines as well as involve the public as part of the guideline development process. This has resulted in Task Force partners (ERSCs [Evidence Review and Synthesis Centres] and the Knowledge Translation program) needing to reduce certain activities and cut the number of employees they can retain.

Recommendation 3: Clarify PHAC's role versus that of the ERSCs with respect to scoping and conducting systematic reviews.

While roles and responsibilities were clearly outlined in Task Force documents such as the Methods Manual; there continued to be some confusion around PHAC's role versus that of the ERSCs. PHAC works closely with the ERSCs, providing scientific and technical support; however, there is a lack of clarity around PHAC's role in scoping and conducting systematic reviews. For some, this role was clear, but others felt PHAC was too involved in the reviews that were seen as an ERSC responsibility.

Source: Office of Audit and Evaluation, Public Health Agency of Canada, *Evaluation of Canadian Task Force on Preventive Health Care*, December 2022.

APPENDIX C: STATEMENT FROM THE MINISTER OF HEALTH IN RESPONSE TO THE CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE

STATEMENT ON BREAST CANCER SCREENING GUIDELINES

I would like to thank the work of the Canadian Task Force on Preventive Health Care for the updated draft breast cancer screening guidelines.

The Task Force is an independent panel created to design national preventive health care guidelines. The purpose of these national guidelines is to provide clear leadership to health care providers.

However, while this process has been independent, I have serious concerns about the Task Force's findings. It is critical that these guidelines provide the best guidance to both Canadians and our health care system. Therefore, I am taking the following steps:

First, I am inviting leading experts on breast cancer to carefully review the draft guidelines and to share their critical analysis during the consultation period. I've called for an extension of the public consultation period with stakeholders from 6 weeks to a minimum of 60 days, so that everyone can contribute on this deeply important issue.

Secondly, I have asked the Chief Public Health Officer to convene the senior provincial and territorial officials and key experts to review the guidelines and to share their best practices.

The Task Force has identified important research gaps and uncertainties that we will address urgently through the following.

- I have directed the Canadian Institute for Health Research (CIHR) to work with the Chief Public Health Officer, Canada's Chief Science Advisor, officials at Women and Gender Equality Canada as well as key partners to figure out what the research gaps are.

- I have instructed Public Health Agency of Canada (PHAC) to increase support to community organizations to raise awareness on breast cancer screening, empowering women, particularly women with ethnicities at higher risk, to make informed decisions about their health care.

- I have asked Statistics Canada to accelerate the next phase of analysis of disaggregated data, including race and age.

Lastly, I also asked PHAC to accelerate the launch of the external expert review that will examine the processes of the Canadian Task Force on Preventative Health Care and provide recommendations to improve the process for the Task Force to ensure that we are responding in a timely manner to emerging needs and expectations of Canadians.

It is important that Canadians trust the process of public health guidance. Public health guidance must protect Canadians. That is why I am taking these actions today to make sure that Canadians have the resources they need to keep themselves and their loved ones safe and healthy.

The Honourable Mark Holland
Minister of Health

Source: Mark Holland (@markhollandlib), "Statement on breast cancer screening guidelines," X, 30 May 2024, 1:58 p.m.

APPENDIX D: RESPONSE OF THE PUBLIC HEALTH AGENCY OF CANADA TO THE MOTION DATED 13 JUNE 2024 OF THE HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH

RESPONSE TO JUNE 13, 2024 HESA [HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH] MOTION

Study of Breast Cancer Screening Guideline

Motion:

That, given that the federally created Canadian Task Force on Preventive Health Care decided not to lower the breast cancer screening age guidelines, and that, Breast Cancer Canada said it was "deeply concerned" by the task force's guidelines, and so were the majority of witnesses, the committee report to the House that the decision by the Canadian Task Force on Preventive Health Care should be immediately reversed and breast cancer screening should be extended to women in their 40s, as this will help save lives; that the Minister of Health urge the task force to go back to the drawing board and revisit the guidelines based on the latest science; and that the Public Health Agency of Canada table to this committee the parameters given to the task force to update breast cancer screening guidelines.

Response:

*Note: this response is specific to the highlighted section of the motion above.

The Canadian Task Force on Preventive Health Care (Task Force) is an independent arms-length body of up to 15 clinicians and methodologists. Given the arms-length and independent nature of the Task Force, PHAC does not provide parameters for the development of clinical screening guidelines, including the update to the breast cancer screening guideline draft recommendations.

APPENDIX E:
LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

BREAST CANCER SCREENING GUIDELINES

Organizations and Individuals	Date	Meeting
As an individual	2024/06/10	122
Dr. Michelle Nadler, Breast Medical Oncologist and Implementation Scientist		
Breast Cancer Canada	2024/06/10	122
Kimberly Carson, Chief Executive Officer		
Coalition for Responsible Healthcare Guidelines	2024/06/10	122
Dr. Shiela Appavoo, Chair		
Dense Breasts Canada	2024/06/10	122
Dr. Paula Gordon, Volunteer Medical Advisor, Clinical Professor at University of British Columbia		
As an individual	2024/06/13	123
Dr. Jean M. Seely, Professor of Radiology, Faculty of Medicine, University of Ottawa		
Martin J. Yaffe, Senior Scientist, Sunnybrook Research Institute, University of Toronto		
Canadian Cancer Society	2024/06/13	123
Ciana Van Dusen, Advocacy Manager, Prevention and Early Detection		
Kelly Wilson Cull, Director, Advocacy		
Canadian Society of Breast Imaging	2024/06/13	123
Dr. Supriya Kulkarni, President		

APPENDIX F:
LIST OF WITNESSES (WOMEN'S HEALTH)

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

Committee Meeting No. 111—HESA (44-1)—Thursday, April 18, 2024

That the committee proceed to the study of breast cancer screening following the study on the opioid epidemic and toxic drug crisis in Canada; that the evidence and documents received as part of the women's health study be also considered in the committee's study of breast cancer screening […].

Women's Health

Organizations and Individuals	Date	Meeting
Canadian Institutes of Health Research	2023/11/27	91
Tammy Clifford, Acting President		
Angela Kaida, Scientific Director, Institute of Gender and Health		
Department of Health	2023/11/27	91
Ed Morgan, Director General, Policy, Planning and International Affairs Directorate		
Cindy Moriarty, Director General, Health Programs and Strategic Initiatives		
Suki Wong, Director General, Mental Health Directorate		
Public Health Agency of Canada	2023/11/27	91
Annie Comtois, Executive Director, Centre for Chronic Disease Prevention and Health Equity		
Shannon Hurley, Associate Director General, Centre for Mental Health and Wellbeing		
Mark Nafekh, Director General, Centre for Health Promotion		

Organizations and Individuals	Date	Meeting
As an individual	2023/11/29	92
Dr. Elaine Jolly, Professor Emeritus, Department of Obstetrics and Gynecology, University of Ottawa		
Dr. Fiona Mattatall, Obstetrician Gynaecologist		
EndoAct Canada	2023/11/29	92
Dr. Catherine Allaire, Co-chair		
Kate Wahl, Executive Director		
McGill University Health Centre	2023/11/29	92
Dr. Dong Bach Nguyen, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery		
Dr. Andrew Zakhari, Doctor, Endometriosis - Centre for the Advancement of Research and Surgery		
As an individual	2023/12/06	94
Dr. Steven Narod, Senior Scientist		
Jacques Simard, Full Professor, Department of Molecular Medicine, Université Laval		
Dr. Anna N. Wilkinson, Doctor of Medicine		
Dense Breasts Canada	2023/12/06	94
Jennie Dale, Cofounder and Executive Director		
Dr. Paula Gordon, Doctor		
As an individual	2024/02/12	101
Dr. Gillian Hanley, Associate Professor, Department of Obstetrics and Gynaecology, University of British Columbia		
Dr. Jessica McAlpine, Professor and Division Head, Division of Gynecologic Oncology, University of British Columbia		
Ovarian Cancer Canada	2024/02/12	101
Valérie Dinh, Regional Director, Quebec		
Tania Vrionis, Chief Executive Officer		

Organizations and Individuals	Date	Meeting
The Society of Gynecologic Oncology of Canada	2024/02/12	101
Dr. Shannon Salvador, President-Elect		
As an individual	2024/02/15	103
Dr. Ghadeer Anan, Medical Oncologist		
Dr. Ambreen Sayani, Scientist		
Dr. Andrea Simpson, Obstetrician Gynaecologist, St. Michael's Hospital, Toronto		
Canadian Cancer Society	2024/02/15	103
Rob Cunningham, Senior Policy Analyst		
Helena Sonea, Director, Advocacy		
Ciana Van Dusen, Advocacy Manager, Prevention		
As an individual	2024/04/08	108
Catriona Hippman, Postdoctoral Research Fellow, BC Reproductive Mental Health Program, BC Women's Hospital and Health Centre		
Dr. Ryan Van Lieshout, Associate Professor, Department of Psychiatry and Behavioural Neurosciences, McMaster University		
Simone Vigod, Professor and Head, Department of Psychiatry, University of Toronto, Women's College Hospital		
Québec Alliance for Perinatal Mental Health	2024/04/08	108
Dr. Tina Montreuil, Associate Professor and Scientist, Montreal Antenatal Well-Being Study		
As an individual	2024/04/11	109
Nichole Fairbrother, Clinical Associate Professor, Department of Family Practice, University of British Columbia		
Centre for Addiction and Mental Health	2024/04/11	109
Liisa Galea, Senior Scientist and Treliving Family Chair, Women's Mental Health		

Organizations and Individuals	Date	Meeting
Kawartha Sexual Assault Centre	2024/04/11	109
Jocelyn Enright, Coordinator, Community Engagement, Communications, and Fundraising		
Persons Against Non-State Torture	2024/04/11	109
Linda MacDonald, Co-Founder		
Jeanne Sarson, Co-Founder		
As an individual	2024/05/02	113
Neeru Gupta, Full Professor, Department of Sociology, University of New Brunswick		
Dr. Ruth Ann Marrie, Professor, Department of Internal Medicine, Max Rady College of Medicine, University of Manitoba		
Dr. Deborah Money, Professor and Head, Department of Obstetrics & Gynecology, University of British Columbia		
MS Canada	2024/05/02	113
Pamela Valentine, President and CEO		

APPENDIX G: LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's webpage for this study.

BREAST CANCER SCREENING GUIDELINES

Appavoo, Shushiela

Batt, Sharon

Borgfjord, Jennifer

Canadian Association of Radiologists

Canadian Cancer Society

Canadian Society of Breast Imaging

Dale, Jennie

Dense Breasts Canada

Gordon, Paula

Kearney, Anne

Kwadrans, Natalie

McIntyre, Fiona

McIntyre, Julie

Pellerin, Renée

Porter, Kimberly

Seely, Jean M.

White, Cheryl

Wilkinson, Anna N.

Yaffe, Martin J.

APPENDIX H:
LIST OF BRIEFS (WOMEN'S HEALTH)

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's webpage for this study.

Committee Meeting No. 111 – HESA (44-1) – Thursday, April 18, 2024

That the committee proceed to the study of breast cancer screening following the study on the opioid epidemic and toxic drug crisis in Canada; that the evidence and documents received as part of the women's health study be also considered in the committee's study of breast cancer screening […].

Women's Health

Action Canada for Sexual Health and Rights

Alliance for Gender Justice in Migration

Alzheimer Society of Canada

Amodu, Oluwakemi

Appavoo, Shushiela

Archibald, Maggie

Arthritis Society Canada

Association pour la santé publique du Québec

Bailey, Paul

BC Coalition of Experiential Communities

BC Reproductive Mental Health Program

Beautycounter

BGC Canada

Borgfjord, Jennifer

Breast Cancer Canada

Bridge2Future

Canadian Association of Social Workers

Canadian Cancer Society

Canadian Centre on Substance Use and Addiction

Canadian Chiropractic Association

Canadian Collaborative for Stillbirth Prevention

Canadian Federation of Nurses Unions

Canadian Medical Association

Canadian Menopause Society

Canadian Physiotherapy Association

Canadian Society for the Advancement of Gynecologic Excellence

Canadian Task Force on Preventive Health Care

Caswell, Cathy

Centre for Addiction and Mental Health

Dale, Jennie

Edmonton Zone Medical Staff Association

Egale Canada

EndoAct Canada

Environmental Defence Canada

Farber, Shira

Fédération des Kinésiologues du Québec

Fertility Matters Canada

Filate, Woganee

Fondation Olo

Gordon, Paula

Gupta, Neeru

Hanley, Gillian

Hart, Gaynor

Heart and Stroke Foundation of Canada

Holland, Carolyn

Holness de Hiller, Ariadne

Huntsman, David

King, Regine

Kraft, Rosilene

Kwadrans, Natalie

Ladha, Tehseen

Leader, Arthur

Lehman, Jeanne

Lindeman, Tracey

London Abused Women's Centre

Louis-Bayliss, Amy

Manitoba Interdisciplinary Lactation Center

McAlpine, Jessica

McGill University Health Centre

McKinstry, Nancy

McTeer, Maureen

Menopause Foundation of Canada

Montreal Antenatal Wellbeing Study

MS Canada

Muslim Advisory Council of Canada

Northern Birthwork Collective

Olson, Marj

Olukotun, Mary

Ordre des diététistes-nutritionnistes du Québec

Organon

Ospina, Maria Beatriz

Ovarian Cancer Canada

Persons Against Non-State Torture

Poole, Nancy

Power Stones Jewelry

Québec Alliance for Perinatal Mental Health

Regroupement Les Sages-femmes du Québec

Regroupement pour la Valorisation de la Paternité

Renzaho, Andre

Research and Education for Solutions to Violence and Abuse

Réseau des Centres de Ressources Périnatales du Québec

Richter, Solina

Salami, Bukola

Sandhu, Manvir

Seely, Jean

Sekyi-Otu, Ato

Shaw, Sarah Naomi

Slight, Annie

Society of Obstetricians and Gynaecologists of Canada

Stuart, Gavin

The Endometriosis Network Canada

The Society of Gynecologic Oncology of Canada

Tremblay Dionne, Érick

Tunde-Byass, Modupe

University of British Columbia Perinatal Anxiety Research Laboratory

Van Lieshout, Ryan

Wellington, Craig

Wilcox, Sherry

Wilkinson, Anna

Women's Legal Education and Action Fund

Women's Rights Matter

Woo, Michelle

Yaffe, Martin

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 122 to 125, 128, and 144) is tabled.

Respectfully submitted,

Sean Casey
Chair