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Bill S-5: The Connected Care for Canadians Act

A Policy Analysis of Canada's Healthcare Crisis and Bill S-5

March 2026 | Matthew Trenholm, MSc, Bearing Institute

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Executive Summary

Nearly 24,000 Canadians died last year while waiting for healthcare according to second-opinion analyses of national waitlist data – not during treatment, not after refusing care, but while waiting. Canada spends more on healthcare per capita than nearly all comparable nations, yet delivers some of the worst access metrics in the developed world. This brief argues that Canada's healthcare crisis is structural, not financial, and that Bill S-5 – the Connected Care for Canadians Act – addresses one important symptom while leaving the underlying disease untreated.

Bearing Institute supports the passage of Bill S-5 with amendments. We recommend six specific, table-ready legislative changes that would transform a modest technical fix into a meaningful healthcare reform: a Frontline-to-Administrative Ratio (FAR) tied to transfer conditions, a National Licensing Portability Accord for healthcare credentials, a Fax-Free Canada Sunset Clause, an enforceable patient data rights framework, a patient-directed data segmentation framework, and an AI re-identification risk assessment standard.

Part 1: The Crisis – Plainly, Measurably, and Lethally

According to data from the Canadian Institute for Health Information (CIHI), wait times for surgery and diagnostic imaging continue to exceed pre-pandemic levels across all major procedure categories. Health systems are simultaneously managing an aging population, rapid demand growth, and a deepening workforce shortage – and none of these pressures are new. They were predictable. They were predicted. And they were ignored.

This is not a collection of unfortunate mishaps. It is a slow-motion collapse hiding behind comforting rhetoric.

Table 1: Wait Time Trends by Procedure, 2019–2024

Procedure	Change in Wait Time (2019–2024)	Benchmark Compliance (2024)	Change vs. 2019
Hip Replacement	Median wait increased	68% within 6 months	↓ Deteriorating
Knee Replacement	Median wait increased	61% within 6 months	↓ Deteriorating
MRI Scan	+15 days median wait	No national benchmark	↓ Deteriorating
CT Scan	+3 days median wait	No national benchmark	↓ Deteriorating
Cancer Surgery (avg.)	+1 to +9 days depending on type	Varies by province	↓ Deteriorating
Radiation Therapy	Compliance declined	94% within 28 days	↓ −3 percentage points
Hip Fracture Repair	Compliance declined	83% within 48 hours	↓ −3 percentage points

Source: Canadian Institute for Health Information (CIHI), "Wait Times for Priority Procedures in Canada, 2025." cihi.ca. Note: More procedures are being performed in absolute terms (+26% hip replacements, +21% knee replacements, +16% MRI/CT since 2019), yet benchmark compliance has still declined, indicating demand is outpacing capacity gains.

Part 2: The Spending Paradox – More Money, Worse Access

The spending paradox is stark. According to OECD Health at a Glance 2025 and CIHI's National Health Expenditure Trends 2025, Canada's health expenditures reached a record 12.4% of GDP in 2024, a figure that grew to an estimated 12.7% in 2025.

At approximately $7,301 USD per Canadian, Canada remains a top global spender, yet the system consistently delivers below-average access to physicians, hospital beds, and diagnostic equipment compared to its peers.

Table 2: Canada vs. OECD Averages – Spending and Access

Indicator	Canada	OECD Average	Assessment
Health spending as % of GDP	12.7%	9.3%	↑ Well above average

Indicator	Canada	OECD Average	Assessment
Per capita spending (USD PPP)	$7,301	$5,967	↑ Well above average
Practising doctors per 1,000 population	2.7	3.9	↓ Below average
Hospital beds per 1,000 population	2.5	4.2	↓ Well below average
CT/MRI/PET scanners per million population	26	51	↓ Half the OECD average
Patients reporting unmet healthcare needs	9.1%	3.4%	↑ Nearly 3× worse
Canadians without a primary care provider	6 million+	Comparable peers: <5%	↓ Significant gap

Sources: OECD Health at a Glance 2025, Canada Country Note (oecd.org); CIHI National Health Expenditure Trends 2025 (cihi.ca); BMC Health Services Research, 2025 (pmc.ncbi.nlm.nih.gov/articles/PMC12032375/)

The Paradox in One Sentence

Canada spends $1,334 more per person on healthcare than the OECD average – yet has half the diagnostic imaging equipment, 30% fewer doctors per capita, and nearly three times the rate of unmet healthcare needs. This is not a funding problem. It is a structural and governance failure.

Part 3: What Is Actually Driving the Crisis

3.1 Administrative Bloat

Frontline workers have been warning about this for years. Recent data reinforces this trend. Labour costs for healthcare management and executive positions grew by 52% between 2019 and 2023 – significantly outpacing growth in frontline clinical staffing. At the same time, physicians are increasingly pulled away from patient care: a 2026 joint analysis by the Canadian Medical Association (CMA) and the Canadian Federation of Independent Business (CFIB) found that Canadian doctors lose approximately 20 million hours each year to administrative tasks – the equivalent of removing 9,000 full-time physicians from the system. This is not simply inefficiency. It is capacity being redirected away from care delivery. Without structural constraints, new compliance requirements risk accelerating this trend – adding administrative demand without increasing care capacity.

Critically, as this brief argues below, Bill S-5 risks making this problem worse before it makes it better. Compliance frameworks often create additional administrative demand.

Without a binding frontline-to-administrative ratio, interoperability regulation will generate a new category of “Digital Transformation Coordinators” rather than nurses.

3.1a The Ratio That Disappeared: Original Data from Alberta Health Services

For years, Alberta Health Services (AHS) – Canada’s largest integrated provincial health authority, serving more than 4.5 million Albertans – published an annual breakdown of its workforce by staff category in the Key Financial Trending section of its annual reports. That data, extracted by Bearing Institute directly from eight consecutive AHS annual reports (2014–15 through 2021–22), reveals a consistent and troubling pattern: management grew faster than clinical staff every year across the full period, and clinical staff as a share of total AHS payroll declined for two consecutive years at the end of the series. The data is reproduced below in the form it appeared in AHS’s own public filings.

Table A: AHS Workforce by Category – Calculated FTEs, 2014–15 to 2021–22

Fiscal Year	Clinical FTEs	Management FTEs	Clinical as % of Total	Mgmt Growth vs. Clinical Growth (YoY)
2014–15	47,346	3,809	79.1%	Baseline year
2015–16	47,893	3,891	79.0%	Mgmt +2.2% / Clinical +1.2%
2016–17	48,710	3,944	79.0%	Mgmt +1.4% / Clinical +1.7%
2017–18	50,178	4,074	79.2%	Mgmt +3.3% / Clinical +3.0%
2018–19	51,588	4,215	79.5%	Mgmt +3.4% / Clinical +2.9%
2019–20	52,793	4,334	79.1%	Mgmt +2.8% / Clinical +2.3%
2020–21	54,112	4,489	78.2% ↓	Mgmt +3.6% / Clinical +2.5%
2021–22	55,484	4,672	77.5% ↓	Mgmt +3.9% / Clinical +2.5%

Source: Alberta Health Services Annual Reports, 2014–15 through 2021–22, Key Financial Trending section (workforce by staff category). Clinical FTEs comprise medical doctors, regulated nurses, health technical and professional staff, and unregulated health service providers. Management FTEs reflect positions classified as management in AHS reporting. ↓ denotes year-over-year decline in clinical share of total payroll. Data compiled by Bearing Institute from primary AHS public filings.

Over the eight-year period for which AHS published this breakdown, management grew by 22.7% while clinical staff grew by 17.2%. In the final two reported years – 2020–21 and 2021–22 – clinical staff fell as a share of total AHS payroll for two consecutive

years, reaching 77.5%: lower than at any point in the preceding six years, and lower than it had been under the final year of the previous provincial government. The direction of travel is unambiguous. Using the 2019–20 figures – the last clean pre-pandemic year – clinical FTEs stood at 52,793 against management FTEs of 4,334: a ratio of approximately 12.2:1. This is the ratio AHS itself sustained during its best-performing years. It is the system's own revealed standard of healthy operation, drawn from its own public filings. Bearing Institute recommends Parliament adopt 12:1 as the documented historical baseline and 10:1 as the minimum legislative floor – preserving room for health authorities to operate below the historical ideal while creating a binding structural constraint against the management creep the data documents. But the full picture has since been obscured: beginning with the 2022–23 annual report, AHS removed this staff category breakdown from its public reporting entirely. The clinical-to-administrative ratio – the very metric Bearing Institute recommends Parliament encode in federal transfer conditions – is no longer published by Canada's largest health authority. Parliament is now being asked to pass legislation that will generate significant new compliance obligations, and with them new administrative hiring pressure, with no public mechanism in place to monitor whether the ratio is being maintained or eroded. The case for a binding, publicly reported Frontline-to-Administrative Ratio as a condition of federal transfer payments is not theoretical. It is the lesson of eight years of data that a health authority chose to stop publishing.

3.2 Fragmentation, Archaic Processes, and the Fax Machine Problem

According to Health Canada's own data on Bill S-5, only 29% of primary care providers currently share patient information electronically outside their practice, and fewer than half of Canadians (47%) can access their own health data online. More than 70% of electronic health information is not shared between providers to support integrated care. In 2026, patients are still handed CDs of their imaging files. Fax machines remain widely used in clinical communication.

These are not harmless inefficiencies. They delay diagnoses, slow referrals, waste clinician time, and directly contribute to worse outcomes. This is what institutional stagnation looks like.

3.3 The Workforce Crisis: Data Without Doctors Is Useless

According to CIHI workforce data cited in recent peer-reviewed research, meeting Canada's current physician demand would require a 49% increase in physician numbers nationwide. Healthcare vacancy rates rose from 3% in 2019 to 5.8% in 2024. Nursing vacancies have nearly tripled since 2016.

Interoperable data is only useful if there is a clinician to read it. Bill S-5 improves the pipes. It does nothing about the shortage of plumbers.

3.4 Provincial Credential Barriers: A "Self-Imposed Tariff" on Healthcare Labour

A March 2026 Policy Options analysis identifies interprovincial licensing barriers as one of the most damaging and most fixable inefficiencies in Canadian healthcare. Interprovincial barriers in the services sector – most notably in healthcare – function as an internal tax equivalent to a 40% tariff, according to a recent International Monetary

Fund (IMF) report. The IMF report, co-authored with University of Calgary economist Trevor Tombe, estimates that fully removing these barriers could raise Canada's real GDP by nearly seven per cent – approximately $210 billion – across all sectors.

Individual provinces are beginning to act on their own: Ontario passed automatic credential recognition for 16 additional healthcare professions in October 2025, and BC implemented same-week physician licensing in January 2025. But piecemeal provincial action is not a national strategy. A qualified CT technologist licensed in British Columbia should be able to work in Ontario the next day. Currently, they cannot.

3.5 Population Growth and the Infrastructure Lag

Canada's population grew by more than one million people in 2023 alone – the fastest rate of growth among G7 nations. The federal government set those population targets. It did not set corresponding targets for hospital beds, training seats, or diagnostic equipment. That is not the fault of the people who arrived. It is a failure of planning by the governments that issued the invitations.

This is not a moral judgment about population levels: it is a straightforward infrastructure accounting problem. Demand for healthcare services rose sharply. Capacity planning did not keep pace. The result is predictable and was predicted: waitlists grew, access deteriorated, and outcomes worsened. The appropriate policy response is aggressive infrastructure scaling – more training seats, more beds, more equipment – tied to the population projections that government already publishes. The failure to plan is the story.

3.6 Accountability: Canada Does Not Lack Reports. It Lacks Consequences.

Responsibility lies first with governments that have prioritized optics over outcomes – announcing funding increases while tolerating dysfunction, waste, and poor outcomes. It lies with health authorities that reward managerial expansion while failing to retain frontline staff. And it lies with a political culture that treats healthcare as a sacred talking point rather than a system that must actually work.

Part 4: Bill S-5 – A Necessary Step That Is Not Sufficient

On February 4, 2026, the federal government re-introduced Bill S-5, the Connected Care for Canadians Act (a re-introduction of Bill C-72, which died when Parliament was prorogued in 2024). The bill requires health IT vendors to adopt common interoperability standards and prohibits data blocking. At its core, it addresses one of the most embarrassing structural failures in Canadian healthcare: the inability of different electronic health record systems to share information.

Table 3: Bill S-5 – Strengths, Gaps, and Jurisdictional Risks

Dimension	Assessment	Detail
Data blocking prohibition	✓ Strong	Addresses Competition Bureau Jan. 2026 findings on vendor lock-in practices
Interoperability standards mandate	✓ Strong in principle	Requires common standards for all health IT vendors operating in Canada
Patient data access rights	⚠ Partial	Patients gain access to their own data, but no enforceable portability or format standards specified
Clinical sector support	✓ Broad	CMA, CFNU, SRPC, CDA, College of Family Physicians all endorsed the bill
Compliance timelines	✗ Missing	No binding deadlines specified in the bill; left entirely to future regulation
Specific technical standards	✗ Missing	All standards left to future regulation – bill's impact is contingent on regulatory follow-through
Provincial application	⚠ Patchwork risk	Only applies where provinces lack “substantially similar” legislation; Quebec/Alberta may invoke this
Small clinic cost burden	✗ Unaddressed	No funding mechanism for independent practices to upgrade to compliant systems
Workforce crisis	✗ Out of scope	Bill is silent on physician/nurse shortages; data-sharing alone does not solve staffing
Administrative bloat	✗ Out of scope	No ratio requirements; compliance may generate new administrative roles
Fax machine elimination	⚠ Implied, not explicit	Data blocking is prohibited, but fax-based referrals are not explicitly prohibited or sunset
Preventive health	✗ Out of scope	Entirely reactive; no prevention mandate or investment framework

Sources: Bill S-5 text (parl.ca); McCarthy Tétrault legislative analysis (mccarthy.ca); MLT Aikins analysis (mltaikins.com); Health Canada news release, February 4, 2026 (canada.ca)

What Bill S-5 Gets Right

The bill has genuine strengths that deserve acknowledgment.

First, it directly targets a documented problem. The Competition Bureau flagged data-blocking practices in January 2026: clinics can face long waits, unreadable data dumps, or excessive fees when attempting to switch software providers or access records. Bill S-5 prohibits these practices and creates an enforcement mechanism with monetary

penalties. This is vendor lock-in as a form of corporate bloat that mirrors the government bloat diagnosed elsewhere in this brief. The bill correctly treats it as a structural problem deserving a structural remedy.

Second, the financial case is compelling. Canada Health Infoway estimates that improved health data interoperability could save the country up to $2.4 billion annually – through reduced duplication of tests, fewer medication errors, faster referrals, and more efficient care transitions. Interoperability is not a luxury. It is a prerequisite for a functioning modern health system.

Third, the bill received exceptional cross-sector support. The Canadian Medical Association, Canadian Federation of Nurses Unions, Society of Rural Physicians of Canada, Canadian Dental Association, and College of Family Physicians all endorsed the legislation. This breadth of clinical support is significant and should carry weight in Parliament.

> *"Nurses welcome the Connected Care for Canadians Act as an important step towards greater transparency and patient safety. Fulsome access to patient health data gives nurses the information they need to make safe decisions and reduces unnecessary stress on frontline providers."* – Linda Silas, President, Canadian Federation of Nurses Unions

The Federal-Provincial Trap: The Risk Ottawa Is Not Talking About

Bill S-5 is federal legislation regulating health data – an area of inherently provincial jurisdiction. The bill's architects anticipated this: under its terms, the Act only applies in provinces and territories that do not have "substantially similar" requirements. This is modelled on PIPEDA's approach to provincial privacy law. The practical risk is a patchwork: Quebec and Alberta are the jurisdictions most likely to legislate their own frameworks, potentially with standards lower than or incompatible with the federal model.

There is also a deeper governance risk. Compliance with the bill's requirements – which are largely undefined pending regulation – will require health authorities to hire staff to manage it. Without a binding ratio between frontline staff and administrators, every new compliance obligation becomes a driver of administrative growth. The federal government must not create an "Interoperability Bureaucracy" that adds a new management layer to a system already drowning in them.

> **Bearing Institute Alert**
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> *The "substantially similar" provincial opt-out is Bill S-5's most significant structural vulnerability. Parliament should amend the bill to require provinces that opt out to publicly demonstrate their equivalence through binding annual reporting to Health Canada – not merely to assert it.*

What Bill S-5 Does Not Address

For all its merits, Bill S-5 is a targeted technical fix applied to a systemic crisis. It would be a mistake to treat its passage as meaningful healthcare reform. Here is what it leaves untouched:

- Administrative bloat: The legislation is silent on the proliferating layers of health system management that consume resources without improving patient care. Compliance requirements may worsen this.
- Workforce shortages: No provisions address physician or nursing shortfalls, training capacity, burnout, or the licensing barriers that prevent qualified professionals from working where they are needed.
- Accountability structures: No outcomes-based accountability mechanisms, no consequences for health authorities that fail to meet care benchmarks, and no transparent performance reporting requirements.
- Preventive health: Entirely reactive in focus – the bill addresses how patient data moves through the system, not how to reduce the burden on the system by keeping Canadians healthier.
- Small clinic cost burden: Independent practitioners and small clinics face the cost of upgrading to compliant systems with no funding offset. This risk – unaddressed in the bill – could drive independent practitioners out of the system, further concentrating care in large institutional settings.
- Infrastructure deficits: Canada's hospital bed capacity (2.5 per 1,000 vs. OECD average 4.2) and imaging equipment gaps (26 scanners per million vs. OECD average 51) are entirely unaddressed.

Part 5: The Prevention Case – Healthcare Investment That Actually Saves Money

One area conspicuously absent from the Bill S-5 debate is preventive health. The political culture treats prevention as a rhetorical commitment while budget cycles reward acute care. This is fiscally incoherent.

Government of Canada analysis – Health Canada, "Investing in Prevention: The Economic Perspective" – documents that prevention interventions consistently outperform treatment in cost-per-outcome analysis across major chronic disease categories. A healthier population requires fewer hospital beds, fewer emergency interventions, and fewer specialist referrals. Every dollar not spent on a preventable hospitalization is a dollar available for the structural deficits documented in Part 2.

Table 4: Evidence for the Financial Return on Prevention Investment

Prevention Area	Financial Evidence	Source
Digital interoperability (Bill S-5 scope)	Up to $2.4B annual system savings; 5.6M patient hours saved	Canada Health Infoway
Electronic health records (prior investment)	$1.3B saved over six years; improved chronic disease management	Canada Health Infoway / Parliament
Diabetes prevention (lifestyle modification)	Up to 58% reduction in cumulative incidence; lower long-term hospitalization costs	Health Canada / PHAC
Physical activity / nutrition interventions	All 8 studied interventions found economically efficient in OECD-cited review	Dalziel & Segal / Health Canada
Public health spending (aggregate)	ROI estimates range from 125% to 3,900% depending on intervention type	CPHA / ScienceDirect
Credential recognition investment	$97M federal FCR Action Fund projected to unlock high-productivity healthcare labour	Budget 2025 / Health Canada

Sources: Health Canada (canada.ca); Canada Health Infoway (infoway-inforoute.ca); Canadian Public Health Association (cpha.ca); Budget 2025 / ESDC.

An enforceable patient data rights framework – Recommendation 4 of this brief – is a prerequisite for prevention: a Canadian who cannot access their own longitudinal health record cannot meaningfully engage with the chronic disease trends, screening reminders, or medication histories that prevention depends on.

Part 6: Legislative Recommendations – Amendments You Can Table

The following four recommendations are structured to be immediately actionable as legislative amendments or complementary policy instruments. Each bridges the gap between Bill S-5's technical scope and the structural reforms Canada's healthcare system actually requires.

> **Recommendation 1: Establish a Frontline-to-Administrative (FAR) Ratio**
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> **The Action:** Amend Canada Health Transfer conditions to require health authorities to maintain a minimum 10:1 ratio of frontline clinical staff (physicians, nurses, allied health, diagnostic technologists) to administrative management. This floor is grounded in original data extracted by Bearing Institute from eight consecutive Alberta Health Services annual reports (2014–15 through 2021–22): during the pre-pandemic baseline years, AHS itself maintained a clinical-to-management ratio of approximately 12:1 – the system's own revealed standard of healthy operation. The 10:1 legislative floor preserves room for operational variation while preventing

the management creep the AHS data documents. Health authorities seeking to hire any new administrative position must first demonstrate FAR compliance. Annually published FAR data for every health authority would become a condition of full federal transfer payments.

The Goal: Ensure that implementing Bill S-5 results in better patient care, not a new class of "Digital Integration Coordinators." Every new compliance framework generates administrative demand; this ratio creates a structural counterpressure. In a 2025 restructuring of NHS England, the UK government moved to abolish 18,000 administrative posts and reduce central staffing by 50%, aiming to redirect £1 billion annually from bureaucracy back into frontline surgical capacity – proof that ratio discipline is both possible and effective.

Legislative Anchor: Canada Health Transfer conditions / Canada Health Act amendment

Recommendation 2: Implement a National Licensing Portability Accord for Healthcare Credentials

The Action: In tandem with Bill S-5, the federal government should lead a National Licensing Portability Accord requiring that any healthcare professional (physicians, nurses, medical radiation and imaging technologists, respiratory therapists, allied health) licensed and in good standing in one province be eligible for provisional licensure in any other province within five business days, at no cost beyond administrative filing. The Accord should be a condition of Connected Care funding.

The Goal: Interoperable data is useless if the workforce is trapped behind provincial borders. A qualified CT technologist in BC should be able to work in Ontario the next week. The IMF estimates that provincial services barriers carry the equivalent of a 40% internal tariff. Ontario and BC have already shown this is achievable – Ontario issued 2-day physician certificates starting January 2026; BC licenses inter-provincial physicians within a week. Federal leadership should codify and require what leading provinces are already doing voluntarily.

Legislative Anchor: Connected Care for Canadians Act – s.7 regulations / Canada Health Transfer conditions

Recommendation 3: Add a “Fax-Free Canada” Sunset Clause to Bill S-5

The Action: Add a Sunset Clause to Bill S-5 rendering fax-based transmission of primary diagnostic data, specialist referrals, and discharge summaries ineligible for federal Connected Care funding after January 1, 2028. The 2028 deadline gives institutions 24 months to comply. Institutions in remote or underserved areas may apply for a 12-month extension with a documented compliance plan.

The Goal: Bill S-5 prohibits "data blocking" but does not explicitly eliminate the fax machine. A hard deadline attached to federal funding creates the institutional urgency that voluntary modernization has repeatedly failed to produce. The fax machine is not merely inconvenient – it is a patient safety risk: delayed referrals, illegible transmissions, and lost records all contribute directly to worse outcomes. Naming it is important. Killing it is necessary.

Legislative Anchor: Bill S-5, s.6 (data blocking provisions) – new subsection

Recommendation 4: Establish an Enforceable Patient Data Rights Framework

The Action: Amend Bill S-5 to include an explicit patient data rights clause guaranteeing every Canadian the right to receive a complete, machine-readable copy of their health record within 5 business days of request, at no charge, in a standardized format. Corresponding enforcement

mechanisms should mirror the administrative penalties already established for vendor data blocking.

The Goal: Bill S-5 focuses on vendor-to-vendor and provider-to-provider data sharing, but says relatively little about the patient's own right to access their records in a portable, standardized format. Without this, patients remain passive recipients of a system that manages their data rather than active participants in their own care. An enforceable patient data rights framework closes the accountability gap at the individual level – and aligns Canada with standards already in force in the EU and Australia.

Legislative Anchor: Bill S-5, new Part – Patient Data Rights / connected to PIPEDA patient access provisions

Recommendation 5: Establish a Patient-Directed Data Segmentation Framework

The Action: Amend Bill S-5 to guarantee every Canadian the right to restrict access to specified categories of their health record – including mental health assessments, substance use records, HIV status, and genetic data – on a provider-by-provider basis. Patients must be able to designate which providers may access which record types, with restrictions enforceable against all parties in the interoperable system. Providers lacking patient consent to a restricted record category may not access it, regardless of system interoperability.

The Goal: Interoperability without patient control over data flows is not empowerment – it is exposure. A fully connected system amplifies the risk that sensitive records reach providers with no clinical need for them. A patient in a small community may have legitimate reasons not to share a psychiatric evaluation or HIV diagnosis with every specialist in a shared network. Working legislative models exist: the EU's GDPR, the US 42 CFR Part 2, and Australia's My Health Record all demonstrate that granular patient control is technically and legally achievable. Canada's framework should meet that standard.

Legislative Anchor: Bill S-5, new Part – Patient Data Segmentation / connected to PIPEDA consent provisions

Recommendation 6: Require an AI Re-Identification Risk Assessment Standard for Health Data

The Action: Amend Bill S-5 to require a binding Re-Identification Risk Assessment before any anonymized Canadian health data is processed by an AI system. The assessment must demonstrate that the anonymization standard applied is robust against AI-assisted re-identification – not merely against a "reasonable person" standard written before large language models existed. Assessments must be conducted by an independent qualified reviewer and filed with the Privacy Commissioner prior to AI processing commencing.

The Goal: Bill S-5 explicitly contemplates AI systems analyzing Canadian health data at scale, but treats anonymization as an adequate privacy safeguard without addressing whether current anonymization standards are AI-resistant. They are not. *The rare event problem* is well-documented: a patient record showing a traumatic injury consistent with a 100-foot fall, admitted on a specific date in a specific region, becomes individually identifiable when cross-referenced with a single news report. A bus crash involving students from a named school makes every anonymized record from that trauma event attributable to a finite, nameable pool of people. PIPEDA's existing anonymization standard was written for human adversaries. The EU's GDPR requires a Data Protection Impact Assessment before high-risk data processing; Canada should require the equivalent, calibrated specifically for AI. Without it, Bill S-5's

> interoperability framework creates a larger, more connected dataset that is easier, not harder, to de-anonymize.
> **Legislative Anchor:** Bill S-5, new Part – AI Data Use / Privacy Act amendment / Privacy Commissioner oversight

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Summary: What Bearing Institute Recommends

Recommendation	Mechanism	Timeline	Est. Impact
1. FAR Ratio (10:1 frontline-to-admin; 12:1 historical baseline)	CHT condition / Canada Health Act	Implement by April 2027	Redirects management overhead to patient care
2. National Licensing Portability Accord	Bill S-5 s.7 regulations / CHT condition	5-day licensure by Jan 2027	Mobilizes qualified workforce nationally
3. Fax-Free Canada Sunset Clause	Bill S-5 s.6 amendment	Fax-free by Jan 1, 2028	Eliminates primary referral safety risk
4. Enforceable Patient Data Rights	Bill S-5 new Part – patient rights	In force with S-5 passage	Puts patients in control of their own data
5. Patient-Directed Data Segmentation	Bill S-5 new Part – Patient Data Segmentation	In force with S-5 passage	Gives patients control over who sees sensitive record categories
6. AI Re-Identification Risk Assessment	Bill S-5 new Part – AI Data Use / Privacy Act amendment	Prior to any AI processing of health data	Closes the anonymization gap that AI-scale processing creates

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Conclusion

Bill S-5 is a welcome and overdue correction to one of the most visible inefficiencies in Canadian healthcare. Prohibiting data blocking, requiring interoperable systems, and creating enforcement mechanisms are all reasonable, evidence-based steps. Bearing Institute supports the passage of Bill S-5 – with the six amendments described in this brief.

But Parliament should not mistake this bill for a reform of Canada's healthcare system. The structural crisis – administrative excess, workforce shortfalls, fragmented provincial accountability, chronic underdevelopment of preventive care, and a political culture that rewards announcements over outcomes – will persist after Bill S-5 becomes law.

Ottawa is fixing the pipes while the building burns. Interoperable data is essential. It is not sufficient. Real reform requires the six structural changes this brief recommends: a ratio that protects frontline staff from administrative sprawl; a licensing accord that treats healthcare professionals as a national workforce; a deadline that finally kills the fax machine; a patient data rights framework that places Canadians at the centre of their own care; patient-directed data segmentation that ensures interoperability does not become involuntary exposure; and an AI re-identification standard that closes the gap between privacy rules written for human adversaries and AI systems capable of cross-referencing millions of records simultaneously.

Continuing down the current path is not a neutral choice. It is a lethal one. Canada does not lack studies, reports, or task forces. It lacks consequences for failure. These amendments would begin to change that.

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Matthew Trenholm, MSc, is a co-founder of the Bearing Institute and a published researcher in the Journal of International Health Sciences and Management. He has worked in Canada's busiest emergency room for twenty years.

Bearing Institute is a Canadian public-policy institute focused on legislative research and ready-to-table amendments. Should these observations be useful during third reading debate or Senate consideration of Bill S-5, we would be pleased to provide further analysis.

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