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THE END OF CANADIAN MEDICARE?

Alberta legislation opens the door to U.S. health care

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On December 18, 2025, Alberta became the first province to legislate two-tier health care and private health insurance for medically necessary services. Bill 11 establishes two-tier health care, which is defined as a system that provides faster access to those with the ability to pay privately, and longer public wait times for those who are unable to pay for queue jumping.

This is the latest intervention in the health care system by Danielle Smith's United Conservative government, following a dramatic restructuring of the provincial health authority, transfer of health care facilities' ownership, expansion of for-profit surgical outsourcing, and complex changes to the hospital funding model that create perverse incentives.

Here are 11 things you should know about Alberta's new two-tier health care system—and why it matters for the rest of Canada.

1. Bill 11 legislates two-tier health care in Alberta—the first in Canada

Under Bill 11 (the *Health Statutes Amendment Act*), Alberta is the first province to allow "dual practice" where doctors can work simultaneously in both the public system and the private-pay market. Bill 11 amends the *Alberta Health Care Insurance Act* by creating a new category of doctor or surgeon: "flexibly participating physicians" can charge patients privately while simultaneously maintaining their ability to bill Alberta's public insurance plan. No other province in Canada allows this. Dual practice has been roundly criticized by health policy experts based on the large body of Canadian and international evidence that a two-tier system increases public wait times and creates unequal access based on income.

2. Bill 11 establishes "dual practice" where physicians can work concurrently in the publicly funded system and private-pay market

Bill 11 amends the *Alberta Health Care Insurance Act* and creates a new relationship between doctors and surgeons and the Alberta public insurance plan. Under this dual practice model, "flexibly participating physicians" are those who provide publicly insured health services and "non-plan services." These "flexibly participating physicians" may decide, on a case-by-case basis, whether the service requires the patient to pay out of pocket. While the Alberta government stated that dual practice will be limited to some surgical specialties, the legislation as passed allows all physicians and surgeons to engage in dual practice.

Although flexibly participating physicians must first provide patients with information about the cost of the non-plan service, there is an inherent power imbalance in the doctor-patient relationship. A patient who needs medical care is in a vulnerable position and will feel pressured to pay in order to receive that care, if they have the means. If they do not, they will end up at the back of the line, despite their medical need.

The *Alberta Health Care Insurance Act*, prior to Bill 11 amendments, was similar to legislation in other provinces that requires doctors to un-enroll from the public insurance plan if they want to work in the private-pay market and directly bill patients. Other provinces require physicians to choose whether they are in the publicly funded system or not (in Ontario, physicians can't un-enroll from the public plan). This requirement

maintains a financially viable public system by preventing the movement of physicians to focus their time in the private-pay market.

The bill shrouds these arrangements in the language of "flexibility" for participating physicians, however, a recent investigation by journalist Charles Rusnell found that some Alberta doctors—primarily surgeons and anaesthetists—were being scheduled to work in for-profit, chartered surgical facilities (CSFs) despite their objections. Rusnell's exposé also revealed that CSF shifts were being prioritized over public hospital shifts, at government direction. While the explicit terms of Bill 11 would seem to make this kind of political strong-arming unnecessary, it is equally likely that these tactics will actually intensify under a new system that puts corporations and cabinet—not medical professionals—in control of decision-making.

3. Bill 11 creates Canada's first private insurance market for medically necessary care—driving up health care costs

When dual practice is allowed, it encourages high-income patients to buy private health insurance to cover these new costs. An unrestricted private health insurance market—which Bill 11 creates—is likely to increase health care costs. We can look at the United States to see how much a system dominated by private insurance and profit-taking drives up health care costs for patients, employers, and government. As employers and individuals purchase private health insurance, the profits of private insurers, investor-owned facilities, and their physicians drive up the costs of medically necessary procedures.

As a result, the public insurance plan must pay increasingly more to doctors and investor-owned facilities where they perform services because the cost of the same basket of services is bid up by increasing profits, often disguised as "administrative costs." The result is that health care costs rise rapidly for the government (the public insurance plan), placing a greater burden on public finances. Over time, health care spending increases to excessive levels that often encourage governments to narrow the scope of services that are insured. It's a race to the bottom.

4. The introduction of private payment increases public wait times

Contrary to claims from the Alberta government, Alberta's two-tier system will not reduce public wait times. Rather, the introduction of private payment for publicly insured services will increase public wait times as physicians and surgeons focus their time in the lucrative and less complex private-pay market.

Despite differences in how jurisdictions regulate private financing (i.e. private payment), a large body of Canadian and international research evidence clearly shows that private financing increases wait times for those waiting in the public system. In a comprehensive review of the experiences with private financing in OECD countries, the authors concluded that:

> [P]ublic-sector waiting lists and times are longer in nations with parallel private sectors... A parallel private sector may in fact draw resources out of the public sector and/or put in place incentives that have the effect of increasing waits in the public sector. Waiting lists for publicly financed services are likely to respond to infusions of public, not private, finance.

These findings are consistent with other international analyses (from Australia and the UK), as well as an international evidence synthesis published in the *British Medical Bulletin*, that found little evidence that private financing reduced public waiting times. This large body of evidence showing that private finance increases public wait times formed the basis for the B.C. Supreme Court to reject the legal challenge led by the for-profit Cambie Surgeries Centre to strike down sections of B.C.'s public health care legislation.

5. Bill 11 unbundles hospital care and opens the door for user fees

Bill 11 continues the Alberta government's direction of "unbundling" hospital care into services that are publicly funded (at no cost to the patient) and user-pay services. Under the amended *Alberta Health Care Insurance Act*, the minister can create "approved programs" and "specific programs" that are publicly insured. This likely begins the process of the government determining which acute care programs will be available free of charge to patients and which services that will require user fees.

Bill 11 establishes "non-insured hospital services", in which patients are responsible for paying user fees to the hospital operator (keep in mind with previous changes, hospital operators could be for-profit corporations). The legislation also creates "enhanced goods and services", which patients can be billed for. What are possible "non-insured hospital services" and "enhanced goods and services"? We don't know because the government is withholding this information until it passes the accompanying regulations at a later date.

Further reading: See sections 54 and 57 of the amended Alberta Health Care Insurance Act.

6. Bill 11 muddies the definition of a "hospital" and allows private, for-profit hospital operators

As part of the government's direction of blurring which hospital services are insured/publicly funded and which services might require direct patient fees, the government has muddied the definition of an Alberta hospital. Bill 11 introduces a new form of "hospital services facility" that may be owned and operated by a public, non-profit or for-profit "health services facility operator." Governments engaged in privatization initiatives tend to blur the definitions, so the very essence of public entities lose their meaning and confuse citizens. In Alberta, the government is doing exactly that.

Further reading: See section 45 of the amended Alberta Health Care Insurance Act.

7. Bill 11 encourages the private insurance market with group insurance plans for medically necessary care

Bill 11 adds a new section to the *Alberta Health Care Insurance Act* to allow and encourage group insurance plans for private-pay health services. The major aim of Bill 11 is to encourage the creation of a much larger private health insurance market, likely encouraging existing employer-sponsored insurance plans to expand into medically necessary health care.

Further reading: See section 69 of the amended Alberta Health Care Insurance Act.

8. Bill 11 encourages hospitals to compete for revenue from user fees and private health insurance

The original intent of hospital insurance legislation in every province—and the *Canada Health Act*—was to prevent physicians and facilities from charging patients for necessary medical care. Now the Alberta government is creating health care insurance and provider markets where every patient is seen as a source of revenue.

Bill 11 adds new government powers to "[determine] the operating costs of hospital services facilities" and determine how hospital operating costs must be shared by government and patients. This new language clarifies that the Alberta government intends for hospitals to compete for revenue from patients and private insurers by selling "enhanced" and "non-insured goods and services" in the private-pay market. Bill 11 also allows the government, through regulation (passing a new law is not required), to allow hospital operators to bill patients for "authorized charges" of "non-insured hospital goods and services." It is possible that this will also be a growing source of revenue for private hospital operators, if they are allowed to charge patients for services that were previously publicly funded.

This policy direction builds on previous government reforms, including the transfer of hospital properties and assets from Alberta Health Services to Alberta Infrastructure. At a United Conservative party members-only event in August, Premier Smith spoke of plans where the government retains ownership of the capital assets, but leases them to operators to provide services, which could include private, for-profit entities. Taken together, these reforms suggest that the provincial government will require hospitals to compete with each other for patient revenue from user fees and private insurance, and encourage hospitals to reduce operating costs by reducing their largest expenditure—staffing levels.

Further reading: See section 71 of the amended Alberta Health Care Insurance Act.

9. The threat of U.S. control is real: Alberta's private health care delivery and insurance markets are likely to attract U.S. investors

Under Bill 55, passed in May, the Alberta government previously established the potential for public hospitals to be owned and operated as private, for-profit hospitals. Bill 11 goes further by encouraging health facilities to compete for revenue from private-pay services. These facilities are likely to put pressure on physicians to charge patients directly in order to increase revenue.

The U.S. has the largest for-profit health care provider and insurance markets in the world. The cumulative effect of these reforms—allowing physicians to work in both the public system and private-pay market, encouraging investment in for-profit surgical facilities and hospitals, and building the insurance market for medically necessary health care—is very likely to attract U.S. investment interest. A 2023 CCPA report, At What Cost?, documented U.S. investor interest in provincial surgical outsourcing markets. Alberta's two-tier health system is likely to spur much greater interest, especially if other provinces follow.

Canada's international trade and investment agreements provide limited protection to the entrance of U.S. investors and insurance corporations to the Canadian health care market. Once these corporations enter the Canadian market, they will become entrenched and protected by trade and investment agreements. We will not have U.S.-style health care, we will have U.S. health care.

10. Dual physician practice and the private-pay market require long public waits

The business case for private payment for elective surgeries and other medically necessary services requires long public wait times. Contrary to claims by the Alberta government that the introduction of dual physician practice and private payment will shorten public waits, the private-pay market demands that there are public wait times to attract patients to purchase care. If the government's plans actually achieve shorter public wait times, there is no market for privately financed care. There is a perverse incentive for physicians and surgeons to make their public wait lists longer in order to drum up business for their private-pay work.

11. Bill 11 is at odds with the *Canada Health Act*

The Canada Health Act establishes criteria for provincial health insurance plans that provinces must maintain in order to receive federal health funding. These principles include public administration, comprehensiveness, universality, portability, and accessibility. The amended *Alberta Health Care Insurance Act* (Bill 11) likely violates multiple sections of the *Canada Health Act*, including the principles of universality and accessibility.

"Universality" requires that the provincial health insurance plan must ensure "uniform terms and conditions" for everyone in the province. By encouraging private payment for publicly insured health services, the Alberta government has effectively ended universal health care in the province by encouraging preferential access for medically necessary care through a private-pay market.

Under the *Canada Health Act*, "accessibility" requires that provinces "must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons." Put simply, provincial governments must not introduce measures—like tiered access to publicly insured health services—that establish preferential access for some and impede access for others.

Bill 11 is at odds with the universality and accessibility principles of the *Canada Health Act*, which puts its federal funding in jeopardy. In 2025-26, the Alberta government will receive $6.6 billion through the Canada Health Transfer—about 28 per cent of the $24 billion Alberta health budget. It is likely that the Alberta government is setting up a political and legal confrontation with Ottawa over the *Canada Health Act*, which risks the future of this important legislation.

There is a growing threat if other provinces join Alberta—including Ontario as the largest market—by introducing similar two-tier legislation (Saskatchewan Premier Scott Moe is already signalling that it will follow Alberta). The more provinces that join Alberta, the greater the likelihood that it will lead to the dismantling of the *Canada Health Act* as the federal framework that upholds provincial public health insurance plans. This could end Canadian medicare as we know it.

What's next?

Two-tier health care has clearly arrived in Canada. Bill 11 and dual practice fundamentally reshape the Alberta health care system. Already, the insurance industry is expressing excitement about the door that has opened. There are three things we will be keeping an eye on with the rapidly changing health policy landscape.

First, will the Alberta government—as it has promised—limit, by regulation, which medical and surgical specialities that may engage in dual practice? And will there be any other guardrails limiting how much time doctors and surgeons may spend working in the private-pay market like we see in other jurisdictions? Will the Alberta government transparently report on public wait times by specialty area so we can evaluate the effects of dual practice?

Second, how many will elect to work as "flexibly participating physicians" and will most of them concentrate their private-pay practice in for-profit facilities or also in public hospitals? This will start to paint a picture of the extent to which equitable health care access has been eroded in Alberta.

And finally, will the federal government remain silent on the potential multiple violations of the *Canada Health Act*? Will civil society be compelled to seek a court order to force the federal government to enforce the *Canada Health Act*? We will be seeking answers in coming months to these important questions on the future of Canadian medicare.

This report was created in a collaboration between the Canadian Centre for Policy Alternatives and the Parkland Institute. This report is available free of charge at www.policyalternatives.ca and www.parklandinstitute.ca. The Canadian Centre for Policy Alternatives (CCPA) and the Parkland Institute are independent policy research organizations. This report has been subjected to peer review and meets the research standards of both centres. The opinions in this report, and any errors, are those of the author(s) and do not necessarily reflect the views of the CCPA, the Parkland Institute or funders of the report.

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