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ESNA

March 5, 2026

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The demolition of Alberta's public system

- Bill 11 part of a broader health system reform agenda:
  - AHS restructuring
  - Transfer of health facility ownership
  - Expansion of for-profit surgical outsourcing
  - New hospital funding model with perverse incentives

Bill 11 creates two-tier healthcare

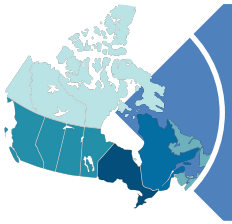
Two-tier health care:

a system that provides faster access to those with the ability to pay privately, and longer public wait times for everyone else

- "Dual physician practice" – MDs can work simultaneously in the public system and the private-pay market
- "Flexibly participating physicians" can provide publicly insured services and "non-plan services"
- MDs can bill the public plan and decide whether to charge patients privately (out-of-pocket or insurance) on a *case-by-case basis*
- Must provide patient with information, but no requirement to report to government which services require private payment
- Perverse incentives *and* more administrative burden

No other province allows this.

Alberta's "dual practice" is unique in Canada



Other provinces: MDs must elect to in the public system or not – and un-enroll from the public insurance plan to directly bill patients.

In Ontario, physicians can't un-enroll from the public plan.

Prevents double billing (public plan & privately), extra billing (patient fees in addition to billing the public plan) and patients paying for preferential access

Quebec requires MDs to work five years in public system before going private due to exodus from the public system

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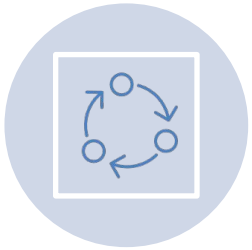
Private payment increases public wait times

- Public sector waiting times are longer in countries parallel private sectors

When you create two systems, you haven't cloned the workers needed to deliver that care - and we already have a staffing crisis.

When a doctor works on a private-pay basis in a for-profit facility, public hospitals are left with more complex cases, fewer staff and resources.



This triggers a negative feedback loop: overloaded staff burn out and turn to private sector in order to improve working conditions and pay.

As resources shift from public hospitals to for-profit providers, public capacity is strained and waits increase for complex procedures. Public sector left with the most complex and resource-intensive cases.

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Dual physician practice requires long public waits

- The business case for private payment depends on long public wait times
- If government's claims of delivering shorter wait times comes true, there is no market for private-pay services and insurance
- There is a perverse incentive for physicians/surgeons and facilities to make their public wait list longer in order to drum up business for their private-pay work

Bill 11 creates Canada's first private insurance market for medically necessary care

(insured physician and hospital services under the *Canada Health Act*)

Encourages high-income patients to buy private health insurance

As employers & individuals purchase private insurance, the profits of private insurers & investor-owned facilities drive up the costs of medical procedures.

The cost of the same basket of services is bid up by increasing profits & "administrative costs"

Costs rise rapidly for the public insurance plan, placing a greater burden on public finances.

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

Private health insurance for medically necessary care

- Bill 11 creates a private health insurance market for medically necessary physician and hospital services

- 3.3 million Albertans already have extended health insurance coverage (CHLIA, 2025)
  - 68 active insurers in Alberta, only three are non-profit

- Growth of private insurance market depends on:
  - Forthcoming regulations
  - How much of the workforce shifts into the private-pay market?
  - Do employer-sponsored plans offer queue-jumping insurance?
  - Is the market unattractive to insurers? (e.g., boycotts)
  - Are hospitals forced to compete with for-profit CSFs for patient revenue via private health insurance? (Yes, it seems…)

Hospitals to compete for revenue from patients

- Bill 11 muddies the definition of a public hospital in Alberta to one that can be operated by for-profit entities

- Intent of hospital insurance legislation in every province—and the *Canada Health Act*—was to prevent physicians and facilities from charging patients

- Bill 11 creates private health care insurance and provider markets where every patient is a source of revenue – selection biased towards healthiest and wealthiest

The threat of US control is real

- Alberta's private health care delivery and insurance markets likely to attract US investors
- We live next to the largest for-profit provider and insurance markets in the world
- 2023 CCPA *At What Cost?* documented US investor interest
- Trade agreements provide limited protection against the entrance of US investors and insurance corporations – once entrenched hard to undo
- We won't have US-style health care, we will have US health care
- An entry point for US control – will this be exploited?

Bill 11 is at odds with the *Canada Health Act* (CHA)

- Likely violates multiple sections of the CHA including universality and accessibility criteria
- "Uniform terms and conditions and on a basis that does not impede or preclude … reasonable access"
- 28% of Alberta health budget at risk if federal health transfer clawed back
- What's next?
  - Bill 11 dual physician practice section has not been proclaimed
  - Will there be any guardrails through regulation?
  - Silence from the federal gov't – will this change?
  - Will civil society be compelled to seek a court order to force federal gov't to enforce the *CHA*
  - Will other provinces follow Alberta?

THANK YOU

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