Emma Phillips
Direct Line: 416.979.4240
Fax: 416.591.7333
ephillips@goldblattpartners.com
Our File No. 26-486

April 30, 2026

Via E-mail (jmaclean@nupge.ca)

Mr. Jason MacLean
Chair
Canadian Health Coalition
2841 Riverside Dr.
Ottawa ON K1V 8X7

Dear Mr. MacLean:

Re: **Opinion re Compliance of Alberta Bill 11 with *Canada Health Act***

On December 18, 2025, Alberta enacted the *Health Statutes Amendment Act, 2025 (No. 2)*,[1] also known as 'Bill 11'. Bill 11 amends the *Alberta Heath Care Insurance Act*[2] by establishing the legal framework for the right of physicians to engage in dual practice—amounting to the most extensive privatization of payment for medically necessary services in Canada since the *Canada Health Act* was enacted in 1984.

You have asked for our opinion as to whether Bill 11 is consistent with the protections and requirements of the *Canada Health Act*, including assessing whether the federal government has grounds to conclude that Bill 11 is inconsistent with the *CHA*. As set out below, in our opinion there are very strong and compelling arguments that Bill 11 violates the *Canada Health Act*.[3]

Bill 11 allows physicians to engage in dual practice, with the result that some patients will be able to access medically necessary services more quickly based solely on their ability to pay. By entrenching "queue-jumping", Bill 11 contravenes the principles of comprehensiveness, accessibility, and universality protected and required by the *Canada Health Act,* and violates the prohibitions against extra-billing and user fees. As the government of Canada submitted in the *Cambie* proceedings, "the longstanding objective of the publicly-funded healthcare insurance system generally, and of the *Canada Health Act*…in particular, has been to ensure equitable access

[1] *Health Statutes Amendment Act, 2025 (No. 2),* SA 2025, c 21. ("Bill 11")
[2] *Alberta Health Care Insurance Act*, RSA 2000, c A-20.
[3] *Canada Health Act*, RSC 1985, c C-6 ("*Canada Health Act*").

to medically required services based on an individual's medical need rather than the ability to pay."[4] The dual practice provisions of Bill 11 erode the core protections and purposes of the *Canada Health Act* to such a degree that it is difficult to imagine what would be left of the *Canada Health Act* if the legislation is allowed to operate.

This opinion is structured as follows:

- Section A provides a summary overview of the key provisions of Bill 11 as these relate to permitting physicians to engage in dual practice and to charging patients privately for providing medically required services;

- Section B outlines the key protections and requirements of the *Canada Health Act*;

- Section C summarizes relevant Minister of Health "interpretation letters" which guide the interpretation of the *Canada Health Act*;

- Section D assesses the extent to which Bill 11 violates the *Canada Health Act* criterion of universality (Section D1), accessibility (Section D2), comprehensiveness (Section D3), and the ban on extra-billing and user fees (Section D4);

- Section E summarizes the inconsistency of Bill 11 with the various Minister of Health Canada Health Act Interpretation Letters over the past four decades;

- Section F summarizes the judicial findings of the BC courts in the *Cambie* litigation with respect to the inconsistency of dual practice with the protections and requirements of the *Canada Health Act*;

- Section G then reviews the position taken by the federal government in Cambie that dual practice is inconsistent with the requirements of the *Canada Health Act*;

- Section H briefly summarizes the Alberta Court of Appeal decision in *Allen*, recognizing that dual practice and private duplicative insurance is inconsistent with governing principles of the *Canada Health Act*;

- Section I provides our response to anticipated claims that the Alberta government may make; and

- Section J provides a brief conclusion.

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[4] Attorney General of Canada's Responding Factum, *Cambie Surgeries Corporation, et al. v. Attorney General of British Columbia, et al.*, Court of Appeal File No. CA47004, 16 April 2021, para 2. ("Attorney General of Canada Factum on Appeal".)

A. WHAT DOES BILL 11 DO?

Bill 11 is a large omnibus health-care statute that received Royal Assent in Alberta on December 11, 2025, and is being brought into force in stages from late 2025 through 2027. This opinion focuses on those provisions in Bill 11 that rewrite parts of the *Alberta Health Care Insurance Act* and related legislation to allow physicians to charge patients for medically necessary procedures, including those delivered in public hospitals and in for-profit investor-owned clinics and facilities, while *also* working in the publicly funded system. As a result, Alberta is now the only province in Canada to allow physicians to operate simultaneously in both the publicly-funded system and a private-pay market, creating what is commonly referred to as a "dual practice" structure.

Specifically, Bill 11 permits what are defined as "flexibly participating" physicians to decide, on a case-by-case basis, and in relation to physicians services that Alberta has determined to be medically required, whether to provide those medically required services as an *insured Plan* service (billed to the public Plan) or as a *non-insured non-Plan* service (billed privately to the patient). In other words, "flexibly participating physicians" can charge patients privately while simultaneously maintaining their ability to bill Alberta's public insurance plan -- allowing them to move in and out of the publicly funded system, and thereby creating a parallel private pathway for the provisions of medically necessary care to insured residents of Alberta.

No other province in Canada allows physicians to engage in dual practice. Prior to the introduction of Bill 11, the *Alberta Health Care Insurance Act* was structured similar to legislation in other provinces that require doctors to un-enroll entirely from the public insurance plan if they want to work in the private-pay market and directly bill patients. (The exception is Ontario, which does not permit physicians to un-enroll from the public plan at all.) In other words, unenrolled physicians can receive payment from their patients but not from the publicly-funded plan; conversely a physician who is enrolled in the publicly-funded system is not permitted to accept private payment from their patients. This approach—which *only* permits physicians to accept private payment for services that would be otherwise publicly insured if they operate entirely outside the public insurance system—was a compromise accepted at the outset of the creation of Canada's publicly-funded physician services system and reaffirmed at in 1984 under the *Canada Health Act*. Across Canada, only a relatively small number of physicians are "unenrolled"; the overwhelming majority choose to work within—and be paid by—their publicly funded provincial health insurance systems.[5]

Bill 11 constitutes a radical departure from this longstanding and accepted approach, by amending the *Alberta Health Care Insurance Act* to create three categories of physicians who can provide medically necessary services:

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[5] Minister of Primary and Preventive Health Services Adriana LaGrange reported that 14 physicians were unenrolled and operating in the private sector as of November 2025. See e.g. "*Alberta bill allows doctors to toggle between public and private pay for surgeries*", Global News. Lisa Johnson, November 24, 2025: https://globalnews.ca/news/11541472/alberta-public-private-surgery-bill-11/

- a "participating physician", who provides only publicly insured medically required health services, (labelled "Plan services"), and does not provide any privately funded medically required non-Plan services;
- a "non-participating physician", who provides only privately funded medically required services (non-Plan services) and receives no publicly insured payments (except in certain emergencies); and
- a new category of "flexibly participating physician", who may provide both publicly insured medically required health services ("Plan services") and also privately funded non-Plan but medically required services, i.e. a flexibly participating physician may engage in dual practice and do so on an individual case-by-case basis.[6]

"Non-Plan services" are defined under Bill 11 in such a way that they include not only non-medically necessary services (which are not insured by the Plan), but most critically also services that are medically necessary when provided by participating physicians under the Plan. In other words, what defines a "non-Plan service" is not whether the service is medically necessary, but rather whether the service is being provided by a flexibly participating physician who has chosen to operate outside of the Plan. As such, Bill 11 allows flexibly participating physicians enrolled in the Plan and providing publicly paid medically required insured services to also provide medically required services on a private pay basis to insured Albertans, despite those same services otherwise being treated as insured health services under the Plan. Importantly, these services would be considered to be "medically required" under the *Canada Health Act*.[7]

Before providing a non-Plan service, both a flexibly participating and non-participating physician must disclose their status to the patient at the time of service, describe the service, specify the fee, explain that no public benefit is payable, and inform the patient they could obtain the same service as an insured service from a participating or flexibly participating physician, and receive written acknowledgment and agreement.[8]

Bill 11 also adds a new section to the *Alberta Health Care Insurance Act* to allow and encourage private group insurance plans to pay for health services provided by flexibly-participating (and non-participating) physicians when they provide non-Plan but medically required services.[9] This presumably reflects the objective of Bill 11 in encouraging the creation of a much larger private health insurance market, likely encouraging existing employer-sponsored insurance plans to expand into duplicative coverage for medically necessary health care.

Under Bill 11, the Minister of Health maintains the authority to restrict which services or specialties can be offered as non-Plan services, set conditions for when non-Plan as opposed to insured Plan medically required services can be provided, or prohibit non-Plan services in certain

[6] Bill 11, s. 1(3)(c) (1.1).
[7] Bill 11, s. 1(3)(f).
[8] Bill 11, s. 1(12).
[9] Bill 11, s. 1(46).

areas, for the purpose of ensuring adequate publicly insured services.[10] However, while the Alberta government has suggested that certain medical services may be excluded from the new dual practice system,[11] the legislation as passed allows all physicians, including surgeons, to engage in dual practice.

Finally, Bill 11 also provides that hospital operators, which pursuant to earlier amendments to the *Alberta Health Care Insurance Act* can include for-profit corporations, may now charge patients for "non-insured hospital services" and for "enhanced goods and services".[12] The scope of such services has not yet been defined by the Alberta government but is expected to be the subject of forthcoming regulation.

B. WHAT ARE THE PROTECTIONS AND REQUIREMENTS OF THE *CANADA HEALTH ACT*?

The underlying purpose of Canadian health care policy is explicitly set out in section 3 of the *Canada Health Act* as follows:

> *The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.* [13]

To accomplish this objective, the CHA establishes the criteria and conditions that the provinces and territories must fulfill to receive the cash contributions for health care from the federal government under the Canada Health Transfer. To be eligible for federal cash transfer payments, provincial and territorial health care systems must meet five criteria: public administration (s. 8); comprehensiveness (s. 9); universality (s. 10); portability (s. 11); and accessibility (s. 12).

The "comprehensiveness" criterion requires that the health care insurance plan of each province must insure all insured health services provided by hospitals, medical practitioners, or dentists. In turn, "insured health services" are defined in section 1 to include "physician services", which are defined as "any medically required services rendered by medical practitioners."

[10] Bill 11, s. 1(12).
[11] In a press briefing before the passage of the *Act*, Minister of Primary and Preventive Health Services Adriana LaGrange indicated that cancer and emergency services would be offered through the public plan only, however Bill 11 does not include any such restrictions. Restrictions will depend on Ministerial regulations, which have not yet been released. See e.g. "*Alberta bill allows doctors to toggle between public and private pay for surgeries*", Global News. Lisa Johnson, November 24, 2025: https://globalnews.ca/news/11541472/alberta-public-private-surgery-bill-11/
[12] Bill 11, s. 54(1).
[13] *Canada Health Act*, s. 3.

The "universality" criterion is intended to ensure that 100% of insured persons in a province are entitled to publicly-funded health insurance coverage, and that those services are provided on uniform terms and conditions.[14]

The "accessibility" criterion in s. 12(1)(a) requires that a plan must provide for insured (medically required) health services "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." In this respect, while the CHA does not prohibit all private activity in health care, it is designed to prevent two-tier access to medically required services, and to ensure that those medically required services remain available without financial or other barriers.

Where the *Canada Health Act* criteria are not complied with, sections 14 to 17 provide discretionary authority in Cabinet to withhold cash contributions to the province in an amount, "having regard to the gravity of the default".

In addition, the *Canada Health Act* directs that provinces and territories must not permit extra-billing (s. 18) or user charges (s. 19) for insured health services,[15] because these out-of-pocket patient charges create barriers to universal and accessible care.

Extra-billing is defined as "the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province". User charges are defined as "any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan."

Amounts charged to patients in the form of either extra-billing or user charges must be deducted from cash contributions made under the Canada Health Transfer (s. 20): the *Canada Health Act* provides that where a province fails to comply with the prohibitions against extra billing and user charges, the federal government "shall" deduct from the cash transfer payment to the province an amount that the Minister of Health determines to have been charged through extra-billing or user charges.[16]

Notably, in fiscal year 2026-27, Alberta will be receiving over seven billion dollars in federal government funding under the Canada Health Transfer, so that the Alberta government is putting significant federal funding at risk in enacting and implementing Bill 11.

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[14] *Canada Health Act*, s. 10.

[15] Insured health services are defined as hospital services, physician services and surgical-dental services, provided to insured persons. "Insured persons" includes Canadian residents except for members of the Canadian Forces, persons serving a term of imprisonment within a federal penitentiary, and residents of a province or territory who has not completed a minimum period of residency or waiting period (not to exceed three months).

[16] *Canada Health Act*, ss. 20(1) and 20(2).

C. INTERPRETATION LETTERS UNDER THE *CANADA HEALTH ACT*

Since the *Canada Health Act* came into effect in 1984, federal Ministers of Health have issued several "interpretation letters" to their provincial and territorial counterparts with respect to obligations under the CHA. These interpretation letters outline the federal government's formal position with respect to the CHA's criterion and requirements and bear considerable relevance to whether Bill 11 complies with both the letter and spirt of the *Canada Health Act*.

In 1985, only a year after the enactment of the *Canada Health Act,* then Minister of Health Jake Epp issued the first interpretation letter. Minister Epp explained that the CHA "seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services."[17]

Ten years later, former Minister of Health Diane Marleau issued a second interpretation letter, articulating the federal government's position with respect to the requirements of the *Canada Health Act* as it applies to private clinics:[18]

> **Where [facility or extra] fees are charged for medically necessary services in clinics which receive funding for these services under a provincial health insurance plan, they constitute a financial barrier to access. As a result, they violate the user charge provision of the Act** (section 19) … Facility fees are objectionable because they impede access to medically necessary services. Moreover, **when clinics which receive public funds for medically necessary services also charge facility fees, people who can afford the fees are being directly subsidized by all other Canadians. This subsidization of two-tier health care is unacceptable**.
>
> The formal basis for my position on facility fees is twofold. The first is a matter of policy. In the context of contemporary health care delivery, **an interpretation which permits facility fees for medically necessary services so long as the provincial health insurance plan covers physician fees runs counter to the spirit and intent of the Act**. While the appropriate provision of many physician services at one time required an overnight stay in a hospital, advances in medical technology and the trend toward providing medical services in more accessible settings has made it possible to offer a wide range of medical procedures on an out-patient basis or outside of full-service hospitals. The accessibility criterion in the Act, of which the user charge provision is just a specific example, was clearly intended to ensure that Canadian residents receive all medically necessary care without financial or

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[17] Epp, Jake. "Letter to Provincial and Territorial Counterparts." Ottawa: Health Canada. June 18, 1985. https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2019-2020.html#annb ("Epp Interpretation letter")

[18] Marleau, Diane. "Letter to Provincial and Territorial Counterparts." Ottawa: Health Canada. January 6, 1995. https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2019-2020.html#annb ("Marleau Interpretation letter")

other barriers and regardless of venue. It must continue to mean that as the nature of medical practice evolves.

[emphasis added]

In 2005, Health Minister Ujjal Dosanjh issued an interpretation letter which specifically addressed the problem of dual practice:[19]

> **I am writing to you today about the issue raised by physicians who practice on both a publicly insured and a private pay basis (dual practice). The time has come to ensure that this situation does not become established practice, whereby some patients can access insured health services on the basis of their ability to pay and not strictly on the basis of need.** For this reason, I believe it is necessary for me to clarify the Government of Canada's position on this issue.
>
> **Where physicians are allowed to practice on both a publicly insured and a private-pay basis, this creates a serious risk of undermining the capacity and sustainability of the public health care system.** Therefore, it is disconcerting to hear that dual practice is occurring in some jurisdictions.
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> Under the recently announced Public Health Care Protection Initiative… the Government of Canada has confirmed its commitment to address the issue raised by the dual practice of physicians providing the same medically necessary services on both a publicly insured and private-pay basis. **Such dual practice can give rise to conflict of interest by physicians and create an incentive for them to stream patients to their private-pay practice, thereby allowing them to jump the queue, resulting in unequal access in the public system. In my view, the public sector must not subsidize private care.**
>
> I wish to clarify that I am not seeking to prevent physicians practising within the public system from providing uninsured services such as, for example cosmetic services; for which they may be compensated directly by their patients.
>
> However, I am concerned that **dual practice will impede the ability of patients to access medically necessary services on the basis of need, not ability to pay. To the extent that dual practice impedes access on uniform terms and conditions, it is inconsistent with the intent of the accessibility criterion of the Canada Health Act.**
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> [emphasis added]

[19] Dosanjh, Ujjal. "Letter to Provincial and Territorial Counterparts." Ottawa: Health Canada. November 28, 2005. ("Dosanjh Interpretation letter")

In 2019, Minister of Health Ginette Petitpas Taylor provided the following interpretation with respect to diagnostic services provided in hospitals and in private facilities and clinics, in a fourth ministerial interpretation letter outlining the Diagnostic Services Policy:[20]

> **One of the overarching objectives of the *Canada Health Act* is to ensure that Canadians have access to medically necessary care based on their health needs and not their ability or willingness to pay.** However, in many jurisdictions, patients are charged for medically necessary diagnostic services provided at private clinics. Since the inception of the *Canada Health Act*, the federal position has always been that all medically necessary physician and hospital services - including diagnostic services - must be covered by provincial and territorial health insurance plans.
>
> **If an authorized provider has referred a patient for a medically necessary diagnostic test, the status of the procedure as a publicly insured service should not change simply because the service is delivered in a private clinic rather than in a hospital. I do not accept the premise that since some patients are willing to pay for expedited access to medically necessary services, they should be provided with a venue to do so. This practice results in patients jumping the queue twice – first, for the diagnostic service itself and then for any follow-up care that may be required. Simply put, this is not fair and goes against the fundamental principle of Canadian health care - that is, that access should be based on health need, not on the ability or willingness to pay.**
>
> The *Canada Health Act* does not preclude the private delivery of insured services. Many insured health services are provided to Canadians in privately owned facilities and are paid for by the provincial or territorial health insurance plan. As long as there are no patient charges, the provinces and territories can provide insured services as they best see fit. However, **my clarification of the status of medically necessary diagnostic services through this letter means, in effect, that any charges to patients for these services will be considered to be in contravention of the *Canada Health Act.***
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> [emphasis added]

Most recently, in 2025, Health Minister Mark Holland wrote to his provincial counterparts advising that the *Canada Health Act* will not permit health care professionals—such as nurse practitioners and pharmacists—to charge privately for providing physician-equivalent services. Consistent with the interpretation letter of Minister Petitpas Taylor, Minister Holland created the new CHA Services Policy, reinforcing the federal government's position that the *Canada Health Act* does not permit private payments for medically required services (extending the understanding

[20] Petitpas Taylor, Ginette. "Letter from Health Minister Ginette Petitpas Taylor to Provincial and Territorial counterparts." Ottawa: Health Canada. August 8, 2018. https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2019-2020.html#annb ("Petitpas Taylor Interpretation letter")

of such services to include other regulated health providers whose scope of practice did not overlap with physicians prior to the enactment of the CHA in 1984).[21]

Interpretation letters are significant because the CHA, as a federal statute, is binding on the federal government. As such, these letters offer insight into how the federal government interprets its own responsibilities in administering and enforcing the CHA, and its expectations of the provinces in order to receive health transfer payments. Notably no other piece of legislation in Canada is associated with 'interpretative letters', and as a result courts have considered these letters to have particular weight in understanding the conditions of receiving federal funding. As the BC Court of Appeal held in the *Cambie* decision, discussed in further detail below:

> The judge also correctly considered various policy interpretation letters issued by federal Ministers of Health, intended to assist the provinces in understanding the conditions to receive for federal funding. These letters expressed concern about extra billing, private clinics, dual practice, and patients using private services, such as diagnostic services, to jump the queue that had developed in some provinces.[22]

As the interpretation letters illustrate, since the enactment of the *Canada Health Act,* the federal government has consistently taken the position that the most fundamental and core condition of the CHA is that medically necessary services are provided on the basis of need and not ability to pay, and that permitting physicians to provide medically necessary services on a privately funded basis, while at the same time providing such services through the publicly-funded system, violates the *Canada Health Act.*

D. DOES BILL 11 VIOLATE THE *CANADA HEALTH ACT*?

In our opinion, there is a very strong and compelling basis for the federal government to conclude that Bill 11 contravenes the *Canada Health Act*, both on the face of the legislation and in terms of its substance and effect.

D1. UNIVERSALITY (s. 10 of the CHA)

Section 10 of the CHA requires that 100% of insured residents must be entitled to insured health services on "uniform terms and conditions".

On its face, Bill 11 compromises the universality principle. It authorizes flexibly participating physicians to provide what are in substance insured and medically required physician services under the *Canada Health Act* (euphemistically characterized in Bill 11 as "non-Plan services") on

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[21] Holland, Mark. "Letter to provinces and territories on the importance of upholding the Canada Health Act – 2025." Ottawa: Health Canada. January 10, 2025. https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act/letter-provinces-territories-january-2025.html ("Holland Interpretation letter")

[22] *Cambie* Appeal Decision at para 298.

a private-pay basis. This formalizes a two-tier system where insured persons who can pay out-of-pocket or through their employee benefit plan get faster/better access to medically necessary services.

In practice, this means that insured persons are not receiving services on "uniform terms and conditions" – two Albertans with the same medical need but different incomes will face systematically different opportunities and barriers when it comes to accessing required medical care. Although both individuals are nominally "entitled" to insured services, the terms and conditions under which those services are actually obtained are no longer uniform. For one group, the term of access is "wait, or pay and receive timely care"; for the other, it is "wait, perhaps for a clinically unreasonable period." This divergence is a function of Bill 11's statutory architecture, not of incidental private choice. Thus, by creating the circumstances where income or access to private insurance becomes a condition of timely access, Bill 11 contravenes the universality principle and the CHA.

Importantly, universality cannot be satisfied by a bare, formal designation or definition of "insured persons" or "insured services." It requires that <u>all</u> insured persons falling within the plan have access to insured health services on substantially the same conditions, consistent with the CHA's objective of preventing or eliminating "financial or other barriers" to insured care. By permitting some insured persons who are able to pay to purchase the "non-Plan" versions of medically required services from a flexibly participating physician—when others can only receive those same medically services through public insurance from the same physician—Bill 11 is hardly providing access to medically required services on "uniform terms and conditions". Rather, the conditions of access diverge sharply. For those with financial means or private insurance, the "term" of access includes the realistic option of timely, privately provided care. For those without financial means, the only term is to remain in public queues, potentially facing longer and clinically significant delays.

The government of Alberta may argue that universality is preserved under Bill 11 because all eligible Alberta residents remain "insured persons" with a statutory entitlement to the same publicly insured basket of hospital/physician services, and Bill 11 does not restrict eligibility to the public plan based on income or other criteria. On this view, all Albertans therefore remain entitled to "uniform" insured services, and the principle of universality is intact.

In our view, this argument does not withstand principled or practical scrutiny. Universality is not about who is *technically* insured; it is about whether medically required services are available on "uniform terms and conditions". A statutory scheme that lets some people buy faster access to medically necessary care based solely on the ability pay entrenches non-uniform conditions.

In practice, Bill 11 creates a two-tier system of access. An insured person with the means to pay can secure timely access to medically necessary care by purchasing non-Plan services. An insured person without such means must depend solely on the public queue, with longer waits and fewer provider options. This hardly makes medically required services available to all Albertans on uniform terms and conditions.

As the BC Supreme Court found in the *Cambie* decision, which rejected a constitutional challenge to the prohibition on dual practice, ensuring a fair and equitable system for the funding and provision of medically necessary health care, based on need rather than ability to pay, is a "core part of the purpose" of the CHA.[23] However, differential access to treatment based on ability to pay is baked into Bill 11's very design.

In fact, there is ample evidence that dual practice worsens both wait times and health outcomes for lower income Canadians. In *Cambie*, the trial judge found that there was clear evidence from a number of jurisdictions that a dual system of practice tends to harm public-system access by drawing physicians and allied professionals out of the public system and increasing wait times in the public system—effectively benefiting a small group of patients who can afford to pay, at the expense of the majority who must rely solely on public care.[24] After an exhaustive review of the evidence at trial, Justice Steeves concluded that physicians in Ireland preferred their private patients to the point of breaching their obligations to public patients, and that the introduction of parallel private insurance in Australia resulted in public practitioners migrating from the public to the private system, thereby increasing wait times.[25] Similarly expert evidence in the *Cambie* trial concluded that where dual practice is permitted, such as in England and New Zealand, there were longer wait lists than in Canada and the Netherlands, which do not permit dual practice.[26] Justice Steeves further accepted the expert evidence that privately funded care primarily benefits the affluent and healthy and that dual practice would likely exacerbate health and wealth inequality, including because privately funded systems with dual practice tend to deprioritize the most complex cases and exclude those with the greatest need, because they are less profitable.[27] As noted, the trial judge's findings were accepted by the Court of Appeal.

Where physicians are allowed to practice on both a publicly insured basis (at rates established by provincial government), and also on a private-pay basis (at market rates), there is inevitably a financial incentive for physicians to allocate more of their time to the private-pay stream where compensation is greater. This shift in medical resources—both physician time and other health human resources—from the publicly funded sector into privately funded practice comes at the expense of the publicly funded system and is likely to result in longer wait times for those who cannot or do not pay privately. Moreover, dual practice creates an incentive for physicians—consciously or not—to redirect patients into private-pay practice, undermining the capacity and sustainability of the publicly funded health care system and resulting in unequal access to health care services.[28]

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[23] *Cambie* Trial Decision at paras 1990-1992.
[24] *Cambie* Trial Decision at paras 2385-2387.
[25] *Cambie* Trial Decision at paras 2263-2265.
[26] *Cambie* Trial Decision at para 2364. Also see reference to the Manitoba Study at para 2366 which concluded that patients using dual-practice surgeons for public surgeries waited longer than patients who used public-only surgeons for public surgeries.
[27] *Cambie* Trial Decision at para 2632.
[28] As Justice Steeves accepted in *Cambie*, "doctors are not immune to financial incentives." *Cambie* Trial Decision at para 2370.

D2. ACCESSIBILITY (S. 12 of the CHA)

Another principle and criterion under the *Canada Health Act* is the commitment to accessibility. Insured persons must have "reasonable access" to insured health services "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." As set out in the *Cambie* decision, the CHA provides that at least with respect to medically necessary services, the Canadian health care system "is premised on a principle of fairness. Patients will be prioritized based on their medical needs and not on their ability to pay."[29]

However, Bill 11 authorizes physicians to sell privately paid non-Plan versions of medically required services, including surgeries, while continuing to be paid by the publicly funded system. In our opinion, the introduction of such dual practice is precisely the kind of "financial or other barrier" that s. 12 is intended to prevent. Charges for private surgeries create a direct financial barrier to more timely treatment for those who cannot pay. For at least some if not many medically necessary services, these services will, as a practical matter, be obtainable in a timely fashion only if the patient pays privately for them as non-Plan services. Those unable to pay, whether out of pocket of through private insurance, will effectively be denied comparable access; the charge itself becomes a financial barrier to timely care. In this sense, Bill 11 can be seen to entrench queue-jumping, allowing patients with financial means to access services earlier than those without, regardless of medical need. Such a structure is clearly inconsistent with access to medical services "without financial or other barriers".

Bill 11 also risks undermining or degrading capacity in the publicly funded system, particularly as physician time and/or capacity shift to the privately funded lane. Reallocation of staff or operating room time to the private pay tier impedes reasonable access to those dependant on the publicly funded system. Moreover, by shifting limited physician and other resources from the publicly funded to the privately funded stream and creating a profitable non-Plan market for medically necessary services, Bill 11 creates powerful incentives for physicians to allocate more of their time to private-pay patients, creating longer wait lists in the publicly funded sector. As Justice Steeves concluded:

> The evidence is clear that doctors are paid more in private clinics than they are paid in the public system. I assume that doctors are motivated in their work for many excellent reasons but it would be naive to think that some would not be attracted to increase their work in areas where the compensation is greater.[30]

Indeed, the introduction of dual practice can actually *incentivize* physicians to maintain longer public wait lists, making privately-paid services more attractive and/or necessary for some patients. Indeed, Justice Steeves found that there is a "real and significant" risk that dual practice creates "perverse incentives" on physicians to prioritize economic interests over patient care. As

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[29] *Cambie* Trial Decision, para 1974.
[30] *Cambie* Trial Decision at para 2370.

the federal government's own expert witness testified at trial, "experience in other jurisdictions which allow duplicative private healthcare suggests that physicians will manipulate wait lists in order to encourage patients to obtain private services."[31]

As a result of Bill 11, patients who cannot pay for "non-Plan" medically required services will be effectively denied timely or as timely access to medically necessary care. Longer wait times in the publicly funded system clearly impose barriers to reasonably accessing medically required physician services, contrary to the CHA; for patients without the ability to pay privately for medical services, Bill 11 creates a financial barrier to reasonable access. As the federal government argued in the *Cambie* appeal, relying on the 2005 interpretation letter of former Minister of Health Ujjal Dosanjh, dual practice not only impedes on uniform terms and conditions but is inconsistent with the intent of the accessibility criterion of the *Canada Health Act*.[32] The combination of paid queue-jumping and foreseeable shift of health care staff into the private-pay tier is precisely the sort of direct/indirect barrier that the accessibility criterion in s. 12 was intended to prevent.

D3. COMPREHENSIVENESS (s. 9 of the CHA)

With respect to the comprehensiveness criterion, which requires that all medically required physician services be insured by the provincial or territorial public insurance plan. In our view, while this criterion has not received as much attention as the 'universality' and 'accessibility' criteria, there is a reasonable argument that once a provincial public insurance plan identifies a physician service as being medically required, the service must be insured and paid for by the provincial plan (at least in respect of physicians who are not entirely operating outside of the public plan because they are not enrolled in the plan at all).

In other words, on this view, in order to satisfy the 'comprehensiveness' criterion in the CHA, if a physician is enrolled in the public plan, then all of the medically required services provided by that physician must be covered by the public plan. If some but not all medically required services provided by a physician are being covered by the public plan, then the public plan is not "comprehensive". On this view, to the extent that the comprehensiveness criterion requires that all medically required physician services be insured by the provincial or territorial public insurance plan, at the very least, once a provincial public insurance plan identifies a physician service as being medically required when provided by a physician participating in the public plan, the service must be insured by, and paid for by, the provincial plan for all insured Alberta residents.

From this perspective, there is a reasonable argument that Bill 11 is inconsistent with the comprehensive requirement, in that services acknowledged by the provincial plan to be medically required are not insured in those circumstances where a physician decides to bill privately for those same services. Bill 11 creates a structure which permits physicians otherwise providing medically required services in the public system to bill privately for some of those medically required

[31] *Cambie* Trial Decision at paras 2506-2511 and see more generally paras 2466-2505.
[32] Attorney General Appeal Factum in *Cambie. Supra* 4 at para 30.

services, resulting in those medically required services not being comprehensively covered by the public plan.

D4. EXTRA BILLING AND USER CHARGES (s. 18 and s. 19)

Another key protection of the *Canada Health Act* is that it explicitly prohibits “extra-billing” and “user charges”.[33] Physicians cannot charge any amount in respect of an insured (i.e. medically required) physician service in addition to the amount paid by or payable under the public Plan.

However, this is precisely what Bill 11 permits. As already noted, in the new regime created by Bill 11, some medically required “non-Plan” services that are identical to insured medically required “Plan” services will be sold privately to insured persons by the same physicians who also operate in the publicly funded Plan. If a medically necessary hip replacement for an insured Albertan is an “insured health service” when done in the publicly funded system, it remains so for the purpose of the *Canada Heath Act* when patients are privately charged for those same medically required services Charging patients privately for that service is effectively extra-billing (where the patients pays more than the Plan provides for a medically required service), or a user charge (where the patient pays any charge for a medically required service that is not payable by the Plan for such a medically required service).

Indeed, as noted above, in the case of facility fees and diagnostic fees, the federal government has already taken the position that provinces cannot circumvent the extra-billing or user-charge ban by letting patients pay for medically necessary services.[34] This principle applies equally to patient payments for medically required services under Bill 11.

The Alberta government may assert that Bill 11 is compliant with the extra-billing and user fee prohibitions under the CHA, pointing out that Bill 11 does not permit physicians to “charge or collect…an amount in addition to the benefits payable by the Minister for the insured health services,”[35] and prohibits charging a fee as a condition of receiving insured services beyond what the Plan pays.[36]

However, these kinds of arguments have never been accepted by federal government itself, which has repeatedly taken the position that physicians who are enrolled within the publicly-funded health insurance plan of a province are bound by the rules that govern the provision of insured health services – namely that insured persons cannot be charged for insured services. As the government of Canada argued in the *Cambie* appeal:

> Any charges to an insured person for an insured service levied by physicians who operate within the bounds of the provincial plan, regardless of where the service is

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[33] *Canada Health Act*, ss. 18 and 19.
[34] See e.g. Petitpas Taylor Interpretation letter, *supra* 22.
[35] Bill 11, s. 1(13)(b).
[36] Bill 11, s. 1(16)(b).

> provided, are considered to be extra-billing or user charges under the *Canada Health Act*.[37]

The courts in *Cambie* agreed, holding that when physicians who are enrolled in the public Plan provide privately paid insured services to insured residents, those physicians are not operating in a parallel private system. They are, in fact, operating within the bounds of the provincial plan and in contravention of the extra-billing and user charge provisions of the *Canada Health Act*.

In this respect, and as noted above, the CHA defines "insured health services" by type of service and patient status (in the case of physicians, medically required services for insured persons) and not by whether a province chooses to pay for them in a given delivery context or in some circumstances but not others. The non-Plan services that flexibly participating physicians are permitted to charge patients for under Bill 11 have already been determined by the province to be medically required physician services for insured Albertans and so lie at the very core of CHA-defined and protected physician services. Put another way, the protection of the CHA is tied to what the province has determined to be medically required under its physician health insurance plan, not which medically required services the provincial plans determine to be payable or not payable under its terms.

Indeed, if a provincial government could simply carve out or re-label for private payment certain medically required services, the protections of the *Canada Health Act* would be meaningless and subject to provincial manipulation and definition.

The federal government has recently further confirmed this approach with Health Minister Mark Holland's announcement in January 2025 of the *CHA Services Policy*. The principle that patients cannot under the CHA face charges for medically required services if those services would otherwise be covered by provincial or territorial health insurance applies directly to services provided by physicians. As Minister Holland stated, patient charges for medically necessary services, whether provided by a physician or other regulated health care professional providing physician-equivalent services, will be considered extra-billing and user charges under the CHA."[38] It is hard to see how Bill 11 could be compliant with this explicit federal understanding.

E. THE FEDERAL GOVERNMENT INTERPRETATION LETTERS ON UNIVERSALITY AND REASONABLE ACCESS

As described above in Section C, the federal government itself has consistently taken a position against dual practice in recognition of its inconsistency with the *Canada Health Act*. As early as 1985, then Minister of Health Epp affirmed that the CHA "seeks to discourage all point-of-service charges for insured services provided to insured persons and to prevent adverse discrimination against any population group with respect to charges for, or necessary use of, insured services."

[37] Attorney General of Canada Appeal Factum, *supra 4* at para 33; Transcript Day 144, G. Mandy, p. 43 line 21 to p. 44 line 9.
[38] Interpretation Letter of Minister Mark Holland, *supra* 23.

While Bill 11 attempts to characterized non-Plan services provided by flexibly participating providers as "uninsured services" under the Alberta health insurance legislation, for the purposes of the *Canada Health Act* such services, to the extent that they are medically required, fall within the guarantees of comprehensiveness, uniform access, and reasonable accessibility. As such, they cannot be provided outside of the publicly funded Plan for a private fee.

The federal government has repeatedly confirmed that dual practice—and allowing a private market for medically necessary health services that are otherwise covered by publicly-funded insurance plans—impedes reasonable access to insured services.

In her 1995 interpretation letter, then Minister of Health Marleau emphasized that "where fees are charged for medically necessary services… they constitute a financial barrier to access…. [such] fees are objectionable because they impede access to medically necessary services."[39] [emphasis added]

Similarly, then Minister of Health Ujjal Dosanjh emphasized in his 2005 letter that "to the extent that dual practice impedes access on uniform terms and conditions, it is inconsistent with the intent of the accessibility criterion of the *Canada Health Act.*" As such, "**paying for insured health services is contrary to the fundamental principle that defines Medicare across Canada of access to health care based on need, not ability to pay**."[40] [emphasis added]

More recently, in 2019 then Minister of Health Ginette Petitpas Taylor provided the following interpretation with respect to payment for medically required diagnostic services provided in private facilities:

> One of the overarching objectives of the *Canada Health Act* is to ensure that Canadians have access to medically necessary care based on their health needs and not their ability or willingness to pay. However, in many jurisdictions, patients are charged for medically necessary diagnostic services provided at private clinics. Since the inception of the *Canada Health Act*, the federal position has always been that all medically necessary physician and hospital services - including diagnostic services - must be covered by provincial and territorial health insurance plans.
>
> …. **I do not accept the premise that since some patients are willing to pay for expedited access to medically necessary services, they should be provided with a venue to do so…. Simply put, this is not fair and goes against the fundamental principle of Canadian health care - that is, that access should be based on health need, not on the ability or willingness to pay.**
>
> …. As long as there are no patient charges, the provinces and territories can provide insured services as they best see fit. However, **my clarification of the status of medically**

[39] Marleau Interpretation letter, *supra* 20.
[40] Dosanjh Interpretation letter, *supra* 21.

> **necessary diagnostic services through this letter means, in effect, that any charges to patients for these services will be considered to be in contravention of the *Canada Health Act*.**[41]
>
> [emphasis added]

Most recently, in 2025, then Health Minister Mark Holland reaffirmed that the *Canada Health Act* does not permit private payments for medically required services.[42]

As a result, based on the federal Minister of Health Interpretation Letters over the past four decades, there can be no doubt that Bill 11 overtly undermines and violates both the letter and spirit of the *Canada Health Act.*

F. THE EVIDENCE AND FINDINGS IN CAMBIE SURGERIES

As noted above, the factual conclusion that dual practice harms access to the publicly funded system has recently been addressed in the courts. In *Cambie*, after a lengthy trial with extensive expert evidence, the British Columbia Supreme Court found that duplicative private financing and dual practice would impede reasonable access to health care for those who cannot afford to pay privately. In *Cambie*, the court carefully reviewed extensive evidence with respect to the impact of dual practice on reasonable and equitable access to health care, including in relation to criteria and requirements of the *Canada Health Act*. That case included a constitutional challenge to restrictions on dual practice, the same dual practice provisions that have now been introduced under Bill 11. The trial was lengthy, comprehensive and complex, involving 194 days of hearing, almost 150 witnesses, and 40 expert reports. At the conclusion of the trial, Justice Steeves rejected the plaintiffs' arguments, holding in his 880-page decision that strong provincial restrictions on dual practice are consistent with constitutional rights (and with the Canada Health Act).[43]

More importantly for the purposes of this opinion, in arriving at that conclusion Justice Steeves found, based on the extensive evidence before the court, that dual practice creates or exacerbates inequity in terms of access, utilization and financing of necessary medical care; would create a second tier of preferential health care services on the basis of ability to pay; and would result in "perverse incentives" for physicians to prioritize private pay patients to the detriment of patients in the publicly funded system who would face longer wait times.[44]

Indeed, the trial judgment was heavily evidence-driven. Among the key findings were the following:

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[41] Petitpas Taylor Interpretation letter, *supra* 22.

[42] Holland Interpretation letter, *supra* 23.

[43] *Cambie Surgeries Corporation v British Columbia (Attorney General),* 2020 BCSC 1310 (CanLII) ("*Cambie* Trial Decision") at paras 2803, 2860-2865, 2936, 2938-2941; *Cambie Surgeries Corporation v. British Columbia (Attorney General),* 2022 BCCA 245 (CanLII) ("*Cambie* Court of Appeal Decision") at para 17.

[44] *Cambie* Trial Decision at paras 2663-2665.

- The objective of the provisions of the British Columbia *Medicare Protection Act*, including the restriction on dual practice, is to preserve a system where access is based on medical need, not ability to pay, consistent with the principles of the CHA.
- The evidence was that removing restrictions and allowing a robust private pay/dual-practice tier would:
    - draw physicians and allied professionals out of the publicly funded system;
    - increase wait times in the publicly funded system; and
    - benefit a small group of paying patients at the expense of the majority who rely solely on publicly funded care.
- The empirical record overwhelmingly supported the conclusion that duplicative private financing and dual practice tend to harm access to the publicly funded system, not improve it.

As a result, the court concluded that there is a real risk that the introduction of dual practice in British Columbia would have a direct negative impact on equitable access to necessary medical services. As Justice Steeves held:

> "This includes equity in access, equity in utilization, equity in finance and equity in health and socioeconomic outcomes. The introduction of duplicative private healthcare would create a two-tier healthcare system where preferential treatment can be purchased either directly or through private insurance. That would discriminate against the poor and the ill. There is evidence that health outcomes are associated with income and permitting duplicative private healthcare would only exacerbate existing health inequities".[45]

On appeal, the British Columbia Court of Appeal carefully reviewed the trial judge's findings and the underlying evidentiary record and accepted his findings. As the Court of Appeal explained, "We have set out this factual analysis at some length because it demonstrates the care with which the judge assessed the evidence. We can see no proper basis to interfere with these conclusions. In our view, the appellants have not offered any basis on which appellate interference could be justified."[46]

Thus, both the BC Supreme Court and the BC Court of Appeal have recognized that provinces are constitutionally entitled to restrict or near-prohibit dual practice, and to do so precisely in order to protect the criteria and requirements of the *Canada Health Act.*

In light of *Cambie*, there is a solid evidentiary foundation for the Minister of Health to conclude that Bill 11's dual-practice and non-Plan regime will impede reasonable access to insured services for those unable to pay privately, contrary to s.12 of the CHA.

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[45] *Cambie* Trial Decision at para 2656.
[46] *Cambie* Court of Appeal Decision at para 144 and see paras 127-144.

G. THE FEDERAL GOVERNMENT'S POSITION IN *CAMBIE*

Notably, the federal government actively intervened in the *Cambie* litigation to defend British Columbia's restrictions on dual practice, extra-billing, and private duplicative insurance, explicitly on the grounds that lifting those restrictions would put the province off-side the CHA's extra-billing and user-charge provisions and threaten accessibility/universality. The federal government's positions in *Cambie* provide compelling and unequivocal support for the federal government to determine that Alberta's Bill 11 does not comply with these same protections under the *Canada Health Act*. In other words, where a province (Alberta) positively facilitates dual practice and charging privately for medically required services, the federal government's position in *Cambie* is that this does not comply with the protections and requirements of the *Canada Health Act*.

Indeed, when the BC Court of Appeal decision was released upholding the trial court's decision concerning the constitutionality of the dual practice restrictions on physicians working within the publicly funded health care system and privately at the same time, the Minister of Health released a public statement,[47] emphasizing that "while the *Canada Health Act* (CHA) was not under direct challenge in this case, the federal government joined the proceedings as a party to support BC in its defence of its legislation, a mirror of the fundamental principles of the CHA, which values equity and fairness over profit and preferential access to required care" and that "any Canadian who requires medically necessary care should be able to receive it based on medical need and not on the ability or willingness to pay. Patient charges—whether they take the form of charges at the point of service or payment for private insurance—undermine equity."

H. THE ALBERTA COURT OF APPEAL'S 2015 ALLEN DECISION

Moreover, in its 2015 decision in Allen v. Alberta,[48] the Alberta Court of Appeal, in dismissing a challenge to the prohibition on private insurance under the *Alberta Health Care Insurance Act* on procedural and evidentiary grounds, specifically recognized the extent to which the prohibition against dual practice and private duplicative insurance is intended to comply with governing principles of the *Canada Health Act*. As the Court of Appeal emphasized:

> [15] The Canadian health care system involves both the federal and provincial levels of government; it is an example of co-operative federalism in action. The challenge to the constitutionality of the system is of interest not only to the present applicant and the Government of Alberta, but engages all Canadian governments. **The system operates**

[47] Duclos, Yves. "Statement from the Minister of Health on the British Columbia Court of Appeal's decision in the Cambie Surgeries case." Ottawa: Health Canada. July 15, 2022. https://www.canada.ca/en/health-canada/news/2022/07/statement-from-the-minister-of-health-on-the-british-columbia-court-of-appeals-decision-in-the-cambie-surgeries-case.html

[48] *Allen v Alberta*, 2015 ABCA 277 (CanLII)

based on some basic principles set out in the *Canada Health Act*, RSC 1985, c. C-6. Section 3 of the *Canada Health Act* states that the "primary objective" of the Canadian health care system is "reasonable access to health services without financial or other barriers". Section 5 lists five program criteria: (a) public administration; (b) comprehensiveness; (c) universality; (d) portability; and (e) accessibility.

[16] **A key aspect of the Canadian health care system is its universality, which has two main components:**

a) Economic Universality. Because basic health care is publicly funded, all Canadians have equal access to it. There are no distinctions to access based on means, wealth or social status.

b) Risk Universality. All Canadians are entitled to access the public health system without proving "insurability". Even those who are frail, elderly, or sick, or who have genetic or other vulnerabilities to particular illnesses, are covered. No Canadian is denied coverage, or expected to contribute more to health care costs, based on his or her medical profile.

These features of the system undoubtedly account, in large measure, for the public support of the system, and the willingness of Canadians to devote the substantial public resources necessary to operate it.

[17] The Alberta Health Care Insurance Plan is complex and is regulated by a number of statutes and regulations. **The majority relate directly to its operation, but some are primarily designed to protect the integrity of the public system**. **For example, s. 3 of the *Health Care Protection Act*, RSA 2000, c. H-1 protects the universality of the system by preventing "queue jumping". Section 9 of the *Alberta Health Care Insurance Act* prevents "extra billing" for basic health services provided by the public Plan. Sections 6 and 8 of that statute effectively require physicians to either opt in or opt out of the public Plan and preclude a physician from providing basic health services both within and outside the Plan.**

[18] As noted, s. 26(2) of the *Act* gives the public Plan a monopoly on health care insurance by preventing the issuance in Alberta of private insurance covering basic health services covered under the Alberta Health Care Insurance Plan. It too is designed to preserve the integrity of the public Plan…

[emphasis added]

As the Alberta Court of Appeal recognized, dual practice is inconsistent with the requirements and criteria of the *Canada Health Act*. This lends further support for the conclusion that Bill 11, by permitting dual practice, violates various protections of the *Canada Health Act*.

I. RESPONSE TO ANTICIPATED ALBERTA GOVERNMENT CLAIMS

For its part, the government of Alberta may seek to argue that the principle of accessibility is protected under Bill 11 because insured persons can still obtain medically required services within the publicly funded system, without charge. They may also argue that privately-paid medical services have always been permitted under the *Alberta Health Care Insurance Act*, albeit only for services provided by non-participating physicians, and that permitting dual practice only increases access to medically necessary services, since those with financial means can pay for services privately thereby purportedly "freeing up" health care resources in the publicly funded system for those who cannot pay privately.

In our opinion, both arguments can be soundly rejected. First, for the reasons already described, there is ample evidence—including from other jurisdictions—that dual practice impedes reasonable access to medically necessary services by drawing resources into the private-pay sector and lengthening wait times in the publicly funded sector. For this reason, Justice Steeves specifically rejected the plaintiffs' argument in *Cambie* that dual practice would "free up" resources in the publicly funded system. After careful review of the expert evidence, Justice Steeves found that there was simply no evidence to back up this assertion.[49] Again, this finding was upheld on appeal.[50]

Second, any comparison with the small private-pay sector that existed prior to Bill 11 must be treated with considerable care. As already described, in the 'compromise' structure which has existed from the outset of Medicare and since the enactment of the CHA in 1984, physicians can choose (except in Ontario) to fully "de-enroll" from the publicly funded system and charge privately for their services. Under this structure, however, the physician cannot accept any payment from the public system and patients who pay privately for medically required services cannot be reimbursed by the publicly funded system. As a result, there is a strong financial incentive for physicians to continue to work within, and be paid by, publicly funded insurance plans and most physicians have chosen not to fully de-enroll—the Alberta Minister of Health reports only 14 unenrolled physicians in the province.[51]

In comparison, dual practice significantly increases the incentives for physicians to operate in the private-pay stream, since there is no requirement on the physician to "de-enroll" from the publicly funded-Plan, and therefore very little risk for the "flexibly participating physician" who can continue to toggle between both systems. Flexibly participating physicians can move in and out of the publicly funded and private-pay systems, including for the same patient or for the same procedures. The only determining factor as to whether a procedure is offered under the public insurance plan or is paid for out of pocket (or with private duplicative insurance) is the patient's

[49] *Cambie* Trial Decision at paras 2319, 2327.
[50] *Cambie* Appeal Decision at paras 131-135.
[51] *Supra* 5.

ability or willingness to pay (or their being the beneficiary of an employer-sponsored private duplicative insurance plan).

As a result, dual practice systems have been recognized as posing a very significant threat to universal, accessible health coverage in Canada. In practical terms, a patient visiting a surgeon for a hip replacement could be told that the same surgeon could perform the hip surgery at no cost within the publicly funded Plan in, say, eight months, or have the surgery performed much sooner if they pay for it out of their own pocket (or by private duplicative insurance).

The Alberta government may also assert that Bill 11 contains safeguards which would prevent harm to the publicly funded system (such as limiting the services that may be offered as plan services, prohibiting specialties or service categories from being provided outside of the public insurance plan, imposing conditions on non-Plan practice, and revoking physician approval as flexibly participating physicians). However, these purported 'safeguards' are no response to the explicit failure of the dual practice provisions, on their face, to respect the requirements and protections of the *Canada Health Act*, or the fundamental concern that any degree of permitted dual practice is inconsistent with and undermine CHA protections. Unless the regulations were to outlaw altogether the very category of flexibly participating physicians established by Bill 11, Bill 11 will constitute a violation of the *Canada Health Act*.

Even if the Alberta government ultimately passes regulations limiting certain specialties or certain procedures from patients paying privately rather than paid under the public plan, the corrosive effect of dual practice will nevertheless be felt in the provision of all other medically necessary health services. Similarly, even if the Minister maintains the authority to revoke a physician's approval as a flexibly participating physician because they have been found to have engaged in unethical conduct, or to have not met the requirement for informed consent by their patients, this in no way addresses the *structural* incentives created by Bill 11 to shift resources into the private payment sector, to refer patients to privately-paid services, and to prolong wait times in the publicly funded sector. Ultimately, the very fact that these potential measures were considered to be necessary simply serves to reinforce the extent to which any dual practice provisions risk undermining the protection of the CHA (assuming the adverse effects of dual practice could ever be adequately policed or regulated).

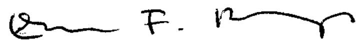
Finally, we understand that the Alberta government has suggested that dual practice of the kind permitted by Bill 11 is also permitted in New Brunswick and Quebec. This is simply not the case. In both provinces, physicians are provided with a choice of practicing within the publicly funded system or entirely opting out or unenrolling from the public system. However, neither province permits physicians to practice concurrently and simultaneously - on a patient by patient and case by case basis - in both the publicly funded system, and in a privately paid market. In neither New Brunswick nor Quebec can physicians simultaneously straddle both the public and private systems at the same time in the way Alberta's Bill 11 envisions. This is the unique and key structural element of Bill 11 that fundamentally undermines the core protections of the *Canada Health Act*.

J. CONCLUSION

As affirmed in *Cambie,* the *Canada Health Act* embodies the fundamental value that medical services should be allocated on the basis of need, not ability to pay. In our opinion, for the reasons set out above, Alberta's Bill 11 breaches that commitment by explicitly enabling differential access to medically necessary care based on ability to pay in the private market. Facilitating a two-tier regime introducing private payment for medically required services which in turn can lead to preferential access is directly contrary to the core requirements, criteria and principles of the *Canada Health Act*. A system that structurally privileges those able to make private payments, as Bill 11 does, undermines the equitable principles of health care allocation that *Cambie* approves and the CHA codifies.

What's more, based on its own public interpretations and commitments in Ministerial "interpretation letters" and before the courts in *Cambie*, the federal government has already articulated precisely why Bill 11 contravenes the *Canada Health Act*. As the federal government argued in *Cambie*, "from a federal perspective, when enrolled physicians charge insured residents for insured services, this is in contravention of the extra-billing and user charge provisions of the *Canada Health Act*"[52] and the "goal of equitable access" to medically necessary health services would be significantly compromised.[53]

Sincerely,



Emma Phillips
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[52] Attorney General of Canada Appeal Factum. *Supra* 4 at para 34.
[53] *Ibid.* para 91.