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Our File No. 26-486

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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 Bill 11 Proposed Regulations

On April 30, 2026, we provided you with our legal opinion which concludes that Alberta's new *Health Statutes Amendment Act, 2025 (No. 2),* also known as 'Bill 11', is contrary to the *Canada Health Act* because it allows some patients to access medically necessary services more quickly based on their ability to pay, and permits extra-billing and user charges.

In reviewing the legality of Bill 11, the federal government subsequently stated that it will need to consider the regulations accompanying Bill 11, purportedly on the basis that the regulations might impact whether Bill 11 is considered compliant with the *Canada Health Act*.

The Alberta government announced its anticipated regulations on June 18, 2026, asserting that these regulations will create "safeguards" in the application of the legislation.

You have therefore asked our opinion with respect to whether the new regulations announced by the government of Alberta will, indeed, bring Bill 11 into compliance with the *Canada Health Act*, or in other respects impact on the conclusions of our April 30, 2026 opinion.

For the reasons set out below, in our view it is clear that the regulations do not in any way address the fundamental concern with Bill 11, which is that Bill 11 entrenches "queue-jumping" and creates a two-tiered system of health services, and 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.

While the regulations that have been announced—most of which have not yet been shared publicly or introduced into law—establish some limitations to the application of Bill 11, they do not change the fundamental architecture of the new system of dual practice and private payment for medically necessary services introduced by Bill 11 or cure Bill 11 of its key failings.

In our view, even if the regulations are introduced as announced, they will not ensure universal access to health care services on uniform terms, as required by the *Canada Health Act*, or prohibit the imposition of extra-billing and user charges. In short, the regulations do nothing to prevent Bill 11 from creating serious inequities in access to medically necessary health services based on ability to pay, contrary the requirements of the *Canada Health Act*.

Brief Background on Bill 11

On December 18, 2025, the government of Alberta passed into law the *Health Statutes Amendment Act, 2025 (No. 2.)*[1]. The *Act*, or 'Bill 11', amends the *Alberta Health Care Insurance Act* by establishing the legal framework for 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. No other province in Canada allows physicians to charge patients privately while simultaneously maintaining their ability to bill Alberta's public insurance plan, what is commonly referred to as a "dual practice" structure.

As set out in our April 30 opinion, by allowing physicians in Alberta to move in and out of the publicly funded system—thereby creating a parallel private pathway for the provision of medically necessary care to insured residents of Alberta—Bill 11 creates the most extensive privatization of payment for medically required physician services since the enactment of the *Canada Health Act*[2] enactment in 1984. The dual practice structure established by Bill 11 is fundamentally inconsistent with, and contrary to, the core objectives and provisions of the *Canada Health Act* ("CHA"), including universality, accessibility, comprehensiveness, and the prohibitions on extra-billing and user charges. The CHA's purpose is to protect, promote, and restore health and to facilitate reasonable access to health services without financial or other barriers.

Bill 11 undermines these principles by enabling a dual track of access: all Albertans remain technically insured, but those able to pay can purchase faster access to the very same medically required services from the same physicians, while others must wait in the public queue. Under Bill 11, a physician is permitted to offer two patients with identical medical needs but with different ability to pay systemically different conditions of access: the one with the ability to pay will have the option of preferential access by paying privately, while the other would not. As such, Bill 11 erects a direct financial barrier to timely care for those who cannot pay. For many procedures, more expedited access will, as a practical matter, be available only to those who can afford private pay fees, while others are left with longer waits in the publicly funded system.

[1] *Health Statutes Amendment Act, 2025 (No. 2)*, SA 2025, c 21 ("Bill 11").
[2] *Canada Health Act,* RSC 1985, c C-6 ("*Canada Health Act*").

Moreover, Bill 11 permits flexibly participating physicians who remain enrolled in the public plan to charge patients privately for medically required services that are identical in substance to medically required *publicly* funded services. In effect, Bill 11 re-labels some medically required services as "non-Plan" services if they are paid for privately—thereby ostensibly allowing the physician to charge the patient privately for the service—even though those very same services would be considered "Plan" services if performed under the publicly funded provincial heath care Plan.

By re-labeling medical services that were previously considered to be "Plan" services (i.e, medically necessary services covered by the publicly-funded insurance Plan) as "non-Plan" services that are paid for privately, Bill 11 permits patients to pay more than the Plan provides for a medically required service, or to pay for a medically required service in addition to the amount that would be payable by the Plan. This is clearly in direct violation of the prohibition on extra-billing and user charges in the *Canada Health Act*.[3] As the federal government has repeatedly affirmed, physicians who are enrolled within the publicly-funded health insurance plan cannot charge insured persons for insured services. In the words of the government's own submissions to the British Columbia Court of Appeal in the *Cambie* case: "**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 provided, **are considered to be extra-billing or user charges under the *Canada Health Act***."[4]

Notably, under sections 18 to 20 of the *Canada Health Act*, the deductions in amounts equivalent to extra-billing and user fees are non-discretionary and mandatory.

Regulations under Bill 11

Following the passage of Bill 11, and facing questions with respect to the legislation's compliance with the *Canada Health Act,* the federal government indicated that it would be necessary to review Bill 11's forthcoming regulations to ensure compliance with the *Canada Health Act*. Speaking to reporters in April 2026, federal Minister of Health Marjorie Michel stated that provincial Health Minister Adriana LaGrange had advised the federal government that she intended for the regulations to stay within the bounds of the *Canada Health Act*.[5] Minister Michel further indicated that federal and provincial health ministries would work together as partners while the regulations were being developed, in order to ensure compliance with the CHA. Minister Michel affirmed the role of the federal health minister as the "guardian" of the *Canada Health Act*.

[3] By way of example, 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 Health Act* when patients are privately charged for those same medically required services.
[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, at para 33; Transcript Day 144, G. Mandy, p. 43 line 21 to p. 44 line 9.
[5] See e.g. "*Health minister cautions Alberta over private health care law*", National Post. Rahim Mohamed, April 28, 2026: https://nationalpost.com/news/canada/health-minister-cautions-alberta-over-private-health-care-law

On June 18, 2026, the Alberta government announced that rollout of the new dual practice system will begin in September. The government commenced an "expression of interest" process several days later on June 22, with a formal application process set to commence later this summer.

At the same time, the provincial government provided some additional detail with respect to the regulations it intends to put in place, including:

- Minimum public-system hours before physicians can offer private surgeries;
- The exclusion of family physicians from dual practice, except those with a subspecialty in anesthesia or surgical assistance;
- Life-threatening and emergency care (e.g. cancer surgeries) remain exclusively publicly funded; and
- Integrated electronic records for privately provided services and mandatory reporting requirements for all physicians.[6]

However, with the exception of a regulation dealing with reporting requirements, none of the regulations have been communicated or enacted.

Instead, the *only* regulations implemented to date are the *Dual Practice Records Regulations* (AR 140/2026), which establish requirements on flexibly participating physicians to establish and maintain records in respect of services provided to patients, whether or not the service is paid for by the provincial public health insurance plan, the patient, or a private insurance company. That regulation further provides that the Minister of Health may require a physician to provide records relating to the provision of services to a particular patient or group of patients, or in relation to the provision of an insured health service or non-Plan services (for example within a particular practice area of specialty).

The government indicated that other regulations, such as the exact hours requirements physicians will need to work in the public system before charging private fees for services, will be worked out "in the coming months".

Do the Regulations Bring Bill 11 Into Compliance with the *Canada Health Act*?

Considerable weight has been put on Bill 11's proposed regulations, both by the provincial and federal ministers of health. Implicit in the public statements of both Minister LaGrange and Minister Michel is the suggestion that such regulations may or will in some way ensure that Alberta's healthcare insurance plan, as amended by Bill 11, is on-side with the requirements of the *Canada Health Act.* A key question to be asked, therefore, is whether the regulations announced

[6] Government of Alberta News Release, June 18, 2026: https://www.alberta.ca/release.cfm?xID=9635394B3EA0C-A442-7865-D1DFF7C58FAFCE1F

on June 18, 2026 would in any way bring Bill 11 into compliance with the *Canada Health Act*. In our opinion, they do not.

First, the narrow regulations passed to date—the only regulations that are legally binding on the Alberta government thus far—merely address record keeping obligations of flexibly participating physicians. These regulations plainly do nothing to limit or mitigate the impact of Bill 11 on the provision of health services in Alberta, other than to ensure records of these services are properly maintained.

Second, even assuming that the additional regulations announced by the Alberta government are ultimately implemented, in our opinion these cannot and would not bring Bill 11 into compliance with the CHA.

Rather, 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 actively undermine, CHA protections.

Even if the Alberta government ultimately passes regulations excluding certain specialties or certain procedures from patients paying privately, the corrosive effect of dual practice will nevertheless be felt in the provision of all *other* medically necessary health services. Equally, even if the regulations ultimately preclude physicians in certain specialties or providing certain services from charging private fees for medically necessary services, the regulations do not preclude *other* physicians who are permitted to work as flexibly participating physicians from engaging in extra-billing or charging user fees, in contravention of the *Canada Health Act*.

In the same vein, whether or not the Minister ultimately implements regulations requiring physicians to work a minimum number of hours in the public system before charging privately for medically necessary services, Bill 11 will still permit physicians working hours beyond those prescribed minimums to engage in conduct that is inconsistent with and undermines the protections and requirements of the *Canada Health Act*. In other words, the regulations may require physicians to work a certain number of hours in the public system before they engage in conduct which contravenes the *Canada Health Act,* but the legislation nevertheless permits conduct that violates the *Canada Health Act.*

Moreover, permitting physicians to provide medically necessary services on a private pay basis inevitably creates structural incentives to shift *other* resources already in short supply into the private payment sector, thereby increasing wait times and reducing access in the publicly insured sphere. This includes not only physicians but other critical infrastructure and health human resources As we noted in our original opinion letter, the British Columbia Supreme Court found in the *Cambie* case that dual practice results in "perverse incentives" for the healthcare system to prioritize private pay patients to the detriment of patients in the publicly funded system who cannot

afford to pay for care and face longer wait times as a result.[7] For this reason, and after a lengthy trial and extensive expert evidence, including with respect to the experience of other jurisdictions with dual practice systems, the Court concluded that the introduction of dual practice in British Columbia would have a direct negative impact on equitable access to necessary medical services where preferential treatment could be purchased either directly or through private insurance, discriminating against the poor and the ill.[8] These findings were in turn upheld on appeal by the British Columbia Court of Appeal.[9]

Ultimately, unless the regulations outlaw altogether the very category of flexibly participating physicians and dual practice established by Bill 11, Bill 11 will inevitably conflict with the commitment of the *Canada Health Act* that access to medical services be on the basis of need, and not ability to pay. The very fact that the potential regulatory measures being floated by the Alberta government are considered to be necessary simply confirms the extent to which any dual practice provisions undermine the protections of the CHA.

Conclusion

Fundamentally, it is the very architecture created by Bill 11 which puts the legislation off-side the *Canada Health Act*. In our opinion, the two-tiered structure for the provision medical services created by Bill 11 cannot and will not be cured by the regulations announced by the Alberta government. Even if these regulations are ultimately implemented, the legislation will continue to contravene the core principles of the *Canada Health Act*, including the requirements for uniform terms and conditions and accessibility, as well as the prohibitions on extra-billing and user charges.

As a result, in our view, in order to ensure that she is truly serving as the "guardian" of the *Canada Health Act*, the federal Minister of Health need not and should not wait for any further regulations. Rather, the Minister should:

a) immediately advise Alberta that once Bill 11 is implemented, she intends to make non-discretionary and mandatory deductions for extra-billing and user fees, after consulting over the amounts to be deducted (as provided for in s. 20 of the CHA); and

b) immediately advise Alberta of her concern that Bill 11 fails to satisfy the accessibility, uniform terms and conditions and comprehensiveness criteria of the CHA, and enter into consultations with Alberta over her concern (as required by s. 14 of the CHA), prior to then referring the matter to Cabinet to determine the federal cash contribution that should be withheld from Alberta as a result of Bill 11's failure to satisfy the requirements of the *Canada Health Act*.

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[7] *Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2020 BCSC 130 (CanLII) at paras 2803, 2860-2865, 2936, 2938-2941.
[8] *Ibid.*, at para 2656.
[9] *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2022 BCCA 245 (CanLII) at para 144 and see paras 127-144.r

Sincerely,

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