SUMMARY OF LEGAL OPINION ON BILL 11

There is a strong and compelling basis for concluding that Alberta's Bill 11 contravenes the *Canada Health Act.* By authorizing physicians to provide medically necessary services through a dual-practice model—a model which allows physicians to provide medically necessary services either through the publicly-funded health system or privately paid on a service-by-service basis—Bill 11 contravenes the core principles of the *Canada Health Act*, including prohibitions against extra-billing and user charges, and the requirement that a provincial health care system be comprehensive, universal and accessible. No other province allows dual practice.

What Bill 11 Does

Bill 11 creates the most extensive privatization of physician services since the enactment of the *Canada Health Act* in 1984, enabling "flexibly participating" physicians to provide medically necessary services either through the publicly funded system or for private payment, and to do so on a service-by-service basis.

In substance, Bill 11 permits queue-jumping and creates a parallel private pathway for the provision of medically necessary physician services which would otherwise be covered under the public healthcare insurance system. Based on evidence from other jurisdictions internationally, this can be expected to worsen wait times and health outcomes for lower income Canadians by drawing physicians out of the public system and creating incentives for physicians to prioritize privately-paying patients.

Bill 11 Violates Canada Health Act Requirements

The express purpose of the *Canada Health Act* (CHA) is to protect, promote, and restore health and to facilitate reasonable access to health services without financial or other barriers. The core principle animating the CHA is straightforward: medically necessary care must be available on the basis of need, not ability to pay. To that end, as a condition of federal health care transfer payments, the CHA requires provincial plans to meet five criteria: public administration, comprehensiveness, universality, portability, and accessibility. In addition, the CHA prohibits extra-billing and user charges for insured services. Where a province violates these requirements, the CHA provides that the federal government will deduct payments to the province from transfer payments.

Bill 11 contravenes the CHA's requirements on multiple fronts.

Under the "comprehensiveness" criterion, provincial plans must insure all medically required physician services. However, Bill 11 allows services that Alberta itself treats as medically required to be sold privately as "non-Plan" services by flexibly participating physicians, rather than being uniformly covered by the public plan. Because Bill 11 permits medically necessary services to be removed from the scope of public insurance—whenever a physician elects to bill privately—the plan can no longer be said to "comprehensively" insure all medically required physician services.

The "universality" criterion requires that 100% of insured residents have access to insured health services on uniform terms and conditions. Bill 11, however, creates a dual track of access under *differing* terms of access: while all Albertans remain technically insured,

those with the ability to pay can purchase faster access to the very same medically necessary services from the same physicians, while others must wait in the public queue. Two patients with identical medical needs but different incomes will now face systematically different conditions of access—one has a realistic option of timely, privately delivered care, the other does not. Under Bill 11, access is no longer provided on uniform terms and conditions and universality is directly undermined.

The "accessibility" criterion requires that insured persons have reasonable access to insured services without direct or indirect financial or other barriers. By authorizing physicians to sell privately paid, non-Plan versions of medically required services, Bill 11 erects a direct financial barrier to timely care for those who cannot pay. For many procedures, timely access will, as a practical matter, be available only to those who can afford private fees, while others are left with longer waits in the public system—institutionalizing "queue-jumping" for healthcare services. At the same time, dual practice can reasonably be expected to shift physician time and operating capacity out of the public system and into the more lucrative private stream, thereby reducing capacity and lengthening wait times for those relying on publicly insured services. Both the out-of-pocket charges and the foreseeable resource shift constitute the kind of direct and indirect barrier to reasonable access that contravene the CHA's accessibility criterion.

Finally, the prohibition on extra-billing and user charges under the CHA bars physicians from charging insured patients any amount in respect of an insured (medically necessary) service beyond what is paid by the public plan. Bill 11, however, permits physicians who remain enrolled in the public plan to charge patients privately for medically required services that are identical in substance to insured services when provided publicly. When an insured hip replacement is performed privately for a fee, that payment functions either as extra-billing (where it is in addition to what the plan would pay) or as a user charge (where the patient pays for a medically necessary service that *should* be covered by the plan). Allowing Alberta to re-label these insured, medically necessary services as "non-Plan" services does not change their status under the *Canada Health Act* and, if accepted, would render the Act's protections meaningless.

The Federal Government's Own "Interpretation Letters" Confirm that Bill 11 Violates the *Canada Health Act*

Since 1985, federal Ministers of Health have repeatedly taken the position that point-of-service charges, private fees for insured services, and dual practice are inconsistent with the objectives of the *Canada Health Act*. This includes a 2005 letter from the Minister of Health which stated that allowing physicians to engage in dual practice creates a serious risk of undermining public access, encourages queue-jumping, and is inconsistent with the accessibility criterion of the Act. Other interpretation letters have subsequently reinforced the same principle by confirming that medically necessary services remain insured even when delivered in private settings, and that charges to patients for such services are not permitted. Notably, the B.C. courts have recognized that these federal government interpretation letters are relevant to the interpretation and application of the *Canada Health Act*.

The *Cambie* Litigation Findings and the Federal Government Position in *Cambie* Confirm that Bill 11 Violates CHA

In the *Cambie* litigation, British Columbia courts reviewed extensive evidence showing that dual practice and duplicative private financing can worsen wait times, divert providers away from the public system, and create incentives for physicians to prioritize private patients. These findings lend unequivocal support to the conclusion that, by its very design, Bill 11 will have significantly adverse consequences for equity, access, and the sustainability of the public system. In short, the findings in the *Cambie* litigation support the conclusion that, by normalizing a private-pay lane for insured care, Bill 11 encourages and permits queue-jumping, widens inequities between patients who can and cannot afford to pay, and weakens the public system by drawing resources into the private market—all in violation of the core principles of the CHA.

Notably, the federal government actively intervened in the *Cambie* litigation to defend British Columbia's restrictions on dual practice, extra-billing, and private insurance. The federal government expressly argued that permitting dual practice would put the province off-side the CHA's extra-billing and user-charge provisions and threaten accessibility and universality.

Indeed, when the BC Court of Appeal decision was released, the Minister of Health released a public statement emphasizing that "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." The federal government was unequivocal in stating that "Patient charges—whether they take the form of charges at the point of service or payment for private insurance—undermine equity." Based on the exact principles argued by the federal government in *Cambie*, Bill 11 violates the CHA.

Conclusion

By facilitating a two-tier regime that introduces private payment preferential treatment, Bill 11 contravenes the core principles and protections of the *Canada Health Act*. Indeed, 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*" and the "goal of equitable access" to medically necessary health services would be significantly compromised.