



December 4, 2025

From: Katherine Fierlbeck
To: Health System Observers
Re: ALBERTA'S PROPOSED HEALTH INSURANCE CHANGES (III)

After our [overview](#) of Alberta's proposed health system changes, and how they may [fit](#) with the *Canada Health Act*, it's time to talk about the implications.

Alberta is proposing to create a new category of “flexibly participating” physicians and “non-plan” services. Its legislation also clarifies that physicians who practice entirely privately are “non-participating,” meaning that they can bill patients directly at whatever price they choose, and that these patients do not get reimbursed by the public system.

The changes to create a flexible option allowing physicians to practice privately are very likely compliant with the *Canada Health Act* because “insured services” in Alberta are still publicly insured. Contrary to what many assume, the *Canada Health Act* does not require all “medically necessary” care to be publicly insured; rather, it states that all insured services must be insured (meaning that provinces determine what services they choose to insure and how to define what is and is not medically necessary care).

The range of possible implications of these revisions is extraordinarily wide, and will depend considerably on any conditions or restrictions that the new legislation authorizes the minister to make. If no restrictions whatsoever are placed on flexibly participating physicians, especially in an environment where healthcare services are scarce, then a “rationally maximizing” physician could simply prioritize the patients willing to pay higher fees directly to gain access more quickly.

Unlike the permitted scope of activity for non-participating physicians that currently exists, flexibly participating physicians would also be able to fall back on public insurance whenever they didn't have sufficient numbers of privately paying customers. If this became a lucrative form of practice, then it would likely draw physicians out of the public sphere into a dual practice prioritizing private patients.

This could mean serious resource constraints for public sector services. However, it could also mean an influx of physicians from other provinces, which would be a net gain for Alberta, if only at the expense of other provinces.

However, if the minister chooses, as has been suggested, to require physicians to provide a minimum level of insured services (by volume or by hours) before they are eligible to provide “non-plan services,” then it is conceivable that some may choose to work extra hours above and beyond the required minimum, thereby creating extra capacity. Nonetheless, this does raise further questions.

On the one hand, if family doctors are already working 50 hours a week, then they may find it difficult to add to their work week.

On the other hand, if surgeons are not working to full capacity because of limited operating theatre time due to health authorities' financial constraints, then it could, rather paradoxically, be difficult for them to meet the minimum number of hours in the public sphere that would allow them to add additional services in the private sector.

Regardless, a separate stream of private services would still privilege patients who have the means to bypass slower public channels. This flies in the face of the egalitarian spirit of Canadian medicare. At the same time, it could, under the right conditions, meet the “maximin” **criterion of justice** set out by John Rawls (based on 18th-century arguments by David Hume), in which inequalities in society are acceptable only if they benefit the least advantaged.

The conditionality is important: Additional capacity that is simply consumed by those with resources is hardly a better system for those with little disposable wealth.

The effects of these revisions in practice could certainly be measured empirically, given sufficient political will. Section 8.1(1) of Bill 11 gives the minister the authority to review how well the system of dual practice is working, but the power is discretionary, and the scope or intent of such a review are not addressed.

Legislation that had at its heart a concern for better service provision for all would have demanded that the minister be required to determine the outcomes, at set points in time, for those unable to avail themselves of “non-plan services.” This would entail some heavy lifting by the province, and underlines the paradox **noted** by Jeremiah Hurley and others that, for private mechanisms to work effectively in the sphere of healthcare, a robust regulatory presence also becomes necessary.

Alberta's proposed revisions do have the capacity to make considerable changes to the current system of healthcare in the province, but it remains unclear to whose advantage these changes will be.

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