# Ontario Health Coalition

# Alberta's "Bill 11" Threat to Public Health Care & Ontario's Ford Government Privatization of Public Hospitals

## Detailed Briefing Note with Sources

**March 2, 2026**

Twin threats to the public health care system across the country and to the public hospital system in Ontario have intensified to a critical level. With the passage of Alberta's "Bill 11" in early December, the existential fight for public health care is upon us. If we are to save public health care and stop U.S. for-profit health insurance from taking over, the whole country will need to build a fight back commensurate to the challenge.

In Ontario, the Ford government's announcements-- the most recent of which was also in early December-- shift unprecedented amounts of public funding and resources away from public hospitals to open an entire new infrastructure of private (for-profit) hospitals and clinics. They are quadrupling the funding for private clinics. At the same time, they are downsizing our public hospitals by pushing them into deficit and forcing cuts under threat of takeover, akin to the takeovers of the schoolboards. Here too, we have been pushed into an existential fight. In the case of our province, the fight is for public hospitals and single-tier health care.

Here are some key facts. The sources for all the data are included in the two appendices at the end of the briefing note:

## Ontario

In the last eight months alone, the Ford government has announced almost $300 million for 61 new private clinics, a number of which are large scale facilities-- essentially private hospitals. According to government projections, these clinics will redirect more than 1.2 million patients away from public hospitals for treatment. This is unprecedented. Since the inception of public hospitals and the 1973 ban on private hospitals, no government has expanded private clinics like this. The scale and scope of hospital privatization planned by Ford will undermine, perhaps fatally, our public hospital system.[1] The majority of the new licenses are for private for-profit facilities and a number of them are owned by for-profit chain corporations. In the call for applications, the province explicitly specified, "Sole proprietors, not-for-profit corporations and for-profit

[1] Private hospitals are banned and the Ontario government is barred – by law – from expanding them. Thus, their go-around has been to try to expand private clinics. There have been approx. 900 private clinics since the inception of the private clinics' legislation in the 1980s. The vast majority are x-ray and ultrasound clinics. There are also abortion clinics (some of which are non-profit), sleep clinics, and some others. 98% of the private clinics are for-profit. No government has expanded their number significantly, though there have been some attempts which we have stopped. The last expansion of this sort was under the Mike Harris/Ernie Eves government near the end of their final term in office, led by Tony Clement as Health Minister. They tried to bring in 15 MRI/CT clinics. In the end they brought in eight. The total funding for private clinics in 2020 was $57 million. They have tried to more than double the funding since but have not been able to meet their targets. The announcements of the last six months would vastly increase capacity, amount to almost $300 million in the new private clinics plus dramatic funding increases for existing private clinics, and involve tens of thousands of procedures and services for more than a million patients. With the latest announcements, the government would more than quadruple the funding for private clinics from the pre-privatization level in 2020. In context, this planned privatization is truly unprecedented.

corporations can apply to the Call for Applications".

At the same time, most of Ontario's hospitals have been pushed into deficit and forced to cut staff and services (already stretched beyond what is possible). Provincial health sector funding is increasing at only 1% per year for the next three years (as per the Fall Economic Statement)-- less than the rate of inflation alone, and far short of aging and population growth. For hospitals, the operational funding increase for the first half of this year was 2.36%, according to Government Estimates, again less than half of inflation, population growth and aging (the Ontario Hospital Association is saying they are 6% per year). The government reported another $660 million in the 3rd Quarter Finances (Ministry of Finance) which would bring it up to roughly 4.75%- roughly 2.4%-- if they actually flow that money. Bottom line, it is not enough even to maintain existing service levels at current utilization rates.

Those private clinics announcements from the last eight months or so, came on the heels of the expansion of the privatization of cataract surgeries in 2024-2025. Already, this first tier of private surgical clinics has brought in unfettered two-tier health care contravening the fundamental principles and laws that govern our public health care (much like the for-profit long-term care industry). Patients – most of them seniors – are being charged hundreds to thousands of dollars when they go to private clinics for their eye surgery. After receiving hundreds of complaints, the Ontario Health Coalition called all the private eye surgery clinics in the province in December posing as patients. In many towns, the Coalition found that *all* the private clinics are violating the Canada Health Act and Ontario's Commitment to the Future of Medicare Act and are charging patients directly for surgery (on top of charging OHIP). In the other towns the majority of the clinics are engaging in this illegal practice. The Coalition recorded the phone calls and will be releasing the evidence in a new report soon.

Despite repeated efforts, formal complaints, lots of media work, a front-page story in the Toronto Star, mobilizing hundreds of people to fill the Galleries in the Legislature and more, the Ford government is refusing to enforce our medicare laws and stop the two-tier extra-billing and user fees. Costs have escalated and are now routinely $4,000 or more per eye, plus $200 or more for eye measurement tests. Patients are already pressuring private insurance companies to cover these costs, which would unravel our public insurance system. The Coalition has multiple complaints from patients who have been charged $8,000- $11,000 for eye surgery that is covered by our public taxes and for which it is illegal to charge them. Seniors have had to take out loans, use all their savings, and even go back to work at age 70 or older in order to pay. To be clear: it is a violation of the Canada Health Act to charge a patient for medically necessary hospital and physician care. User fees, extra-billing, selling queue jumping and two-tier medicare are banned both in federal and Ontario law. We are deeply concerned because the private clinics openly flaunt those laws. In Alberta, private clinics charge up to $50,000 for orthopedic surgeries and if the private clinics are allowed to expand into orthopedics, gynecological surgeries and more, the unfettered expansion of patient charges will cause widespread suffering and inequality. It is no exaggeration to say that the privatization of our hospitals, which is bad enough, are also a fatal threat to Public Medicare.

Details of the announcements are appended with links to source data and information.

## Alberta

Alberta's Bill 11 *The Health Statutes Amendment Act* is, at its core, designed to bring in private health insurance and two-tier medicare and remove the risks for physicians to create that private tier. With its passage, the existential threat for Public Medicare in Canada is here. The new law creates the legislative framework to create a market for private health insurance. It is a direct contravention of the core tenets of the Canada Health Act that prohibits for-profit

health insurance, extra-billing and user fees and two-tier medicare. The law enables physicians to charge the public system and charge patients, sets up a system for private health insurance plans in workplaces and out-of-pocket health care, expressly legalizes two-tier medicare and queue-jumping for those who pay, and authorizes physicians to choose which patients to charge and for which services. If patients cannot pay, the only alternative they have under this law is to try to find a different physician who will not charge them. It is terrible for Albertans, attacks single-tier Public Medicare in Canada and puts at threat public health care across the country. Under our trade agreements, if health insurance is no longer public, it is no longer carved out and safe from trade challenges by U.S. private health insurance companies. The threat posed by this legislation can hardly be overstated.

A more detailed analysis of the legislation is appended here.

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## Conclusion and appeal

We are at a pivotal moment in our province's and our country's history. Either we now lose the ownership and control of our hospitals in Ontario, as was done in the 1990s for long-term care, and we have to grapple with for-profit hospital chains and all the terrible problems that will result, or we beat back this privatization. Either we stop the privatization of our health insurance system and the entry of U.S. for-profit insurance, or we lose Public Medicare.

In Ontario, we will need to pair the issues. We need to do our part to help make a national fightback but we cannot allow all attention to be diverted away from what Ford is doing or we will lose our hospitals.

The Ontario Health Coalition is calling a series of leadership meetings and has developed a campaign plan to build a bigger, more visible public education, organizing and visible fight-back. We know that you feel, as we do, that this is our responsibility, that we cannot allow the dismantling of a hundred years of progress that built our public hospital and public health care systems. It is our watch now, collectively, and when the history of this time is written, we know that you, like us, will want to have done everything we could do. Thank you for your time. We wanted to bring to your attention that the situation is more critical than it has ever been. We hope we can work together to build the fightback, such that it is commensurate to the threat.

# APPENDIX I.

## Ontario government private clinics announcements

Most recent:

- In June the province announced that it awarded licenses to 57 new private clinics, 35 of which are MRI/CT clinics and 22 of which are endoscopy clinics. $155 million over two years to "create" the clinics. The province estimates the MRI/CT clinics will serve more than 800,000 patients and the endoscopy clinics will provide more than 400,000 procedures.
    - These facilities are licensed and the terms of the licenses are up to 5 years unless there is a regulation passed to extend them further under the "Your Health Act" (formerly Bill 60) passed in 2023.
    - One of the "clinics" is the Schroeder Ambulatory Care facility, which is essentially a private hospital. The funding for this Richmond Hill facility alone is $14 million under the June announcement, and it is projected to serve 150,000 patients. At the announcement, Doug Ford noted that they had built a hospital (his words).
- In July the province opened applications for private companies to bid for orthopedic surgeries.
- In December the province announced it will award licenses early in 2026 to 4 new private orthopedic centres. Another $125 million over two years to "create" the centres with a goal of performing 20,000 orthopedic surgeries. The corporations that will receive these new licenses are OV Surgical Centre in Toronto, Academic Orthopedic Surgical Associates of Ottawa (AOAO), the Windsor Orthopedic Surgical Centre, and the Schroeder Ambulatory Centre in Richmond Hill.

Previous announcements:

- In August 2024 the Ministry announced a new round of applications for clinic licenses to privatize 60,000 gastrointestinal endoscopies. They plan to issue licenses in early 2025. That was delayed until the summer of 2025 and though they announced 22 new licenses in June 2025 for private endoscopy clinics, it is not clear when, after that, the new licenses were issued and became operational, if they have done so.
- In June 2024 the Ministry of Health opened applications to issue more licenses for private MRI and CT scan clinics in the fall. Once again, corporations could apply.
- In January 2023 the government announced new diagnostic and surgical clinics in Windsor, Kitchener-Waterloo and Ottawa to privatize 14,000 cataract surgeries per year. $18 million increase for existing private clinics to buy 49,000 hours of MRI and CT scans, 4,800 cataract surgeries, 900 other ophthalmic surgeries, 1,000 minimally invasive gynecological surgeries and 2,845 plastic surgeries such as hand soft tissue repair. The private clinics that were awarded the licenses are TLC Laser Eye Centres in Waterloo, Herzig Eye Institute and Focus Eye Centre in Ottawa, and Windsor Surgical Centre.
- In July 2021 they increased funding to private clinics by $24 million.
- In January 2021 they announced new licenses for private clinics to perform eye surgeries in place of public hospitals. The Ministry of Health issued a "call for applications" and clarified applicants could be a "corporation" rather than a doctor: "The Applicant could be a corporation that operates a Health Facility that meets the criteria for submitting an Application."

# APPENDIX II: ANALYSIS OF ALBERTA'S BILL 11

Alberta's Bill 11 *The Health Statutes Amendment Act* passed in early December. With its passage the existential threat for Public Medicare in Canada is here. The new law sets up two-tier medicare and private health insurance in Alberta. It is terrible for Albertans, destroys single-tier Public Medicare in Canada as a national achievement, and puts at threat public health care across the country.

It would be naïve, indeed, to believe that private insurance companies will stop at the Alberta border. Moreover, the trade agreements carve out public health care only so long as it is public. This new law is an abrogation of our national values that Canadians take care of one another, that we believe in equity and compassion, and that judge and janitor would have an equal interest in a high-quality public health system because access to care would be based on medical need, not how rich you are. It is hard to overstate how destructive this legislation is.

### What we currently have:

Currently, there are a number of protections that Canadians have, which stop the charging of patients for needed health care.

1. The Canada Health Act requires provinces to provide all medically necessary hospital and physician services – and those services when provided by other practitioners where provinces allow it – under public health insurance.
2. Extra-billing and user fees for medically necessary hospital and physician services are banned.
3. Provinces are required to provide health care on equal terms and conditions, without financial barriers.
4. In the provinces, physicians have an interest in staying in public health care because a) they are doing incredibly well by it (they are in the top 1-2% of income earners) and b) because they have to fully opt out of public health care and not bill the public health system if they want to charge for care. (Note: In Ontario, physicians cannot opt out at all.) Thus, there is a barrier to opting out. They would have to believe they could create an entire practice of privately paid patients and be able to make as much money or more from it.

### What Alberta is doing:

With their new law, Alberta has brought in private for-profit health insurance. It is not hyperbole to call that U.S. style. It is indeed U.S. style private health insurance and two-tier health care. It is unprecedented. It wipes out equal access to care based on medical need, not wealth. It wipes out the prohibition on both charging patients and the public health system. It pays lip service to the prohibitions on extra-billing and user fees but since they can charge patients and private insurance for the entire service, and there are no price controls, their protection of equality is rendered meaningless. The new law is written to remove the barriers to the creation of a "market" for private health insurance. That is the purpose. The method to do so is to allow doctors to charge both public and private and to jump back and forth at will. Under this plan, the public system will be the safety net while they build private health care.

### Purposefully manipulative language to make the extreme sound moderate

A quick note about language. It is disturbing to see the media coverage and commentary about this new law. A lot of it uses words like "dual practice", "hybrid", "public and private". This language confuses the actual substantive goal with the means to get there. The clear goal of the legislation is to set up a market for private health insurance and with it, two-tier health care. There are entire sections of the legislation

that serve no policy goal, and run counter to the public interest, except that they clear the way to make it easer to bring in and expand private health care. Please remember that the framing of this issue has long been planned by the forces that want to dismantle and privatize Public Medicare in Canada.

In November 2005, Dr. Brian Day hosted a "Saving Medicare Summit" in Vancouver. The conference openly advocated full two-tier medicare. Given the framing in the media and commentary right now, it is timely to remind ourselves that at this conference, Preston Manning, founder of the Reform Party, recommended the delegates to: Present their ideas as a "compromise": "Canadians love compromise." Redefine two-tier medicare as between the status quo and the U.S. private system. Make the extreme seem moderate. Make the proponents of public health care seem extreme.

> *"Once the battle over language has been won,"* Manning said*, it will be politically easier to follow is substantive prescription: completely dismantle national Medicare, have the federal government hand over more taxing power to the provinces and let them handle Medicare as they please.*

To really get a sense of how deliberate the plans and how deliberate the language to sell them and overcome Canadian resistance to privatization, here is an article quoting their strategies in their own words.

The following is a quick summary and initial analysis of the Bill.

## Summary of the Legislation:

This Act amends the Alberta Health Care Insurance Act to create the legal framework for two-tier medicare and the establishment of private health insurance and private payment for medically necessary care. It also removes the risks that create barriers to the growth of a private health insurance market.

To enable these, the Act makes related changes to health cards, billing enforcement, health information sharing, and hospital/agency statutes.

Some commentators and media have focused on language such as "dual practice", "hybrid" and "public and private"; anything to avoid saying "two tier health care" and "privatization". Their language is both confusing and fails to capture the main intent. The legislation expressly sets up two-tier health care. It expressly creates private health insurance and private payment for health care. It will drive the creation of a market for private insurance in Canada, threatening public health care across the country. It removes barriers and risks so that those physicians who want to charge patients for care can do so, and they can at the same time use the public health care system as a safety net to ensure they make the amount of money they want.

There are few protections for health planning and no price controls. There is very little that could mitigate the escalating prices, gross inequities, and loss of access to public health care that this plan to privatize health care will create. It is a giant step toward private U.S. style health care.

## Consequences:

- Alberta's new law brings in U.S. style private health insurance, including workplace plans. They will not stop at the Alberta border. This legislation will feed a market of private health insurance that will use every method they can to expand across Canada.
- It threatens public health care in Alberta and across Canada, and it violates our core values of equity and compassion. Health care will no longer be provided to executives, farmers, the middle class and the working class equally. It will be provided based on who can afford it and those who private health insurance companies will cover.

- It threatens Canadian sovereignty, ending national public health care which is foundational to our uniqueness and difference from the United States.
- It threatens single-tier Public Medicare across Canada by making health insurance private, thus no longer protected from trade agreements with the United States. As long as our health insurance is public, we can stop U.S. private health insurance from moving in. When that is gone, we no longer have the carve out.
- It will cause a sharp escalation in prices and costs for health care services. In the U.S., private insurance and out-of-pocket costs are extremely variable and are very high across the board, often many times the cost for diagnostics, treatments and procedures in Canada. European countries with private health insurance also have higher costs than we do.
- It will cause gross inequities and loss of access to public health care, favouring high income earners, large urban centres with a profitable "market" of private pay patients, and younger and healthier people who private health insurance companies see as profitable. It will cause a loss of services for the elderly, those with chronic health conditions and ill health, everyone who cannot afford the high cost of private health insurance and out-of-pocket charges, rural communities and the north, among others.
- Costs will increase for employers and will be passed on through co-pays and deductibles to employees also. Employers will face new private health insurance costs. The experience from the U.S. is that on top of new costs for employers, employees will face deductions from payroll to pay for health insurance, and on top will have deductibles. When employees lose their jobs, they lose their health insurance.
- Unions will be pressed into bargaining for health insurance coverage and that will replace wages, pensions and other benefits.
- It will seriously impede, if not make impossible, sound planning for the provision of public health care services as physicians can move back and forth between public and private without time delays.
- Staffing shortages for public health care will worsen, compounding the gross inequities created by private health insurance.
- People will have to pay for health care both through taxes and private payment. It is an added cost, not a cost reduction.

## Alberta Health Care Insurance Act Amendments:

Here is a quick summary and analysis of the main changes.

1. The changes set up three categories of physicians and two categories of dentists:

- Participating physicians who provide insured health services (AHCIP, which is Alberta's equivalent to Ontario's OHIP, Quebec's RAMQ, or BC's MSP).
- "Flexibly participating physicians" who provide insured health services (AHCIP) and privately insured services
- Opted-out physicians who provide only privately insured services
- For dentists the changes create two categories – those in and those out. They do not include the "flexibly participating" in – and out at the same time – category. NB. Specific changes to opted in and opted out dentistry run throughout the Act but we are not covering them here. We are focusing only on public health care services.

These changes mean that physicians can provide publicly insured (AHCIP) health services, or they can opt out entirely, or they can both bill the public plan and charge privately.

Prior to this, Alberta physicians had to be in or out. If they opted out, they couldn't bill the public health system (AHCIP). This was a protection for the public system, ensuring that most physicians would stay in the public system and thus Albertans' access to care would be protected because opting out entirely would be risky and would make it harder to make a good income. (To do so they would have to make an entire practice from the small "market" of wealthy executives to make their entire income.) Notably, physicians have been among the prime beneficiaries of Public Medicare. They have very high incomes under our public health care system without any extra user charges. Across Canada, doctors are in the top 5% of income earners in every community and many, if not most, are in the top 1%. Those who want to charge more want to make more than they are currently.

2. The changes also set up private workplace health insurance plans for current and former employees. This is notable and appears to be one of the main goals, if not the main goal, of this legislation.

3. In order to opt-out or be both in- and out- (i.e. a "flexibly participating" physician) the physician must notify the Minister of Health in writing. The Act specifies that physicians can go back and forth, meaning they can jump and out of the public insurance system entirely, or jump into and out of being "flexibly participating", as they wish at any time and without any delay. To do so, they simply have to notify the Minister in writing. However, in the Act, they expressly do not have to tell the Minister what services they are providing under public insurance and what services they are selling privately and they are not required to get prior approval.

The implications of this are significant because it means the Minister would lose ability to gauge what public health care services are being delivered and where. Since physicians can jump back and forth after simply sending a notice to the Minister, those services would be subject to significant variability at any time, making it much more difficult-- if not impossible-- to plan for equitable and sufficient public health care services. Furthermore, private health insurance indisputably creates inequities and the ability for the Minister to reduce those is severely limited by the way they have written this bill.

The Alberta government has tried to deal with the obvious problems of gross inequities created by this plan by adding in clauses that enable the Minister to restrict which services can be sold by opted-out and "flexibly participating" physicians and by setting conditions, circumstances, restrictions and other controls over what services can be sold privately. These clauses are insufficient to counter the fact that they have expressly allowed physicians not to tell them what services they are providing inside and outside the public health system and to jump back and forth at any time without delay. People would have to raise a hue and cry over poor access to care, and force the Minister to take action. Given how much this legislation is slanted in favour of the private insurance industry and physicians who want to charge (higher) prices privately, it is not clear how inequitable things would have to get to force the Minister to take action. (We have to understand, the legislation purposely sets up an inequitable health care regime. Thus, the Alberta government anticipates tolerating a level of inequity that we have never seen before.)

Why would they not require physicians to register what they are going to privatize, or delay jumping in and out of the public insurance system? All of this is explained by the next change (listed below). The goals appears to be to create a private health insurance market and to enable physicians maximum flexibility to move into and out of it with little risk. This legislation does not reflect the public interest in health planning or in improving access to care. It reflects the interests that want to remove barriers to creation of a private health insurance market by removing the risks. It creates easy pathways of entry into the private market for physicians with the ability to go back and forth at will without even notifying the

Health Minister of which particular services the public system will be providing, until the Minister collects records after-the-fact.

Nowhere does it say that a patient has the right to informed consent about whether or not a physician wants to charge them or bill the public plan. The choice is left up to the physician alone. (If a patient can't pay, they have to go without or go elsewhere, but the choice about which stream to put the patient is the doctor's, under this law.) Patients are not at the centre of this Act, in fact, quite the opposite.

In addition, the Minister is restricted from issuing orders, restrictions, conditions etc. on what services can be privatized by a clause saying that s/he must give 90 days notice to physicians unless the Minister deems it appropriate or necessary for the adequate provision of health services.

It is reasonable to conclude from these policy choices that the Act was written for the private health insurance industry and physicians who want to bill both the public system and privately with impunity and without risk.

4. A "flexibly participating" physician may decide on a case-by-case basis whether to provide a service described as a non-plan (i.e. privately paid) or covered (AHCIP) service. Thus, the physician determines whether they want to charge the patient or not and when.

The patient does not have the right to choose whether they get public coverage-- nor for which services-- with that particular doctor. Under the changes in the Act, the patient must simply be notified of the physician's choice to have the patient pay, the nature of the service that is subject to private payment, how much the patient is required to pay, that the patient cannot get reimbursed by the public system (AHCIP) for that service, and that they can go elsewhere to try to find a physician who will charge the public system (AHCIP). The physician is required to get the patient to sign off on the agreement to pay and the amount. If the patient will not sign off, they would have to go without the service or try to find another doctor who won't charge them.

The physician cannot both charge the public system (AHCIP) and the patient (i.e. extra bill the patient) for the privately-paid service. The physician cannot charge user fees as a condition of receiving a publicly insured service (AHCIP). This appears to be a nod to the Canada Health Act, which bans user fees and extra-billing. It is dubious whether Alberta will start enforcing these provisions. In any case, they are bringing in entire private health insurance and private payment, so doctors can charge patients directly for medically needed services. Whatever equality effect the ban on user fees and extra-billing had under a public insurance system is completely destroyed by private health insurance. Moreover, the Canada Health Act was written to ensure that Canadians be provided health care on equal terms and conditions and without financial barriers. Obviously, this legislation destroys any right to equality in access to health care.