AMA Proposed Safeguards for Dual Practice in Alberta – Executive Summary (Submitted April 30, 2026)

Purpose

This executive summary accompanies the Alberta Medical Association's full submission on proposed safeguards for physician dual practice in Alberta.

The attached report sets out **70 safeguards** developed by the AMA Dual Practice Task Force to protect **equitable access, patient safety, workforce sustainability, accountability and public system integrity** should Alberta proceed with any form of dual practice.

Key message

The AMA does not oppose policy exploration or innovation.

However, **dual practice without strong safeguards creates significant and foreseeable risks** to Alberta's public health care system, patients and workforce.

If dual practice proceeds, it must be **tightly regulated, public interest driven, data transparent, workforce protective and fully accountable for downstream costs and harms**.

AMA's bottom line

Dual practice must not displace or delay publicly funded care, divert scarce health workforce from public services, introduce preferential access based on ability to pay, shift private sector risks or costs onto the public system, or undermine patient safety, continuity of care or public trust.

Seven safeguard themes

The AMA's 70 safeguards are organized across seven system level themes.

1. **Policy, governance and oversight**
   A single statutory oversight framework with mandatory participation, monitoring, enforcement and clear triggers for corrective action when harms emerge.

2. **Legal, ethical and professional standards**
   Identical professional, ethical, quality, transparency and informed consent standards across public and private care, with clear responsibility for complications.

3. **Workforce sustainability and equity**
   Enforceable public service participation requirements, protections for rural and underserviced communities, and limits on private activity when public capacity is at risk.

4. **Quality and patient safety**
   Unified provincial standards for credentialing, privileging, adverse event reporting, continuity of care and clinical appropriateness.

5. **Social supports and equity impacts**
   Safeguards to prevent downstream burdens on patients, families and communities, including rural access protections and required equity impact assessments.

6. **Health data integration and transparency**
   Unified wait list management, full integration with public health data systems and community-based providers, and public transparency of ownership, outcomes and system impacts.

7. **Financial integrity and cost effectiveness**
   Full cost recovery, accountability for downstream public costs, prohibition of facility or add on fees for insured services and preservation of Alberta's regulatory authority.

Why these safeguards matter

Experience in other jurisdictions demonstrates that **dual practice without safeguards reliably increases inequity, workforce strain and public system costs**, while eroding public confidence.

The AMA's safeguards are designed to **prevent predictable harms, preserve policy flexibility, maintain regulatory control and protect Alberta patients and communities first**.

Closing

The AMA submits this report to ensure that if dual practice proceeds in Alberta, it does so in a way that strengthens rather than weakens the public health care system.

The **AMA is ready to actively support government** in shaping a dual practice approach that delivers results while protecting patients, the workforce and the public system. **We want to help do this right** for Albertans.

ALBERTA MEDICAL ASSOCIATION

AMA Proposed Safeguards

for Dual Practice in Alberta

Prepared for Primary and Preventative Health Services (Government of Alberta)

April 30, 2026

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Background

Established in January 2026, the AMA Dual Practice Task Force brought together seven physicians with diverse experience across Alberta's health system and familiarity with dual practice-style models in other jurisdictions. Informed by an AMA Executive Summary and December 2025 environmental scan, the Task Force identified key risks and developed 70 proposed safeguards with respect to dual practice that are relevant to the Alberta context.

Scope

This document summarizes Alberta-relevant risks and proposed safeguards to support successful dual practice policy design and implementation in Alberta. Content is organized by broader system themes, with safeguards under each that reflect key considerations identified by the Task Force to help maintain equitable access, service quality, accountability and system integrity.

Policy, governance and oversight

7 safeguards

Fragmented accountability across multiple authorities

1. Create a single provincial statutory oversight body with authority across public and private physician practice, including dual practice.

Inconsistent enforcement of rules and limits

1. Establish a separate (non-partisan) auditing / oversight body with authority to:
    - assess compliance
    - identify emerging system-level risks
    - trigger policy review when unintended effects are detected

Lack of monitoring for non-compliance

1. Leverage and enhance existing provincial data systems to create integrated public- private reporting mechanisms with mandatory obligations for participating physicians and facilities to support monitoring and timely policy adjustment.

Private (corporate) interests influence rules, pricing, allowed services and reporting obligations.

1. Establish a publicly governed, standardized contractual framework for private facility and physician participation.
2. Protect equitable access to publicly insured care by preventing preferential access or indirect cost-shifting that occurs at the expense of public system.
3. Establish enforceable standards for financial disclosure, conflict-of-interest transparency and informed consent in private-pay care.
4. Monitor private insurance market dynamics and their impact on the publicly insured system.

Legal, Ethical & Professional

13 safeguards

Role conflict and moral distress among clinicians

1. Professional and ethical standards must be identical across public and private settings, regardless of payment source.
2. Dual practice participation must include mandatory transparency to patients regarding publicly insured options and expected wait times.
3. Conflict-of-interest standards must be formally reinforced as a condition of participation in dual practice.
4. Clinicians engaged in dual practice must have access to confidential ethics consultation and reporting mechanisms.

Emergence of inequitable access to care based on the ability to pay

1. Publicly insured care must prioritize Alberta residents and be protected from displacement, acceleration or preferential access resulting from private payment pathways.
2. Legislation must clearly define what constitutes a medically necessary service.

Blurred boundaries around public resource use for private gain

1. Public resources must not be used for private delivery except where explicitly authorized under contract with full cost recovery and defined public benefit.
2. Mechanisms must ensure that private operators assume appropriate financial responsibility for complications and downstream public costs arising from privately delivered care.
3. Financial transparency and safeguards must prevent double billing and indirect public subsidy of private services.

Patient protection and informed financial consent

1. Implement a standardized financial disclosure and informed consent framework for privately paid services, with explicit prohibitions on misleading or coercive practices.

Trainees unprepared for ethical issues in private settings

1. Undergraduate and postgraduate medical education must include structured, mandatory training on ethical decision-making in mixed public–private practice environments.
2. Learners training in private or mixed public–private clinical settings must be protected by defined supervision standards.
3. Dual practice participation should be limited to physicians who have completed a defined period of independent practice within Alberta's public health system.

Workforce

29 safeguards

Finite workforce (MDs and non-MDs)

1. Public service participation must be clearly defined and enforceable within dual practice models.
2. Mechanisms are required to limit private activity when public capacity is at risk.
3. Clear and explicit policies governing opt-out arrangements.
4. Dual practice policies must consider impacts on the non-physician workforce.
5. Systems are required for monitoring, reporting and real-time workforce oversight.
6. Standards and controls are required for private facility accreditation and operation.

7. Long-term workforce supply and retention must be actively supported.

Rural workforce pressures

1. Defined public service requirements must apply in rural practice settings.
2. Private activity must be structured to protect continuity of rural services.
3. Urban–rural workforce redistribution is a key factor in licensing and credentialling frameworks.
4. Policy should include sustained measures to support rural recruitment, retention and patient access over the longer term.
5. Fly-in / fly-out (FIFO) workforce arrangements should operate under clear governing conditions.

Different employment conditions and physician behavioural incentives

1. Public call participation must be clearly defined and equitably structured.
2. Private clinical activity within dual practice models should be transparent and structured to support equitable access across regions.
3. Compensation, incentives and recruitment factors should align with public system needs.
4. Employment protections and workload sustainability must be supported within public practice model.

OR access, staffing and system bottlenecks

1. Private OR activity must be structured to avoid undermining public OR staffing capacity.
2. Public OR workforce availability must not be compromised by private recruitment practices.
3. Off-hours and shared staffing models represent potential system design options.
4. OR system bottlenecks must be understood before expanding private activity.

Managing complications and continuity of care

1. Accountability for post operative complications must be clearly assigned.
2. Public hospital privileges and call participation must support continuity of care.
3. Standardized pathways are needed for routing post operative complications.
4. Private sector capacity for managing complications should be considered within system design.
5. Post operative complication reporting and monitoring must be supported.

Training and education

1. Learner involvement in dual practice must be governed through PGME-led frameworks.
2. Academic teaching roles and protected teaching time must be preserved.
3. Private facility participation in training must be transparent and demonstrable.
4. Incentives or recognition for private facilities supporting training should be considered.

Quality and Patient Safety

4 safeguards

Overtreatment and clinical appropriateness

1. Privately delivered services within a dual practice model must follow evidence-based appropriateness standards and clinical pathways to reduce unwarranted variation and protect patient safety.

Infection prevention and stewardship variability

1. Apply identical IPAC and stewardship standards across facilities.

Credentialing and privileging inconsistencies

1. Require unified provincial standards and accreditation across all care sites.

2. Require unified provincial standards for credentialing, privileging and revalidation for all clinical care providers.

Social Supports

5 safeguards

Downstream support burden and capacity shifting

1. No private expansion unless a bundled payment (cost) model is in place for the same catchment to protect public home and community support needs (e.g. home care, rehab, community nursing, social work, equipment)
2. Licensing approval for private facilities must require a rural access plan that reduces barriers to travel and follow-up, to prevent widening rural and remote access gaps.
3. Implement a caregiver burden screening tool to be integrated in pre-operative evaluation for surgical booking at private facilities.

Urban-rural access imbalance

1. Apply rural restriction triggers in single-coverage corridors where private participation would worsen waits, weaken local services or remove the last specialist or critical support resource.

Support access inequities

1. An equity impact assessment and mitigation plan (income, disability, rurality, Indigenous communities) is required before dual practice implementation.

Health Data Integration

5 safeguards

Complication and adverse event attribution failure

1. Reporting requirements must ensure that complications and adverse events arising from non-hospital surgical facility care remain linked to the originating facility, with transfer protocols requiring transparent and portable data linkage across settings.
2. Complications arising from care delivered in non-hospital surgical facilities must be captured through the same provincial adverse event reporting, review and oversight processes, regardless of where they are ultimately managed.

Corporate ownership opacity and dual-loyalty invisibility

1. Mandatory public registry of non-hospital surgical facility ownership, including all physician shareholders and governance roles; updated annually.

Waitlist data distortion under dual-pathway access

1. Provincial wait-list management must be unified and robust, include a clear auditing function, and track patient status across public and private care pathways, including entry, removal, and re-entry on public waitlists related to private care, with these changes reported separately from reductions attributable to public-system capacity.

Information gaps affecting community-based practitioners (e.g., GPs, pharmacists, physiotherapists) disrupting follow-up, rehabilitation and ongoing care across settings

1. Data integration requirements must explicitly include community-based practitioners to support continuity of care across settings. e.g. mandatory CII/CPAR integration.

Financial and Cost-effectiveness

7 safeguards

Revenue leakage and diversion of public resources to subsidize privately delivered care

1. When public infrastructure is used to support private procedures, mandatory revenue sharing beyond cost recovery must be in place to reinvest in public system capacity.

Regulatory and oversight costs of dual practice borne by the public system, not private operators

1. Licensing fees and annual levies on private operators must fully fund the incremental regulatory and oversight costs of dual practice.

Private insurance market cost escalation may drive up public costs for the same services

1. Mandatory price alignment mechanisms to prevent private fee schedules from exceeding public Schedule of Medical Benefits beyond a defined margin, with escalation thresholds and sunset clauses.

Facility fees and chargeable add-ons to publicly insured care

1. No “non-insured hospital services” or “enhanced goods and services” category may be established in regulation without formal *Canada Health Act* compliance review and public consultation. Patients must not be charged facility fees or other ancillary charges for publicly insured procedures.

International and domestic investor entry into the Alberta system creating trade and investment agreement lock-in

1. Dual-practice operators should be subject to ownership and control transparency requirements, with safeguards to ensure clear Alberta-based accountability and to prevent opaque control structures or excessive market concentration that could undermine the public interest.
2. Operator agreements must include sunset and exit provisions that preserve Alberta’s right to revoke authorization in the public interest.
3. Legislation must recognize health services as a public interest matter and preserve Alberta’s ability to regulate under an applicable trade and investment agreement.