NOTICE OF ARBITRATION

UNDER THE ARBITRATION RULES OF THE UNITED NATIONS COMMISSION ON INTERNATIONAL TRADE LAW AND THE NORTH AMERICAN FREE TRADE AGREEMENT

MELVIN J. HOWARD, CENTURION HEALTH CORPORATION, HOWARD FAMILY TRUST

CLAIMANT/INVESTOR,

AND:

THE GOVERNMENT OF CANADA

RESPONDENT/PARTY.

NOTICE OF ARBITRATION: JANUARY 5, 2009

Pursuant to Article 3 of the United Nations Commission on International Trade Law ("UNCITRAL") and Articles 1116 and 1120 of the North American Free Trade Agreement ("NAFTA"), the Claimant, hereby initiates on its own behalf and on behalf of its enterprises (*see* Section C below) recourse to arbitration under the UNCITRAL Rules of Arbitration (Resolution 31/98 Adopted by the General Assembly on December 15, 1976).

A. DEMAND

Pursuant to Article 1120(1)© of NAFTA and Article 3(a) of UNCITRAL, the Claimant hereby demands that the dispute between it and the Respondent be referred to arbitration under the UNCITRAL Rules of Arbitration.

Pursuant to Article 1119 of NAFTA, on July 16, 2008, the Investor served written notice of its intent to submit a claim to arbitration (the "Notice of Intent") on the Party which notice was, accordingly, more than ninety (90) days before the submission of this claim. As detailed in Section F below, at least six (6) months have passed since the events giving rise to the Investor's claim as required by Section B of NAFTA Chapter 11 (Article 1120(1)). As detailed in Section F below, no more than three (3) years have passed since the date on which the Investor and Enterprise first acquired, or should have acquired, knowledge of the Party's breach of the obligations provided in Section A of Chapter 11 of NAFTA, and knowledge that the Investor and Enterprise have incurred loss and damages by reason of, or arising out of, that breach (NAFTA Article 1117(2)). Pursuant to Article 1118, on December 3, 2008 the Claimant sent a letter to the Respondent requesting consultation. As a courtesy the Claimant allowed time to pass as an election was called in the midst of these proceedings. Then on December 8, the Claimant was notified that previous counsel for the Government of Canada would no longer be representing Canada in these proceedings and that other counsel would be assigned. Based on this information and past experiences with provincial authorities and the unforeseen event of Parliament being dissolved after it was just elected. It was decided to serve the Government of Canada with formal notice of Arbitration.

B. CONSENT TO ARBITRATION

Pursuant to Article 1121 of NAFTA, the Claimant and its enterprises consent to arbitration in accordance with the procedures set out in NAFTA. The Claimant and its enterprises hereby waive their rights to initiate or continue before any administrative tribunal or court, or other dispute settlement procedures, any proceedings with respect to the measures outlined herein and alleged to be breaches of Canada's obligations under NAFTA. Except for proceedings for injunctive, declaratory or other extraordinary relief, not involving the payment of damages, before an administrative tribunal or court under federal or provincial laws of Canada.

C. NAMES AND ADDRESSES OF PARTIES

CLAIMANT/INVESTOR ENTERPRISES RESPONDENT/PARTY

Claimant/Investor **MELVIN J. HOWARD**, **CENTURION HEALTH CORP HOWARD FAMILY TRUST** 2436 E. Darrel Road, Phoenix, Az 85042

Respondent/Party **GOVERNMENT OF CANADA** Office of the Deputy Attorney General of Canada Justice Building 284 Wellington Street Ottawa, ON K1A OH8

D. ARBITRATION CLAUSE OR ARBITRATION AGREEMENT INVOKED

Claimant invokes Section B of Chapter 11 of NAFTA, and specifically Articles 1116, 1120 and 1122 as authority for the arbitration. Section B of Chapter 11 of NAFTA sets out the provisions agreed to concerning the settlement of disputes between a Party and an investor of another Party.

E. CONTRACT OUT OF OR IN RELATION TO WHICH THE DISPUTE ARISES

The dispute is in relation to the Claimant's investments in Canada and the damages that have arisen out of the Government of Canada's ("Canada") breach of its obligations under Chapter 11 and Chapter 15 Section A of NAFTA.

F. GENERAL NATURE OF THE CLAIM AND AMOUNT INVOLVED

OBLIGATIONS BREACHED AND RELEVANT PROVISIONS

The Investor alleges that the Government of Canada has breached its obligations under Section A of Chapter 11 of NAFTA, including the following provisions:

(i) Article 1105 – Minimum Standard of Treatment; and (ii) Article 1110 – Expropriation and Compensation. Article 1502 - Monopolies and State Enterprises. Article 1503 - State Enterprises.

The relevant provisions of the NAFTA include:

ARTICLE 1105 – MINIMUM STANDARD OF TREATMENT

1. Each Party shall accord to investments of Investors of another Party treatment in accordance with International Law, including fair and equitable treatment and full protection and security.

Article 1110 – Expropriation and Compensation.

1. No Party may directly or indirectly nationalize or expropriate an investment of an Investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment ("expropriation"), except:

(a) for a public purpose;
(b) on a non-discriminatory basis;
© in accordance with due process of law and Article 1105(1); and (d) on payment of compensation in accordance with Paragraphs 2 – 6. 2. Compensation shall be equivalent to the fair market value of the expropriated investment immediately before the expropriation took place ("date of expropriation") and shall not reflect any change in value occurring because the intended expropriation had become known earlier. Valuation criteria shall include going concern value, asset value, including declared tax value of tangible property, and other criteria, as appropriate, to determine fair market value.
3. Compensation shall be paid without delay and shall be fully realizable.

Article 1502 - Monopolies and State Enterprises

1. Nothing in this Agreement shall be construed to prevent a Party from designating a monopoly.
2. Where a Party intends to designate a monopoly and the designation may affect the interests of persons of another Party, the Party shall:

(a) wherever possible, provide prior written notification to the other Party of the designation; and
(b) endeavor to introduce at the time of the designation such conditions on the operation of the monopoly as will minimize or eliminate any nullification or impairment of benefits in the sense of Annex 2004 (Nullification and Impairment).
3. Each Party shall ensure, through regulatory control, administrative supervision or the application of other measures, that any privately owned monopoly that it designates and any government monopoly that it maintains or designates:
(a) acts in a manner that is not inconsistent with the Party's obligations under this Agreement wherever such a monopoly exercises any regulatory, administrative or other governmental authority that the Party has delegated to it in connection with the monopoly good or service, such as the power to grant import or export licenses, approve commercial transactions or impose quotas, fees or other charges;
(b) except to comply with any terms of its designation that are not inconsistent with subparagraph (c) or (d), acts solely in accordance with commercial considerations in its purchase or sale of the monopoly good or service in the relevant market, including with regard to price, quality, availability, marketability, transportation and other terms and conditions of purchase or sale;
(c) provides non-discriminatory treatment to investments of investors, to goods and to service providers of another Party in its purchase or sale of the monopoly good or service in the relevant market; and
(d) does not use its monopoly position to engage, either directly or indirectly, including through its dealings with its parent, its subsidiary or other enterprise with common ownership, in anticompetitive practices in a non-monopolized market in its territory that adversely affect an investment of an investor of another Party, including through the discriminatory provision of the monopoly good or service, crosssubsidization or predatory conduct.

Article 1503 - State Enterprises

1. Nothing in this Agreement shall be construed to prevent a Party from maintaining or establishing a state enterprise.
2. Each Party shall ensure, through regulatory control, administrative supervision or the application of other measures, that any state enterprise that it maintains or establishes acts in a manner that is not inconsistent with the Party's obligations under Chapters Eleven (Investment) and Fourteen (Financial Services) wherever such enterprise exercises any regulatory, administrative or other governmental authority that the Party has delegated to it, such as the power to expropriate, grant licenses, approve commercial transactions or impose quotas, fees or other charges.
3. Each Party shall ensure that any state enterprise that it maintains or establishes accords non-discriminatory treatment in the sale of its goods or services to investments in the Party's territory of investors of another Party.

FACTUAL BACKGROUND

1. The Investor, - Howard Family Trust ("HFT") a Canadian Irrevocable Family Trust formed a Canadian business corporation named Regent Hills Health Centre Inc. ("RHHC") On December 13, 2003. Howard Capital Management a US limited partnership involved in asset management manages the Howard Family Trust. The Howard Family Trust owns 100% of Regent Hills. Regent Hills has contracted for the purchase of 9.5 acres in Vancouver (the "Land") upon which it was to build the largest privately owned health center in Canada to offer orthopedics, plastic surgery, general surgery and other health care services to the public on a fee for service basis and likely through contracts with Canadian Health Authorities, the Ministry of Defense and the Royal Canadian Mounted Police (the "Center"). Regent Hills was to complete the purchase of the Land with borrowed funds, as described below.

2. Regent Hills contracted with DGBK Architects, a Canadian architecture firm specializing in health care design and compliance with health care regulations, to design the Center. In addition, Regent Hills was negotiating a Project Management Agreement to a fixed price for construction with Ledcor Construction Limited, a Canadian contracting and construction firm specializing in health care construction and compliance with health care construction requirements. The Center was anticipated to be complete and open for operation in February of 2007. The Howard Family Trust was to be the beneficiary of a Mortgage from Regent Hills on the real estate upon which the Center is built and on the fixtures thereon.

3. Financing of Regent Hills:

US Issuer:	Regent Hills Health Centre LLC
Borrower:	Regent Hills Health Centre
Par Amount:	$54,340,000
Issue:	Loan Program Notes (Variable Rate Series A) (Installment No. 1) (the "Notes")

Purpose:	The proceeds of the Notes will be used to (i) to finance the construction and furnishings and (ii) finance certain costs incurred in connection with the issuance of the Notes.
Tax Status:	Taxable
Bondholder Security:	Irrevocable direct pay letter of credit from a financial institution
Letter of Credit Security:	FIRST MORTGAGE INTEREST AND SECURED BY AN ASSIGNMENT OF THE RENTS AND LEASES
Final Maturity:	2029
Amortization:	Level
Interest Rate Mode:	Variable Rate: weekly
Interest Rate Determination:	The remarketing agent will set the interest rate weekly to reflect market conditions for comparable short-term taxable securities
Calculation of Interest:	Interest of the Notes will be computed on the basis of actual number of days elapsed over a year of 365 days (366 in leap years)
Interest Payments:	Weekly Mode: monthly
Principal Payments:	Annually to Noteholders
Optional Redemption During Weekly Rate Period:	Borrower may redeem the Notes at its option in whole or in part at par plus accrued interest on any interest payment date with at least 45 days advance notice.

*Preliminary, subject to change

Borrower Conversion Option:	Borrower may elect to convert Notes from the weekly rate to a daily rate or a fixed rate mode upon 45 days advance notice. The interest rate on the Notes would be established at the time of conversion based on the prevailing market conditions
Tender Option (Demand Purchase Option):	AN OWNER OF A NOTE HAS THE OPTION TO TENDER ITS NOTE ON ANY BUSINESS DAY WITH AT LEAST SEVEN DAYS ADVANCE NOTICE

Remarketing Fee:	0.125% PER ANNUM OF THE PRINCIPAL AMOUNT OF NOTES OUTSTANDING IN WEEKLY RATE MODE; PAID SEMIANNUALLY IN ARREARS
Issuance Costs:	THE BORROWER WILL BE RESPONSIBLE FOR THE PAYMENT OF ALL REASONABLE COSTS PERTAINING TO THE ISSUANCE OF THE NOTES, INCLUDING UNDERWRITER'S COUNSEL FEES AND EXPENSES
Annual Letter of Credit Fee:	ESTIMATED AT 1.5% OF PAR AMOUNT OF NOTES OUTSTANDING, PLUS 51 DAYS OF COVERED INTEREST AT 12% PAID ANNUALLY IN ADVANCE
Upfront Letter of Credit Commitment Fee:	ESTIMATED AT 0.25%
Other Annual Fees:	TRUSTEE - $5,500, RATING SURVEILLANCE - $3,500
Underwriter and Remarketing Agent:	ZIEGLER CAPITAL MARKETS GROUP

4. Surgical services to be included in Regent Hills in 12 surgical suites:

COSMETIC PLASTIC SURGERY

- Abdominoplasty – Tummy Tuck
- Breast Augmentation – Implants
  Breast Augmentation – Tuba
- Breast Lift/Reduction
- Cosmetic Dermatology
- Endoscopic Forehead Lift
- Eyelid Surgery
- Facelift & Neck Surgery
- Laser Skin resurfacing
- Otoplasty (Ear)
- Surgery of the Nose

- Ultrasonic Liposuction

PLASTIC – RECONSTRUCTIVE

- Open Capsulectomy Breast
- Exc. Gynecomastia
- Exc. Hyperhydrosis
- Synovectomy wrist, carpal tunnel release
- Exc. Dupuytren's contracture, palmar fasciotomy
- Tenolysis Finger, exc, tumor on finger
- Removal of k-wire, pins in finger/hand
- Tendon Repair
- Open Reduction of Finger
- Ulnar nerve transposition
- Blepharoplasty-unilateral
- Blepharoplasty-bilateral
- Lid Repair (insured)
- Rhinoplasty, Septorhinoplasty
- Closed Reduction Fractured Nose
- Open Reduction Fractured Nose
- Scar revisions
- Skin Graft
- Excision of Cysts, lipomas, biopsy
- Fat injection to face
- Otoplasty

LASER DENTISTRY

- SMILE RECONSTRUCTION
- LASER TEETH WHITENING
- LASER GUM THERAPY
- MERCURY FREE DENTISTRY
- FRESH BREATH TREATMENTS

ARTHROSCOPY

- ACL ligament repair
- Ankle - diagnostic; menisectomy or repair
- Knee - diagnostic; menisectomy or repair
- Shoulder repair

ORTHOPAEDIC SURGERY

- Torn Cartilage
- Torn Ligaments
- Removal Bone & Cartilage

- ACL
- Arthroscopy of knee
- Excision of Pre-patellar bursa, Baker's cyst
- Removal of plantar neuroma
- Removal of ganglion
- Incise flexor tendon sheath of thumb
- Incise carpal ligament
- Excision lump on toe, excision toenail, excision metatarsal
- Excision Olecranon Bursa
- Excision Lipoma on shoulder
- Hip replacement

OPHTHAMOLOGY

- Blepharoplasty
- Cataract with/without intraocular lens (IOL) implant
- Corneal transplantation
- Dacryocystorhinostomy
- Entropian/Ectroptian repair
- Excision of Chalazions
- Glaucoma Surgery
- Ptosis Repair
- Strabismus repairs
- Vitrectomy

GENERAL SURGERY

- Fistula in Ano
- Hemorrhoids
- Hernia Repair
- Inguinal
- Femoral
- Abdominal wall
- Varicose vein stripping and ligation
- Stripping of Varicose Veins-Unilateral
- Stripping of Varicose Veins-Bilateral
- Hemorrhoidectomy, Sphincterectomy, Fistulectomy
- Exc. Pilonidal Sinus
- Excision of Perianal Warts
- Anal Dilitation
- Excision of Anal Tags, Polyps, Nodules
- Inguinal Hernia Repair-unilateral (with or without plug)
- Inguinal Hernia Repair-bilateral (with or without plug)

EARS NOSE & THROAT

- Adenoidectomy
- Myringotomy/Tube
- Myringoplasty

- Pressure equalizing tube
- Surgery for Snoring
- Rhinoplasty,
- Septal reconstruction
- Submucous resection
- Diathermy
- Myringotomy and Insertion of Drainage Tubes,
- Removal of tubes
- Removal of cyst lower eyelid, forehead, lip, biopsy of cheek
- Removal of mass on uvula,
- Removal of tonsillar wart
- Removal of nasal lesion,
- Removal of wart on nose, biopsy of nose
- Excision of oral lesion
- Biopsy of tongue
- Release of tongue tie
- Excision of neck mass (more extensive than simple biopsy)
- Cauterization of Nasal Septum, Turbinates
- SMDT
- Septoplasty
- Removal Mass / Fibroma / Stenosis in Ear Canal
- Closed Reduction Fractured Nose
- Open Reduction Fractured Nose
- EUA Nose, Nasopharynx, Ear

PODIATRY

- Bunions
- Hammertoes
- Ingrown nails
- Tendon transfers

HIP REPLACEMENT

LASER EYE SURGERY

LIGHT NERO SURGERY

HEALTH & HEART AMBULATORY PROGRAMS DIAGNOSTIC & TREATMENT SERVICES

Physical & Occupational Therapy
Imaging CT, MRA, PET, Cyber Knife, Ultrasound, Mammography , X-ray
On-Site Laboratory Service
Administration & Human Resources
Administration services will be integrated to home office
On-Site staff Educational Resource Center
Staff Facilities
Day Care Services
Dinning Room
Gym
Spa **Observation Recovery / After Care and Treatment Beds**

On Wednesday, November 23, 2005 due to the constant barriers and delays by regional authorities the Investor was informed that the construction budget had increased to a **Total Capital Costs Including Beginning Cash and Working Capital Revolver of $181,060,202.**

REGENT HILLS HEALTH CENTRE

Item	Description	sf	$ / sf	Total $	
a.	Outpatient surgical space & inpatient rooms	100,000	490.00	49,000,000	*1
b.	Modalities - MRI, CT, Pet Scan & Radiosurgery	10,000	550.00	5,500,000	*2
c.	Rehab	30,000	325.00	9,750,000	
d.	Staff lounge & change rooms	5,000	160.00	800,000	
e.	Facility office & clinic space	54,000	180.00	9,720,000	*1

f.	Children day care	6,000	120.00	720,000
g.	Dedicated admin/atrium	10,000	140.00	1,400,000
	TOTAL	**215,000**		**76,890,000**
	$ / SF FOR FACILITY		**357.63**	

*1 No equipment - all medical gases and connections such as for instrumentation provided

*2 No major equipment such as MRI, PETSCAN, X'RAY etc.

5. Centurion Health Corporation now Centurion Health Corporation Trust ("CHCT")- on September 21, 2001, the Company entered into a Securities Purchase Agreement and Plan of Reorganization, which was amended on December 27, 2001, newly issued Common Stock, was issued for 100% of the outstanding shares of Great Northern Health, Inc., a Nevada corporation engaged in the healthcare business in Canada the predecessor. Name changed to Centurion Health Corporation a Delaware corporation is a health management company. The initial strategic component to the Company's corporate plan was the implementation of an Ultrafast CT diagnostic unit and other medical technology. The Ultrafast CT Scanner is the only non-invasive tool able to diagnose the presence of coronary artery disease. This advanced technology, like the "Gamma Knife" is currently not available in Canada. It was to provide Canadian's access to proven non-invasive diagnostic medical technology. Through its wholly owned subsidiary Holy Cross Heart and Health Center Ltd., the company purchased the first Ultrafast CT Scanner in Canada.

6. The *Canada Health Act* (hereafter called the Act) received Royal Assent on 1 April 1984. Through this Act, the federal government ensures that the provinces and territories meet certain requirements, such as free and universal access to insured health care. Accordingly, the Federal Government of Canada through the Act constitutes both a "state enterprise" and a "government monopoly" for purposes of NAFTA Articles 1502 and 1503. Canada, governments are the main source of funding for health care because they play a key role in the insurance market. They explain that government intervention is necessary to correct potential problems for social equity in the operation of the private insurance market. They claim that private insurance companies could refuse to insure high-risk clients or force them to pay a much higher premium to offset the risk. They believe that government insurance can correct the shortcomings in the private market by protecting the broadest possible cross-section of the population and avoiding unreasonable premium hikes which ultimately effect no improvement in the state of health. Second, they maintain that the private insurance market does not have a regard for economic equity. They argue that in a private insurance market, individuals with health problems and a low income would be subject to the same fee structure as high-income individuals; thus, economically disadvantaged individuals would have to assume a relatively higher proportion of health-care costs. This does not mean, however, that the private sector is totally absent from this field in Canada. Private health-care insurance exists, but its scope is limited. To be more precise, the private market provides additional coverage for health services that are not insured by the public plan or that are only partially insured by it. Moreover, the delivery of health care is largely in the hands of the private sector most medical practitioners are in private practice

and hospitals are to great extent private, non-profit organizations.

Government Health Care in Canada

7. The federal and provincial governments have very different responsibilities in health care. Strictly speaking, the federal government cannot establish and maintain a national health-care insurance plan because it cannot regulate the delivery of health care to individuals; under the Canadian Constitution and its interpretation by the courts, health care is a field primarily under provincial jurisdiction. The only explicit references in the Constitution to health-care issues give the federal government jurisdiction in matters relating to navy hospitals and quarantine. In addition, the federal government is responsible for delivering health services to groups that fall under its jurisdiction, such as Aboriginal peoples, the Canadian forces, veterans, and inmates in federal penitentiaries. Provincial governments are responsible for:

Determining how many beds will be available in a province;

Determining what categories of staff will be hired;

Determining how the system will serve the population;

Approving hospital budgets;

Negotiating fee scales with medical associations; and

Administering the public health-care insurance plan in their own province.

8. The federal government has intervened in the health-care field by using the constitutional "spending power," which enables it to make a financial contribution to certain programs under provincial jurisdiction, generally subject to provincial compliance with certain requirements. It is the constitutional imbalance between powers and responsibilities, together with inter-provincial equity factors, that brought about federal transfers such as those to the health-care sector. The scale of transfer payments from the federal government to the provincial governments has increased in Canada as a result of the characteristics of the constitution and reality. It is because Canadian provinces have been given the most expensive responsibilities, while being limited to direct taxation, and because many of them have found themselves faced with a tax base below the national average, that recourse to the spending power has become so important in the practical workings of Canadian federalism. Consequently, the federal government has intervened in areas under provincial jurisdiction, but without changing the division of powers stipulated in the Constitution. Although the federal government is not responsible for health-care administration, organization or delivery, it can exert considerable influence on provincial health-care policies by using the political and financial leverage afforded by the spending power. In fact, by setting the requirements for providing federal funding, the *Canada Health Act* has to a large extent shaped provincial health-care insurance plans throughout the country.

Historical Background of Canadian Medicare

9. Public health-car insurance or Medicare as it is known today, in which the federal government's financial contribution is linked to provincial compliance with specific requirements, dates back to the late 1950s. Under the *Hospital Insurance and Diagnostic Services Act* of 1957 and the *Medical Care Act* of 1966, the federal government made an offer to the

provinces to fund approximately half the cost of all insured health services. In return for federal contributions, the provinces – as part of their public health-care insurance plans – undertook to insure hospital and physician services and to comply with certain requirements, such as universality. These two Acts did not prevent provinces from demanding a financial contribution from patients; however, because federal contributions were proportional to provincial government expenditures, the provincial governments had nothing to gain from imposing direct patient charges. In fact, the revenue from such charges would have resulted in a reduction in the federal contribution. This implicit reduction mechanism thus strongly deterred provinces from adopting any form of direct patient charges, such as extra-billing and user charges.

10. In 1977, this formula of shared costs was replaced by a method of block funding based on cash transfers and tax point transfers as part of Established Programs Financing (EPF). Both federal Acts on hospital services and medical care and the requirements attached to them were retained. However, the implicit mechanism for deducting federal contributions was eliminated with the EPF, because federal funding was no longer linked to provincial government expenditures; this resulted in a proliferation of direct patient charges. For example, Newfoundland, New Brunswick, Quebec, Ontario, Saskatchewan, Alberta and British Columbia levied user charges; and extra-billing was authorized in most provinces. The federal government saw this situation as posing a threat to the principle of free and universal access to health services throughout the country. It was therefore anxious to reassert its commitment to the principle of universal health-care insurance; and it relied heavily on the criterion of economic equity to justify its intervention. *Canada Health Act*, which, as stated earlier, was passed on 1 April 1984. The Act combined and updated the two federal Acts of 1957 and 1966. The national principles were reaffirmed in the Act, but extra restrictions were specifically added to deter any form of direct patient charges and to provide citizens of all provinces with access.

11. Since 1 April 1996, the *Canada Health Act* has been linked to the Canada Health and Social Transfer (CHST), which merged EPF transfers with Canada Assistance Plan (CAP) transfers. The method of calculation adopted for the CHST is similar to that used for the EPF, and includes both cash transfers and tax point transfers. The provinces must meet all the requirements of the Act in order to be eligible for the full cash transfer.

12. The *Canada Health Act* sets out nine requirements that provincial governments must meet through their public health-care insurance plan in order to qualify for the full federal contribution under the CHST. These nine requirements include five criteria, two specific provisions and two conditions. **The five criteria are public administration, comprehensiveness, universality, portability, and accessibility; they apply to insured health services.** The two specific provisions relate to user charges and extra-billing for insured health services. The two conditions pertain to the provision of provincial information and provincial recognition of federal contributions; they apply to both insured health services and extended health-care services.

13. In 1996, the federal government has imposed penalties on provinces that permit private clinics to demand facility fees from patients for medically required services, having determined that such facility fees constitute user charges. These penalties were applied to four provinces. Until now, however, there has been no discretionary penalty for failure to comply with the five criteria stipulated in the Act, despite some complaints regarding, for example, portability and comprehensiveness. There are claims that several provinces are violating the criterion of portability. For example, in 1988, Quebec refused to sign the

reciprocity agreement whereby other provinces would be reimbursed according to their own rates for services they provided to Quebeckers outside Quebec. Moreover, Canadians must increasingly resort to private insurance when abroad: New Brunswick, Quebec, Saskatchewan, Alberta and British Columbia have reduced their coverage for emergency hospital services obtained outside Canada. Some experts, who accuse the federal government of inaction in this area, explain that the scope of the portability criterion is clearly defined in the Act, where the terms and conditions for reimbursement of out-of-province services are stipulated. Likewise, some people believe the criterion of comprehensiveness is not being observed in practice, because provinces do not necessarily cover the same basket of insured health services or medically required services. They also believe that cutting government expenditures could compromise this principle even further and that the process of de-insuring begun in recent years could lead to the balkanization of provincial health-care insurance plans. Federal legislation defines only the major outline of insured services and leaves each province complete freedom to determine what services its public plan will provide. However, de-insurance emphasizes the gaps between provinces in their coverage of health-care services; these discrepancies are likely to become increasingly difficult to justify. Moreover, de-insurance with the sole purpose of reducing public health expenditures has enabled the private health care market to flourish. This raises the question when a service is medically necessary?

14. In November 1999 report (Chapter 29), the Auditor General of Canada pointed out that six cases of non-compliance had been resolved through discussion and negotiation; however, four of them took 14 to 48 months to resolve, while the remaining two went on for as long as five years without any penalty. **In September 2002 report (Chapter 3), the Auditor General of Canada identified twelve new possible cases of non-compliance that had arisen since 1999; Health Canada once again attempted to resolve them through means other than penalties. Only two of these cases have been resolved.**

15. On 4 February 1999, federal and provincial governments (with the exception of Quebec) signed the Social Union Framework Agreement, in which the governments reaffirmed their commitment to the five criteria of the *Canada Health Act*. The agreement also offers a process for avoiding and/or resolving disputes over interpretations of the Act. In his November 1999 report, the Auditor General of Canada welcomed this process and recommended that it be used to resolve new or outstanding issues relating to the interpretation and application of the *Canada Health Act*. **In April 2002, the federal, provincial and territorial governments agreed on a dispute avoidance and resolution process. To date, however, there has been no recourse to this new process.**

Privatization in Canada

16. Privatization is the process whereby the government transfers some of its activities or responsibilities to the private sector. With respect to health care, privatization of financing is not the same as privatization of delivery. Privatization of financing is achieved by shifting the burden of funding away from public health-care insurance plans and towards patients and/or their private insurance companies. Privatizing the delivery of health care implies greater reliance on individuals and institutions outside government for the production and provision of health-care services. In Canada, difficulties with respect to privatization revolve primarily around the financing of health care, because health-care delivery is already largely private in nature. In fact, governments deliver relatively few health-care services directly. Most health-care providers (e.g., physicians, physiotherapists and pharmacists) are in private practice; they are not government employees. The vast majority of hospitals

and long-term care institutions are not-for-profit and are privately owned; although they are funded by government, they are not owned by government. Privatization of health-care financing can be achieved in two ways: either actively, by containing public health-care costs; or passively, by shifting the care outside traditional settings. Active privatization is the direct result of the partial or total de-insurance of publicly funded health services. In the 1990s, in an effort to reduce public health-care costs and to balance their budgets, most provinces limited the coverage provided under their health-care insurance plans. For example, the removal of warts is no longer covered in Nova Scotia, New Brunswick, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia, but it remains publicly insured in Newfoundland, Quebec and Prince Edward Island. Although stomach stapling is covered in most provinces, it is not insured in New Brunswick, Nova Scotia and the Yukon, and patients in these provinces/territories must pay for this procedure. In addition, coverage varies widely across the country in the areas of reproductive services.

17. Passive privatization mainly refers to the gradual shift towards non-institutional care provided in the home and the community. Less invasive medical techniques and shorter hospital stays have allowed Canadians to receive more medical care in their homes and in the community. As a result, many services that are deemed medically necessary today are not publicly insured because they are not provided in hospitals or by physicians. Consequently, many commentators contend that the realities of health care have shifted considerably since 1984, when the *Canada Health Act,* with its focus on hospitals and physician services, was passed. In other words, the definition of "medically necessary services" has not kept pace with the way services are now delivered.

DE-INSURED HEALTH CARE SERVICES BY PROVINCE

Service*	Province
Routine circumcision of newborn	Nfld, PEI, NS, NB, Ont, Alta, Yk
Xanthelasma excision (removal of fatty spots on eyes)	Nfld, NS, Ont
Hypnotherapy	Nfld
Removal of impacted teeth	Nfld
Otoplasty	Nfld, PEI, NB, Ont, Alta
Gastroplasty (stomach stapling)	NB, NS, Yk
Tattoo removal	Sask, Man, Ont

Reversal of sterilization	PEI, NB, Ont, Man, Sask, Alta, Yk (uninsured service in NS and BC)
Penile prosthesis	NS, Ont, Sask
Psychoanalysis	Man, QC
Eye examination (people aged 19 to 64)	PEI, NS, NB, QC, Man, Sask, Alta
Wart and benign skin lesion removal	NS, NB, Ont, Man, Alta, Sask, BC
Second or subsequent ultrasounds in uncomplicated pregnancies	NS, BC
In vitro fertilization	Ont, Man (uninsured service in Nfld, NS, NWT)
Simple sclerotherapy (removal of varicose veins)	QC, Ont, Man (uninsured service in NS)
Artificial/intrauterine insemination	NS, NB (uninsured service in Alta)
Ear wax removal	NS
Anaesthesia associated with a non-insured service	NB, Sask, Alta
Chiropractic services	Sask
Epilation of facial hair	PEI, Ont
Eye refractions	Nfld, Sask
Cosmetic surgery	Alta (uninsured service in Nfld, NS, PEI, NB, QC, Man, Sask, BC, Yk, NWT)

Breast reduction/augmentation	NS, NB, Ont, BC

* Some exceptions may apply and all surgeries are not listed on this list.

18. The issue over privatization surfaced in 1995, when the federal government implemented its policy on private clinics. There are two categories of private clinics: semi-private clinics and fully private clinics. Semi-private clinics are facilities that receive public funding for medically required services under a provincial health-care insurance plan, but also demand payment ("facility fees") from the patient. For the federal government, facility fees present a problem because people who can afford to pay them get faster access to services. In 1995, the federal Minister of Health stated that such semi-private clinics fall under the *Canada Health Act* because: (1) they are included in the definition of "hospitals" set out in the Act; (2) they provide medically necessary services; and (3) they receive public funding. Therefore, semi-private clinics contravene the *Canada Health Act* because the facility fees they require from patients constitute a form of user charges.

19. Fully private clinics are facilities that receive no government funding the physicians are not reimbursed by the provincial health-care insurance plan and their patients must pay the full cost of the services rendered to them. The creation of such clinics does not result in a reduction in provincial transfers, and the provisions relating to extra-billing or user charges do not apply in such cases. The *Canada Health Act* requires provincial health-care insurance plans to be accountable to the provincial government and to be non-profit, thereby effectively preventing private insurance plans from covering medically required services. Moreover, the majority of provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick and Nova Scotia) prohibit private insurance companies from covering services that are also guaranteed under public health-care insurance plans.

20. But in 2000, when the Alberta government enacted legislation (Bill 11) with respect to contracting with the private sector for medically necessary surgical services. **This legislation allows Regional Health Authorities (which are publicly funded) to contract with a private provider – either a for-profit or a not-for-profit entity – for the provision of surgical services. Regional Health Authorities are also responsible for coordinating the delivery of uninsured surgical services requiring an extended stay by the patient.** The Alberta government believes that contracting with privately operated facilities for surgical services is not in violation to the Canada Health Act. The Alberta government believes that the Act does not prevent a public health-care facility from contracting out any of its services to the private sector.

21. In some provinces, the operation of private clinics that offer MRI (Magnetic Resonance Imaging), X-ray, ultrasound and CT scanning services and now private surgical centers have been operating without any penalties from the federal government. In September 2000, the federal Minister of Health wrote to his counterparts in Alberta and Quebec to obtain more information on private MRI clinics operating in these provinces. The federal government since then has taken no further action against these facilites.

22. Then in June 2005 in a landmark decision the Supreme Court of Canada ruled that the Quebec government couldn't prevent people from paying for private insurance for health-care procedures covered under medicare. In a 4-3 decision, the panel of seven justices said banning private insurance for a list of services ranging from MRI tests to cataract surgery was unconstitutional under the Quebec Charter of

Rights, given that the public system has failed to guarantee patients access to those services in a timely way. As a result of delays in receiving tests and surgeries, patients have suffered and even died in some cases, justices Beverley McLachlin, Jack Major, Michel Bastarache and Marie Deschamps found for the majority. This decision has a direct impact on NAFTA and the World Trade Organization (WTO) agreements. Government measures affecting private health insurance are governed by the financial services rules of the WTO's General Agreement on Trade in Services (GATS). NAFTA's expropriation rules this applies fully to the health care sector.

23. This Supreme Court ruling, in effect puts Canada's provincial health insurance plans right into competition with private carriers. This would nullify the GATS "governmental authority" exclusion, exposing both private and public health insurance to the treaty. Provincial policies, guided by the Canada Health Act, deliberately discourage the growth of private insurance markets by, for example, setting fee caps, restricting direct and extra-billing, and preventing public subsidy of private practice. The Investor views these policies as illegal trade barriers. In covered sectors such as health insurance, the GATS guarantees foreign service providers the right to enter the market and full access to the same government subsidies and other advantages given to domestic service providers.

Canada Health Care and NAFTA

24. The Canadian public health care system is not shielded from NAFTA nationalization/expropriation provisions, as thought particularly private health insurers, if those private interests are excluded. Canada has assumed market access and national treatment commitments respecting health insurance under the *General Agreement on Trade in Services* (GATS). Canada is relying on Annex I reservation that grandfathers all non-conforming provincial measures existing on January 1, 1994 and by an Annex II reservation that covers health services established or maintained for a public purpose. However the expropriation provision is not covered by reservations. U.S. and Mexican investors have direct rights of action against the Canadian government for breaches of these provisions. The most important provisions of the WTO Agreement are the market access and national treatment. Since however, the expansion of the public component of the health care system to private sector providers has in effect eroded the shield from full NAFTA national treatment requirements provided by Annex I reservation since 1994. The NAFTA agreements generally require that the federal government ensure compliance by provincial and local governments. NAFTA Article 1105 requires each NAFTA Party to ensure that all necessary measures are taken in order to give effect to NAFTA provisions, including (except where otherwise provided) their observance by provincial governments. A number of WTO agreements, notably the *General Agreement on Trade in Services* (GATS) and GATT 1994,4 set out express provisions requiring that Member countries ensure compliance by regional governments. Compliance by provincial governments may be taken as the general rule both under NAFTA and the WTO agreements. Canadian public health care system is that it establishes a government monopoly in each province for payment of insured health services. Both NAFTA Chapter Fifteen and the GATS set out requirements for the designation and maintenance of monopolies.

Investment and Services

25. NAFTA Chapters Eleven and Twelve set out obligations respecting investment and crossborder trade in services. The health care system affects the delivery of services

and the investments of firms that deliver those services. The GATS also imposes obligations respecting trade in services. Canada's health care system is based upon the payment of subsidies. Article 1502(2) sets out requirements that must be observed if a Party (including a provincial government) intends to designate a monopoly. Prior notice must be given to other NAFTA Parties and the Party must introduce conditions on the operation of the monopoly that will minimize or eliminate nullification and impairment of certain NAFTA provisions including NAFTA Chapter Twelve (Cross-Border Trade in Services). It would be extremely difficult to expand the public component of health care under NAFTA Article 1110 (Expropriation and Compensation). While the *Canada Health Act* is a federal statute, it sets out certain requirements that must be satisfied for provinces to receive grants.

National Treatment Obligations Under Articles 1102 and 1202

Articles 1102 and 1202

26. The combined effect of Article 1102(1) and (2) is to require that the federal government and each province accord to investors of the United States and Mexico and their investments treatment no less favourable than that it accords, in like circumstances, to its own investors and their investments with respect to the establishment, acquisition, expansion, management, conduct, operation, and sale or other disposition of investments. NAFTA Article 1102(3) establishes a special rule when applying Article 1102(1) and 1102(2) to measures of provincial governments that requires **that the province accord treatment no less favourable than the most favourable treatment accorded, in like circumstances, by that province to investors, and to investments of investors, of the Party (i.e. Canada)**.

Treatment No Less Favourable

27. Articles 1102 and 1202 address situations in which U.S. or Mexican investors and their investments, or U.S. or Mexican cross-border service providers, are treated differently and less favourably than their Canadian counterparts. Case law respecting national treatment provisions under other trade agreements like GATT 1947, GATT 1994 and the GATS has equated "no less favourable treatment" with "equality of competitive opportunities". It is under this interpretation and others that we are filing this claim. Under this interpretation, if a single U.S. investment is treated less favourably than a single domestic investment, this is a **de jure*de facto* violation** to the extent that Canada's health care system treats Canadian firms more favourably than U.S. or Mexican firms. A measure that excludes or severely limits the extent to which a U.S. or Mexican firm can engage in an activity connected with the health care system, when compared to its Canadian counterparts.

Annex II Reservation

28. NAFTA Articles 1108(3) and 1206(3) permitted each NAFTA Party to exempt sectors from the application of the foregoing NAFTA articles by listing the sectors in its Schedule to NAFTA Annex II. Unlike the Annex I reservations, which do not permit future changes that increase nonconformity. Canada listed a reservation for Social Services as follows:

"Canada reserves the right to adopt or maintain any measure with respect to the provision of public law enforcement and correctional services, and the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education,

public training, health and child care." However we argue that the reservation does not cover for-profit or not-for-profit health care services.

Expropriation and Compensation Under Article 1110

Article 1110

NAFTA Article 1110(1) provides as follows:

29. "No Party may directly or indirectly nationalize or expropriate an investment of an investor of another Party in its territory or take a measure tantamount to nationalization or expropriation of such an investment ("expropriation"), except:

(a) for a public purpose;

(b) on a non-discriminatory basis;

(c) in accordance with due process of law and Article 1105(1); and

(d) on payment of compensation in accordance with paragraphs 2 through 6."

Paragraphs 2 to 6 set out rules respecting the calculation of compensation.

NAFTA Article 1110 and Expropriation Under International Law

30. Article 1110 has the effect of codifying the international law standard respecting expropriation. Customary international law requires that states provide compensation to aliens for expropriated property. For example when a state does not take property outright but applies measures that have the same effect.

Minimum Standard of Treatment Under Article 1105

31. NAFTA Article 1105(1) is entitled **Minimum Standard of Treatment** and reads as follows:

"Each Party shall accord to investments of investors of another Party treatment in accordance with international law, including fair and equitable treatment and full protection and security." On July 31, 2001, the NAFTA Free Trade Commission (NAFTA Commission) adopted an agreed interpretation that interpreted Article 1105 as applying the minimum standard of treatment under international law and that the references to "fair and equitable treatment" and "full protection and security".

32. Both private and public services are subject to GATS. There is an exclusion in GATS for public services "provided in the exercise of government authority" if they are "supplied neither on a commercial basis nor in competition with one or more service suppliers." Since almost all of Canada's public sector health care services are also provided in the private sector, or at least have commercial relationships with private suppliers, it is not exempt under this definition. GATS directs governments to avoid the "trade-distortive effects" of public subsidies.

The Violation (or breach)

33. NAFTA Articles 1502(3)(a) and 1503(2) each require Canada to ensure that government monopolies and state enterprises, do not abuse the authority delegated to them to maintain or provide a designated monopoly. It is an abuse of such authority for state enterprises or government monopoly to act in a manner inconsistent with the obligation owed by NAFTA Parties under the Agreement.

34. The Government of Canada subsidizes and leverages the monopoly run health care system by using the infrastructure established under its delegated authority to run a universal health care system. The *Canada Health Act* sets out nine requirements that provincial governments must meet through their public health-care insurance plan in order to qualify for the full federal contribution under the CHST. These nine requirements include five criteria, two specific provisions and two conditions. **The five criteria are public administration, comprehensiveness, universality, portability, and accessibility; they apply to insured health services.**

35. The Government of Canada abuse of its delegated authority to run the health care monopoly constitutes a breach of Canada's national treatment obligation under NAFTA Article 1102 and its minimum standard of treatment obligation under NAFTA Article 1105 among other NAFTA obligations. The national treatment standard has been violated because Canada does not provide US private sector competitors such as private surgical centers and private insurance carriers to the same access as its Canadian counter-part.

36. The existence of such abusive behavior on the part of Canada is evidence of a discriminatory nature or a **de jure*de facto* violation.** By not allowing the investor the same rights to build and operate its surgical facility in effect a direct trade barrier. Giving cause that Canada uses anti-competitive practices to keep out American health care and insurance companies.

37. Canada's failure to use the necessary mechanisms of regulatory control, or administrative supervision of its Provincial bodies. To allow NAFTA members the same accord as Canadian members constitute a breach of the agreement. Moreover, Canada has failed to accord the most favorable treatment available to the Investor and its investments under NAFTA Article 1102.

38. Canada has also breached NAFTA Article 1110 through its general conduct it allowed the expropriation of the Investor's health care technology. In so doing Canada failed to treat the investment in accordance with international law.

39. Through successive Canadian federal and provincial governments the Investor has experienced since 1997. Discriminatory, anti-American anti-competitive practices and as a result have suffered numerous losses. Canada has not fulfilled its part to control, supervise or apply measures to ensure that its provincial bodies act consistent with its NAFTA obligations. There are 72 private surgical hospitals and 42 private MRI/CT facilities not one is 100% owned by a US company. Yet Canadian companies are free to own and operate all types of health care facilities and services with no government restrictions in the US. This also includes Canadian insurance companies through their wholly owned subsidiaries.

Losses Suffered As A Result Of Breach

1. Loss of value of its investments in Canada

2. Loss of business opportunities

3. Fees and expenses of $ 4,700,000.00 Four Million Seven Hundred Thousand

4. Loss of Goodwill

5. Loss of Profits

G. RELIEF SOUGHT AND DAMAGES CLAIMED

The Investor claims damages for the following:

1. A sum not less than **U.S. $160,000,000.00 One Hundred Sixty Million United States Dollars** in compensation for the damages caused by Canada's failure to accord the Investor the minimum standard of treatment and in expropriating of its medical technology. These measures are inconsistent with its obligations contained in Part A of Chapter 11 and Chapter 15 of NAFTA;

2. Costs associated with these proceedings, including all professional fees and disbursements;

3. Pre-award and post-award interest at a rate to be fixed by the Tribunal; and

4. Such further relief that counsel may advise and that the Tribunal may deem appropriate.

5. Tax consequences of the award to maintain the integrity of the award.

H. STATEMENT OF CLAIM

Pursuant to paragraph 4(c) of Article 3 of the UNCITRAL Rules of Arbitration, the Investor has included its Statement of Claim with this Notice of Arbitration.

I. APPOINTMENT OF ARBITRATORS

Pursuant to Article 1123 of NAFTA, the Investor and the Party have agreed on the number of arbitrators, which shall be three, and on the procedure for appointment. One arbitrator is to be appointed by each of the disputing parties and the third, which is the presiding arbitrator, shall be appointed by agreement of the disputing parties.

DATE OF ISSUE: JANUARY 5, 2009.

HOWARD CAPITAL MANAGEMENT LP

2436 E. Darrel Road Phoenix, Az 85042

/s/

Melvin J. Howard Management of the Investor and Enterprises

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