

# ON-RESERVE HEALTH CARE: OPTIONS AND OPPORTUNITIES

Jeanie Lanine and Kathryn Deo,<sup>1</sup> Woodward and Company

First Nations health care is in crisis<sup>2</sup>. In addition, the provision of complete, effective, and culturally sensitive health care to First Nations communities requires a familiarity with and respect for First Nations community and cultural values and patients' healing beliefs and practices. This paper will explore alternatives that may be available to First Nations to support the development of community health facilities and programs on-Reserve.

## For-Profit Health Care in Canada

In Canada, private medical clinics may legally charge fees for non-insured medical services such as laser eye surgery, cosmetic surgeries and preventative screenings for cancer. Private medical clinics may also charge for medically necessary procedures excluded from the *Canada Health Act*, including injuries covered by workers' compensation insurance schemes; injuries caused by motor vehicle accidents which are insured by Insurance Corporation of British Columbia; injuries to members of the Royal Canadian Mounted Police; and health care for veterans, Canadian Armed Forces personnel and tourists.

More controversial are the increasing number of clinics which are charging fees for what most provinces deem to be medically necessary services, such as medical imaging, joint replacements, knee surgeries and colonoscopies. Wait-lists of a year or more for such services have created an opportunity for profit for private clinics willing to step into the grey areas of the *Canada Health Act* by providing insured services faster for a fee.

The profit potential of private clinics is considerable. In the case of a Magnetic Resonance Imaging ("MRI") clinic, a Vancouver firm offers turn-key MRI clinics that include desks, chairs, computers, decor, coat hangers and an MRI machine for \$1.45 million.<sup>3</sup> An average MRI costs about \$800,000 per year to run. A clinic performing 10 MRIs a day at an average price of \$600, five days a week for 50 weeks a year will have

---

<sup>1</sup> We are very grateful for the contributions of Murray Browne, Scott Waters and Mike Guthrie, all of Woodward & Company.

<sup>2</sup> "First Nations peoples' health is in crisis. First Nations people, when compared with the Canadian public, face much higher rates of chronic and communicable diseases, and are exposed to greater health risks because of poor housing, contaminated water and limited access to healthy food and employment opportunities. The demand for institutional and related continuing care services for First Nations will grow rapidly over the next several decades due to increases in the number of First Nation members aged 55 and older. The 55- 64 year age group will increase by 236% and the 65+ group by 229% in this period. Life expectancy of First Nations males will increase from 59.2 to about 72 years by 2010 and from 65.9 to 79 years for First Nations females. There will be 57,000 more First Nations members aged 65 and older in 2021." ("First Nations Action Plan on Continuing Care", Assembly of First Nations, June 2005).

<sup>3</sup> Millenium Technology Inc. quoted in, Ross Sutherland, "*Scanning For Profit: A Critical Review of the Evidence Regarding For-Profit MRI and CT Clinics* prepared for the Ontario Health Coalition" Sept. 2002 <<http://www.web.net/~ohc/docs/rossreport.htm>>.

an income of one and a half million dollars a year. At this rate the MRI would be paid off in just over two years, leaving about \$700,000 a year above costs.<sup>4</sup>

While private clinics providing insured services for a fee are a potential violation of the *Canada Health Act*, the ability of the federal government to sanction businesses individually is minimal. The federal government may, however, penalize the provincial government for allowing privately-run health care units by reducing federal health care transfer payments to the province. The amount of any deduction would be based on the gravity of the default. The process is apolitical with the two levels of government negotiating the amount of federal funding to be withheld.

Typically, in Canada, the federal government has not been vigilant in penalizing provinces for failing to curb private medical clinics. Although provinces have generally not condoned the proliferation of private medical clinics at the political level, neither have they moved to shut them down. This may be due, in part, to the commonly-held belief that the public health care system fails to deliver services within a reasonable timeframe, and the fact that private payers reduce the cost of health care to the public.

In British Columbia, medical services fall under the regime of the *Medicare Protection Act*. Although the preamble and the “purpose” section at s. 2 provide that the intent is to ensure that “access to necessary medical care” is based on need and not an “individual’s ability to pay”, the Act does allow for insured services to be provided at facilities approved by the Medical Services Commission. Further, the College of Physicians and Surgeons of British Columbia has set up a committee, which screens and provides accreditation to medical and surgical facilities and clinics. This committee has accredited several clinics that provide insured services, and charge facility fees, to patients wishing to “jump the line”. In British Columbia, then, the waters are murky at best.

Of significance to the debate on private health care is the recent Supreme Court of Canada case, *Chaoulli v. Quebec (Attorney General)*,<sup>5</sup> which held that Quebec provincial legislation banning insurance for private health care for insured services was a violation of the right to life and personal security under the Quebec *Charter of Human Rights and Freedoms*.<sup>6</sup> This decision was based on the majority of the Court concluding that publicly insured health care services were not provided in a timely manner in Quebec. The court was divided on whether the right to life, liberty, security of the person guaranteed under the s.7 of the *Canadian Charter of Rights and Freedoms* (the “*Charter*”), had been breached.

The implication of *Chaoulli* for the rest of Canada is uncertain, but what is significant is that the judges hearing the case agreed that if patients are suffering from a life-threatening or painful condition, with no recourse from extended delays in obtaining services, then their rights are being violated. This violation extends not only to death and physical harm resulting from long wait times, but to mental stress as well. Every

---

<sup>4</sup> Ibid.

<sup>5</sup> 2005 SCC 35.

<sup>6</sup>R.S.Q., c. C-12, ss. 1, 9.1.

province in Canada is now anticipating *Charter* challenges to laws presently in place that suppress private sector health care.

In the context of First Nations, given the current health crises faced by a number of Aboriginal groups, a strong argument could be made that the publicly funded system fails to provide adequate care to First Nations. The implication is that a s. 7 *Charter* argument may be made for alternative and privately financed or insured health services for First Nations.

It is clear that support for private medical care is growing in areas where the public system is failing patients. At its annual general meeting in August of 2005, the Canadian Medical Association, which represents Canada's 62,000 doctors, defeated a motion stating that a parallel private health care system should not be permitted in Canada. In addition, a motion to allow Canadians to purchase private care if the public system fails to deliver service in a timely manner was passed by a two-to-one margin. This is a change in position for the CMA, which last voted on the issue in 1996.

### **A Self-Governing Right to for-Profit Medicine**

For a First Nation wishing to develop private mainstream medical or care facilities on Reserve, the political climate is volatile: thoughtful planning is required. A clinic offering non-insured services will not be controversial, but the provision of insured services, such as medical imaging, will likely raise media alarm bells. This will be so particularly where a First Nation asserts an aboriginal self-governing right to regulate and administer traditional western medicine for profit on Reserve.

One First Nation, Muskeg Lake Cree Nation, is constructing a medical clinic in Saskatchewan, which will serve the Aboriginal community, clients of the Workers' Compensation Board, and referrals from physicians. Media reports have labeled this clinic, "the gateway to privatization", citing the fact that provincial laws governing health care have no jurisdiction on land controlled by First Nations' governments.<sup>7</sup>

Contrary to media reports, the jurisdiction of a First Nation to regulate private health care on-Reserve is uncertain. Although Canada has acknowledged an aboriginal right to regulate health as part of a right to self-government, federal policy is to ensure that Aboriginal jurisdictions and authorities work in harmony with jurisdictions that are exercised by other governments.

The government takes the position that negotiated rules of priority may provide for the paramountcy of Aboriginal laws, but may not deviate from the basic principle that those federal and provincial laws of overriding national or provincial importance will prevail over conflicting Aboriginal laws. Therefore, a First Nation that asserts its right to self-govern through the provision of for-profit medical care may find itself facing significant political roadblocks, and a constitutional court case.

---

<sup>7</sup> Amy Ehman, "First Nations' clinics: Gateway to privatization?" *Canadian Medical Association Journal*, 13 April 2004 <<http://www.cmaj.ca/cgi/content/full/170/8/1215>>.

## An Aboriginal Right to for-Profit Medicine

An Aboriginal right to health care has never been acknowledged by the federal government or decided in the courts. Rather, the courts have clearly recognized the fiduciary responsibility of the federal government to protect Aboriginal people in many matters, one of which, it could be argued, is health. Canadian courts have recognized that aboriginal rights are essentially defined as “way of life rights”, the recognition of which required evidence of the fact that:

- 1) Aboriginal law is a usage, a tradition or a custom that is central, necessary and an integral part of that specific culture of the aboriginal society;
- 2) The customs and traditions must not be exercised only marginally or occasionally;
- 3) Regular practices, traditions and customs must be an integral part of that culture since before contact with European settlers.<sup>8</sup>

Likewise, in *Van der Peet*, Justice Lamer concluded:

“Aboriginal rights are not general and universal: their scope and content must be determined on a case basis. The fact that one group of aboriginal people has an aboriginal right to do a particular thing will not be, without something more, sufficient to demonstrate that another aboriginal community has the same aboriginal right. The existence of the right will be specific to each aboriginal community”.

This point is important because any argument based on an aboriginal right to private health care would have to be based specifically on the traditions and customs of the First Nation claiming them.

In addition, the courts have said that customary rights may be exercised in a modern form of a practice that existed prior to European contact. In 1931, Lord Atkin for the Privy Council expressed the view that there is “no doubt” that a custom is capable of evolving without losing its “essential character of custom,” so long as it can be shown that it continues to be “recognized by the native community whose conduct it is supposed to regulate.”<sup>9</sup> Nevertheless, Canadian law is not entirely settled with respect to the extent to which aboriginal custom can continue to evolve while still being recognized as conferring rights and obligations.

In *Sparrow*, the Supreme Court of Canada expressed the opinion that “the phrase ‘existing aboriginal rights’ must be interpreted flexibly so as to permit their evolution over time,” and explicitly rejected a “frozen rights” approach.<sup>10</sup> This suggests that aboriginal customs may continue to evolve and still be constitutionally protected as

---

<sup>8</sup> *R. v. Van der Peet*, [1996] 2 S.C.R. 507

<sup>9</sup> *Elko v. Government of Nigeria (Office Administering)*, [1931] A.C. 662 (P.C.) at 673.

<sup>10</sup> [1990] 1 S.C.R. 1075 at 1093

“existing rights,” so long as they meet the continuity requirements as outlined in *Vanderpeet* and *Delgamuukw*.

To be brief, an aboriginal rights argument supporting a First Nation’s jurisdiction to operate a privately run western health care operation providing insured services for a profit does not appear to have a strong chance of success.

### **Making it Work: Financing on-Reserve Health Care**

Although there are indications of legal and political change, given the uncertainties, a First Nation wishing to increase on-Reserve health care quality and revenues might choose to start with a development plan that makes use of non-controversial funding sources to build capacity and infrastructure before considering how far to push against federal and provincial health-care boundaries.

#### ***Aboriginal Medicine***

It seems likely that a First Nation would be able to operate a clinic or health centre on-Reserve offering traditional Aboriginal medicine. This would clearly fit within the Aboriginal rights framework articulated above, and would provide a real benefit to the community. Further, Aboriginal medicine would not likely be considered an insured service, and therefore a clinic offering those services would not be in conflict with the *Canada Health Act*.

#### ***Federal and Provincial Funding***

Many First Nations in BC are already managing their own health programs under health transfer agreements through the Health Canada. Health Canada’s funding for on-Reserve medical programs is mainly in the area of public health, health promotion, prevention programs and services and programs such as Aboriginal Head Start. Health Canada provides funding for primary care where a First Nation is in a particularly remote geographic location or where such funding is not provided by a province or territory. Health Canada publishes the First Nations and Inuit Health Program Compendium, which contains a summary and description of the programs funded by the Branch.

While this paper does not provide a comprehensive overview of provincial, federal, and non-government funding opportunities for on-Reserve health care, identifying and accessing all available funding, including pilot projects and community partnerships, is critical.

#### ***University Partnerships***

A First Nation wishing to increase on-Reserve health care quality and revenues might be to form a partnership with a medical school to develop a research and treatment facility for Aboriginal medicine. A partnership with a university has some significant advantages for a First Nation including enhanced federal and provincial funding opportunities for

health care research, availability of interns, administrative support, and greater public and political support.

The University of British Columbia's (UBC) Faculty of Medicine has recognized the need to work with First Nations to improve health in communities. The mandate of department's Division of Aboriginal People's Health is "to work respectfully with Aboriginal peoples to strengthen their health and well being through collaborative partnerships in education and training of physicians; research with community partners; and promotion of effective service delivery."<sup>11</sup>

In addition to the Vancouver campus, UBC also offers physician training through the University of Victoria Island Medical Program and the University of Northern British Columbia (UNBC) Northern Medical Program. The UNBC program specializes in remote and rural medicine and may offer excellent partnership opportunities to First Nations in the region.

### ***Private Investment***

Although it is generally more difficult to attract private investors on-Reserve due to factors such as legal and regulatory uncertainty, underdeveloped infrastructure and difficulty obtaining financing,<sup>12</sup> First Nations do have a number of under-utilized competitive advantages.

Perhaps one of the biggest advantages that First Nations have is control of undeveloped land and the potential to control larger tracts as treaty claims are settled. Development of these lands will depend on location to a certain extent, although even remote lands may be suitable for uses such as resort and recreation. In the case of on-Reserve medicine, the ownership and control of well-located lands significantly decreases the start-up costs required to do business.

A second competitive advantage enjoyed by First Nations on-Reserve is the section 87(a) of the *Indian Act* which exempts from taxation the interest of an Indian or a band in reserve lands or surrendered lands. This exemption would apply to status employees of on-Reserve health clinics. In addition, First Nations entering into business with outside investors may be able to maximize on-Reserve income that might have otherwise have been taxed in the hands of a corporation through the use of flow-through business structures such as contractual joint ventures and limited partnerships.

In a limited partnership or contractual joint venture arrangement, an investor who is not an Indian or a band may indirectly benefit from the section s.87 exemption, as the agreement with the First Nation may direct partnership start-up losses, capital cost allowance and interest expense to the investor. These losses and expenses are valuable

---

<sup>11</sup> University of British Columbia Division of Aboriginal Peoples Health, <http://www.familypractice.ubc.ca/aph/research.html> (accessed January 23, 2006).

<sup>12</sup> First Nations Fiscal Institutions Initiative: Building a Better Future. Online: [http://www.fnfi.ca/documents/Final\\_FNFI%20Booklet-11-04-e.pdf#search='ten%20times%20harder%20itab'](http://www.fnfi.ca/documents/Final_FNFI%20Booklet-11-04-e.pdf#search='ten%20times%20harder%20itab') (accessed January 10, 2006).

tax preference items that can be used by the investor to minimize taxable income and increase profit. This is a win-win situation, as the band is non-taxable, and loses neither income nor opportunity from the arrangement.

### **Making it Work without Own-Source Revenue**

A First Nation with sufficient administrative capacity and financing to build a health or health and social services building and invest in for-profit medicine may be in a position to access the valuable tax exemption provided by Section 149(1)(d.5) of the *Income Tax Act*.

Section 149 provides a general income tax exemption to a corporation, commission, or association that is at least 90% owned by one or more municipalities in Canada, as long as no more than 10% of its income is from outside the municipality (with some exceptions). The s.149 exemption is broader than the *Indian Act* exemption, as it is not geographically restricted to a reserve.

Whether a band can be considered a municipality for the purposes of these provisions of the *Income Tax Act* is unclear. This area of law is marked by conflicting decisions and changes in Canada Revenue Agency (“CRA”) policy. In *Otineka Development Corp. v. R.*,<sup>13</sup> the Tax Court of Canada found that the term “municipality” must be given its ordinary meaning, and not just that assigned by the provincial legislation governing municipalities. Therefore, the Opaskwayak Cree Nation, both in the powers that it exercised and the services that it provided, was considered a municipality for the purposes of s. 149(1)(d). It had passed by-laws for most of the purposes contemplated by ss. 81 and 83 of the *Indian Act*, provided services to the band members in a large number of areas, and had a sophisticated structure relating to its governance.

CRA policy after the decision in *Otineka* was to require a band to fit itself within the facts of that case in order to qualify as a municipality. However, the decision in *Otineka* was called into question by the Quebec Court of Appeal in *Tawich Development Corporation v. Quebec*.<sup>14</sup> In *Tawich*, the Court held that bands could not be municipalities within the meaning of s. 985 of the *Quebec Taxation Act*, which has identical wording to the relevant sections of the *Income Tax Act*. The Court found that merely exercising municipal functions was not sufficient to attribute to a body the status of a municipality. Instead, the Court held that this status could only be achieved as a result of statute, letters patent, or order.

Although the CRA has chosen to follow *Tawich* to deny bands access to this exemption as municipalities, the Department of Finance has recently determined that, from a tax policy perspective, corporations owned by First Nations previously entitled to a tax exemption under *Otineka* should continue to have access to the exemption.

---

<sup>13</sup> *Otineka Development Corp. v. R.*, [1994] 1 C.T.C. 2424 (T.C.C.) [*Otineka*].

<sup>14</sup> *Tawich Development Corporation v. Quebec (Deputy Minister of Revenue)*, [2000] 3 C.N.L.R. 383 (Que. C.A.) [*Tawich*].

On February 27, 2004, the Minister of Finance released a revised package of draft technical amendments to the *Income Tax Act*, including an amendment to the exemption in s.149(d.5). The amendment extends the exemption to include any corporation, commission or association at least 90% of the capital of which was owned by one or more entities each of which is a municipal or public body performing a function of government in Canada, which is consistent with the bodies described in paragraph 149(1)(c) of the Act.

These amendments, which will be retroactive to May 8, 2000, are intended to settle the law with respect to the tax-exempt status of band owned corporations and are good news for many band-owned businesses located on-Reserve.

### **Conclusion**

In conclusion, on-Reserve medical facilities may provide enhanced community care for First Nations members, tax-exempt jobs for status members, an income stream, and infrastructure development. Once a medical facility has been built, a First Nation will be in a strong position to evaluate the role for-profit medicine may play in the future.