Court File No. CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY

Applicants

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE

Respondents

FACTUM OF THE APPLICANTS

June 21, 2024

GOLDBLATT PARTNERS LLP
20 Dundas Street West, Suite 1039
Toronto, ON M5G 2C2

Steven Shrybman (20774B)
Tel: 613-858-6842
Email: sshrybman@goldblattpartners.com

GOLDBLATT PARTNERS LLP
30 Metcalfe Street, Suite 500
Ottawa, ON K1P 5L4

Benjamin Piper (58122B)
Tel: 613-482-2464
Email: bpiper@goldblattpartners.com

Lawyers for the Applicants

TO: **MINISTRY OF THE ATTORNEY GENERAL**
Constitutional Law Branch
McMurtry-Scott Building
720 Bay Street, 4th Floor
Toronto, ON M7A 2S9

S. Zachary Green (48066K)
Tel: 416-326-4468
Email: zachary.green@ontario.ca

Cara Zwibel (50936S)
Tel: 416-894-3107
Email: cara.zwibel@ontario.ca

Emily Owens (80144G)
Tel: 416-389-3687
Email: emily.owens@ontario.ca

Lawyers for the Respondents

Table of Contents

PART I - THE FACTS

Overview

1. The More Beds, Better Care Act (Bill 7) applies to a particularly vulnerable cohort of hospital patients who are designated as needing an "alternate level of care" ("ALC") and are waiting to be admitted to a long-term care ("LTC") home. These patients are older, and suffer from various comorbidities including dementia. The vast majority are in the final stages of life and a significant minority have less than three months to live. A substantial number of these patients have been found to be incapable of making their own and independent decisions about their care and are represented by a substitute decision maker ("SDM").

2. Bill 7 allows these ALC patients, and these patients alone, to be deprived of their personal autonomy over where they will live and the medical treatment and healthcare they will receive by authorizing a placement coordinator ("PC") from Home and Community Care Support Services ("HCCSS") to unilaterally, and without the patient's consent, seek and authorize admission to a LTC home that the patient does not believe can meet their needs. In doing so, without consent, the PC may share the patient's personal health information with any number of potential LTC homes. Once a discharge order is written an ALC patient who fails to leave the hospital within 24 hours will be charged $400 a day if they remain in hospital.

3. Bill 7 amends the *Fixing Long-Term Care Act, 2021*, S.O. 2021, c. 39, Sched. 1 ("*FLTCA*") and the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A ("*HCCA*"). Both statutes establish a paramount role for informed consent as critical to their respective purposes of fostering and supporting the well-being of patients and LTC residents.

4. Bill 7 includes no purpose provision. No legislative or public hearings were held before the Bill 7 was passed. Other than the purposes of the FLTCA and HCCA in respect of which Bill

7's provisions are entirely incompatible, the only other guidance concerning the purpose of the legislature in passing Bill 7 is provided by the statements of the Minister of Long Term Care when tabling Bill 7 for second reading, that "Our priority is for people to live and receive care where they can have the best possible quality of life close to their family, caregivers and friends" and further, for ALC patients to receive "the appropriate level of care in an appropriate setting."

5. The evidence summarized below shows Bill 7 does not in fact advance these purposes. Rather, the effects of the Bill are to deprive these patients of consent with respect to the medical treatment and health care they will receive by coercing them to accept beds in LTC homes that will be less likely to provide for their proper care, safety, or quality of life. This is because these beds are likely to be in homes that: are older and offer few amenities; are further from family and community; have a poorer record of regulatory compliance and resident care; are understaffed; are less likely to meet the cultural, religious and linguistic needs of these patients; or, have some combination of these characteristics. The uncontroverted expert evidence in this proceeding is that ALC patients admitted to such homes will suffer a 10% greater risk of death, and a 25% greater risk of hospital re-admission.

6. The applicants contend that these effects are antithetical to the purposes of FLTCA and the HCCA which include, "enhance[ing] the autonomy of persons" for whom admission to LTC is proposed; ensuring a significant role for supportive family members when a person lacks the capacity to make a decision about admission to LTC home; and, ensuring that residents of a LTC home can "live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met," in accordance with and only with, the resident's or the SDM's consent.

7. The applicants submit that the Bill discriminates against these patients and deprives them

of their life, liberty and security by targeting these uniquely vulnerable patients who are neither the cause nor the solution to the problem Bill 7 purports to address. In so doing, Bill 7 has deprived these patients of their rights guaranteed by ss. 7 and 15 of the *Charter*.

A. Bill 7 in Context

8. As the Minister has acknowledged, Ontario has too few hospital beds to meet the needs of its population and the provincial government has committed to increasing hospital capacity to bring it more in line with provincial and international norms.[1]

9. As Ontario's population has aged, the need to provide health care services to elderly individuals who can no longer be cared for in the community has grown. At one time, these care needs would often have been provided in extended care or other hospital settings. However, in the past three decades Ontario closed 31 public hospitals, 6 private hospitals, and 6 provincial psychiatric hospital sites that provided such care.[2]

10. In consequence of the decline in public hospitals beds, while the number of people living into old age with complex care needs has grown, the number of residents in long-term care requiring skilled medical care has increased significantly.[3] Unfortunately, Ontario's LTC sector is under-resourced and ill-equipped to meet this demand, and even the best LTC homes struggle to provide proper care to a resident population with increasing acuity and care needs.[4]

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[1] Ontario, Legislative Assembly, *Hansard*, 43rd Parl, 1st Sess (23 August 2022) at 0900 (Hon P Calandra) (**Hansard Tuesday 23 August 2022**) also see Dr. Carpenter's acknowledgement that Ontario has a relatively low number of hospital beds per capita, Affidavit of Travis Carpenter sworn February 21, 2024 ("**Carpenter Affidavit**"), para. 39, Joint Record (**JR**), Vol. 5, Tab 15, p. 1781.
[2] Affidavit of Dr. Pat Armstrong sworn March 13, 2023 (**Armstrong Affidavit**), paras. 17-23, JB, Vol 1, Tab 3, p. 57-61.
[3] *Idem*.
[4] *Office of the Auditor General of Ontario Value for Money Audit* (**Auditor General**), Exhibit 1, to Transcript of Cross Examination of Sandra Iafrate (**Iafrate Cross**) JR, Vol VI, Tab 27A, Affidavit of Dr. Amit Arya sworn March 23, 2023 (**Arya Affidavit**), paras. 18-22, Vol. 1, Tab 4, p. 177-179; Affidavit of Dr. Samir Sinha sworn March 21, 2023 (**Sinha Affidavit**), para. 38, JR, Vol. IV, Tab 12, p. 1484.

11. The LTC sector has too few beds to meet the demand for long term care and there are wait lists that are years long for admission to LTC homes that have a good reputation for providing the reliable and quality care would-be residents are seeking.[5] There are now approximately 80,000 LTC beds in Ontario. There are approximately 65,000 individuals on wait lists at any one time seeking access to one.[6] During 2023, and at any one time, there were 2500 patients waiting in hospital for LTC. In the first full calendar year since Bill 7 went into effect, the number of these patients has grown by over 30% and they are waiting significantly longer in hospital for admission to a LTC home.[7]

12. There is no disagreement among the experts who have given evidence in this proceeding that Ontario's health care system is ill equipped and very often fails to provide the medical care and health care services that these ALC patients require.[8]

B. Admission to Long-Term Care

13. The legal regime governing admission to LTC in Ontario is set out in the FLTCA and the HCCA which applies fully to all LTC applicants other than ALC patients waiting for LTC. These Acts establish the rules concerning application and admission to LTC and are based on respect for the dignity, security, safety, and comfort of individuals,[9] as well as respect for their right to

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[5] See discussion See discussion in section "F" herein

[6] Response to Questions Taken Under Advisement at Cross Examination of Sandra Iafrate dated April 15, 2024 (**Iafrate Responses**), JR, Vol. VII, Tab 35A, p. 3174: As at March 31, 2024: 40,119 applicants waiting in the community; 5,719 applicants waiting in hospital and 21,813 applicants waiting in Long-Term Care home.

[7] Responding Affidavit of Dr. Samir Sinha sworn April 2, 2024 (**Responding Sinha Affidavit**), paras. 10-13, JR, Vol. IV, Tab 13, p. 1701-1704.

[8] Sinha Affidavit, para. 63, JR, Vol. IV, Tab 12 p 1494; Affidavit of Dr. Jordan Pelc sworn February 23, 2024 (**Pelc Affidavit**), para. 16, JR, Vol. V, Tab 21, p. 2151-2152; Transcript of Cross Examination of Dr. Rhonda Crocker Ellacott dated April 17, 2024 (**Ellacott Cross**), Qs 140-41, JR, Vol. VI, Tab 25, p. 2564-2565; Affidavit of Dr. Maurice St. Martin affirmed April 11, 2023 (**St. Martin Affidavit**), paras. 22-35, JR, Vol. IV, Tab 14, p. 1752-1759.

[9] *Fixing Long-Term Care Act, 2021*, S.O. 2021, c. 39, Sched. 1 **[*FLTCA*]**, s. 1: "The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

informed consent.

14. With the exception of these ALC patients, if deemed eligible for admission to a LTC homes, individuals are free to choose the LTC homes they wish to be admitted to, must consent to be admitted to a LTC home, and that consent must: (a) relate to the admission; (b) be informed; (c) be given voluntarily; and (d) not be obtained through misrepresentation or fraud. An applicant must provide written consent to the disclosure of all information necessary to deal with the application (FLTCA, s. 51(5));

15. An SDM representing an ALC patient, in making decisions about admission to LTC on behalf of an incapable person, must comply with the principles set out in *HCCA,* which require SDMs to make decisions that reflect the wishes that the incapable person had expressed while capable, or, if this was unknown, or impossible to comply with, that reflect the incapable person's best interests.[10]

16. As noted, Bill 7 amendments to the *FLTCA* and *HCCA*,[11] and to regulations under these Acts and the Public Hospitals Act,[12] fundamentally change the process for admission to LTC for a specific cohort of ALC patients for whom LTC is the discharge destination. These patients occupy a bed in a hospital under the *Public Hospitals Act* and have "been designated by an attending clinician in the hospital as requiring an alternate level of care because, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting".[13]

17. Pursuant to the amendments to the *FLTCA* that apply only to these particular ALC patients,

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[10] *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A [***HCCA***], ss. 41, 42.
[11] The *More Beds, Better Care Act, 2022* introduces ss. 60.1, 61(2)(h.1) and 61(2)(h.2) to the *FLTCA* and introduces ss. 47(3) and (4) to the *HCCA*, as well as making other small consequential amendments.
[12] O. Reg. 484/22: *General* amends O. Reg. 246/22: *General*, enacted under the *FLTCA*, to introduce ss. 240.1, 240.2, 240.3 and 240.2; O. Reg. 485/22: *Hospital Management* and O. Reg. 486/22: *Hospital Management* both amend R.R.O. 1990, Reg. 965: *Hospital Management*, enacted under the *Public Hospitals Act*, R.S.O. 1990, c. P.40, to add ss. 16(3.1), (4), (5) and (6).
[13] *FLTCA*, s. 60.1(1).

and pursuant to the amendments to the HCCA that apply only to an SDM representing such a patient, a PC may, *inter alia,* do the following, "with our without a request from an attending clinician," and without the ALC patients consent:

> "i. Determine the ALC patient's eligibility for admission to a long-term care home.
>
> ii. Select a long-term care home or homes for the ALC patient in accordance with the geographic restrictions that are prescribed by the regulations.
>
> iv. Authorize the ALC patient's admission to a home.

18. Bill 7 also deprives these patients of their right to control access to their personal health information by authorizing a PC, physician or registered nurse to "collect, use or disclose personal health information" as necessary in order to exercise their authority to require admission to a LTC without the consent of the ALC patient.[14] These provisions apply "despite any other provision of … any other Act,"[15] thereby excluding the operation of *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A., in relation to these patients.

19. Under the regulations introduced with Bill 7, the PC must inform these ALC patients or their SDM, "that if they do not consent to submit an application for a determination of eligibility that … the PC shall proceed to determine eligibility, and if eligible, identify a home or homes for the patient"[16] and either the PC, or the hospital discharge team, will advise the patient that they will be charged $400 a day if they remain in hospital for more than 24 hours of being discharged for admission to LTC home.[17]

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[14] *FLTCA*, s. 60.1(3)5; O. Reg 462/22: *General*, ss. 240.1(9), (10).
[15] *FLTCA*, s. 60.1(3).
[16] O. Reg 246/22: *General*, s. 240.1(5)(d)
[17] Admissions to LTC for ALC Patients – Field Guidance to HCCSS Placement Co-ordinators, Exhibit A to Affidavit of Sandra Iafrate sworn February 23, 2024 (**Iafrate Affidavit**), JR, Vol. V, Tab 17A, p. 1977, and see Affidavit of Nora Chaloner affirmed April 27, 2023 (**Chaloner Affidavit**), paras. 12 and 17, JR, Vol. 1, p. 351-352 and Affidavit of Bonnie Parkinson affirmed May 25, 2023 (**Parkinson Affidavit)**, para. 6, JR, Vol. III, Tab 11, p. 1408.

20. Consequential amendments to s. 16(4) of Regulation 965 to the Public Hospitals Act state that a patient is "no longer in need of treatment in the hospital' whose admission to a LTC home has been authorized under Bill 7, shall be ordered discharged from the hospital.[18]

21. Bill 7 also deems all actions taken pursuant to these amendments to the FLTCA and the HCCA to be consistent with the *Residents' Bill of Rights*, which, among other things, protects the rights of LTC residents to be treated with respect and dignity, to be free from abuse and neglect, to consent to and participate fully in determining their care, to have their personal health information kept confidential, and to have ongoing and safe support from their caregivers.[19]

22. Bill 7 allows these ALC patients to appeal a determination of *ineligibility* to the Appeal Board, but there is no right of appeal or to seek review from the other determinations made under Bill 7, including to authorize the admission of the ALC patient to LTC home without their consent.[20]

C. WHO ARE THE ALC-LTC PATIENTS AND WHAT CARE DO THEY NEED?

(i) ALC Patient Cohorts

23. ALC patients are comprised of two main groups. The first are those who require LTC home admissions (referred to hereinafter as "ALC-LTC" patients); the second and larger group of ALC patients are typically waiting for further hospital care in another hospital setting. This latter cohort typically transitions for further care within days or weeks. Bill 7 doesn't apply to these patients, but only to those waiting for LTC.[21]

24. The 2500 or so ALC-LTC patients waiting for LTC care occupy approximately 5.8% of

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[18] O.Reg 965 R.R.O. 1990, Reg. 965: *Hospital Management*, ss. 16(1), (2), (3).
[19] *FLTCA*, s. 60.1(9).
[20] *FLTCA*, s. 60.1(8).
[21] Sinha Affidavit, paras. 11-15, JR, Vol. IV, Tab 12, p. 1473-1474.

the 43,000 active hospital beds in the province.[22] Most of these patients are waiting in post-acute care beds which are principally developed and resourced to provide rehabilitative and complex continuing care.[23]

(ii) ***The Health Status of ALC-LTC Patients***

25. More than 80% of ALC-LTC patients are 65 years or older.[24] The vast majority suffer from incurable conditions often associated with age (e.g. advanced lung disease, congestive heart failure, or frailty) and have a limited life expectancy.[25] They often need highly specialized forms of medical care or complex continuing care because they have multiple chronic conditions and specific ongoing medical care needs that require access to specially trained care staff. Approximately two-thirds of those who enter a LTC home in Ontario are living with a diagnosis of dementia, while close to ninety per cent are living with some form of cognitive impairment. A large number of these patients also lack the capacity to make LTC placement decisions and may be represented by a SDM.[26]

26. There is no dispute that the needs of ALC-LTC patients do not fit well into typical post-hospital care settings including in LTC homes, many of which are ill-equipped to deal with patients with complex medical care needs.[27]

D. THE ALC DESIGNATION

27. The practice of designating patients as requiring an alternate level of care is one that

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[22] Iafrate Responses, JR, Vol. VII, Tab 35; Transcript of Cross Examination of Dr. Abhishek Narayan dated April 18, 2024 (**Narayan Cross**), JR, Vol. VII, Tab 30.
[23] *Provincial Monthly Alternate Level of Care Performance Summary : Provincial and Sub-Region Level,* January 2024, Exhibit A to Sinha Responding Affidavit, JR, Vol. III, Tab 13A, p. 1707.
[24] *Idem,* JR, Vol. III, Tab 13A, p. 1713.
[25] Arya Affidavit, para. 5, JR, Vol. I, Tab 4, p. 172.
[26] Iafrate Responses, JR, Vol. VII, Tab 35C, p. 3186: 227 of 424 ALC-LTC patients placed in LTC homes chosen by the placement coordinator were determined to be incapable.
[27] Pelc Affidavit, para. 16, JR, Vol. V, Tab 21, p. 2151-2152; Sinha Affidavit, para. 18, JR, Vol. IV, Tab 12, p. 1475; Armstrong Affidavit, para. 4, JR, Vol. I, Tab 3, p. 51.

predates Bill 7 by several decades and various guides have been published concerning best practices for making this designation.[28] More recently Ontario Health published the "Alternate Level of Care ALC Reference Manual (2021).[29]

28. Prior to Bill 7 the ALC designation was simply an administrative tool, not a diagnosis, and it was typically used to indicate that a person was ready to move on from a particular clinical setting but carried no legal consequences.[30] For example, a patient admitted to hospital for a hip fracture, a stroke or a heart condition could be designated as an ALC patient when the acute care required to manage that condition was completed and the patient either required further hospital care but in a different hospital unit or setting, or required transfer back to their own home or to a LTC home to meet their ongoing care needs. A patient may also be designated ALC on successive occasions as they transition from various hospital setting, such as rehab, to other discharge destinations.[31]

29. The ALC-LTC designation is highly contextual and is applied in different ways in different hospital settings,[32]and is not standardized across the sector.[33] The designation is not being used with precision or consistently by physicians or other clinicians or non-clinicians that are authorized to make the designation.[34]

30. When asked, the respondent's expert physician witnesses each offered a different

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[28] Sinha Affidavit, para. 4, JR, Vol. IV, Tab 12, p. 1469-1470. "Definitions and Guidelines to Support ALC-LTC Designation in Acute Inpatient Care" published by Canadian Institute for Health Information ("CIHI") in 2016; https://www.cihi.ca/sites/default/files/document/acuteinpatientALC-LTC-definitionsandguidelines_en.pdf; and a reference manual published by Cancer Care Ontario in 2017.
[29] Ontario Health ALC Reference Manual (2021), Exhibit C to Pelc Affidavit, JR, Vol. V, Tab 12C.
[30] Pelc Affidavit, paras. 7, 8, JR, Vol. V, Tab 21, p. 2148-2149.
[31] Sinha Affidavit, para. 5, JR, Vol. IV, Tab 12, p. 1470-1471.
[32] Sinha Affidavit, paras. 5-7, JR, Vol. IV, Tab 12, p. 1470-1472; and see Pelc Affidavit, para. 8, JR, Vol. V, Tab 21, p. 2149.
[33] Sinha Affidavit, paras. 5-7, JR, Vol. IV, Tab 12, p. 1470-1472; and see Affidavit of Dr. Abhishek Narajan dated February 23, 2024 (**Narayan Affidavit**), para. 8, JR, Vol. VII, Tab 20, p. 2136.
[34] Sinha Affidavit, paras. 4, 6, JR, Vol. IV, Tab 12, p. 1469-1471.

encapsulation of what they consider the term to mean, and referred variously to one or more of the three different guides to its application noted above. In doing so, none quoted the statutory definition of the term, nor averted to the legal consequences that now follow from the designation.[35]

31. Dr. Sinha's evidence is that it is not uncommon for some patients to be prematurely or incorrectly designated as ALC-LTC patients for various reasons. First, there are patients with various co-morbidities unrelated to the acute care they received which have remained unaddressed, in some cases because they went unrecognized. Second, the patient's condition may have changed since they were first designated as ALC-LTC patients, and they once again need acute care or even palliative care.[36]

32. Third, pressures, that have been building on the capacity of hospitals to meet the care needs of those they serve, are leading to ALC-LTC designations being made earlier and earlier during the hospital stay of many patients to facilitate their earlier discharge from hospital.[37] Conversely, on other occasions, but for the same purpose, hospital administrators may exert pressure on clinicians to discourage ALC-LTC designations if the patient can be persuaded to return home and make the application for LTC from there.[38] As Ms. Meadus attests, it is not uncommon for patients

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[35] Carpenter Affidavit, para. 16, JR, Vol. V, Tab 15, p. 1771-1772: "Would you feel comfortable as the most responsible physician discharging the patient from acute care at this point in time"; Pelc Affidavit, para. 7, JR, Vol. V, Tab 21, p. 2148-2149: "As an approximate rule of thumb, we ask ourselves if it would be clinically appropriate to discharge a patient if there were currently a bed available to them in their next destination."; Narayan Affidavit, para. 6, JR Vol. V, Tab 20, p. 2135: A patient must be deemed medically stable in order to be designated ALC. Although there is no formal definition of medical stability, it is generally considered to be when a patient no longer requires the supports and clinical expertise of an inpatient acute care program.

[36] Sinha Affidavit, paras. 5-7, JR, Vol. IV, Tab 12, p. 1470-1472.

[37] Sinha Affidavit, paras. 8-9, JR, Vol. IV, Tab 12, p. 1472-1473; St. Martin Affidavit, paras. 22-35, JR, Vol. IV, Tab 14, p. 1452.

[38] Carpenter Affidavit, para. 22, JR, Vol. V, Tab 15, p. 1773-1774; Transcript of Cross Examination of Dr. Travis Carpenter dated April 18, 2024 (**Carpenter Cross**), Qs 149-153, JR, Vol. IV, Tab 24, p. 2478-2480.

to be told, falsely, that they must leave the hospital in order to apply for LTC.[39]

E. HOW LONG DO ALC-LTC PATIENTS WAIT IN HOSPITAL AND WHY

33. There is no evidence that the time ALC-LTC patients spend waiting in hospital is related to any reluctance on their part to leave the hospital either for home, or to a LTC home. As described in the following paragraphs, the considerable time it may take for them to be discharged from hospital is, in virtually all cases, a consequence of time it takes medical care teams and HCCSS to determine whether and where to discharge to the patient. As described in section "F" below, virtually all ALC-LTC patients fully cooperate in efforts to facilitate their timely discharge to LTC.

34. As described by Ontario Health, the transition from hospital to LTC is to "be an interdisciplinary and collaborative process amongst hospital staff, including the discharge coordinator, the patient's health care providers and support services, such as HCCSS, and including the patient, family and/or caregiver(s)."[40]

35. The transition process proceeds in two principal stages. The first involves a multi-disciplinary team of physicians, nurses and other hospital staff that will determine the patient's readiness for discharge from the particular care setting, and the discharge destination for that patient. There may be some overlap, but where the discharge destination is to home with supports or to LTC, HCCSS plays the primary role.[41]

(i) Is the Patient Stable and Ready for Discharge from the Care Setting

36. The ultimate discharge destination is also a two-step process. The first determines the "most appropriate discharge designation" ("MADD") for a patient without regard to whether that discharge destination is feasible or available. Thus a MADD that identifies further hospital care in

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[39] Affidavit of Jane E Meadus affirmed April 11, 2023 (**Meadus Affidavit**), para. 122, JR, Vol. II, Tab 9, p. 594.
[40] Admissions to LTC for ALC Patients – Field Guidance to HCCSS Placement Co-ordinators, Exhibit A to Iafrate Affidavit, JR, Vol. V, Tab 17A, p. 1974, 1979.
[41] Iafrate Affidavit, para. 4, JR, Vol. V, Tab 17, p. 1964.

rehab, palliative care, or in a hospice may, upon investigation, that discharge destination may not be available or feasible.[42] A care team may observe a patient for "weeks, months or longer as teams try to develop clinically-appropriate discharge plans".[43] If the patient's condition changes, the designation once made, may be removed if further acute care is required.[44]

37. Where MADD options aren't available or feasible, LTC is often chosen as the sub-optimal discharge designation.[45] The ALC summaries prepared by OH indicate that approximately for 10-14% of these patients a LTC home is not the MADD. [46]

(ii) ***Home First***

38. In general, both the hospital and HCCSS are committed to returning a patient to their home whenever that is feasible. As Ms. Iafrate explains, "Usually, the discharge destination is determined by the hospital, although Home and Community Care does have a home first philosophy where we will explore going home. We know that most patients want to go home."[47]

39. Investigating the feasibility of home care typically involves meetings among the members of the discharge team, HCCSS and the family to determine whether the necessary supports required can be reliably provided by publicly funded programs.[48] The lack of sufficient and consistent government funding for programs proven to be cost effective and efficient,[49] greatly limits the

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[42] Ontario Health ALC Reference Manual (2021), Exhibit C to Pelc Affidavit, JR, Vol. V, Tab 12C, p. 2237-2239.
[43] Pelc Affidavit, para. 14, JR, Vol. V, Tab 21, p. 2147.
[44] Narajan Affidavit, para 7, JR, Tab 20, p 2135.
[45] Sinha Affidavit, paras 24, 65, JR, Vol. IV, Tab 12, p. 1478, 1495, and see Pelc Affidavit, para. 16, JR, Vol. V, Tab 21, p. 2151-2152.
[46] *Provincial Monthly Alternate Level of Care Performance Summary : Provincial and Sub-Region Level,* January 2024, Exhibit A to Sinha Responding Affidavit, JR, Vol. IV, Tab 13A, p. 1710.
[47] Iafrate Cross. Q 17, JR, Vol. VII, Tab 27, p. 2611.
[48] See 246/22 s. 172(1)(d) "... the publicly-funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person's requirements;"
[49] Sinha Affidavit, paras. 63–70, JR, Vol. IV, Tab 12, p. 1494-1498; and see Narayan Cross, Qs 17-62, JR, Tab 30, pp 2879-2890.

feasibility of this option for many patients who would otherwise be able to return home.[50] Nevertheless, unsuccessful efforts to arrange for a discharge to home and community care can take weeks.[51]

40. Other than for the definition of ALC, these stages of the discharge process are essentially unaltered by Bill 7.

(iii) ***The Admission Process to a LTC home***

41. Once LTC is identified as a likely discharge destination, a PC will determine the patient's eligibility for admission to LTC in accordance with the regulations under the FLTCA.[52][53] To be deemed eligible for LTC an individual must, inter-alia, require: nursing care to be available on site 24 hours a day; assistance with activities of daily living throughout the day; on-site supervision and monitoring to ensure their safety and well-being. A PC must also determine that publicly-funded community-based services and other supports are not sufficient, in any combination, to meet the person's requirements, and finally, that the person's care requirements can be met in a long-term care home.[54]

42. The PC also arranges for an assessment of a patient's health and requirements for medical treatment and health care, which must be provided to any prospective LTC home.[55] Under Bill 7, a physician can now be requested to complete such an assessment for a non-consenting ALC-LTC patient based only on a review of the existing records, in other words without having interviewed

[50] Sinha Affidavit, para. 67, JR, Vol. IV, Tab 12, p. 1496.
[51] Carpenter Cross, Q 47, JR, Vol. VI, Tab 24, p. 2420.
[52] Iafrate Affidavit, para. 4, JR, Vol. V, Tab 17, p. 1964 and *Admissions to LTC for ALC Patients – Field Guidance to HCCSS Placement Co-ordinators*, Exhibit A to Iafrate Affidavit, JR, Vol. V, Tab 17A, p. 1976.
[53] Reg 246/22, s. 172(1).
[54] *Idem.*
[55] Iafrate Affidavit, para. 9, JR, Vol. V, Tab 17, p. 1966.

or examined the patient or otherwise consulted with the hospital care team.[56]

43. When questions exist about the capacity of a patient to consent to being admitted to a LTC home, an evaluation of their capacity will be performed, usually by a PC.[57] An incapable patient is typically represented by an SDM - usually a member of the family or an attorney. [58]

44. If the patient is eligible, the PC will begin the process of meeting with the patient, the patient's family and the SDM or official guardian where one has been appointed. As described by Sandra Iafrate, "It's a very iterative process, it can take multiple days, multiple sessions with the family to really understand what's most important to the family, what the discharge destination is."[59]

45. The PC will recommend all LTC choices, and patients and their families are encouraged to tour homes, virtually or in person. Some homes limit in-person visits to one specified day each week.[60] Ms. Iafrate describes the importance of visiting prospective homes this way:

> …. it's part of the counselling for long-term care, absolutely. We would encourage family members or anyone to visit or to look at their website or look at their virtual tours. … [so they can] get a sense if the environment, if the home is an environment that they could see their loved one living in or they could see themselves living in. To meet with the staff, to talk about their programming, to see if it's a good fit for them.[61]

46. The utility of such inquiries has been significantly diminished under Bill 7 because where an ALC-LTC patient or SDM investigates or visits a home, and finds it to be unsatisfactory and not "a good fit", they may nevertheless feel compelled to select the home to avoid the

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[56] Arya Affidavit, paras. 30-3, JR, Vol. I, Tab 4, p. 181-182, and Carpenter Affidavit, para. 36, JR, Vol. V, Tab 15, p. 1780.
[57] *HCCA s. 4.*
[58] Iafrate Under Advisements, JR, Vol. VII, Tab 35B, p. 3178.
[59] Iafrate Affidavit, para. 4, JR, Vol. V., Tab 17, p. 1964.
[60] Iafrate Affidavit, para. 8, JR, Vol. V, Tab 17, p. 1965-1966; and Meadus Affidavit, para 38, JR, Vol, II, Tab 9, p. 567.
[61] Iafrate Cross, Q 115, JR, Vol. VI, Tab 27, p. 2638.

consequences of withholding their consent,[62] and discover only after being admitted that there is no prospect of transitioning to a preferred home.[63]

47. Upon receipt of a request from HCCSS, a LTC has five days to respond.[64] When a LTC is unable to provide the care an ALC-LTC patient may require, the home will refuse the prospective admission.[65] As Dr Pelc explains, LTC homes "frequently" decline admission requests on the grounds that their care needs cannot be met.[66] Dr. St. Martin describes this same problem from the perspective of a LTC home.[67] When admission to a LTC home is refused, HCCSS will often attempt to address the concerns of the LTC home to overcome its objection.[68] This back and forth can also take time.

48. In many cases however, the most significant cause of delay in transitioning from the hospital is simply the lack of long-term care beds as evidenced by the very long wait lists for admissions particularly for homes that provide better and more suitable care. The Respondent's witness Ms. Ellacott, the CEO of the Thunder Bay Hospital states that in her region there has been a long-term care bed shortage for a very long time and the problem is only getting worse.[69]

49. In spite of the number of hospital and HCCSS people involved in collaborative efforts to work with patients and their families, and in light of the series of determinations and processes that are involved, over 60% of these patients are discharged from acute care beds in less than 30

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[62] Parkinson Affidavit, paras 6, 15, JR, Vol. III, Tab 11, p. 1408, 1411.
[63] *Idem,* para 28, JR, Tab 11, p 1414; Parkinson Affidavit, para. 28, JR, Vol. III, Tab 11, p. 1414; and Chaloner Affidavit, para. 22, JR, Vol. I, Tab 6, p. 353.
[64] *O. Reg. 246/22 s. 200(2).*
[65] Iafrate Affidavit, para. 12, JR, Vol. V, Tab 17, p. 1967-1968.
[66] Transcript of Cross Examination of Jordan Pelc dated April 11, 2024 (**Pelc Cross**), Q 67, JR, Vol. VII, Tab 31, p. 3040.
[67] St. Martin Affidavit, paras. 13-35, JR, Vol. IV, Tab 14, p. 1748-1759.
[68] *Admissions to LTC for ALC Patients – Field Guidance to HCCSS Placement Co-ordinators*, Exhibit "A" to Iafrate Affidavit, JR, Tab 17A, p 1984.
[69] Affidavit of Dr. Rhonda Croker Ellacott affirmed February 23, 2024 (**Ellacott Affidavit**), para. 13, JR, Vol. V, Tab 16, p. 1952; Ellacott Cross, Qs 140-41, JR, Vol. VI, Tab 25, p. 2564-2565.

days.[70] In other cases, the transition may take longer.

50. Patients who take longer to transition to LTC typically have special needs or barriers that make transition to LTC difficult.[71] The evidence shows that some patients wait for months in hospital for their condition to stabilize, and even then their care needs may be so considerable that it is difficult to find any feasible discharge destination for them, including to LTC.[72]

F. CHOOSING A LTC HOME

(i) Proximity and Culture

51. Choosing LTC homes often takes place at one of the most stressful times in the lives of an ALC-LTC patient and their family, and generally a great deal of thought is put into their choice of a LTC home where the patient will likely spend the rest of their lives. Most often LTC homes are chosen that are close to family and friends, meet specific ethno-cultural needs or care needs, and that have a good reputation for providing quality care.[73]

52. Because even the best LTC home struggle to properly care for residents, the support of family caregivers is not just critical for the resident receiving it, but also frees up overworked staff to care for other residents who do not have the benefit of support from their families. In addition, short staffing does not allow enough time for healthcare staff to provide companionship and emotional support, which is essential to easing the high prevalence of social isolation and loneliness for LTC residents, in itself a major health risk.[74]

53. Therefore, proximity to family and community (which often will include members of their

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[70] *Provincial Monthly Alternate Level of Care Performance Summary : Provincial and Sub-Region Level,* January 2024, Exhibit A to Sinha Responding Affidavit, JR, Vol. IV, Tab 13A, p. 1714.
[71] *Idem*.
[72] Responses to Questions taken Under Advisement at the Cross Examination of Scott Jarrett (**Jarrett Responses**), JR, Tab 36, A – D, p. 3188 – 3368.
[73] Meadus Affidavit, para. 52, JR, Vol. II, Tab 9, p. 572, Arya Affidavit, paras. 9-24, JR, Vol. I, Tab 4, p. 174-179, Sinha Affidavit, paras. 52-54, JR, Vol. IV, Tab 12, p. 1489-1490.
[74] Arya Affidavit, paras. 12-14, JR, Vol. I, Tab 4, p. 175-176.

religious institution, social club, or neighbours) not only allows a resident to be visited by people they know, love or feel close to, but also makes it easier for family caregivers to assist with a variety of care duties which may be direct (e.g. assistance with feeding, helping manage the resident's behaviours) or indirect (e.g. shopping for personal items for the resident, advocating for the resident, and helping the resident with financial affairs). Recent research shows that over 50% of spouses visit LTC on a daily basis.[75] As the evidence of Nora Chaloner shows, when homes are some distance away access can be a serious problem for elderly spouses who no longer drive particularly in communities where there is little if any public transit.[76]

54. Language, religious, and cultural considerations are another key consideration for would-be LTC residents. When non-anglophone patients are admitted into an LTC home which is not specialized to provide culturally specific care, proximity to allow regular and frequent access for family caregivers and community members becomes even more important to ensure resident safety and wellbeing.[77] A recent study demonstrated how language disconcordance is associated with increased mortality and adverse outcomes for frail patients.[78] Culturally-specific homes, estimated to account for only 8% of all LTC homes in Ontario, tend to have wait lists that are often years long.[79]

(ii) ***Quality of Care***

55. The notoriety associated with the tragic failures of certain LTC homes to protect patients during the covid 19 pandemic prompted the government to establish the "Long-term Care Covid

[75] *Idem.*
[76] Chaloner Affidavit, paras. 14-26, JR, Vol. I, Tab 6, p. 351-355.
[77] Arya Affidavit, paras. 15-17, JR, Vol. I, Tab 4, p. 176-177.
[78] Arya Affidavit, para. 17, JR, Vol. I, Tab 4, p. 177.
[79] Arya Affidavit, para. 15, JR, Vol. I, Tab 4, p. 176; Auditor General, JR, Vol. VI, Tab 27A, p. 2717.

19 Commission"[80] to inquire into the causes of the catastrophe. The reports of the Commission, the Auditor General and the work of advocacy groups has raised public awareness about the disparity of care among LTC homes.[81]

56. A recent study by the Auditor General, which is highly critical of the lack of transparency surrounding the implementation of Bill 7, describes critical differences in the capacity among LTC homes to provide proper care, and finds that:

> At least a quarter of all homes failed to consistently reach the provincial targets for direct-care hours in 2021/22 and 2022/23.[82]
>
> … staff-to-resident ratio also varied significantly… especially during the evening and overnight shifts, with ratios of up to 1:80 for nurses (one nurse for 80 residents) and 1:30 for PSWs in some homes.[83]
>
> About half of all homes fell below the provincial target for direct-care hours by allied health professionals (AHPs) such as nurse practitioners, physiotherapists, occupational therapists and social workers. Many homes were severely lacking services from certain AHPs [and] 74% of homes provided zero hours of direct care from nurse practitioners.[84]
>
> … examples [were found] where residents' aggressive behaviours led to physical harm or harassment of other residents and/or staff. Homes often do not have sufficient resources to effectively manage these behaviours.[85]
>
> Out of 626 long-term care homes, only 57 are designated to serve specific ethnocultural or religious groups. For these 57 homes, the median wait time was up to five years in 2022/23, more than eight times longer than for all homes, depending on the region.[86]
>
> …. not all homes have staff who can communicate with residents in their first language, which is especially important for those with dementia, who are more likely to revert to their mother tongue as their condition intensifies.[87]

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[80] Marrocco, F. N. A. Coke & J. Kitts (2021) Ontario's Long-Term Care COVID-19 Commission Final Report. Toronto: Queen's Printer of Ontario https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf, pp.38-39 (**the Commission**).
[81] Affidavit of Natalie Mehra, affirmed April 11, 2023, paras. 20-27, JR, Vol. II, Tab 10, p. 1065-1068.
[82] Auditor General, JR, Vol. VI, Tab 27A, p. 2686.
[83] *Idem*.
[84] *Idem,* JR, Vol. VI, Tab 27A, p. 2687.
[85] *Idem*.
[86] *Idem.*
[87] Auditor General, JR, Tab 27A, p. 2686-2687.

57. Commenting on the disparity of care among LTC homes, the Long-Term Care Commission describes the poor performance of for-profit LTC homes that dominate the sector in Ontario:

> Numerous studies and system reviews over the past two decades have highlighted the variations in quality of care and resident outcomes between for-profit, not-for-profit and municipal homes, including:
>
> - Staffing: For-profit homes tend to offer lower wages and benefits to their staff, have higher staff turnover, and have lower staffing levels and staff-skill mix (i.e., the mix of medical and non-medical staff).
>
> - Quality of care: Residents in for-profit homes tend to have a higher prevalence of pressure ulcers, more hospital admissions, and increased incidents of excessive and inappropriate use of psychoactive medications.
>
> - Infrastructure: For-profit entities own more of the province's older homes; these homes were built according to the design standards in place at the time of construction, prior to the newer provincial structural and design standards; as a result, they have more three- and four-person rooms (and therefore crowding).
>
> - Consumer preference: The long-term care waitlist is shorter for for-profit homes (32 per cent) compared to not-for-profit and municipal homes (68 per cent).[88]

58. A large number of LTC homes are older and operating under standards far below those of the present, and are not designed to meet current infection control protocols. Their residents were hit hardest by COVID-19. These homes still represent a large percentage of the long-term care homes in Ontario,[89]and as noted, stressors on LTC homes have become even more acute given the transition away from hospital care for these patients, and the growing need for more complex care by an aging population.[90]

59. Unlike publicly funded hospitals, many LTC homes aren't accredited against Canadian standards, and some aren't accredited at all. While most non-profit LTCs are accredited under the

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[88] The Commission p. 38-39.
[89] Auditor General, JR, Tab 27A, p. 2693, 2723.
[90] Armstrong Affidavit, para. 22, JR, Vol. I, Tab 3, p. 59-60.

Canadian standards used by public hospitals, most for-profit homes that are accredited have chosen a US standard that is considered less demanding.[91]

60. While all LTC homes are regulated under the same legislation, reports of their regulatory compliance show that some homes consistently have much poorer records.[92] Inadequate regulatory control, which contributed to the tragic performance of some Ontario LTC homes during the pandemic, remains a serious problem.[93]

61. Other differences in the standard of care in LTC homes arises from the fact that while homes receive roughly the same, if inadequate,[94] provincial funding, many municipal homes and certain not-for-profit homes are able to provide significant additional funding to support care services for their residents.[95]

62. The capacity of LTC homes to provide needed palliative care similarly varies greatly. Several peer reviewed studies document these differences and their consequences, which not only deprive residents of much needed care, but increase their risk of transfer to hospital at end-of-life.[96] This gap in end-of-life care, (in particular, lack of medication prescribing) in LTC homes accounts for thousands of potentially preventable hospital transfers annually. This is the type of quality of care deficiency that accounts for some homes having short wait lists and therefore being

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[91] Sinha Affidavit, paras. 41-42, and 46, JR, Vol. IV, Tab 12, p. 1485, 1487.
[92] Sinha Affidavit, para. 44, JR, Vol. IV, Tab 12, p. 1486 and Exhibit C: 2021 Report on Compliance with Long-Term Care Legislation JR, Vol. IV, Tab 12C, 9. 1675-1679.
[93] Auditor General, Office of the Auditor General of Ontario Preparedness and Management Special Report on Pandemic Readiness and Response in Long-Term Care April 2021 https://auditor.on.ca/en/content/specialreports/specialreports/COVID-19_ch5readinessresponseLTC_en202104.pdf
[94] Arya Affidavit, para. 10, JR, Vol. I, Tab 4, p. 174-175 and see fn 6; Hsu, Amy T et al. "Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership" (2016) 35:2 *Canadian Journal on Aging* 175.
[95] The Commission pp. 80-81
[96] High-prescribing LTC homes transferred only 10% of their residents to hospital for end-of-life care, while low-prescribing facilities transferred up to 30% of their residents to hospital for EOL care.// High-prescribing LTC homes transferred only 10% of their residents to hospital for end-of-life care, while low-prescribing facilities transferred up to 30% of their residents to hospital for EOL care.

the most likely to be the one ALC-LTC patients are pressured to select, or to be selected by the PC.[97]

(iii) ***The myth of the bed blocker***

63. Apart from wishing to return to their own homes, ALC-LTC patients want to spend their final days in a LTC home that can meet their needs.[98] However, given the very long wait list for the better homes, they have always been encouraged, (and the vast majority have acceded to such requests) to be flexible in choosing prospective LTC homes.[99]

64. The Respondent's expert witness Dr. Pelc states that he has encountered only two patients in his entire time in practice who refused to accept a bed in LTC that was offered for reasons he didn't explore.[100] Drs. Sinha and Arya have never met such a patient.[101]

65. As described above, certain patients remain in hospital longer than others but for reasons entirely beyond their control. Nevertheless, the *sub-rosa* discussion concerning such patients labels them "bed-blockers'. Dr. Arya describes this phenomenon this way.

> I want to comment on the not uncommon and very unfortunate perception that it is somehow the fault of ALC-LTC patients that they are occupying acute care hospital beds that are needed by others. In fact, these patients find themselves in this circumstance very much against their wishes. Many want to return home, and often can't understand why they cannot do so. Most others are anxious to leave the hospital for a LTC home they have chosen. In light of long wait lists for a chosen home, virtually all patients are willing, when the options are compassionately explained to them, to compromise by applying for placement in LTC homes with shorter wait lists. It is only on very rare occasions that I see patients or SDMs who, at least at first, are unwilling to accept something other than their preferred choices. But even in these cases, patient and compassionate discussion about what is ultimately in the patient's best interest will create the trust necessary for them to

[97] Arya Affidavit, paras. 24, 29, 33 and 36 JR, Vol. I, Tab 4, p. 179.
[98] Arya Affidavit, paras. 9-24, JR, Vol. I, Tab 4, p. 174-179, Sinha Affidavit, paras. 52-54, JR, Vol. IV, Tab 12, p. 1489-1490.
[99] Pelc Cross, Q 77, JR, Vol. VII, Tab 31, p. 3049.

[100] Pelc Cross, Qs 86, 89-92, JR, Vol. VII, Tab 31, p. 3055-3056.
[101] Sinha Affidavit, para. 57, JR, Vol. IV, Tab 12, p. 1492-1493; Arya Affidavit, para. 50, JR, Vol. I, Tab 4, p. 188-189.

accept the wisdom of such compromise.[102]

66. There is no dispute that the overwhelming majority of patients or their SDMs make rational decisions about choosing homes they wish to spend their final days in and will compromise when advised that their preferred choices have long wait lists.

G. THE IMPACTS OF BILL 7

(i) On Informed Consent

67. A person who accepts to receive care in a certain setting, is essentially permitting everyone working in the 'circle of care' to access and share information that enables all members of the team to care for that individual.[103] Dr. Sinha describes consent as "sacrosanct" in the physician-patient relationship, and consent not only includes the right to choose treatment but also to decide what information the patient wishes to share with their own healthcare professional and have them share with others.[104] "One reason why consent is so important is because it is fundamental to building a trusting relationship between patients and their physicians or other healthcare professionals." [105]

68. Some personal health information about a patient may seem inconsequential, such as how often the patient should be bathed or what mobility issues they may have, "but dispensing with a person's right to consent to share their personal health information can quickly extend into much more sensitive areas, such as those concerning a person's prior issues of abuse, a history of trauma, or a significant mental health issue."[106]

69. There are many reasons why people want control over what personal health information can be shared with others, including that sharing certain information might prejudice and

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[102] Arya Affidavit, para. 50, JR, Vol. I, Tab 4, p. 188-189.
[103] Sinha Affidavit, para. 32, JR, Vol. IV, Tab 12, p. 1481.
[104] Sinha Affidavit, para 27, JR, Vol. IV, Tab 12, p. 1479.
[105] *Idem.*
[106] Sinha Affidavit, para. 29, JR, Vol. IV, Tab 12, p. 1480.

negatively affect their care, further stigmatize them, or put them in an unsafe situation. Obtaining consent gives a patient the ability to understand what information might be shared, why it is being shared, with whom.[107]

70. As noted, Bill 7 authorizes a PC to apply for and authorize admission to an LTC home the patient hasn't chosen. In aid of doing so, and also without the patients consent, the PC may share the patient's personal health information with many individuals or teams operating outside the hospital environment and of which the patient may have no knowledge or relationship.[108] The harms caused by such a breach of confidentiality of the patient's health record are described in the preceding paragraphs.

71. Bill 7, its regulations, and the practices of HCCSS, also provide the means to pressure and coerce ALC-LTC patients to add homes they would otherwise reject to their list of 'preferred' LTC homes, and to leave the hospital once their admission to a LTC home is authorized, including to one selected by the PC without the ALC-LTC patient's consent.

72. The prospects of losing control over the use and dissemination of their personal health information is one of the factors[109] that may 'persuade' a patient to accede to pressure from a PC to list a home urged upon them to their lists of selected homes.[110] If they refuse, ALC-LTC patients lose their rights to participate in the admissions process as set out in ss. 49 to 54 of the Act; and the right for their SDM to honour their wishes concerning PC decisions about acceptable LTC homes.[111] Ultimately they would face a daily fee of $400 for remaining in hospital if they refuse

[107] Sinha Affidavit, para. 31, JR, Vol. IV, Tab 12, p. 1481.
[108] Sinha Affidavit, para. 32, JR, Vol. IV, Tab 12, p. 1481.

[110] Chaloner Affidavit, paras. 7-15 , JR, Vol. I, Tab 6, p. 349-352 and Parkinson Affidavit, paras. 6-19, JR, Vol. III, Tab 11, p. 1408-1412.
[111] Bill 7, s. 9 amending the *Health Care Consent Act.*

to go to a home chosen in this manner.[112]

73. The prospect of facing these deprivations and potential consequences belies any notion that that the selection of, or acquiescence to admission to an 'unwanted' LTC home is a result of the exercise of informed consent.

74. Moreover, to further 'persuade' patients to select homes they would not otherwise choose, patients may be encouraged to believe that being placed in such an 'unwanted' home will only be temporary, and that all LTC homes provide the same quality of care.[113] Neither of these representations is truthful or accurate.

75. Bill 7 has been promoted with claims that admission to a LTC home that HCCSS has urged a patient to add their list of preferred homes, "will be placed in a priority status on the wait list for a preferred home while in a temporary arrangement in a long-term care home."[114] In fact, when a patient accedes to such a request, they will lose their priority status for relocation to a home they voluntarily listed, and are very likely to spend their final days in a home they only reluctantly agreed to select upon the promise that a such a placement would be "temporary". [115]

76. The only way for a patient to preserve their crisis status for relocation is to accept a bed in a LTC home selected by the PC without their consent, even though by doing so means their exclusion from the admissions process for such a home, and control of the dissemination of their personal health information.

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[112] Sinha Affidavit, para. 34, JR, Vol. IV, Tab 12, p. 1482.
[113] See discussion herein at para 78.
[114] Meadus Affidavit, paras. 106-108, JR, Vol. II, Tab 9, p. 588-589 and Exhibit "Q" (JR, Vol. II, Tab 9Q, p. 1052): Memo to Health System Partners, From Nancy Matthews, DM, Ministry of Long-Term Care; Dr. Catherine Zahn, DM, Ministry of Health and Matthew Anderson, President and CEO, Ontario Health RE: Bill 7 Implementation to Support Ontario's Plan to Stay Open: September 14, 2022
[115] Sinha Affidavit, para. 56, JR, Vol. IV, Tab 12, p 1491-1492; and Meadus Affidavit, paras. 107-108, JR, Vol. II, Tab 9, p. 589; Affidavit of Gail Herrington sworn June 27, 2023, para. 38, JR, Vol. I, Tab 7, p. 370-371.

77. Confounding any notion of personal autonomy, patients are presented with an impossible choice. On the one hand a patient may agree to select a home other than one they believe can meet their needs, in order to preserve their right to participate in the admissions process, and have some control over the sharing of their personal health information.[116] On the other hand, if they wish to preserve any hope of being relocated to a home they believe can meet their needs and provide proper care, they must allow the PC to proceed to select homes without their consent.[117]

78. Another misleading representation made to patients concerns the quality of care provided by an LTC home. PCs are to provide these patients with certain information about an ALC-LTC home, but on the question of the quality of care, the Field Guide only suggests that PCs say "All LTC homes are required to meet the same standards of care, regardless of home type, ownership model, location, size, etc"[118] implying that all LTC homes are equally capable of meeting the needs of the patient when this is clearly not the case.

(ii) ***On the Quality of Care***

79. The coercive measures established by Bill 7 will result in many ALC-LTC patients being placed in LTC homes that will not be able to properly provide for their proper care and safety.

80. This is a consequence of ALC-LTC patients more often being admitted to homes that relatively few have chosen, often because they have poor records.[119] These will often be LTC homes run by for-profit LTC corporations where, as noted, there is a 10% higher risk of death and a 25% higher risk of re- hospitalization.[120]

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[116] *Idem.*
[117] Meadus Affidavit, paras. 112-114, JR, Vol. II, Tab 9, p. 590.
[118] Exhibit A to Iafrate Affidavit, JR, Vol. V, Tab 17A, p. 1977 and Iafrate Cross, Qs 110-113, JR, Vol. VI, Tab 27, p. 2637-2638.
[119] Armstrong Affidavit, para. 6, JR, Vol. I, Tab 3, p. 52-53, and see critique of the quality of care in such homes by the Commission described in para. 57 herein.
[120] Arya Affidavit, para. 33, JR, Vol. I, Tab 4, p. 182.

81. In uncontroverted evidence Dr. Arya sums up this way: "Thus, overriding the preferences of a patient will be more likely to result in placement into a LTC home with a poor record of resident care, far away from the oversight, care and support of family and other community members. The inevitable result of this would be increased risk of suffering by and possible hastening of death for the LTC resident."[121]

82. Under Bill 7 ALC-LTC patients are also more likely to be placed in homes where they have difficulty communicating with staff or other residents due to a language barrier, or where they share little in common with other residents in terms of culture or religion.[122]

83. Similarly, and again in evidence that is uncontroverted, Dr. Sinha states:

> "Where an ALC-LTC patient is persuaded or coerced into applying for, or accepting an admission offer to a home they may never have heard of or that they deliberately chose not to apply to, it will rarely be as well-suited to their particular needs. If individuals are placed into LTC home's whose location makes support from their families and community more difficult or even impossible, the consequences will in many instances be dire for that person's overall health and well-being."[123]

(iii) ***On Ethical Practice***

84. As described by Dr Arya, Bill 7 also presents physicians with an ethical dilemma arising from the physician's obligation to advise a patient of the best options for them, including for LTC. In some cases, this may mean advising against a LTC home that would be less likely to properly provide for their care. Therefore, when deciding whether to accept a proffered admission to such a home, a patient may be in the impossible position of knowing that if they accept the advice of their physician and decline, onerous consequences are likely to follow.[124]

85. As noted, Bill 7 also directs physicians to conduct an assessment of a ALC-LTC patient

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[121] Arya Affidavit, para. 36, JR, Vol. I, Tab 4, p. 183.
[122] *Idem.*
[123] Sinha Affidavit, para. 53, JR, Vol. IV, Tab 12, p. 1490.
[124] Arya Affidavit, paras. 29-31, JR, Vol. I, Tab 4, p. 181-182.

"for the purpose of determining the ALC-LTC patient's eligibility for admission to a long-term care home",[125] that is to be based "solely on a review of the existing hospital records relating to the patient." This creates another ethical problem for physicians, who will know that such a limited assessment will also be used to determine whether their care needs can be met in LTC.[126]

86. Finally, Bill 7's consequential amendments to s. 16 of Regulation 965 to the *Public Hospital Act* stipulate that a patient is no longer in need of treatment in the hospital if the admission of the ALC-LTC patient to a long-term care home has been authorized, whereupon a physician is required to discharge the patient.[127]

PART II - LAW AND ARGUMENT

A. Bill 7 Interferes with the Rights to Life, Liberty and Security under Section 7 of the *Charter*

87. Section 7 of the *Charter* guarantees that "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Underlying the rights in s. 7 is a concern for the protection of individual autonomy and dignity.[128] In order to establish a violation of s. 7 of the *Charter*, a claimant must establish two things:[129]

a. That a government measure interferes with their life, their liberty or their security of person; and

b. That infringement is not done in accordance with the 'principles of fundamental justice.'

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[125] FLTCA Reg. 246/22 s. 240.1 (7) and (8) as amended by Reg. 484/22.
[126] St. Martin Affidavit, paras. 22-35, JR, Vol. IV, Tab 14, p. 1752-1759.
[127] See para. 20 herein.
[128] *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331 [***Carter***], at para. 64.
[129] *Canadian Council for Refugees v. Canada (Citizenship and Immigration)*, 2023 SCC 17 [***CCR***], at para. 56; *Carter* at para. 55.

88. In assessing whether there has been an interference with life, liberty or security of person, the Court should ask whether the measure causes a limitation or negative impact on, an infringement of, or an interference with these rights.[130] A risk of a deprivation will suffice.[131] In addition, there must be a "sufficient causal connection" between the legislation or state action and the negative impact, but this does not require that impugned state action "be the only or the dominant cause of the prejudice suffered by the claimant."[132]

(i) ***Bill 7 interferes with ALC-LTC patients' right to liberty***

89. In *Carter*, the Supreme Court described the right to liberty and security of the person this way:

> The law has long protected patient autonomy in medical decision-making. In Manitoba (Director of Child & Family Services) v. C. (A.), 2009 SCC 30, [2009] 2 S.C.R. 181 (S.C.C.), a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" entitles adults to direct the course of their own medical care (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also R. v. Parker (2000), 49 O.R. (3d) 481 (Ont. C.A.)) ….[133]

90. In other words, the right to 'liberty' under s. 7 protects "the right to make fundamental personal choices free from state interference,"[134] and to protect matters that are "fundamentally or inherently personal such that, by their very nature, they implicate basic choices going to the core of what it means to enjoy individual dignity and independence."[135]

91. Among such protected "fundamental personal choices" are: decisions respecting a person's

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[130] *CCR* at para. 56; *Carter* at para. 55.
[131] *CCR* at para. 56; *Carter* at para. 62.
[132] *Canada (Attorney General) v. Bedford*, 2013 SCC 72, [2013] 3 SCR 1101 [***Bedford***], at para. 76.
[133] *Bedford,* at para. 67.
[134] *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44 (CanLII), [2000] 2 SCR 307 [***Blencoe***], at para 54; *Carter,* at para. 68; *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 [***Godbout***], at para. 66, *per* La Forest J. (for 3 judges).
[135] *Godbout,* at para. 66, *per* La Forest J. (for 3 judges).

own medical care, including the right of a woman "to decide for herself whether or not to terminate her pregnancy;"[136] the right of a parent to make decisions as to the medical care of their child;[137] and "[T]he intensely personal considerations that often inform an individual's decision as to where to live," which falls within the "irreducible sphere of personal autonomy" protected under s. 7.[138]

92. Bill 7 infringes an ALC-LTC patient's liberty rights by depriving them of personal autonomy with respect to their medical treatment and health care, both directly, through express provisions within the legislation and indirectly, through the legislation's effect" to compel them to apply and accept admission to LTC homes that may isolate from the care and support of family and community; place them in an environment that is discordant with their culture, language and religion, and deny them of necessary medical treatment and health care.[139]

93. The direct deprivations of liberty rights established by Bill 7 authorize a PC i) to assess the eligibility of an ALC patient for LTC, and apply for admission to LTC on behalf of the patient without the ALC-LTC patient's consent or a request from a responsible clinician that they do so[140]; ii) to "collect, use, or disclose personal health information …."[141] of the ALC-LTC without their consent; and to request a clinician to assess an ALC-LTC's patient's medical condition and care needs without having to meet with or examine the patient but based only on hospital records.[142]

94. The effective coercive measures that are permitted under Bill 7 and which negate informed consent – which is inherent in the exercise of autonomy in medical decision making, include the following:

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[136] *R v Morgentaler*, [1988] 1 SCR 30, p 172 [***Morgentaler***], *per* Wilson J.
[137] *B (R) v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315.
[138] *Godbout,* at para. 66, *per* La Forest J. (for 3 judges).
[139] Paras. 82-83 and 92 herein.
[140] S. 60.1(3) as amended
[141] O. Reg. 246/22: General, s. 240.1 (3) 5.
[142] O. Reg. 246/22: General, s. 240.1(7) and (8)

- Being advised that failing to select a particular LTC home or homes[143] will result in being deprived of their rights in respect of being of the process of seeking admission to a home; being excluded from having any control of how their personal health information will be shared with such homes or any number of them; and inevitably having to pay $400 day, a fee they can't afford, if they fail to leave the hospital within 24 hours of being discharged for admission to a LTC, including one selected without their consent. [144]

- being lead to believe that all LTC homes provide the same quality of care, which is very far from the truth.[145]

- Being lead to believe that their admission to a home they unwillingly agree to select will only be temporary, when in fact they will have no reasonable prospect of ever being relocated to home they have willingly chosen.

95. Bill 7 further facilitates this non-consensual coercive process by lowering the threshold for discharging ALC-LTC patients from hospital. All other patients can only be discharged if they are "no longer in need of treatment in the hospital," ALC-LTC patients are to be discharged if they refuse to leave the hospital when their admission to a LTC is authorized. [146]

96. Each of these effects represent significant deprivations of the right to liberty of ALC-LTC patients. Taken together, they represent a multi-pronged assault on a patient's fundamental right to exercise informed consent and participate in their medical treatment and care decisions, to control access to their most private health information, and to choose where they live in what will typically be the final months of their life. These choices are fundamental personal decisions and are inherent in one's dignity, autonomy and ability to make meaningful determinations about one's own life. The legislative scheme under Bill 7, which both directly and effectively strips certain ALC patients of their ability to make such decisions renders the right to make fundamental personal choices free from state interference illusory.

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[143] O. Reg 246/22: *General*, s. 240.1(5)(d).
[144] Sinha Affidavit, para. 34, JR, Vol. IV, Tab 12, p. 1482.
[145] Section F (ii) and para. 78 herein.
[146] R.R.O. 1990, Reg. 965: *Hospital Management*, ss. 16(1), (2), (3).

(ii) ***Bill 7 interferes with ALC-LTC patients' right to security of person***

97. Here again the Supreme Court in *Carter* has summarized the law:

> … Security of the person encompasses "a notion of personal autonomy involving . . . control over one's bodily integrity free from state interference" (Rodriguez, at pp. 587-88, per Sopinka J., referring to *R. v. Morgentaler*, [1988] 1 S.C.R. 30) and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering (New Brunswick (Minister of Health and Community Services) v. G. (J.), [1999] 3 S.C.R. 46, at para. 58; Blencoe, at paras. 55-57; *Chaoulli*, at para. 43, per Deschamps J.; para. 119, per McLachlin C.J. and Major J.; and paras. 191 and 200, per Binnie and LeBel JJ.).[147]

98. The risks associated with certain and largely for profit LTC homes have been described above and include a higher risk of death and of being readmitted to hospital.[148]

99. In *Chaoulli* the Supreme Court found this harm to include protection from state action that denies "timely health care for a condition that is clinically significant to their current and future health" which results "in psychological and emotional stress and a loss of control by an individual over her own health."[149]The risk of psychological harm and stress arising from being placed in a home that fails to provide proper care and the loss of control in making these critical choices therefor also represents an infringement of the right to security of the person.

100. As noted by the Supreme Court in *Morgentaler* this infringement can also result from uncertainly about the availability of medical care: "Not only does the removal of decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress."[150] There is no dispute that the poor record of providing proper

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[147] *Carter*, at para. 64 [emphasis added]
[148] Paras. 80 herein.
[149] *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791 [***Chaoulli***], at paras. 122-123.
[150] *Morgentaler*, at para. 56.

care is a key factor discouraging an applicant for LTC from selecting a home with such a reputation or record. The uncertainty surrounding being placed in such a home is further exacerbated when the admission to the home is obtained without the ALC-LTC patient's consent, or informed consent. This is only more problematic when the admission is authorized on the basis of an inadequate account of the ALC-LTC patient's care needs, [151] which as noted, occurs when physician or registered nurse is asked to assess patients, without their consent, based on hospital records alone. The corrosive impact this can also have on the confidence an ALC-LTC patient will have in the advice of their physician has also been described.[152]

101. Finally, the social isolation and deprivation of family care that results when an ALC-LTC patient is placed in a LTC home too far from family and community supports is exceedingly detrimental to their health and well-being, and this is particularly true for ALC-LTC patients who are ill and nearing the end of their lives. The Applicants submit that for these reasons Bill 7 further deprives ALC-LTC patients of their right to physical and psychological security of person.

(iii) ***Bill 7 interferes with ALC-LTC patients' right to life***

102. In *Carter*, the Supreme Court adopted the approach taken by the Court in *Chaoulli v. Quebec* and in *PHS*,[153] namely that "the right to life is engaged where the law or state action imposes death or an increased risk of death on a person, either directly or indirectly...."[154]

103. There is no dispute that there is very substantial difference in the quality of care LTC homes provide. As documented by the Long-term Care Commission and others, these are the very homes that are the least likely to be selected by those applying for LTC (paras above). Because such

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[151] See evidence discussed above concerning record based assessments and St. Martin's account of the impact on care that may result; St. Martin Affidavit, paras. 13-14, 18-19, and 28-32, JR, Vol. IV, Tab 14, p. 1748, 1751, 1754-1755.
[152] Paras. 67-70 herein.
[153] *Chaoulli*, at para. 123, *per* McLachlin CJ and Major J. See also *PHS* at paras 92-93.
[154] *Carter,* at para. 62.

homes have much shorter wait lists, they are therefore most likely to be the homes that ALC-LTC patients are pressured, or coerced into choosing and being admitted to.

104. The uncontroverted expert evidence in this case also establishes that in consequence of being compelled to accept a bed in a LTC that cannot reliably provide the medical treatment and health care required, an ALC-LTC patient is at risk of "increased suffering and death." Moreover, this risk has been quantified in a peer reviewed study as presenting a 10% higher risk of death in for-profit LTC homes (see para. 80 above).

105. Studies published in leading medical journals or carried out by CIHI also document the failure of many LTC homes to provide palliative care to residents who are either admitted to hospital for such EOL care, or who die in the LTC home without such care (see discussion above at 62).

106. The uncontroverted evidence in this proceeding establishes a causal connection between Bill 7 and an increased risk of death for the ALC-LTC.

B. The Deprivations of Life, Liberty and Security of Person Caused By or Contributed To by Bill 7 are Not in Accordance with the Principles of Fundamental Justice

107. Where a government measure is found to interfere with life, liberty and/or security of person, it must then be shown that the deprivation is not in accordance with the principles of fundamental justice. The Supreme Court has found that the principles of fundamental justice require that the government measure must not be (a) arbitrary, (b) overbroad, or (c) have consequences that are grossly disproportionate to their object.[155]

(i) The Purpose of Bill 7 and Related Regulations

108. Central to the assessment of whether an interference with life, liberty and/or security of

[155] *Carter,* at para, 72.

person is a breach of fundamental justice is determining the purported purpose of the government measure. Here, the most reliable indicator of legislative purpose is a statement of purpose within the subject law,[156] however Bill 7 contains no purpose clause or preamble.

109. In absence of a purpose clause, courts must consider the text, context, and scheme of the legislation as a whole. A court may also consider extrinsic evidence such as legislative history and government publications, but such evidence must be used with caution because statements in the legislative record may be "rhetorical and imprecise" and not truly a statement of *parliamentary* purpose. Courts should strive to arrive at a precise and succinct statement that faithfully represents the legislative purpose of the impugned provision. Overly broad, multifactorial statements of purpose can artificially make impugned provisions unassailable to arguments of overbreadth or arbitrariness.[157]

110. Accordingly, the impugned provisions of Bill 7 must be interpreted in light of the purposes of the LTCA and the HCCA, both of which place the right to informed consent at the very center of their respective legislative regimes. In the case of the FLTCA, the fundamental principle to be applied in the interpretation of the Act is that a LTC home be a place "where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."[158] In the case of the HCCA it is "to enhance the autonomy of persons for whom admission to a care facility is proposed,"[159] by "requiring that wishes with respect to … admission to a care facility … be adhered to," and "to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about …

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[156] *R. v. Sharma*, 2022 SCC 39, at para. 28 [***Sharma***], *R. v. C.P.*, 2021 SCC 19, [2021] 1 S.C.R. 679, at para. 88.
[157] *R. v. Safarzadeh-Markhali*, 2016 SCC 14, [2016] 1 S.C.R. 180, at paras. 24-36; *R. v. Moriarity*, 2015 SCC 55, [2015] 3 S.C.R. 485, at paras. 24-31; *Sharma,* at paras. 87-91; *R. v. Ndhlovu*, 2022 SCC 38, at paras. 61-64.
[158] FLTCA s. 1.
[159] HCCA s. 1(c).

admission to a care facility."[160]

111. The extrinsic evidence available concerning the purpose of Bill 7 is found in the legislative debates when the Minister of Long-Term Care spoke to the purpose of Bill 7, stating that, "Our priority is for people to live and receive care where they can have the best possible quality of life close to their family, caregivers and friends."[161] and further, for ALC-LTC patients to receive "the appropriate level of care in an appropriate setting."[162]

(ii) ***Are the Deprivations of Bill 7 Arbitrary***

112. The Courts have defined a law as *arbitrary* where the effect of a law has no rational connection, or undermines, or is inconsistent with its purpose. Regardless of how the judge describes this lack of connection, the ultimate question remains whether the evidence establishes that the law violates these basic norms.[163]

113. As part of its survey of Canadian jurisprudence on S. 7 of the *Charter*, the Supreme Court in *Bedford* summed up these evidentiary requirements this way:

> The evidence may, as in *Morgentaler*, show that the effect actually undermines the objective and is therefore "inconsistent" with the objective. Or the evidence may, as in *Chaoulli*, show that there is simply no connection on the facts between the effect and the objective, and the effect is therefore "unnecessary". Regardless of how the judge describes this lack of connection, the ultimate question remains whether the evidence establishes that the law violates basic norms because there is no connection between its effect and its purpose. This is a matter to be determined on a case-by-case basis, in light of the evidence.[164]

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[160] HCCA s. 1e.
[161] Hansard Tuesday 23 August 2022 (Hon P Calandra).
[162] *Idem*.
[163] *Bedford*, at para. 119.
[164] *Idem.*

114. As described above in some detail,[165] the evidence in this proceeding establishes that by design and effect, the impugned provisions of Bill 7 are inconsistent with, undermine, and are in fact antithetical to the stated purposes of the FLCTA and HCCA and as well with the purpose articulated by the Minister by:

a. directly, or the through the means of coercion, depriving ALC-LTC patients of their personnel autonomy to exercise informed consent in choosing a LTC to which they will be admitted. The consequential effect for many ALC-LTC patients is being admitted to a LTC Home that is too far from family, discordant with their language, and culture, and unable to provide from their proper care and safety; and by,

b. depriving certain ALC-LTC patients of the right to determine whether, how, and with whom their personal health information may be shared.

115. If the purpose is, as the Minister claims, to provide better care and autonomy for ALC-LTC patients – clearly Bill 7 is not doing this. The effects and deprivations described above cannot, by nature, be regarded as providing better care or increasing autonomy for ALC-LTC patients.

116. Putting aside the disconnect between Bill 7 and the purposes of the FLTCA and HCCA, and even if one concedes that at least some ALC-LTC patients will receive better medical treatment and care in a LTC than in hospital, the evidence belies any contention that Bill 7 has actually expedited the transition from hospital for the vast majority of ALC-LTC patients. As for the claim that patients will receive better care in LTC home, that depends entirely on the quality of care they are likely to receive in the hospital or the particular LTC home. As Dr. Sinha points out, hospitals typically have better staffing levels, more and better paid staff with the right mix of

skills and experience to manage complex needs, and better access to specialist advice and care.[166] It will also depend on whether the hospital has implemented senior friendly practices to ameliorate the risks of hospital stays.[167] The evidence of the failures of many LTC homes to provide necessary and reliable care has been well documented including by the Long-Term Care Covid-19 Commission and the Auditor General.[168]

117. As the Court in *Chaoulli* emphasized, the court looks to "evidence rather than to assumptions" and the evidence clearly shows that the length of time an ALC-LTC patient spends waiting in hospital has little if anything to do with the exercise of their right to consent. It is instead primarily a consequence of the difficulty of i) determining whether the patient can be discharged from hospital, ii) identifying an appropriate discharge destination iii) determining whether that appropriate care is feasible, and iv) working with patients to find a suitable LTC home, or proceeding without their consent to find a LTC that is capable and willing to provide the often complex care needs of ALC-LTC patients.

118. Finally, the evidence also indicates that in two respects Bill 7 is likely to have the effect of actually increasing the number of ALC-LTC patients in hospital, a consequence that is borne out by the data gathered and published by Ontario Health.[169] The first is because, given the very long wait lists for LTC homes, admission to hospital may be the best or only way for individuals who urgently need LTC to gain admission to a LTC home because of the higher priority they will be given as an ALC-LTC patient for access LTC.[170] The second dysfunctional effect is to increase the number of former ALC-LTC patients who will be readmitted to hospital because the LTC home

[166] Sinha Affidavit, para. 25, JR, Vol. IV, Tab 12, p. 1478.
[167] Affidavit of Dr. George Heckman sworn March 3, 2023, para.15-22, JR, Vol. I, Tab 8, p. 420-423 and Exhibit 1 to Ellacott Cross, JR, Vol. VI, Tab 25A.
[168] Section F (ii) herein.
[169] Para. 131 herein.
[170] Sinha Affidavit, para. 37, JR, Vol. IV, Tab 12, p. 1483.

they've been placed in cannot properly care for them.

119. However the arbitrary test may be formulated, and whether the benchmark is only the statutes being amended or includes the Minister's statements in Parliament, the evidence clearly shows that the effects of Bill 7, whether in whole or in part, cannot be considered consistent with or connected with purposes of either statute, and certainly not to the Ministers stated goals of ensuring that ALC-LTC patients "live and receive care where they can have the best possible quality of life close to their family, caregivers and friends" and receive "the appropriate level of care in an appropriate setting."[171]

(iii) **Overbreadth**

120. A government measure will be overbroad where it "is so broad in scope that it includes some conduct that bears no relation to its purpose," or whether the means chosen by the legislature "infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature."[172]

121. A law will be overbroad if it overreaches in a single case, even if it is rational in other cases.[173] As a result "laws that are broadly drawn to make enforcement more practically run afoul of s. 7 should they deprive the liberty [or life and/or security of person] of even one person in a way that does not serve the law's purpose," and considerations of the practicality of applying the law are left to s.1.[174]

122. At best, Bill 7 purports to address a vanishingly small number of individual cases where an ALC-LTC patient might unreasonably refuse to consent to apply or be admitted to a particularly

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[171] Hansard Tuesday 23 August 2022.
[172] *Bedford,* at para. 112; *Carter,* at para. 85.
[173] *Bedford,* at paras. 113 and 123; *Ndhlovu,* at para. 78; *CCR,* at para 141.
[174] *Ndhlovu,* at paras. 78 - 84.

LTC home. There is no dispute[175] that it is exceedingly rare for an ALC-LTC patient to do so. Rather the evidence clearly shows that prior to Bill 7 ALC-LTC patients are willing to be pragmatic in choosing a LTC home notwithstanding their reservations about the suitability of such a home or the quality of care they are likely to receive there.

123. The evidence also shows that in the very rare instance where this is not the case, and the patient is incapable, HCCSS has not sought an order from the Consent and Capacity Board where it believes the SDM is not acting in the patient's best interests.[176] Nor is there any evidence that obtaining such an order before was unduly difficult or burdensome.

124. Furthermore, Bill 7 could have been crafted more narrowly, for example to apply only where a ALC-LTC patient refuses to select a stipulated number of LTC homes, or in circumstances where there are a certain number of vacant LTC beds, or where there are no crisis patients waiting at home to take an available bed.

125. Instead, Bill 7 applies uniformly to *all* ALC-LTC patients, regardless of their specific health needs, personal circumstances, or whether they have been willing to engage constructively in the process of selecting an LTC home. Despite a complete absence of demonstrated need, *all* ALC-LTC patients are deprived of their right to informed consent in respect of their right: (a) to choose a LTC home; (b) to control the sharing of their personal health information with people outside the hospital environment; or (c) to remain in hospital if they still require care in the hospital.

126. Beyond the excessively broad application of Bill 7, Bill 7 is also overbroad by relying on an ALC designation that is vague, inconsistently applied and on occasion just wrong. The lack of clarity or clear criteria for determining whether and when to designate a patient as ALC-LTC can

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[175] Para. 64 herein.
[176] HCCA, ss. 42, 53; Meadus Affidavit, paras. 134-135, JR, Vol. II, Tab 9, p. 598.

lead to arbitrary or discriminatory application of Bill 7. This is further evidence of overbreadth.[177]

127. All agree that prior to Bill 7 the ALC designation was simply an administrative measure, and as the respondent's witnesses attest, that approach has not changed since the enactment of Bill 7,[178] notwithstanding the legal consequences that now follow from it. Furthermore, the Crown has led no evidence as to how the term is interpreted by non-physician clinicians that also have the authority to designate a patient as ALC-LTC. Furthermore, the evidence establishes that clinicians are often pressured by hospital administrations to use their authority in a manner that will hasten the discharge of patients whether the designation is warranted on clinical grounds or not.[179]

128. When an ALC-LTC designation results in a patient losing fundamental rights to informed consent to where they live and the health care they will receive; to protect personal medical information; and is being put at significant risk of physical and psychological health harm, the imprecision in its application is particularly serious. The fact that Bill 7 applies to countless ALC-LTC patients for whom it is wholly unnecessary, makes it grossly overbroad as compared with any objective it might advance.

(iv) ***Gross disproportionality***

129. Finally, a law will be grossly disproportionate where "the impact of the restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure." The analysis "compares the law's purpose, 'taken at face value', with its negative effects on the rights of the claimant and asks if this impact is completely out of sync with the object of the law,"[180] as it clearly is in respect of ALC-LTC patients.

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[177] Section "D" herein.
[178] Pelc Affidavit, para. 17, JR, Vol. V, Tab 21, p. 2152.

[180] *Carter,* at para. 89; *Bedford,* at para. 120; *CCR,* at para. 147.

130. The many and serious impacts of Bill 7 have been exhaustively detailed above. Simply put, Bill 7 clearly deprives ALC-LTC patients of the fundamental rights to informed consent to where they are likely to spend their final days, and to the protection of their personal health information. It prevents ALC-LTC patients from fully participating in the choice of a suitable LTC home, instead exposing them to a coercive process designed to compel their admission to a LTC whether it is one they have not or would otherwise not have chosen, or that does not meet their needs. By authorizing a limited medical assessment of LTC patient's condition and care needs, Bill 7 undermines the quality of care and increases the chances of unsuitable placements. By subjecting ALC-LTC patients to a coercive process in order to discharge them from hospital to an LTC homes that does not meet their linguistic, ethno-cultural or care needs, and that may be farther from caregivers, family and friends, Bill 7 exposes ALC-LTC patients to serious risks to their psychological and physical health and, based on the evidence, the risk of premature deaths.

131. Even if one were to accept that reducing waiting times for ALC-LTC patients would improve their quality of care there is no demonstrable evidence that Bill 7 had this effect and there is considerable evidence that it likely has had the opposite effect. As noted, since Bill 7 has gone fully into effect, the number of ALC-LTC patients waiting in hospital has grown, and these patients are waiting even longer in hospital.[181]

132. Despite claims that "patient flow" has improved since the Bill went into effect, there is no demonstrable evidence that this has occurred, or that even in a hospital where this may be true, that the improvement is in any way related to Bill 7.[182]

133. Taken together, the harms caused by Bill 7 are clearly grossly disproportionate, whether

[181] Para. 12 herein.
[182] Sinha Responding Affidavit, paras. 2-9, JR, Vol. IV, Tab 13, p. 1699-1701.

they are weighed against its purported objectives or against any evidence of its actual benefits.

(v) ***Conclusion on s. 7 of the Charter***

134. As is clearly established above, Bill 7 deprives ALC-LTC patients of their rights to life, liberty and security of person, throughout the process of applying for and admission to LTC. Those deprivations are arbitrary, overbroad and grossly disproportionate with respect to either the Province's stated objectives for Bill 7, the broader objectives of the FLCTA and HCCA, or even the secondary consequence of freeing up acute care hospital beds. Bill 7 therefore violates s. 7 of the *Charter*.

C. Bill 7 Violates s. 15(1) of the *Charter*

135. Bill 7 also violates s. 15 of the *Charter* as it is discriminatory on the basis of age and disability. It disadvantages ALC-LTC patients by imposing unique burdens on them and depriving them of basic protections available to other patients. It does so in a manner that has a disproportionate impact on the basis of age and certain forms of disability (chronic and terminal), and which reinforces, perpetuates and exacerbates the pre-existing disadvantages already experienced by this vulnerable group.

(i) ***The framework for establishing a violation of s. 15(1) of the Charter***

136. Under s. 15(1) of the *Charter*, "[e]very individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." In a challenge under s. 15(1), the claimant must demonstrate that the impugned law or state action: (a) on its face or in its impact, creates a distinction based on enumerated or analogous grounds; and (b) that the distinction is discriminatory in that it imposes a burden or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or

exacerbating disadvantage.[183]

137. At step one of the s. 15(1) test, claimants must demonstrate a disproportionate impact on a protected group, as compared to non-group members,[184] and must prove the impugned law, in its impact, *creates* or *contributes to* a disproportionate impact on the basis of a protected ground.[185] To meet that test, a law "may include seemingly neutral rules, restrictions or criteria that operate in practice as 'built-in headwinds' for members of protected groups," or there may be an "absence of accommodation for members of protected groups".[186]

138. Two types of evidence will be helpful in proving that a law has a disproportionate impact on members of a protected group. First, "evidence about the physical, social, cultural or other barriers which provide the 'full context of the claimant group's situation'," which could be introduced from the claimant, expert witnesses or through judicial notice. Second, "evidence about the outcomes that the impugned law or policy (or a substantially similar one) has produced in practice," which could "provide concrete proof that members of protected groups are being disproportionately impacted."[187] Nevertheless, the Supreme Court recognizes that claimants have an "asymmetry of knowledge (relative to the state)" and "[t]o give proper effect to the promise of s. 15(1)… a claimant's evidentiary burden cannot be unduly difficult to meet."[188]

139. The Supreme Court has made it clear that, at the first stage of the s. 15(1) test, "heterogeneity within a claimant group does not defeat a claim of discrimination." The fact that there may be a "range of need or vulnerability" among the group to which the claimant belongs,

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[183] *Sharma,* at paras. 56 and 141; *Fraser v. Canada (Attorney General)*, 2020 SCC 28, [2020] 3 S.C.R. 113 [***Fraser***], at paras. 27, 50.
[184] *Sharma,* at para. 40.
[185] *Fraser,* at paras. 32-34; *Sharma,* at para. 42.
[186] *Fraser,* at paras. 52-54.
[187] *Fraser,* at paras. 56-58; *Sharma,* at para. 49.
[188] *Sharma,* at para. 49.

or that not all persons belonging to the relevant group are equally mistreated or even affected by the law, does not defeat the claim.[189]

140. The second stage of the s. 15(1) inquiry requires the claimant to show that the law perpetuates, reinforces, or exacerbates disadvantage.[190] At this stage of the test, there is no "rigid template"[191] and although it may assist the judge to look at several factors, none are "necessary components." Further, it is not necessary to demonstrate any intent to discriminate:[192] Notably, at second stage of the analysis the "goal is to examine the impact of the harm caused to the affected group,"[193] while examining factors such as: ""[e]conomic exclusion or disadvantage, [s]ocial exclusion . . . [p]sychological harms . . . [p]hysical harms . . . [or] [p]olitical exclusion."' and the analysis "must be viewed in light of any systemic or historical disadvantages faced by the claimant group."[194] At the second stage the Court may also consider the broader legislative context, arbitrariness, stereotyping and prejudice.[195]

(ii) ***Bill 7 has a disproportionate impact on ALC-LTC patients on the basis of age and disability***

141. The evidence establishes that Bill 7 has a disproportionate effect on the basis of two intersecting enumerated grounds: age and disability (specifically age-related, chronic and/or terminal illnesses). While not all older or chronically/terminally ill patients are targeted by Bill 7, the vast majority of patients targeted by Bill 7 are older than 75, chronically ill (most commonly with dementia), and/or terminally ill. They typically suffer from multiple chronic conditions often

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[189] *Fraser,* at paras. 85-92; *Nova Scotia (Workers' Compensation Board) v. Martin*, 2003 SCC 54 (CanLII), at paras. 76.

[190] *Fraser,* at paras. 76, 78.
[191] *Fraser,* at paras. 76.
[192] *Sharma,* at paras. 53, 55.
[193] *Fraser,* at paras. 76.
[194] *Ibid.*
[195] *Sharma,* at paras. 53, 56.

associated with age, require highly specialized treatment, and have limited life expectancy.[196] Many lack the capacity to make LTC placement decisions and may be represented by an SDM.[197] Accordingly, Bill 7 has a disproportionate impact on the basis of age and disability, an enumerated ground under s. 15(1) of the *Charter*.

(iii) ***Bill 7 imposes a burden or denies a benefit***

142. Bill 7 targets ALC-LTC patients, and thus a vulnerable subset of older and disabled people, for the imposition of burdens and denial of benefits. As set out above, Bill 7 singles out ALC-LTC patients and deprives them of the right to informed consent and protection of personal medical information that other patients in Ontario are guaranteed. It has the effect of coercing them into LTC homes that may not provide adequate medical care for their needs, which may not be linguistically or culturally appropriate, and which may be located far from necessary family and community supports. In consequence, ALC-LTC patients are denied their autonomy and their dignity and are subjected to serious risks of psychological and physical harm and even premature death. This impact is more severe on those older ALC-LTC patients with limited financial resources, who cannot afford a $400 daily fee and are therefore more likely to be subject to coercion under the Bill 7 process.

(iv) ***Bill 7 perpetuates, reinforces or exacerbates disadvantage***

143. Bill 7 perpetuates, reinforces, and exacerbates the disadvantages that older and disabled ALC-LTC patients already experience. As discussed above, this patient group is vulnerable in many respects: physically, mentally, and in terms of their capacity to advocate for themselves and consequent likelihood of having their fundamental needs overlooked. These vulnerabilities are the

[196] Sinha Responding Affidavit, para. 8, JR, Vol., IV, Tab 13, p. 1701.
[197] Pelc Affidavit, para. 16, JR, Vol. V, Tab 21, p. 2151-2152; Sinha Affidavit, para. 21, JR, Vol. IV, Tab 12, p. 1476; Armstrong Affidavit, para 5, JR, Vol. I, Tab 3, p. 51.

very reason for the strong consent and privacy protections in the *FLTCA* and *HCAA*. By excluding this patient group from those fundamental and necessary protections, Bill 7 exacerbates their pre-existing vulnerability, exposing them to further indignity and harm.

144. Further, Bill 7 reflects and promotes the stereotyping and prejudice to which older patients are already subject in hospitals and in the health care system. It is based on the insidious and discriminatory stereotype that ALC-LTC patients are "bed blockers" implying they are somehow responsible for the shortages of care options available for them,[198] by treating patient consent as the barrier to timely and appropriate LTC placement. The evidence exposes the "bed blocker" stereotype to be a myth. There is no evidence that ALC-LTC patients unreasonably refuse admission to an appropriate LTC bed. Delays in LTC placements are attributable to the multifaceted processes of hospital medical care, hospital discharge teams, and those of HCCSS, and most importantly to the chronic shortage of LTC beds capable of meeting the complex care needs of these patients.

(v) ***Further considerations on S. 15***

145. The application of Bill 7 to older ALC-LTC patients is arbitrary. It fails to respond to the actual capacities and needs of ALC-LTC patients. To the contrary, its effect is to coerce the placement of ALC-LTC patients into LTC homes that may be inappropriate to their actual medical, social and cultural needs. It allows physicians to screen ALC-LTC for placement on the basis of paper records as opposed to an in-person interview and examination which is necessary for a proper assessment of patient capacity and need. It disregards ALC-LTC patients' need for privacy and capacity for autonomy, wrongly treating these as barriers to timely LTC placements instead of essential elements of a dignified and effective process.

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[198] Sinha Affidavit para. 59, JR, Vol. IV, Tab 12, p. 1493.

146. An examination of the legislative context also reveals Bill 7 to be discriminatory. As detailed above in the s. 7 analysis, Bill 7's effects are inconsistent with and contrary to any of the objects of, or policies underlying, the *FLTCA,* the *HCAA* or the Bill 7 itself. Bill 7 is not part of a scheme designed to allocate resources among a number of different groups. To the contrary, Bill 7 irrationally targets and excludes ALC-LTC patients from a scheme intended to protect the autonomy, privacy and basic dignity of all patients in the province's healthcare system.

147. Accordingly, Bill 7 discriminates on the basis of age and disability, and therefore violates s. 15(1) of the *Charter*.

D. Section 1

148. The Applicants will respond to the s. 1 justification advanced by the Province in their reply.

PART III - REMEDY

149. A declaration that the following impugned provisions and related practices (referred to collectively as "Bill 7"), infringe on the rights of individuals subject to the impugned provisions, to life, liberty and security of person under s. 7 of the *Charter*, and that these deprivations are not in accordance with the principles of fundamental justice:

a. Sections 2, 3 and 9 of the More Beds, Better Care Act, 2022, S.O. 2022, c. 16 (Bill 7), amending the Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1 (FLTCA) and the Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A (HCCA);

b. Section 2 of O. Reg. 484/22: under the FLTCA;

c. O. Reg. 485/22 and O. Reg. 486/22: under the Public Hospitals Act, RSO 1990, c P.40; and

d. the administrative practices adopted to implement these legislative and regulatory amendments.

150. A declaration that Bill 7 infringes on the rights of other individuals subject to the impugned provisions to the equal protection and equal benefit of the law without discrimination based on age under s. 15 of the *Charter*;

151. A declaration that these violations cannot be saved under s. 1 of the *Charter*; and are therefore invalid and of no force and effect pursuant to s. 52 of the Constitution Act, 1982;

152. Their costs of this Application on a substantial indemnity basis; and

153. Such further and other relief as counsel may advise and this Honourable Court may deem just and appropriate.

154. Given the clear evidence that Bill 7 has not accomplished any of its stated purposes, there is no reason to suspend the declaration of invalidity and further perpetuate the harms on elderly ALC-LTC patients detailed above.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

June 21, 2024

GOLDBLATT PARTNERS LLP
20 Dundas Street West, Suite 1039
Toronto, ON M5G 2C2

Steven Shrybman (20774B) / Benjamin Piper (58122B)

Lawyers for the Applicants

SCHEDULE "A" – LIST OF AUTHORITIES

Case Law

1. *B (R) v Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315
2. *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44 (CanLII), [2000] 2 SCR 307 [***Blencoe***]
3. *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331 [***Carter***]
4. *Canada (Attorney General) v. Bedford*, 2013 SCC 72, [2013] 3 SCR 1101 [***Bedford***]
5. *Canadian Council for Refugees v. Canada (Citizenship and Immigration)*, 2023 SCC 17 [***CCR***]
6. *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791 [***Chaoulli***]
7. *Fraser v. Canada (Attorney General)*, 2020 SCC 28, [2020] 3 S.C.R. 113 [***Fraser***]
8. *Godbout v. Longueuil (City)*, [1997] 3 S.C.R. 844 [***Godbout***]
9. *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, *[1999] 3 S.C.R. 46*
10. *Nova Scotia (Workers' Compensation Board) v. Martin*, 2003 SCC 54 (CanLII)
11. *Ontario (Attorney General) v. G*, 2020 SCC 38, [2020] 3 S.C.R. 629
12. *R. v. C.P.*, 2021 SCC 19, [2021] 1 S.C.R. 679
13. *R. v. Moriarity*, 2015 SCC 55, [2015] 3 S.C.R. 485
14. *R v Morgentaler*, [1988] 1 SCR 30 [***Morgentaler***]
15. *R. v. Ndhlovu*, 2022 SCC 38
16. *R. v. Safarzadeh-Markhali*, 2016 SCC 14, [2016] 1 S.C.R. 180
17. *R. v. Sharma*, 2022 SCC 39 (CanLII) [***Sharma***]

Secondary Sources

1. Ontario, Legislative Assembly, *Hansard*, 43rd Parl, 1st Sess (23 August 2022) at 0900 (Hon P Calandra)(**Hansard Tuesday 23 August 2022)**
2. Marrocco, F. N. A. Coke & J. Kitts (2021) Ontario's Long-Term Care COVID-19 Commission Final Report. Toronto: Queen's Printer of Ontario https://files.ontario.ca/mltc-ltcc-final-report-en-2021-04-30.pdf, [**the Commission**]
3. The Commission Report, May 3, 2024 https://www.cp24.com/video?clipId=2194386

SCHEDULE "B" – STATUTES, LEGISLATION, REGULATIONS

Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1

***Fixing Long-Term Care Act*, 2021, S.O. 2021, c.39, Sched. 1, s.s. 1, 51(5), 60.1(1), 60.1(3), 60.1(8), 60.1(9)**

1. Home: the fundamental principle
The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

51(5) Application in accordance with regulations
An application for authorization of admission shall be made in accordance with the regulations and the applicant shall provide written consent to the disclosure of all information necessary to deal with the application.

60.1 (1) This section applies to a person who,
(a) occupies a bed in a hospital under the *Public Hospitals Act*; and
(b) has been designated by an attending clinician in the hospital as requiring an alternate level of care because, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting. 2022, c. 16, s. 2.

60.1 (3) This section authorizes the following actions, or any part thereof, to be performed in respect of an ALC patient without their consent or the consent of their substitute decision-maker, despite any other provision of this Act, the regulations or any other Act:

1. An attending clinician who reasonably believes that an ALC patient may be eligible for admission to a long-term care home may request that a placement co-ordinator carry out any of the actions listed in subparagraphs 2 i to iv.
2. A placement co-ordinator may do the following, with or without a request from an attending clinician:
    i. Determine the ALC patient's eligibility for admission to a long-term care home.
    ii. Select a long-term care home or homes for the ALC patient in accordance with the geographic restrictions that are prescribed by the regulations.
    iii. Provide to the licensee of a long-term care home the assessments and information set out in the regulations, which may include personal health information.
    iv. Authorize the ALC patient's admission to a home.
    v. Transfer responsibility for the placement of the ALC patient to another placement co-ordinator who, for greater certainty, may carry out the actions listed in this paragraph with respect to the ALC patient.
3. A physician, registered nurse or person described in paragraph 3 of subsection 50 (5) may conduct an assessment of the ALC patient for the purpose of determining the ALC patient's eligibility for admission to a long-term care home.

4. A licensee of a long-term care home must do the following:
    i. Review the assessments and information provided by the placement co-ordinator in respect of the ALC patient.
    ii. Approve the ALC patient for admission as a resident of the home after reviewing the assessments and information provided by the placement co-ordinator, unless a condition for not approving the admission listed in subsection 51 (7) is met.
    iii. Admit the approved ALC patient when they present themselves at the home as a resident after,
    A. the placement co-ordinator has determined the patient's eligibility for admission to the home,
    B. a bed becomes available, and
    C. the placement co-ordinator has authorized the patient's admission to the home.
5. A person with authority to carry out an action listed in paragraph 1, 2, 3 or 4, a hospital within the meaning of the *Public Hospitals Act* or any other person prescribed by the regulations may collect, use or disclose personal health information if it is necessary to carry out an action listed in paragraph 1, 2, 3 or 4. 2022, c. 16, s. 2.

60.1(8) An ALC patient may apply to the Appeal Board for a review of a determination of ineligibility made by a placement co-ordinator under this section, and the Appeal Board shall deal with the appeal in accordance with section 59. 2022, c. 16, s. 2

60.1(9) Despite subsection 3 (2), this section and any regulations made under clause 61 (2) (h.1) or (h.2) shall not be interpreted or construed as being inconsistent with the Residents' Bill of Rights. 2022, c. 16, s. 2.

Health Care Consent Act, 1996, S.O. 1996, c. 2, Sched. A

***Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, s.s. 1(c), 1(e), 4, 41, 42, 53**

1(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed and persons who are to receive personal assistance services by,
    (i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
    (ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to a care facility or personal assistance services, and
    (iii) requiring that wishes with respect to treatment, admission to a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 1 (c) of the Act is repealed and the following substituted: (See: 2017, c. 25, Sched. 5, s. 54 (2))

(c) to enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to or confining in a care facility is proposed and persons who are to receive personal assistance services by,

(i) allowing those who have been found to be incapable to apply to a tribunal for a review of the finding,
(ii) allowing incapable persons to request that a representative of their choice be appointed by the tribunal for the purpose of making decisions on their behalf concerning treatment, admission to or confining in a care facility or personal assistance services, and
(iii) requiring that wishes with respect to treatment, admission to or confining in a care facility or personal assistance services, expressed by persons while capable and after attaining 16 years of age, be adhered to;

1(e) to ensure a significant role for supportive family members when a person lacks the capacity to make a decision about a treatment, admission to a care facility or a personal assistance service;

4(1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).
(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services. 1996, c. 2, Sched. A, s. 4 (2).
(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be. 1996, c. 2, Sched. A, s. 4 (3).

Note: On a day to be named by proclamation of the Lieutenant Governor, section 4 of the Act is repealed and the following substituted: (See: 2017, c. 25, Sched. 5, s. 56)

4(1) A person is capable with respect to a treatment, admission to or confining in a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission, confining or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 2017, c. 25, Sched. 5, s. 56.
(2) A person is presumed to be capable with respect to treatment, admission to or confining in a care facility and personal assistance services. 2017, c. 25, Sched. 5, s. 56.
(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission, the confining or the personal assistance service, as the case may be. 2017, c. 25, Sched. 5, s. 56.

41 Section 20 applies, with necessary modifications, for the purpose of determining who is authorized to give or refuse consent to admission to a care facility on behalf of a person who is incapable with respect to the admission. 1996, c. 2, Sched. A, s. 41.

42(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:
1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests. 1996, c. 2, Sched. A, s. 42 (1)

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;

(b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and

(c) the following factors:

1. Whether admission to the care facility is likely to,

i. improve the quality of the incapable person's life,

ii. prevent the quality of the incapable person's life from deteriorating, or

iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.

2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.

3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.

4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances. 1996, c. 2, Sched. A, s. 42 (2).

53 (1) If a substitute decision-maker is required by paragraph 1 of subsection 42 (1) to refuse consent to the incapable person's admission to a care facility because of a wish expressed by the incapable person while capable and after attaining 16 years of age,

(a) the substitute decision-maker may apply to the Board for permission to consent to the admission despite the wish; or

(b) the person responsible for authorizing admissions to the care facility may apply to the Board to obtain permission for the substitute decision-maker to consent to the admission despite the wish. 2000, c. 9, s. 39 (1)

(1.1) If the person responsible for authorizing admissions to the care facility intends to apply under subsection (1), the person shall inform the substitute decision-maker of his or her intention before doing so. 2000, c. 9, s. 39 (2).

(2) The parties to the application are:

1. The substitute decision-maker.

2. The incapable person.

3. The person responsible for authorizing admissions to the care facility.

4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 53 (2).

(3) The Board may give the substitute decision-maker permission to consent to the admission despite the wish if it is satisfied that the incapable person, if capable, would probably give consent because the likely result of the admission is significantly better than would have been anticipated in comparable circumstances at the time the wish was expressed. 1996, c. 2, Sched. A, s. 53 (3).

Public Hospitals Act, R.S.O. 1990 c.P.40

More Beds, Better Care Act, 2022

More Beds, Better Care Act, 2022

2 The Act is amended by adding the following section:

2. ALC patients

60.1 (1) This section applies to a person who,

(a) occupies a bed in a hospital under the *Public Hospitals Act*; and

(b) has been designated by an attending clinician in the hospital as requiring an alternate level of care because, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting.

3. Definitions

(2) For the purposes of this section,

"ALC patient" means a person described in subsection (1); ("patient en NSD")

"attending clinician" means a person who is authorized under the *Public Hospitals Act* to issue a discharge order for the ALC patient. ("clinicien traitant")

4. Certain actions may be performed without consent

(3) This section authorizes the following actions, or any part thereof, to be performed in respect of an ALC patient without their consent or the consent of their substitute decision-maker, despite any other provision of this Act, the regulations or any other Act:

1. An attending clinician who reasonably believes that an ALC patient may be eligible for admission to a long-term care home may request that a placement co-ordinator carry out any of the actions listed in subparagraphs 2 i to iv.

2. A placement co-ordinator may do the following, with or without a request from an attending clinician:

i. Determine the ALC patient's eligibility for admission to a long-term care home.

ii. Select a long-term care home or homes for the ALC patient in accordance with the geographic restrictions that are prescribed by the regulations.

iii. Provide to the licensee of a long-term care home the assessments and information set out in the regulations, which may include personal health information.

iv. Authorize the ALC patient's admission to a home.

v. Transfer responsibility for the placement of the ALC patient to another placement co-ordinator who, for greater certainty, may carry out the actions listed in this paragraph with respect to the ALC patient.

3. A physician, registered nurse or person described in paragraph 3 of subsection 50 (5) may conduct an assessment of the ALC patient for the purpose of determining the ALC patient's eligibility for admission to a long-term care home.

4. A licensee of a long-term care home must do the following:

i. Review the assessments and information provided by the placement co-ordinator in respect of the ALC patient.

ii. Approve the ALC patient for admission as a resident of the home after reviewing the assessments and information provided by the placement co-ordinator, unless a condition for not approving the admission listed in subsection 51 (7) is met.

iii. Admit the approved ALC patient when they present themselves at the home as a resident after,

A. the placement co-ordinator has determined the patient's eligibility for admission to the home,
B. a bed becomes available, and
C. the placement co-ordinator has authorized the patient's admission to the home.

5. A person with authority to carry out an action listed in paragraph 1, 2, 3 or 4, a hospital within the meaning of the *Public Hospitals Act* or any other person prescribed by the regulations may collect, use or disclose personal health information if it is necessary to carry out an action listed in paragraph 1, 2, 3 or 4.

5. Limitation, reasonable efforts to obtain consent required

(4) The actions listed in subsection (3) may only be performed without consent if reasonable efforts have been made to obtain the consent of the ALC patient or their substitute decision-maker.

6. Actions to be performed in accordance with regulations

(5) Subject to subsection (6), sections 49 to 54 do not apply to the actions listed in subsection (3), and instead the actions shall be performed in accordance with the procedures, requirements, criteria, restrictions and conditions, if any, that are set out in the regulations.

7. If consent provided

(6) An ALC patient or their substitute decision-maker may provide their consent to any stage of the process described in this section and, if the consent is provided, the relevant portions of sections 49 to 54 and the regulations apply to the stages of the process to which they have consented, subject to any modifications or exemptions set out in the regulations.

8. Limitation

(7) Nothing in this section authorizes any person to restrain an ALC patient to carry out the actions listed in subsection (3) or to physically transfer an ALC patient to a long-term care home without the consent of the ALC patient or their substitute decision-maker.

9. Review of determination of ineligibility

(8) An ALC patient may apply to the Appeal Board for a review of a determination of ineligibility made by a placement co-ordinator under this section, and the Appeal Board shall deal with the appeal in accordance with section 59.

10. Interaction with Residents' Bill of Rights

(9) Despite subsection 3 (2), this section and any regulations made under clause 61 (2) (h.1) or (h.2) shall not be interpreted or construed as being inconsistent with the Residents' Bill of Rights.

3 Subsection 61 (2) of the Act is amended by adding the following clauses:

(h.1) governing the actions that may be performed under section 60.1 with respect to ALC patients, including,

(i) prescribing and governing any procedures that must be followed in performing the actions,

(ii) specifying any requirements, criteria, restrictions or conditions that apply to the actions,

(iii) modifying the application of any provision of this Act or the regulations to the actions, subject to any requirements, restrictions or conditions that may be set out,

(iv) providing exemptions from any provisions of this Act or the regulations in relation to the actions, subject to any requirements, restrictions or conditions that may be set out,

(v) governing the collection, use and disclosure of personal health information as described in paragraph 5 of subsection 60.1 (3), which may include prescribing additional persons who can collect, use or disclose personal health information in accordance with that paragraph;

(h.2) modifying the application of any provision of sections 49 to 54 or the regulations, or providing exemptions from them, with respect to ALC patients who have consented to the application process as described in subsection 60.1 (6);

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A.

Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A.

Canadian Charter of Rights and Freedoms

Canadian Charter of Rights and Freedoms, s.s. 7 and 15.1

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
Section 7 guarantees the life, liberty and personal security of all Canadians. It also requires that governments respect the basic principles of justice whenever they intrude on those rights. Section 7 often comes into play in criminal matters because an accused person clearly faces the risk that, if convicted, his or her liberty will be lost.

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

O. Reg. 246/22

O.Reg 246/22, s.s. 172(1), 240.1(5)(a) and (d)

172. (1) A placement co-ordinator shall determine a person to be eligible for long-term care home admission as a long-stay resident only if,
(a) the person is at least 18 years old;
(b) the person is an insured person under the *Health Insurance Act*;
(c) the person,
(i) requires that nursing care be available on site 24 hours a day,
(ii) requires, at frequent intervals throughout the day, assistance with activities of daily living, or
(iii) requires, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure their safety or well-being;
(d) the publicly-funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person's requirements; and
(e) the person's care requirements can be met in a long-term care home.

240. (1) This section applies when the Director has made a determination that residents of a long-term care home urgently need to be relocated to another home to protect their health or safety.

(5) For the purposes of applying this Regulation under the circumstances where this section applies,

(a) subsections 179 (3) and (4) of this Regulation shall be read as if they said "three business days" rather than "five business days";

(d) Column 2 of Item 9 of the Table to section 200 of this Regulation shall be read as if it referred to the time at which the applicant agreed to proceed with an application under section 50 of the Act;

O. Reg. 484/22

O.Reg. 484/22, s.s. 240.1(7) and (8)

240.1

(7) The placement co-ordinator may request that an assessment of the matters described in clauses (6) (a) to (e) be conducted by a physician, a registered nurse in the extended class or a registered nurse on the staff of the hospital for the purpose of determining the ALC patient's eligibility for admission to a long-term care home.

(8) Where a placement co-ordinator requests an assessment of an ALC patient under subsection (7) in a situation where the patient or their substitute decision-maker, if any, does not consent to the patient being assessed for the purpose of determining their eligibility for admission to a long-term care home, the person conducting the assessment shall base their assessment solely on a review of existing hospital records relating to that patient.

O. Reg. 485/22

O. Reg. 486/22

R.R.O. 1990, Reg. 965: Hospital Management

R.R.O. 1990, Reg 965: Hospital Management, s.s. 16(1), (2) and (3)

16. (1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician, registered nurse in the extended class or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, extended class nursing, dental or midwifery staff designated by a person referred to in paragraph 1. O. Reg. 346/01 s. 4; O. Reg. 216/11, s. 5; O. Reg. 159/17, s. 2.

(2) Where an order has been made with respect to the discharge of a patient, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order. R.R.O. 1990, Reg. 965, s. 16 (2).

(3) Despite subsection (2), the administrator may grant permission for a patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order. R.R.O. 1990, Reg. 965, s. 16 (3).

ONTARIO HEALTH COALITION AND ADVOCACY CENTRE FOR THE ELDERLY (Applicants)	HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO, THE MINISTER OF HEALTH, and THE MINISTER OF LONG-TERM CARE (Respondents)	Court File No.: CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

FACTUM OF THE APPLICANTS

GOLDBLATT PARTNERS LLP
20 Dundas Street West, Suite 1039
Toronto, ON M5G 2C2

Steven Shrybman (20774B)
Tel: 613-858-6842
sshrybman@goldblattpartners.com

GOLDBLATT PARTNERS LLP
30 Metcalfe Street, Suite 500
Ottawa, ON K1P 5L4

Benjamin Piper (58122B)
Tel: 613-482-2464
bpiper@goldblattpartners.com

Lawyers for the Applicants