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

REPLY FACTUM OF THE APPLICANTS

August 30, 2024

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A. Introduction and Overview

1. The entire edifice of the Respondent's argument is built on the assertion that the primary purpose of Bill 7 is "to reduce the number of ALC patients in hospital who are eligible for Long Term Care home admission.". According to that conception such ALC-LTC patients are disembodied numbers, and their need for LTC that can meet their needs becomes an extraneous consideration. That contention is not consonant with the purposes and framework of the statutes Bill 7 amends.

2. The Applicants have demonstrated the several ways that Bill 7 violates ALC-LTC patient's *Charter* rights under ss. 7 and 15. These include serious harm to the health and well-being of these patients that is substantially caused by Bill 7 forcing them to choose and accept admission to unsuitable and unsafe LTC homes. They have also shown that these deprivations are not in accordance with the principles of fundamental justice.

3. On the right to equality there is no dispute between the parties that ALC-LTC patients are disproportionately older and suffer chronic and/or terminal illnesses. On that basis, it is clear that Bill 7 has a disproportionate effect on the basis of age and disability. Moreover, in its submissions the Respondent perpetuates the very stereotypes it denies exist by referring to these patients as having a "priority" …. to stay in hospital"[1], "who make choices to lengthen their hospital stay,"[2] and are "free to leave hospital at any time".[3] In the voluminous record of this proceeding there is no evidence that such entitled, selfish and willful patients exist.[4]

4. The Respondent's claim these deprivations are warranted given the need to reduce the

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[1] Factum of the Respondent dated August 2, 2024 ("**RF**"), para. 104.
[2] RF, para. 131.
[3] RF, para. 73.
[4] Arya Affidavit, "The Myth of the Bed Blocker", JR, Vol. I, Tab 4, pp. 188-189.

number of ALC-LTC patients in hospital. Even if this were the purpose of Bill 7, the evidence clearly shows that Bill 7 has been both ineffective and counter-productive. Since the implementation of Bill 7 the numbers of ALC-LTC patients has grown substantially and they are waiting even longer in hospital. Moreover, in effect Bill 7 has likely increased hospital admissions in two ways. First, because by giving all ALC-LTC patients priority access to any LTC bed that becomes available, individuals, in urgent need of care but who are waiting at home for a LTC bed, deteriorate to the point of needing hospitalization. Second, by placing ALC-LTC patients in LTC homes which are unable to provide the care they need, a significantly greater number of these former patients are readmitted to hospital.

5. For these reasons the Applicants submit that as Bill 7 violates ss. 7 and 15 of the *Charter*, and further that the Respondent has failed to meet their burden to justify the deprivations under s.1 and that as a result the Applicant's requested relief should be granted.

B. Factual Errors, and Misleading Assertions

6. The Respondent's submissions include a number of erroneous and misleading statements. While some of these are addressed below, the following are repeated throughout the factum.

7. First, the Respondent often describes ALC-LTC patients as no longer in need of hospital care.[5] For the vast majority of ALC patients, no such determination has been made. Most ALC patients do in fact need and receive further hospital care in another setting,[6] but so do a significant minority ALC-LTC patients who have been incorrectly designated as ALC-LTC,[7] or who are

[5] See RF, paras. 42, 69, 119, 124, 130, 130, and 131 for a material related error, and 150.
[6] *Provincial Monthly Alternate Level of Care Performance Summary : Provincial and Sub-Region Level,* January 2024 [**ALC Summary**], Exhibit A to Sinha Responding Affidavit, JR, Vol. IV, Tab 13A, p. 1710.
[7] Sinha Affidavit, paras. 4-9 JR, Vol. IV, Tab 12, pp. 1470-1472; and St. Martin Affidavit, paras. 22-32, JR, Vol. IV, Tab 14, pp. 1752-1757.

unable to access needed hospital care in another setting because it is not available to them.[8] Ontario Health ALC summaries support these unmet health care needs by indicating that for more than 10% of ALC-LTC patients, LTC is not the most appropriate discharge destination.[9]

8. The Respondent is also incorrect in stating that under the legislation the maximum distance of a home that an ALC-LTC patient may be compelled to accept admission to is 170 km. In fact residents of Northern Ontario may, when other options aren't available, be sent to homes anywhere in the province.[10]

9. The Respondent also greatly overstates the impact of ALC-LTC patients on the hospital system.[11] In reality, ALC-LTC patients occupy 5% of Ontario's 44,000 hospital beds and only half of these patients are waiting in acute care beds,[12] access to which is identified by the Respondent's witnesses as the primary concern. It is true that ALC-LTC patients stay in hospital significantly longer than do many other patients in acute care, but these lengthier stays are not the result of any unwillingness to leave the hospital for LTC homes capable of meeting their care needs.[13]

C. The Purpose of Bill 7

10. Defining the purpose of the impugned measures is a necessary step of the ss, 7 and 1 analysis, and as noted, this is fundamental point of departure between the parties herein. The Respondent's position is that:

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[8] Sinha Affidavit, paras. 22-24 JR, Vol. IV, Tab 12, pp. 1477 – 1478.
[9] See fn. 6, ALC Summary, p. 1709.
[10] O Reg 246/22 s 240.2(8).
[11] RF para. 35.
[12] See fn. 6, ALC Summary, p. 1707.
[13] Factum of the Applicants dated June 21, 2024 ("**AF**"), Part "E".

> The purpose of the amendments made by Bill 7 is to reduce the number of ALC patients in hospital who are eligible for LTC home admission in order to maximize hospital resources for patients who need hospital-level care.[14]

11. This position ignores the guiding "modern principle" of statutory interpretation that the words of a statute must be read "in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act, and the intention of Parliament."[15]

12. The scheme and objectives of the *Fixing Long Term Care* Act (*FLTCA)*, are clearly focused on meeting the needs of individuals who require long-term care, and the *Act* is explicit about how its provisions, including those amended by Bill 7, are to be interpreted. Section 1of the *FLTCA*, provides:

> 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.[16] [emphasis added]

13. Similarly the *Health Care Consent Act* (*HCCA*) provides that its purpose, inter alia, is to: "enhance the autonomy of persons for whom treatment is proposed, persons for whom admission to a care facility is proposed."[17] It is relevant that purpose statements expressly speak to the values of dignity, security and autonomy that are central to the *Charter*. To propose that Bill 7 be interpreted in a manner that simply ignores the explicit purposes of the statutes Bill 7 amends, and which the impugned provisions form part of, is untenable.

14. The Respondent makes no effort to reconcile Bill 7 with the purposes of the *FLTCA* and

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[14] RF, para. 102.
[15] *Rizzo & Rizzo Shoes Ltd. (Re)*, 1998 CanLII 837 (SCC), para. 21 and see *Bell ExpressVu Limited Partnership v Rex*, 2002 SCC 42, para. 26.
[16] *Fixing Long-Term Care Act*, 2021, SO 2021, c 39, Sched. 1, s 1 [***FLTCA***].
[17] *Health Care Consent Act*, 1996, SO 1996, c 2, Sched. A, s 1 [***HCCA***].

HCCA but instead rely on a selective reading of the Minister of Long Term Care's introductory statement for Bill 7 to parliament.[18] Statements in parliament are considered secondary sources and often unreliable. Nevertheless, the Minister's statement provides no support for the Respondent's position, in fact it does the opposite because the Minister is explicit about the purpose of Bill 7:

> "**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."[19]

15. At best, freeing-up hospital beds for others to use is a hoped for consequence of ensuring that ALC-LTC patients are admitted to LTC homes that can assure they will "have the best possible quality of life close to their family, caregivers and friends."

16. However, if the purpose of Bill 7 is taken to be as the Respondent has framed it, the Applicants rely on the evidence and argument of their primary factum and the submissions herein to meet their obligation to establish the infringements of ALC-LTC patient rights under s. 7 they allege Bill 7 to have caused, and to show that these deprivations were not in accordance with fundamental justice.

D. Justiciability

17. The Respondent implicitly is asking this court to consider the claim in this case to be non-justiciable.[20] First it argues that health care issues arising in this case are intractable, or implacable problems, and beyond the competence and mandate of the court to resolve.[21] The Applicants are not asking this court to solve the structural and resource problems of our health care system and it

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[18] RF, para. 120.
[19] Hansard Tuesday 23 August 2022 (Hon P Calandra).
[20] RF, paras. 66-77.
[21] RF, paras. 66, 69, and 71.

agrees that it has no authority to do so.

18. As a variant of this argument the Respondent states that no remedy sought in this proceeding can have any impact on the problem of bed shortages.[22] This too is irrelevant to the court's mandate or any part of the test it must apply to determine *Charter* compliance. As the evidence shows, there are several proven and cost effective ways to reduce hospital admissions, and readmissions from LTC, which at the same time will improve the health and well-being of ALC-LTC patients.[23] But these are matters for the government or parliament to take up, and are relevant here only for the purposes of judging whether they were considered by the Respondent to support its claim to justification under s. 1.

19. The Respondent also contends the Applicants are asserting a right for ALC-LTC patients occupy a hospital bed for as long as they wish. They are not. As the courts have held, while the *Charter* does not confer an entitlement to health care,[24] where the government does provide healthcare it must do so in a manner consistent with the *Charter*.[25] Accordingly the Applicants are asking this court to determine whether, in seeking to address health care system problems arising from the shortages of both LTC and hospital beds, parliament has done so in a manner that infringes the *Charter* rights of ALC-LTC patients under ss. 7 and 15 of the *Charter*.

E. Section 7 – The right to life liberty and security of the person

20. The Applicants allege that Bill 7 infringes on the rights of ALC-LTC patient's life, liberty and security of the person, and on each of these distinct and separate rights. A deprivation of any of these rights, even in respect of one person is sufficient to show the harm required to meet the

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[22] RF, paras. 68-69.
[23] See discussion infra, paras 53-54.
[24] *Chaoulli v Quebec (Attorney General),* 2005 SCC 35, para. 104.
[25] *Ibid.*

first part of the s.7 analysis.[26] The Applicants contend that in fact, Bill 7 infringes on the *Charter* rights of thousands of ALC-LTC patients and for the most part these harms are uncontested.

21. The Respondent state that the evidence of the Applicants' witnesses who describe the impact of Bill 7 on their loved ones,[27] could easily resolve this case in their favour, but asks the court to "reconcile" the needs of these ALC-LTC patients with "the legitimate interests of all patients." [28] That argument belongs with the Respondent's submissions on s.1 and is not relevant to determining whether the rights of these ALC-LTC patients (the spouses and a parent respectively of the affiants) have been infringed.

22. The Respondent nevertheless argues that the harms ALC-LTC patients suffer cannot be *Charter* infringing because they are "free to leave the hospital any time" and will suffer only a monetary not penal consequence if they stay in the hospital after their admission to a LTC home is authorized.[29] This is wrong for two reasons. First, Bill 7 also permits other direct consequences if a patient refuses to select LTC homes that Home and Community Care Support Service (HCCSS) staff urge them to choose, in which case HCCSS may: choose and apply for admission to LTC homes; share the patient's personal health information with any number of them; and then authorize their admission to an LTC home, all without the ALC-LTC patient's consent.[30] In addition, amendment to regulations under the *Public Hospitals Act* permit a clinician to discharge an ALC-LTC patient who declines admission to a LTC home, but without making the

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[26] *Canada (Attorney General) v Bedford*, 2013 SCC 72 [***Bedford***], para. 127.
[27] Parkinson Affidavit, JR, Vol. III, Tab 11, pp. 1407-1416; Chaloner Affidavit, JR, Vol. I, Tab 6, pp. 348-356; and Herrington Affidavit, JR, Vol. I, Tab 7, 362-378.
[28] RF, paras. 76-77.
[29] RF, para. 72.
[30] *FLTCA, supra* note 14, s 60.1(3).

determination the patient is no longer clinically in need of hospital care.[31]

23. Second, the most important effect of Bill 7 is to deprive ALC-LTC patients of autonomy by compelling them to choose and then accept admission to a LTC home they would not have otherwise chosen and that cannot assure them of the care they need because the LTC home is too far from needed family and community supports; has a record of failing to provide proper care; leave them isolated from their culture, religion and values; or any combination of these deficiencies.[32]

24. The courts have held that in determining whether there is a sufficient causal connection between the legislation and the constitutional deprivations alleged, it is necessary to engage in a practical and pragmatic analysis that is alive to the context.[33] Here the Court must look at the legislative scheme as a whole, and be alive to the significant imbalance of power between patients and physicians and hospital decision makers. Thus, in analysing the effects of an impugned measure, the Court can determine whether there is real and meaningful choice for the individuals subject to the measures. To be eligible for admission to LTC an ALC-LTC must be determined to be dependent on daily care, and be unable to care for themselves or be cared for in the community. Therefore, whether the ALC-LTC patient can or cannot afford a $400 daily charge, leaving the hospital is not a meaningful option.[34]

25. The courts have consistently recognized that laws or state actions that meaningfully contribute to interferences with an individual's life, liberty, or security, constitute a violation of

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[31] RRO 1990, Reg 965, ss 16(1), (2), (3).
[32] AF, paras. 79-83.
[33] *Bedford*, *supra* note 24, paras. 31 and 76.
[34] *Bedford, supra* note 24, paras. 79-90.

s.7.[35] The coercive nature of a measure, particularly one that forces individuals to endure suffering, restricts personal autonomy, or leaves them without alternatives, is a defining factor in the analysis under s.7.

26. It is also well established that s. 7 applies outside of the criminal law context and does not require the threat of a penal prohibition. The section has been applied in challenges involving health insurance prohibitions,[36] state funded legal counsel in family law proceedings,[37] and to making fundamental personal choices about one's life that affect individual freedom and dignity, such as choosing where to live.[38]

27. Finally, the standard of causation under s. 7 is not one of a "singular antagonist" as the Respondent claims. Rather, as noted, the standard is that of a "sufficient causal connection" having regard for the context of the case,[39] which, "*does not require* that the impugned government action or law *be the only or the dominant cause of the prejudice suffered by the claimant"*, and is satisfied by a reasonable inference, drawn on a balance of probabilities."[40] For ALC-LTC patients the consequences of declining to choose a LTC home, or of refusing admission to a home they have not chosen, forces them to choose and then accept admissions to a LTC home that will result in, and cause them harm.

28. Most of the Respondent's argument concerning the *Charter* deprivations the Applicants allege with respect to the personal health information of ALC-LTC patients is dedicated to making

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[35] See *Bedford, supra* note 24, and see *Carter v Canada (Attorney General),* 2015 SCC 5 [***Carter***] and see also *Chaoulli supra,* note 22.
[36] *Chaoulli supra,* note 22.
[37] *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, 1999 CanLII 653 (SCC).
[38] *Godbout v. Longueuil (City)*, 1997 CanLII 335 (SCC), para. 66.
[39] *Bedford, supra* note 24, para. 78.
[40] *Ibid,* para. 76 [emphasis added].

the point that a person has no unqualified right to determine whether, how, and with whom their personal health information may be shared.[41] It misapprehends the Applicants' argument, which is, that by allowing the personal health records of ALC-LTC patients to be shared without their consent, Bill 7 infringes their rights to life, liberty and security of person.

29. In respect of liberty, it is the threat of having one's personal health information, which an individual may view as including sensitive and even prejudicial information, shared with an unknown number of strangers.[42] It is the coercive threat of having that happen, and the impact of that coercion on ALC-LTC patients' right to informed consent that offends their right to liberty. [43] In respect of security of the person it is the psychological and emotional stress of losing control over personal health records that is the infringing effect of Bill 7.[44] In respect to "life", it is the erosion of trust between the physician and the ALC-LTC patient, that is essential to the patients care, that is a casualty of depriving the patient of knowing that sensitive and private information they may wish to convey, will be kept in confidence.[45]

F. Section 15

30. The Respondent's arguments on s. 15(1) ask this Court to adopt a formalistic comparator based approach that has repeatedly been rejected by the Supreme Court.[46] It argues that Bill 7 does not cause any differential impact because "ALC patients are treated identically by Bill 7 no matter what their age or disability," and Bill 7 only targets patients "who make choices to lengthen their hospital stay"[47]. These submissions apart from being factually incorrect, are inconsistent with the

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[41] RF, paras. 92 – 98.
[42] AF, paras. 67-70 and references to the Sinha Affidavit, JR, Vol. IV, Tab 12, p. 1466, noted therein.
[43] AF, para. 93.
[44] AF, para. 100.
[45] AF, paras. 67-70 and references therein to the Sinha Affidavit, JR, Vol. IV, Tab 12, pp. 1466, noted therein.
[46] See *Moore v British Columbia (Education),* 2012 SCC 61, paras. 29-31.
[47] RF, paras. 129 and 134.

adverse effects discrimination analysis set out by the Supreme Court, under which, "[i]nstead of asking whether a law explicitly targets a protected group for differential treatment, a court must explore whether it does so indirectly through its impact on members of that group."[48]

31. The cases cited by the Respondent endorse this approach,[49] and only denied s. 15(1) claims because the evidence before them was flawed. In *Ontario Teacher Candidates' Council*, the statistical evidence was "preliminary and incomplete" and did not establish a differential impact.[50] In *Fair Change*, there was an absence of first-hand evidence showing differential impact of the law on most of the groups at issue and other significant flaws in the evidence, including "significant concerns about the reliability of some of the expert evidence."[51] For individuals with mental health illnesses and addictions, the Court found no evidence that the law caused or contributed to the disadvantage faced by that group, rather than reflecting pre-existing disadvantage.[52]

32. In contrast, Bill 7 explicitly targets ALC-LTC patients, depriving them of rights accorded to all other hospital patients and causing a range of other negative impacts, as detailed in the Applicants' primary factum. The Respondent seemingly accepts that ALC-LTC patients are disproportionately elderly and suffer from chronic and/or terminal illnesses, even compared to the hospital population.[53] It is clear that Bill 7 causes or contributes to the disproportionate effect on

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[48] *Fraser v Canada (Attorney General)*, 2020 SCC 28 [***Fraser***], para. 53.
[49] *Ontario Teacher Candidates' Council v Ontario (Education)*, 2023 ONCA 788, paras. 66-67 and 69 [***OTCC***]; *Fair Change v His Majesty the King in Right of Ontario*, 2024 ONSC 1895, paras. 324, 328-329 [***Fair Change***] *R. v Sharma*, 2022 SCC 39 [***Sharma***], explicitly endorsed the adverse effects discrimination analysis in *Fraser*: see paras. 46-49. It clarified that there must be evidence that the law or measure caused or contributed to the differential treatment faced by a protected group, rather than simply reflecting a pre-existing disadvantage: see *Sharma,* paras. 40, 42-45.
[50] *OTCC, supra* note 47, para. 7.
[51] *Fair Change*, *supra* note 47, paras. 330, 333, 338, 344, 348, 350, 352, 367, 387, 389, 393, 395.
[52] *Fair Change supra* note 47, paras. 380, 383-384.
[53] RF, para. 132.

ALC-LTC patients on the basis of age and disability.

33. The Respondent argues that Bill 7 is not discriminatory because an ALC-LTC designation is point-in-time and can be changed, and is therefore not 'immutable'.[54] Yet the ALC-LTC designation is not the ground of discrimination at issue; it is the patient's age and/or disability. There is no support in the case law for the suggestion that because the disadvantage suffered by a group may change over time, this somehow negates the discriminatory effect of Bill 7.

34. Finally, the Province suggests at para 132 that Bill 7 is not discriminatory because "[a]ny law directed at hospital patients will mostly affect people who are older or ill." This reasoning would immunize all laws directed at hospitals from a s. 15 challenge on the basis of age or disability. Moreover, Bill 7 targets only ALC-LTC patients, a group that the Province accepts as being disproportionately elderly and disabled as compared with other patients in respect of fundamental rights respecting consent to treatment.

G. Section 1

35. The Respondent bears the burden of proving that the deprivations of the Bill 7, if proven, are nevertheless justified under s. 1. It has made no effort to do so in respect of Bill 7 if its purpose is, as the Applicants have argued it must be, to ensure that ALC-LTC are admitted to LTC homes that can meet their needs, as the FLTCA, the HCCA and Minister have defined them. Therefore, the following submissions address the Crown's claim to justification under s.1 on the grounds that the purpose of Bill 7 is taken by the court to be as the Respondent has defined it.

H. The Respondent Has Failed to Meet its Evidentiary Burden

36. Canadian courts have consistently emphasized the importance of evidence in meeting the

[54] RF, para. 130.

Respondent's burden of demonstrating that the objective of an impugned measure is sufficiently important to justify infringing a *Charter* right.[55] Speculation cannot satisfy the Crown's burden. There must be a solid evidentiary foundation demonstrating that the objective is pressing and substantial.[56]

37. The Respondent has adduced little evidence concerning the impacts of Bill 7 on those waiting for a hospital bed occupied by an ALC-LTC patient. This is in sharp contrast to the extensive, detailed and uncontroverted evidence the Applicants have introduced about the unmet demand for LTC, the wide variation in the quality of care LTC homes provide, and the health care needs and preferences of ALC-LTC patients.[57]

38. Despite the fact that several of their affiants gather, or have access to very detailed evidence concerning the status and flow of patients admitted or scheduled for care in hospital,[58] they have presented no data or empirical evidence concerning the number of individuals who are unable to access hospital care, the nature of their health care needs (eg. acute, palliative, in-hospital rehabilitation, complex continuing care, psychiatric care etc.), how long such would-be patients must wait for that needed care, or about the various constraints that may be impeding their access to it.

39. Instead the Respondent has offered anecdotes that in some hospitals on some occasions, the hospital may not have a bed available for a patient who is admitted to hospital through the emergency ward.[59] Respondent witnesses also state that they believe that "patient flow" has

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[55] *R v Oakes*, 1986 CanLII 46 (SCC), paras. 42 and 66 [***Oakes***] and *Bedford,* supra note 24, para. 126.
[56] *RJR-MacDonald Inc. v Canada (Attorney General),* 1995 CanLII 64 (SCC), paras. 128-129 [***RJR***].
[57] AF, Parts C, E, and F and evidence referred to therein.
[58] Ellacott Cross, Q 6, JR, Vol. VI, Tab 25, p. 2521, and ALC Summary, see fn. 6.
[59] See for example, Carpenter Affidavit, para. 28, JR, Vol. V, Tab 15, p. 1776; and Musyj Affidavit, para. 18, JR, Vol. V, Tab 19, pp. 2011-2012.

improved in their hospitals since the advent of Bill 7, but they provide no data or other evidence to support their opinions.[60] In any event, even if correct, the performance in their particular hospitals are clearly anomalous given the detailed evidence from Ontario Health that the number of ALC-LTC patients has grown substantially since Bill 7 was implemented and they are waiting even longer to transition to LTC.

40. Second, the Respondent has also failed to adduce evidence establishing a causal relationship between the presence of ALC-LTC patients eligible for LTC and any hospital bed shortage. No evidence is offered concerning the other factors that may be impeding access to hospital level care, such as staffing constraints, the failure of the Province to provide sufficient hospital capacity to meet societal needs,[61] or the failure of hospitals to organize hospital services to meet the complex hospital care needs of older patients.[62]

41. These failures to adduce objective evidence concerning matters essential to meeting the burden of proof under both the threshold and subsequent stages of the *Oakes* analysis, means that the Respondent has manifestly failed to establish that the *Charter* infringements at issue are nevertheless justified under s.1.

I. Reducing the Number of ALC-LTC Patients in Hospital is Neither a Pressing nor Substantial Objective

42. The courts have been clear that the burden of demonstrating that infringements of *Charter* rights are justified under s. 1 is not an easy one to overcome,[63] and must, at the first stage of analysis prove on the basis of objective evidence that the purpose of any impugned measure is

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[60] Jarrett Affidavit, para. 13, JR, Vol. V Tab 18, p. 2002; Ellacott Affidavit, para. 8 Vol. V, Tab 16, p. 1951.
[61] Armstrong Affidavit, paras. 17-23, JR, Vol. I, Tab 3, pp. 57-61.
[62] Sinha Affidavit, paras. 22-24 JR, Vol. IV, Tab 12, pp. 1477-1478.
[63] *RJR, supra* note 54, para. 129.

both pressing and substantial.[64]

43. As noted, the Respondent has failed to adduce the objective evidence required to show that removing ALC-LTC patients from the hospital is pressing. Other than for broad statements and a handful of anecdotes, it has adduced no evidence about the extent or the nature the unmet need for hospital level care, or about the relative role among other factors, that the presence of ALC-LTC patients in hospital might be playing. It is simply asking this Court to assume, absent evidence of the nature, scale and context of any such need, that reducing the number of ALC-LTC patients in hospital is a pressing and substantial objective. Where the Province adduces no objective evidence to prove that its purported purpose is both pressing *and* substantial, as is the case here, there is no need for further inquiry and its claim of justification under s. 1 must fail.

J. The Lack of Rational Connection

44. Nevertheless, if the Respondent is found to have met its burdens under the first stage of the *Oakes* analysis, it must then prove that the *Charter* infringements at issue are proportional, and must balance competing interests arising from broader societal goals with the rights of the claimants. The Respondent must also prove that the effects of Bill 7 are logically related to the goal it seeks to achieve, without being arbitrary, unfair, or based on irrational considerations.[65] In addition, violations of s.7 of the *Charter* are unlikely to be justified under section 1.[66]

45. In their factum, the Applicants address the reasons why, if defined in a manner that is consonant with the purposes of the *FLTCA* and the *HCCA*, Bill 7 is arbitrary because there is no rational connection between depriving, whether through direct or coercive means, patients of

[64] *Oakes, supra* note 53, para. 69.
[65] *Oakes, supra* note 53, para. 70.
[66] *Bedford, supra* note 24, para. 129.

consent to choose a LTC home when their consent is the principle means of matching homes with their particular needs.

46. However, if the purpose of Bill 7 is taken "to be reducing the number of the ALC-LTC patients in hospital beds", the evidence shows Bill 7 also has no rational connection to this objective because the *effects* of the measures it introduces are not only ineffective but counterproductive.[67] They are ineffective because as noted, since Bill 7 came into effect, the number of ALC-LTC patients waiting in hospitals has increased substantially.[68]

47. The measures are counterproductive (and therefore irrational or arbitrary) because by coercing ALC-LTC patients to accept being admitted to LTC homes that cannot provide proper care, then create a cycle of re-hospitalization. The expert evidence, data, and empirical studies show, that placing ALC-LTC patients in homes that do not have the ability to properly care for them significantly increases their likelihood of being readmitted to hospital.[69]

48. Another counterproductive effect of Bill 7 arises from effectively replacing the right of hospitals to request that their ALC-LTC patients be given priority access to LTC homes where the conditions in the hospital warrant,[70] with a blanket designation of all ALC-LTC patients as "crisis" candidates for LTC, thus giving them priority for any available LTC bed.[71] In consequence, a number of the 40 thousand people waiting at home for a bed in LTC may become so ill as to require hospital admission, and some may even be induced to seek hospital admission as the only means of being admitted to LTC.[72]

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[67] *Bedford, supra* note 24, para. 119.
[68] ALC Summary, Exhibit A to Sinha Responding Affidavit, JR, Vol. IV, Tab 13A.
[69] Arya Responding Affidavit, paras. 2-6, JR, Vol. I, Tab 5, pp. 273-275.
[70] O Reg 246/22 s 188(4).
[71] O Reg 246/22 s 240.3(2).
[72] AF, para. 118, referring to Sinha Affidavit, para. 37, JR, Vol. IV, Tab 12, p. 1483.

K. Minimal Impairment

49. As the Supreme Court explains, the determination of whether a *Charter* infringing measure is minimally impairing, requires a thorough examination of alternatives to ensure that any limitation on *Charter* rights is justified and represents the least intrusive means of achieving the legislative objective. The government will be required to show that there are no less rights-impairing means of achieving the objective "in a real and substantial manner."[73] The analysis at this stage is meant to ensure that the deprivation of *Charter* rights is confined to what is reasonably necessary to achieve the state's object.[74]

50. Therefore, even if the purpose of Bill 7 is taken to be reducing the number of ALC-LTC patients in hospital beds, there is ample evidence that there are less intrusive, and more effectives means for achieving that objective. The Respondent has adduced no evidence that such alternatives were considered, and no legislative hearings were held that might have elucidated any such consideration.

51. The provisions of Bill 7 could have readily been tailored to target the purported problems arising from ALC-LTC patients' exercising their right to personal autonomy in choosing a LTC home. The overbreadth of Bill 7 indicates the enormous scope for reducing its application. To begin with the Respondent does not dispute that before the implementation of Bill 7, the vast majority of ALC patients were willing to compromise in choosing LTC homes if their options were compassionately explained to them. The Respondent states that nevertheless at least some patients refuse a bed offer. However, in all the evidence adduced by their witnesses - hospital CEOs, physicians involved directly in discharging ALC-LTC patients, and a manager of HCCSS

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[73] *Carter, supra* note 33, para. 102.
[74] *Ibid*.

– the Respondent points to only five examples of ALC-LTC patients who are said to have refused to either choose or be admitted to a LTC home, and even then, the circumstance surrounding those purported refusals is unclear.

52. There are any number of alternative means that could have been considered for addressing such a small problem, including limiting the application of the Act to persons who refuse to willingly list a specified number of LTC homes, or by placing such patients in chronic care beds. As another example, the Bill could be tailored to address the problem that ALC-LTC designations may be incorrectly made,[75] including as a result of pressure from hospital administrations, for clinicians to use their discretion in respect of ALC designations to speed their discharge of patients, whether clinically warranted or not.[76] The Bill could be tailored to allow for the review of such designations where reasonable grounds exist for a challenge.

53. More importantly there is considerable evidence establishing that there are cost effective alternatives to Bill 7 that provide more systemic solutions. These include THP@home, a program that Dr. Narajan (Respondent witness) manages and describes as "very effective" in reducing hospital stays and readmissions. Describing the success to this program, Dr. Narajan estimated that it had resulted in 6,200 bed days saved during the short time the program was operating and did so, much more cost effectively, than had those beds been occupied.[77]

54. Yet another alternative would require LTC homes to provide adequate palliative care. Dr. Arya (the Applicants' witness) cites several peer-reviewed studies showing the benefits of doing

[75] Sinha Affidavit, paras. 5-7, JR, Vol. IV, Tab 12, pp. 1470-1472.
[76] AF, para. 32 and see Sinha Affidavit, paras. 8-9, JR, Vol. IV, Tab 12, pp. 1472-1473; St. Martin Affidavit, paras. 22-35, JR, Vol. IV, Tab 14, p. 1452, Carpenter Affidavit, para. 22, JR, Vol. V, Tab 15, p. 1773-1774; Transcript of Cross Examination of Dr. Travis Carpenter dated April 18, 2024, Qs 149-153, JR, Vol. IV, Tab 24, p. 2478-2480.
[77] AF, para. 39 referring to Narayan Cross, Qs 17-62, JR, Tab 30, pp. 2879-2890.

so. One showing that improving the prescribing of End of Life medication and care to LTC residents reduced hospital admissions by 2/3rds, thus preventing thousands of potentially preventable hospital transfers annually.[78] Another shows that patients supported by palliative home care spent fewer days on average in hospital in the last year of their lives.

55. It is not for this court to determine whether the Province should have taken another path, but only whether these or other reasonable alternatives for achieving its objective were considered. The Respondent failed to adduce any evidence proving that it did so, and therefor has manifestly failed to prove that Bill 7's *Charter* infringing measures are minimally impairing, on this ground as well.

L. Proportionality

56. The evidence concerning the nature of the harms suffered by ALC-LTC patients under Bill 7's regime, as described in detail by the Applicant's expert witnesses include: being coerced to accept admission to LTC homes more likely to isolate them from family, community and culture, and further increasing their risk of suffering, and death.

57. As briefly described above Bill 7 also impinges upon and damages the trust relationship between patients and healthcare providers, the importance of which was underscored in *Rodriguez v. British Columbia (Attorney General).*[79]

58. As described above, in contrast, the record includes little evidence about the harm suffered by those who may need a hospital bed that is occupied by an ALC-LTC patient. The only material evidence offered are accounts of patients admitted to hospital but waiting in the emergency wards

[78] Arya Responding Affidavit, para. 3, JR, Vol 1, Tab 5, p. 275.
[79] 1993 CanLII 75 (SCC).

because there is no hospital bed for them.[80] No objective empirical evidence is offered about the nature and scale of this problem.

59. In contrast, the effects on ALC-LTC patients of inadequate care, social isolation, psychological distress, and premature death, when placed in LTC that are too far from family, discordant with cultural needs, and unable to provide necessary care, are described in detail and are not disputed.

60. The Respondent failed to adduce any objective and demonstrable evidence to support the putative benefits it attributes to Bill 7. Accordingly, the Applicants submit there is no evidentiary support for concluding that Bill 7 strikes a justifiable balance between competing societal goals.

61. In conclusion, the applicants submit that Bill 7 fails all stages of the *Oakes* test. The law does not serve a pressing and substantial objective in a manner that is rationally connected to the goal the Respondent has articulated, it is not minimally impairing of *Charter* rights, nor proportionate in its effects. Accordingly, the *Charter* infringements arising from Bill 7 cannot be justified under s. 1 of the *Charter*.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

August 30, 2024

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[80] See for example, Carpenter Affidavit, para. 28, JR, Vol. V, Tab 15, p 1776; and Musyj Affidavit, para. 18, JR, Vol. V, Tab 19, pp. 2011-2012.

SCHEDULE "A"

1. *Bell ExpressVu Limited Partnership v Rex*, 2002 SCC 42
2. *Canada (Attorney General) v Bedford*, 2013 SCC 72
3. *Carter v Canada (Attorney General)*, 2015 SCC 5
4. *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35
5. *Fair Change v His Majesty the King in Right of Ontario*, 2024 ONSC 1895
6. *Fraser v Canada (Attorney General)*, 2020 SCC 28
7. *Godbout v. Longueuil (City)*, 1997 CanLII 335 (SCC)
8. Hansard Tuesday 23 August 2022 (Hon P Calandra)
9. *Ontario Teacher Candidates' Council v Ontario (Education)*, 2023 ONCA 788
10. *Moore v British Columbia (Education)*, 2012 SCC 61
11. *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, 1999 CanLII 653 (SCC)
12. *R v Oakes*, 1986 CanLII 46 (SCC)
13. *R. v Sharma*, 2022 SCC 39
14. *Rizzo & Rizzo Shoes Ltd. (Re)*, 1998 CanLII 837 (SCC)
15. *RJR-MacDonald Inc. v Canada (Attorney General)*, 1995 CanLII 64 (SCC)
16. *Rodriguez v. British Columbia (Attorney General)*, 1993 CanLII 75 (SCC)

SCHEDULE "B"

Charter of Rights and Freedoms

Rights and freedoms in Canada

1 The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society

Life, liberty and security of person

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.

Equality before and under law and equal protection and benefit of law

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.

Affirmative action programs

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

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

Purposes

1 The purposes of this Act are,

(a) to provide rules with respect to consent to treatment that apply consistently in all settings;

(b) to facilitate treatment, admission to care facilities, and personal assistance services, for persons lacking the capacity to make decisions about such matters;

Note: On a day to be named by proclamation of the Lieutenant Governor, clause 1 (b) of the Act is amended by striking out "admission to care facilities" and substituting "admission to or confining in care facilities". (See: 2017, c. 25, Sched. 5, s. 54 (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,
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(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;

(d) to promote communication and understanding between health practitioners and their patients or clients;

(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; and

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to a care facility or personal assistance services. 1996, c. 2, Sched. A, s. 1.

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

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

(f) to permit intervention by the Public Guardian and Trustee only as a last resort in decisions on behalf of incapable persons concerning treatment, admission to or confining in a care facility or personal assistance services

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

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.

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.

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O. Reg. 246/22: GENERAL under Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1

s 188(4) An applicant shall be placed in category 1 on the waiting list for a long-term care home if the applicant,

(a) occupies a bed in a hospital under the *Public Hospitals Act*, requires an alternate level of care and requires an immediate admission to a long-term care home;

(b) the hospital is experiencing severe capacity pressures; and

(c) the Agency has, taking into account consultation with the affected hospital and the appropriate placement co-ordinator, verified these pressures to the appropriate placement co-ordinator in writing and set out the time period for which the verification applies.

s 240.2(8) The restrictions set out in clause (7) (b) do not apply where there is not a long-term care home within the radius that would otherwise apply, or there are limited vacancies in the available homes, in which case the placement co-ordinator shall select the home or homes that are next closest to the patient's preferred location. O. Reg. 484/22, s. 2.

240.3 (2) If the ALC patient or their substitute decision-maker, if any, has made an application for authorization of admission under section 51 of the Act to a home or homes or agrees to the application for authorization of admission to a home or homes selected by the placement co-ordinator under section 60.1 of the Act, the placement co-ordinator shall place the patient in category 1 of the waiting list referred to in section 188 of this Regulation in respect of every waiting list on which they are placed unless the patient would otherwise be placed in a higher ranking category. O. Reg. 484/22, s. 2.

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R.R.O. 1990, Reg. 965: HOSPITAL MANAGEMENT under Public Hospitals Act, R.S.O. 1990, c. P.40

Discharge of Patient from Hospital

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

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