

CITATION: Ontario Health Coalition and Advocacy Centre for the Elderly v. His Majesty the King in Right of Ontario, 2025 ONSC 415
COURT FILE NO.: CV-23-00698007-0000
DATE: 20250120

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:)	
)	
Ontario Health Coalition and Advocacy Centre for the Elderly)	Steven Shrybman and Benjamin Piper, for the Applicants
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)	S. Zachary Green, Cara Zwibel, and Emily Owens for the Respondent
Respondent)	
)	
)	
)	HEARD: September 23 and 24, 2024

ROBERT CENTA J.

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1. Overview

[1] The Ontario health care system is large, complex, and of enormous importance to all who need its services. This case concerns the interface between two crucial parts of this system:

hospitals and long-term care homes. In particular, this case concerns how elderly patients who no longer require the intensity of resources or services provided in a hospital transition to a long-term care home. A patient who no longer requires hospital-level care is called an alternate level of care patient or ALC patient.

- [2] Absent issues of scarcity, the transition process would be relatively straightforward. The ALC patient would apply to the long-term care home of their choice. The patient could choose the home with the best services, facilities, and ratings, the one that was closest to their community of choice, or the one that best supported their linguistic and cultural needs. The ALC patient would wait in the hospital for a day or two, the patient's preferred long-term care home would admit them, and they would move into that long-term care home.
- [3] Unfortunately, no one can wish scarcity away. The parties agree that there are about 65,000 individuals on waitlists for one of the approximately 80,000 long-term care beds in Ontario. In 2023, there were 2,500 ALC patients waiting in a hospital bed for a space in a long-term care home. At the same time, Ontario is coping with a significant shortage of hospital beds. Demand for hospital beds currently exceeds supply. Many hospitals will have ALC patients occupying between 10 and 20 percent of their acute beds at any one time (although not all of these patients are waiting for long-term care). This causes back-ups in emergency departments and intensive care units, the cancellation of surgeries, and very ill patients waiting far longer than is desirable in hallways and other non-traditional spaces. As hospital beds are a scarce resource, very difficult questions arise regarding how best to allocate them.
- [4] Ontario identified that the waitlists for long-term care homes were not all the same length. Sometimes, there were long-term care homes with short or non-existent waitlists. Sometimes, there were ALC patients who wished to remain in hospital while a long-term care home with a years-long waitlist processed their application even though they no longer needed hospital-level care. Sometimes, those same ALC patients occupied beds in hospitals that were experiencing paralyzing bed shortages that imperilled their ability to provide emergency, surgical, and medical care. Only one person can occupy a hospital bed at a time.
- [5] In response to this situation, in August 2022, the Ontario Legislature passed Bill 7, which amended several other pieces of legislation. The purpose of the legislation was to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home, in order to maximize hospital resources for patients who need hospital-level care. The legislation and the regulations that were subsequently enacted made two fundamental changes:
- a. placement coordinators are now permitted to authorize the admission of ALC patients to long-term care homes selected by the placement coordinator without the patient's consent; and
 - b. once a long-term care home that can meet the ALC patient's care requirements offers that patient a bed, the patient must either leave the hospital within 24 hours or pay a daily fee of \$400 to remain in the hospital.

- [6] The Ontario Health Coalition and the Advocacy Centre for the Elderly challenge the constitutionality of Bill 7. As I will explain, I do not grant the Coalition standing in this proceeding, as it is not a legal person. It describes itself as an “unincorporated citizen-based coalition and non-governmental organization.” The Coalition can not commence litigation in its own name. I grant the Advocacy Centre public interest standing to advance this litigation, although I do so reluctantly. It would be preferable to have individuals affected by this legislation bring claims in their own names, so that the constitutionality of the legislation could be determined on the facts of live cases with the Advocacy Centre playing its natural role as counsel to its clients.
- [7] The Advocacy Centre submits that the legislation infringes ALC patients’ rights under s. 7 of the *Canadian Charter of Rights and Freedoms* because it limits the right to life, liberty, and security of the person. It submits that such limitations are not in accordance with the principles of fundamental justice because the legislation is arbitrary, overbroad, and grossly disproportionate. I disagree with both submissions.
- [8] I find that Bill 7 does not violate an ALC patient’s right to life because Bill 7 is not a law or state action that imposes an increased risk of death on the patient. Bill 7 does not prevent any ALC patient from obtaining access to necessary health care. Bill 7 does not even prevent an ALC patient from remaining in hospital even though they no longer require hospital-level care. It only requires ALC patients who refuse an available bed in a long-term care home to pay about one-third of the cost of their care while they remain in the hospital. This cannot violate s. 7 of the *Charter*, because prior cases have determined that s. 7 does not confer a constitutional right to a certain level of funding for health or social benefits. No one has a statutory or common law right to occupy a hospital bed, particularly where a clinician has determined that a patient does not require the intensity of resources or services provided in the hospital care setting.
- [9] I also find that Bill 7 does not limit an ALC patient’s right to liberty or security of the person. Bill 7 does not enact a penal prohibition or impose fines or imprisonment. It does not compel an ALC patient to do, or to refrain from doing anything. It does not authorize anyone to touch, restrain, or physically examine an ALC patient without their consent. It does not permit the hospital to transfer an ALC patient to a long-term care home without their consent.
- [10] Bill 7 permits disclosure of a limited amount of an ALC patient’s personal health information for a limited purpose that is integrally linked to its legislative purpose. Patients do not have an absolute right to control the dissemination of their personal health information. The relevant statutes permit disclosure of an individual’s personal health information without the individual’s consent in many circumstances, including where that disclosure is necessary to facilitate the provision of health care, improve the health care system, protect the public, and allow public officials to discharge their statutory duties. The disclosure permitted by Bill 7 does not limit the right to liberty or security of the person.
- [11] Bill 7 does not limit the right to liberty and security of the person by permitting a paper-based assessment of the patient in circumstances where a patient does not consent to an

examination. A patient can consent to a physical, in-person assessment at any time. Absent that consent, there can be no objection to an assessment on a paper record.

- [12] The Advocacy Centre submits that Bill 7 interferes with a “patient’s fundamental right...to choose where they will live in what will typically be the final months of their life.” As I will explain, an ALC patient has no statutory or common law right to stay in a hospital bed once a clinician has determined that the patient no longer requires hospital-level care. No one, including an ALC patient, has the “fundamental right...to choose” to live in a hospital.
- [13] Bill 7 requires an ALC patient who chooses to wait in the hospital for an available bed in the long-term care home of their choice to pay about one-third of the daily cost of the hospital care they no longer require. I do not accept the Advocacy Centre’s submission that this daily fee is unconstitutionally “coercive.” It is not. The government may create economic incentives and disincentives to behaviour without those economic consequences becoming unlawfully coercive. Relatedly, the Advocacy Centre submits that Bill 7 is unconstitutional because it removes the “leverage” previously held by ALC patients in their “negotiations” with the hospital regarding their transfer to a preferred long-term care home. I reject the troubling suggestion that the constitution protects anyone’s right to hold a hospital bed hostage during negotiations to obtain a private benefit for themselves.
- [14] Finally, Bill 7 does not “negate informed consent” contrary to the right to liberty and security of the person. Nothing in Bill 7 prohibits a patient from seeking or obtaining medical treatment or authorizes medical treatment of a patient without that patient’s consent. Bill 7 does not lower the threshold for discharging ALC patients from the hospital.
- [15] Even if Bill 7 did limit the right to life, liberty, and security of the person, and I find that it does not limit those rights, the deprivation would be in accordance with the principles of fundamental justice. I find that the purpose of Bill 7 is to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care. This statutory scheme is not arbitrary as there is a rational connection between the object of the law and any limit placed on the s. 7 interests of the ALC patient. The provisions in Bill 7 are capable of advancing the legislative purpose. Relatedly, I conclude that Bill 7 is not overbroad. Bill 7 is narrowly tailored to achieve its purposes and its provisions are only triggered when reasonable efforts have been made to obtain a patient’s consent and those efforts have failed. Bill 7’s effects are not grossly disproportionate to its legislative objective.
- [16] I conclude that Bill 7 does not violate an individual’s right to life, liberty, or security of the person and that any deprivation would be in accordance with the principles of fundamental justice because Bill 7 is not arbitrary, overbroad, or grossly disproportionate.
- [17] The Advocacy Centre also submits that Bill 7 violates the equality guarantee in s. 15 of the *Charter* because the legislation discriminates against ALC patients on the basis of age and disability. I disagree. Bill 7 affects all ALC patients waiting for long-term care the same way, regardless of age or disability. ALC patients waiting for long-term care also fit uneasily within the enumerated grounds protected by s. 15 or the previously recognized analogous grounds. Membership in this group is determined both by a transient clinical

assessment that the patient, at a particular moment in time, does not require the intensity of resources or services provided in the hospital care setting and the patient's failure to consent to certain long-term care options available to them. I find that the Advocacy Centre has not proved that Bill 7 created or contributed to any disproportionate impact based on age or disability, which is fatal to its s. 15 argument.

- [18] Finally, even if the provisions of Bill 7 limited the constitutional rights of an ALC patient, Ontario has justified that limitation under s. 1 of the *Charter*. The provisions have a sufficiently important objective and the means chosen by the Legislature are proportional to that objective because they are rationally connected to the objective, minimally impairing of the right, and there is proportionality between the salutary and deleterious effects of the law.
- [19] As stated above, I find that the purpose of Bill 7 is to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care. I conclude that Bill 7's objective is sufficiently important to justify a limitation on rights.
- [20] Ontario has proved that on the basis of reason or logic that there is a connection between the infringement and the benefit sought. Bill 7 furthers an important government aim. There is evidence in the record that ALC patients and their decision-makers modified their behaviour and made different choices in response to Bill 7 than they would otherwise have made. As a result of this modified behaviour, hospital beds were made available on an earlier date than otherwise would have been the case. This evidence demonstrates that the legislation is rationally connected to its objective.
- [21] The Advocacy Centre submits that Bill 7 is not minimally impairing of the constitutional rights of ALC patients. In support of this submission, the Advocacy Centre filed affidavits from experts providing their views on what, in their opinion, would be superior policy solutions to this situation. The experts' proposals included the following: increased funding for hospitals; increased funding for long-term care homes; higher wages for staff working in long-term care homes; increased funding for palliative care; increasing funded home care hours by "20 to 50%"; increased funding for hospice care; increased funding for "senior friendly care"; changing the priorities of the health care system; changing the electronic document system for health care; mandating senior-friendly hospital practices in all hospitals; and increased funding for primary care to prevent hospitalizations.
- [22] While I accept that the Advocacy Centre's experts sincerely hold these views, they are of little assistance to me in determining whether the Legislature's policy choices reflected in Bill 7 are unconstitutional. For reasons of institutional legitimacy and institutional capacity, it is not the role of the court to second-guess how the Legislature chooses to allocate scarce resources. The court must show significant deference to the Legislature's decisions regarding health care spending while ensuring that the government acts within the limits of the constitution. I find that the Legislature made a reasonable choice among many

alternatives to address a pressing and substantial legislative objective when it enacted Bill 7. Ontario has met the minimal impairment test.

[23] Finally, Bill 7 has an important social objective. This goal should not be lightly sacrificed. The evidence on this application satisfies me that Bill 7 addresses a pressing problem, and the benefits of Bill 7 significantly outweigh any of the supposed limitations on rights that it imposes.

[24] I dismiss the application in its entirety.

2. Standing to bring this application

[25] Not every person has standing to commence every imaginable application. The law of standing determines who may bring a case to court for determination. The Supreme Court of Canada explained:

The law of standing answers the question of who is entitled to bring a case to court for a decision. Of course it would be intolerable if everyone had standing to sue for everything, no matter how limited a personal stake they had in the matter. Limitations on standing are necessary in order to ensure that courts do not become hopelessly overburdened with marginal or redundant cases, to screen out the mere “busybody” litigant, to ensure that courts have the benefit of contending points of view of those most directly affected and to ensure that courts play their proper role within our democratic system of government¹

[26] Persons may commence litigation when they have pleaded facts that, if proven, would amount to a cause of action that would entitle them to a remedy. Where a person asserts that legislation interferes with their constitutional rights, courts readily recognize that such a person has standing to commence a proceeding to obtain a remedy. This case is not so simple.

A. The applicants do not have private interest standing

[27] The Coalition and the Advocacy Centre are the only applicants in this proceeding. They do not assert that the legislation infringes their own ss. 7 or 15 *Charter* rights. Instead, they assert that the legislative scheme interferes with the constitutional rights of other persons who are not parties to this proceeding. The fact that the Advocacy Centre represents persons directly affected by the challenged provisions does not mean that the Advocacy

¹ *Downtown Eastside Sex Workers United Against Violence Society v. Canada (Attorney General)*, 2012 SCC 45, [2012] 2 S.C.R. 524, at para. 1, citing *Finlay v. Canada (Minister of Finance)*, [1986] 2 S.C.R. 607, at p. 631.

Centre is itself directly affected by them.² I find that neither the Advocacy Centre nor the Coalition has common law or private interest standing to bring this application.

- [28] Courts use the law of standing to ensure that scarce judicial resources are allocated efficiently to real disputes that affect the interests of real parties. As the Supreme Court of Canada held, “it would be disastrous if the courts were allowed to become hopelessly overburdened as a result of the unnecessary proliferation of marginal or redundant suits brought by well-meaning organizations pursuing their own particular cases.”³
- [29] When I raised the standing issue with counsel for the applicants, they asserted that the applicants had public interest standing to bring this application. There is no reference to public interest standing in the applicants’ notice of application, evidence, or factum. Rule 14.05 creates a procedural mechanism by which parties may bring applications.⁴ Rule 14.05 does not create jurisdiction but assumes it.⁵ A party does not obtain standing simply by invoking rule 14.05.
- [30] Public interest standing is not a given. An applicant seeking public interest standing has the burden to prove that it is entitled to that standing, including that the court should exercise its discretion to grant public interest standing.⁶ Where a party intends to ask the court to grant public interest standing, it should clearly indicate that request in its notice of application or statement of claim and should provide evidence to support that request. This will allow a respondent to understand at an early stage the basis for the applicant’s request for standing, and to take a position on whether to oppose the request. However, even where a respondent does not take a position on an applicant’s request for public interest standing, an applicant should expect the court to raise the issue on its own.⁷

B. *The Advocacy Centre has legal capacity to seek standing but the Coalition does not*

- [31] The Advocacy Centre is a specialty legal clinic funded by Legal Aid Ontario pursuant to the *Legal Aid Services Act*.⁸ The Advocacy Centre provides legal advice and representation to seniors. As a community legal clinic, it must be structured as an independent corporation without share capital.⁹ During oral argument, counsel confirmed that the Advocacy Centre was a corporation. As a juridical person, the Advocacy Centre may seek public interest standing.

² *Campisi v. Ontario (Attorney General)*, 2018 ONCA 869, 144 O.R. (3d) 638, at para. 4.

³ *Canadian Council of Churches v. Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 236, at p. 252.

⁴ *Rules of Civil Procedure*, R.R.O. 1990, Reg 194, Rule 14.05,

⁵ *Grain Farmers of Ontario v. Ontario (Environment and Climate Change)*, 2016 ONCA 283, 130 O.R. (3d) 675, at para. 18; Paul M. Perell and John W. Morden, *The Law of Civil Procedure in Ontario* (5th ed., LexisNexis), at para. 5.273.

⁶ *Downtown Eastside Sex Workers*, at para. 37; *Ontario Place Protectors v. HMK in Right of Ontario*, 2024 ONSC 4194, at para. 15.

⁷ *Ontario Place Protectors*, at para. 15.

⁸ *Legal Aid Services Act, 2020*, S.O. 2020, c. 11, Sch. 15.

⁹ *Legal Aid Services Act*, s. 5(1).

[32] The Coalition, however, is “an unincorporated citizen-based coalition and non-governmental organization.” The Coalition described itself as follows in its notice of application:

8. OHC is an unincorporated citizen-based coalition and non-governmental organization, which represents more than 500 member organizations and a network of local health coalitions and individual members, which together include more than 750,000 Ontarians. OHC’s members include: seniors’ groups; patients’ organizations; trade unions; nurses and health professional organizations; physicians; physician organizations; non-profit community agencies; ethnic and cultural organizations; residents’ and family councils; retirees; poverty and equality-seeking groups; women’s organizations, and others.

9. The OHC is a non-partisan public interest group led by a Board of Directors that includes physicians, the Ontario Nurses’ Association, patient advocates, trade unions, academic experts in health policy, and leaders of community organizations all of whom share a commitment to preserving and strengthening the policies and programs of Canada’s publicly funded health care system committed to providing quality health care to all Canadians based on their needs, not their ability to pay.

10. OHC has a long history of public interest advocacy and engagement on matters of health care policy, programs and law with a key focus on the need to preserve and strengthen quality hospital and long-term care services for the people of Ontario, including for patients that are directly affected by Bill 7.¹⁰

[33] To have legal capacity to commence or continue this application, the Coalition must be a natural person, a corporation, or a body that has been given that capacity by statute.¹¹ The Coalition is none of those things. It is an unincorporated association, which has no legal status apart from its individual members and cannot sue or be sued as an entity absent legislation providing otherwise.¹²

[34] The Coalition is not in the same position as the Downtown Eastside Sex Workers United Against Violence Society, which is a registered British Columbia society whose objects included improving working conditions for sex workers.¹³ Equally, the Coalition is unlike

¹⁰ Emphasis added.

¹¹ *McNamara v. North Bay Psychiatric Hospital* (1994), 16 O.R. (3d) 633 (C.A.); *Jackson v. Toronto Police Association*, 2008 ONSC 68152, at para. 18; and *S. (J.R.) v. Glendinning* (2000), 191 D.L.R. (4th) 750 (Ont. S.C.J.).

¹² *Chmielewski v. Niagara (Regional Municipality) Police Services Board*, 2004 CanLII 4070 (ON SC), at paras. 12-14; *P. (E.D.L.) v. Children’s Aid Society of Metropolitan Toronto*, [1995] O.J. No. 3814, at paras. 14-17; and *McKinney v. Liberal Party of Canada et al.*, (1987), 61 O.R. (2d) 680 (Ont. S.C.).

¹³ *Canada (Attorney General) v. Downtown Eastside Sex Workers*, at para. 5.

the Canadian Council for Disabilities, which is a not-for-profit corporation organized under the *Canada Not-For-Profit Corporations Act*, S.C. 2009, c. 23.¹⁴ Unlike the Coalition, each of those other entities was a juridical person, capable of commencing litigation on its own behalf.

[35] The courts have applied the requirement of juridical personhood more flexibly where an unincorporated association wishes to participate as an intervener. For example, in *Layland*, Dubin C.J.O. granted leave to the Evangelical Fellowship of Canada to intervene as a friend of the court, even though it was not a legal person.¹⁵ Similarly, McMurtry C.J.O. granted leave to the Coalition of Liberal Rabbis for Same-Sex Marriage to intervene in *Halpern*.¹⁶

[36] However, in each of these cases, the court distinguished between permitting an unincorporated association to participate in a civil proceeding as an intervener and permitting an unincorporated association to commence a proceeding. Chief Justice Dubin noted that it was not as important whether the Evangelical Fellowship was a legal person, because it only sought to intervene in an otherwise properly constituted proceeding:

It was submitted that leave should not be granted because the applicant is not a person within the meaning of rule 13. The material disclosed that the applicant has been given leave to intervene in many other proceedings, and I do not give the word “person” in rule 13 the same importance as if the rights of the applicant were being determined.¹⁷

[37] Similarly, McMurtry C.J.O. commented that an objection to an unincorporated association participating as an intervener was an objection “more of form than substance,” when the association can make a useful contribution to the argument of the appeal as an intervener.¹⁸

[38] Here, the Coalition brings this application in its own name. It did not seek leave to intervene, either as a party or as a friend of the court. It did not seek a representation order. Having chosen to take the benefits of not incorporating, the Coalition must accept the corresponding burdens, which include not being able to commence litigation in its own name.

¹⁴ *British Columbia (Attorney General) v. Council of Canadians with Disabilities*, 2022 SCC 27, 62 B.C.L.R. (6th) 213, at para. 6.

¹⁵ *Layland v. Ontario (Minister of Consumer & Commercial Relations)* (1994), 1994 CarswellOnt 2941 (Ont. C.A.).

¹⁶ *Halpern v. Attorney General of Canada*, (2003), 37 R.F.L. (5th) 130 (Ont. C.A.)

¹⁷ *Layland*, at para. 2; see also rule 13.01(1) of the *Rules of Civil Procedure* which provides that: A person who is not a party to a proceeding may move for leave to intervene as an added party if the person claims,

(a) an interest in the subject matter of the proceeding;

(b) that the person may be adversely affected by a judgment in the proceeding; or

(c) that there exists between the person and one or more of the parties to the proceeding a question of law or fact in common with one or more of the questions in issue in the proceeding.

¹⁸ *Halpern*, at para. 7.

[39] In these circumstances, I do not grant the Coalition standing, either private or public interest, to advance this claim.

C. *Public interest standing for the Advocacy Centre*

[40] Public interest standing allows individuals or organizations to bring cases of public interest before the courts even though they are not directly involved in the matter and even though their own rights are not infringed.¹⁹ The decision whether to grant or deny public interest standing is discretionary. When exercising its discretion, the court must assess and weigh three factors:

- a. whether the case raises a serious justiciable issue;
- b. whether the party bringing the application has a genuine interest in the matter; and
- c. whether the proposed application is a reasonable and effective means of bringing the case to court.²⁰

[41] Each factor is to be weighed in light of the underlying purposes that justify limiting standing, and be applied in a flexible and generous manner that best serves the purposes of the following considerations:

- a. efficiently allocating scarce resources and screening out busybody litigants;
- b. ensuring that courts have the benefit of the contending points of view of those most directly affected by the issues; and
- c. ensuring that courts play their proper role within our democratic system of governance.²¹

[42] Courts must also consider the purposes that justify granting standing, which include:

- a. giving effect to the principle of legality; and
- b. ensuring access to the courts and access to justice.²²

[43] In each case, the goal is to strike a meaningful balance between the factors that favour granting public interest standing and those that favour limiting it.

[44] I have no doubt that this case raises a serious justiciable issue, and that the Advocacy Centre has a genuine interest in the matter. It is no busybody. My concern is whether this

¹⁹ *Council of Canadians with Disabilities*, at para. 2.

²⁰ *Council of Canadians with Disabilities*, at para. 28; *Downtown Eastside Sex Workers*, at para. 20.

²¹ *Council of Canadians with Disabilities*, at para. 29; *Downtown Eastside*, at para. 1.

²² *Council of Canadians with Disabilities*, at para. 30; *Downtown Eastside*, at paras. 20, 23, 36, 39-43, 49-50, and 76.

proceeding is a reasonable and effective means to bring this matter to the court. I must ensure that the court plays its proper role in our democratic system of governance.

- [45] The constitutionality of Bill 7 could have been challenged by persons directly affected by the legislation. Proceeding this way would allow the court to decide the constitutional questions against a concrete set of facts, rather than on a hypothetical basis or in a factual vacuum.²³
- [46] As noted above, the Advocacy Centre is a legal clinic founded to provide free legal representation to elderly people, including people affected by Bill 7. The Advocacy Centre filed affidavits from one of its clients, Gail Herrington, who deposed that Ms. Meadus of the Advocacy Centre was her lawyer and provided her with legal advice regarding the regulatory regime surrounding transitional care units and how waitlists for long-term care homes worked. The Advocacy Centre filed fact affidavits from two other people, Bonny Parkinson and Norah Chaloner, who do not state that they received legal advice from the Advocacy Centre.
- [47] The constitutional arguments advanced by the Advocacy Centre in this proceeding could have been marshalled in support of any person directly affected by Bill 7. The Advocacy Centre could then have played its natural role as counsel in a case involving its clients.
- [48] There was no evidence before me that there were any impediments to persons directly affected by Bill 7 acting as the applicant in this case. To the extent that the individuals in long-term care homes were parties under disability, the litigation guardian regime provided by Rule 7 of the *Rules of Civil Procedure* would have addressed that issue. There was no evidence from the Advocacy Centre that it would have been difficult to raise the constitutional issues in cases involving its clients. In my view, where a party seeks to obtain public interest standing, it should provide the court with evidence to demonstrate that the proposed application is a reasonable and effective way to bring the proceeding before the court.
- [49] As I have stated previously, in my view, courts should not grant public interest standing readily, especially to legal clinics who could mount the challenge as counsel for their clients.²⁴ Constitutional litigation is best advanced in a case brought by an individual who has been subject to the challenged statutory provisions.²⁵
- [50] As mentioned above, Ontario did not oppose the Advocacy Centre's request for public interest standing. Ontario was content to proceed with the factual record developed by the parties and to have these constitutional issues determined in this adversarial setting. The Attorney General of Ontario is the guardian of the public interest, even if it does not have a monopoly on that public interest.²⁶ Where the Attorney General of Ontario takes no issue

²³ *R. v. Banks*, 2007 ONCA 19, 84 O.R. (3d) 1 (C.A.), at para. 24; *Vriend v. Alberta*, [1998] 1 S.C.R. 493, at para. 199.

²⁴ *Fair Change v. His Majesty the King in Right of Ontario*, 2024 ONSC 1895, 170 O.R. (3d) 561, at para. 26.

²⁵ *Ontario (Attorney General) v. Bogaerts*, 2019 ONCA 876, 448 C.R.R. (2d) 1, at paras. 32-33.

²⁶ *Frank v. Canada (Attorney General)*, 2014 ONCA 485, 120 O.R. (3d) 732, at para. 18.

with the court granting public interest standing to an applicant in a constitutional case, that is a significant factor in favour of the court exercising its discretion to grant public interest standing to the applicant. The Attorney General's considered view satisfies me that the court will not be stepping outside of its proper role within our democratic system of governance by granting public interest standing to the Advocacy Centre.

[51] In addition, the parties put a significant amount of work into this case, which was heard over two days. While judicial economy is a good reason to be careful about granting public interest standing, this matter has now had a full hearing and there is little efficiency to be gained by not deciding the case. All these considerations also favour granting public interest standing.

[52] In all of the circumstances, I exercise my discretion to grant public interest standing to the Advocacy Centre.

3. The statutory and regulatory scheme prior to Bill 7

[53] The Advocacy Centre challenges the constitutionality of ss. 2, 3, and 9 of the *More Beds, Better Care Act, 2022*, S.O. 2022, c. 16, which amended a host of other statutes as well as and subsequently enacted regulations.²⁷ I will sometimes refer to this package of legislation and regulations as Bill 7.

[54] Before describing the changes resulting from the challenged provisions, it will be useful to explain several features of the statutory and regulatory regime that pre-dated Bill 7.

A. There is no statutory right to be admitted to or remain in a hospital unless that is clinically necessary

[55] In Ontario, there is no statutory right to be admitted or to remain admitted in a hospital unless a responsible clinician is of the professional opinion that it is clinically necessary for the person to be an in-patient at the hospital.

[56] Persons cannot check themselves into hospital simply because they want to be there. Hospitals are required to accept a person as in-patient if, and only if, that person has been admitted to the hospital pursuant to the regulations and the person requires the type of care for which the hospital is approved.²⁸ Moreover, the *Public Hospitals Act* expressly states that hospitals are not required to admit as an in-patient “any person who merely requires custodial care.”²⁹ No person shall be admitted to a hospital as a patient, except on the order

²⁷ The notice of constitutional question reads as follows: “The Applicants intend to question the constitutional validity of: sections 2, 3 and 9 of the *More Beds, Better Care Act, 2022*, S.O. 2022, c. 16, which amends the *Fixing Long-Term Care Act, 2021*, S.O. 2021, c. 39, Sched. I (*FLTCA*) and the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A (*HCCA*); section 2 of O. Reg. 484/22: *General*, enacted under the *FLTCA*; O. Reg. 485/22: *Hospital Management* and O. Reg. 486/22: *Hospital Management*, both enacted under the *Public Hospitals Act*, RSO 1990, c. P.40....”

²⁸ *Public Hospitals Act*, R.S.O. 1990, c. P.40, at s. 20.

²⁹ *Public Hospitals Act*, s. 21(b).

of a physician (or other designated person) holding privileges at the hospital who is of the opinion that it is clinically necessary that the person be admitted.³⁰

[57] Similarly, individuals cannot remain in hospital simply because they want to stay there. Only patients who continue to need treatment in the hospital are permitted to remain in hospital. If a person “is no longer in need of treatment in the hospital” the attending physician shall make an order that the patient be discharged and communicate that order to the patient.³¹ After that order is made, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order or up to 24 hours later, with permission.³²

B. *The designation of patients as ALC*

[58] Long before the enactment of Bill 7, the most responsible physician for a patient would designate patients as alternate level of care (“ALC”). This is an administrative label, not a medical diagnosis, but it is made by the most responsible physician. If the most responsible physician concluded that the patient was ready to be transferred from an acute care bed in a hospital to a different care setting (for example a rehabilitation centre, a hospice, or a long-term care home), the physician would designate that patient as “ALC.” Once a patient no longer needed the intensity of resources or services provided by a hospital, it was appropriate to discharge the patient to home or to a more appropriate facility.

[59] Prior to Bill 7, a patient would be designated ALC when the most responsible physician concluded that the physician would feel comfortable discharging the patient from acute care at this point in time. This designation could be revisited if a patient’s care needs changed; for example, if the patient became more ill and required further acute care. As I will explain, Bill 7 did not change this process.

[60] Designating a patient as ALC triggers an automatic referral to a provincial agency, which is discussed below.

[61] The evidence presented in this case demonstrates that most ALC patients are able to move to a new facility very quickly after designation. For example, the transfer to rehabilitation centres happens promptly after a patient is designated ALC for rehabilitation. Historically, this appears not to have been true for patients designated as ALC for long-term care homes. For a variety of reasons, notably a shortage of spaces in long-term care homes and a high level of demand for spaces in certain long-term care homes, some patients designated ALC for long-term care stayed in hospitals for many months after their discharge date.

C. *Managing the placement of ALC patients into long-term care homes*

[62] The province of Ontario has established an agency to manage the process of placing patients into long-term care homes. At various times, the agency has been known as

³⁰ *Hospital Management*, R.R.O. 1990, Reg. 965, at s. 11.

³¹ *Hospital Management*, R.R.O. 1990, Reg. 965, at s. 16(1).

³² *Hospital Management*, R.R.O. 1990, Reg. 965, at ss. 16 (2) and (3).

Ontario Health atHome, and before that, Home and Community Care Support Services. In addition to managing the placement of persons into long-term care homes, the agency coordinates in-home and community-based health services.

[63] The agency employs placement coordinators who are nested in each Ontario hospital. The placement coordinator determines the most appropriate discharge destination for a patient to be discharged. If a patient is a candidate for admission to a long-term care home, the placement coordinator has the responsibility to assess the patient's eligibility. Pursuant to s. 50 of the *Fixing Long-Term Care Act*, the placement coordinator is required to obtain certain information in order to assess whether or not a person is eligible for admission to a long-term care home. Pursuant to s. 50(4), this information includes:

1. An assessment of the applicant's physical and mental health, and the applicant's requirements for medical treatment and health care.
2. An assessment of the applicant's,
 - i. functional capacity,
 - ii. requirements for personal care,
 - iii. current behaviour, and
 - iv. behaviour during the year preceding the assessment.³³

[64] Where a placement coordinator determines that an ALC patient is eligible for admission to a long-term care home, the placement coordinator will facilitate and oversee the application process. Placement coordinators work with the patient, and where applicable, the patient's substitute decision-maker and family members, to inform them about the application process.³⁴ The regulations under the *Fixing Long-Term Care Act* require the placement coordinator to provide certain information to persons who wish to seek admission to a long-term care home, including:

- a. alternative services the patient may wish to consider;
- b. a resident's responsibility to pay charges for accommodation in a long-term care home and the maximum rates that can be charged;
- c. how to apply for a reduction in the charge for basic accommodation;

³³ *Fixing Long-Term Care Act, 2021*, S.O. 2021, c. 39, Sched. 1, at s. 50 (additional criteria for admission are set out in the regulations under that *Act*, see O. Reg. 246/22, s. 172).

³⁴ Given the frailty of many patients, substitute decision-makers play a vital role for patients who are not capable of consenting to medical treatment or deciding among long-term care home options. This reality is made plain in some of the affidavits filed by the Advocacy Centre on this motion. To improve readability, I will generally refer only to patients and not to "patients or their substitute decision-makers."

- d. the length of waitlists and approximate times to admission for long-term care homes;
- e. vacancies in long-term care homes; and
- f. how to obtain further information about long-term care homes.³⁵

[65] When a patient applies to a long-term care home, the placement coordinator will provide that home with current and relevant information and assessments. The decision to admit the patient lies solely with the long-term care home. Under the *Fixing Long-Term Care Act*, a long-term care home is required to approve an application for admission, unless the home lacks the physical facilities or nursing expertise necessary to meet the patient’s care requirements.³⁶ If the long-term care home approves the application, the patient is either immediately offered a bed or placed on the waitlist. The patient has 24 hours to decide whether to accept the offer and is expected to move in within five days.³⁷

[66] Prior to Bill 7, some Ontario hospitals already had *ad hoc* policies requiring ALC patients to apply to long-term care homes with short waiting lists or requiring those who had been accepted into a long-term care home but refused to leave the hospital to pay a fee that represented a contribution to the cost of their care. For example, the Windsor Regional Hospital charged a daily fee of \$600.

4. Bill 7 and consequential regulatory changes

[67] On August 18, 2022, the Hon. P. Calandra, Minister of Long-Term Care for the province of Ontario, introduced Bill 7: An Act to amend the *Fixing Long-Term Care Act, 2021* with respect to patients requiring an alternate level of care and other matters and to make a consequential amendment to the *Health Care Consent Act, 1996*. Bill 7 received Royal Assent on August 31, 2022, and is known as the *More Beds, Better Care Act, 2022*.³⁸ A series of corresponding changes to regulations followed. Bill 7 amends the prior statutory and regulatory scheme in several important ways.

[68] Bill 7 adds s. 60.1 to the *Fixing Long-Term Care Act, 2021*, which applies only to a person who occupies a bed under the *Public Hospitals Act* and 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.³⁹

³⁵ *General*, O. Reg. 246/22, at s. 171.

³⁶ *Fixing Long-Term Care Act, 2021*, at s. 51(7).

³⁷ *General*, O. Reg. 246/22, at s. 203.

³⁸ *More Beds, Better Care Act, 2022*, S.O. 2022, c. 16.

³⁹ In this context, “clinician” means a person who is authorized under the *Public Hospitals Act* to issue a discharge order for the ALC patient. Bill 7, at s. 2, adding s. 60.1 to the *Fixing Long-Term Care Act*.

- [69] I pause here to emphasize that these amendments do not change the prior practice and the most responsible physician is still the one who designates a patient as ALC. There is no evidence in the record to suggest otherwise.
- [70] At this point, in an ideal world, the ALC patient will consent to be assessed for eligibility for admission to a long-term care home and apply to several long-term care homes, including those with shorter waitlists.
- [71] If the ALC patient does not consent to be assessed or to apply to any long-term care homes at all or will apply only to long-term care homes with very long waitlists, s. 60.1 permits certain actions to be taken without the consent of the ALC patient. These steps can be taken only if reasonable efforts to obtain the appropriate consent have failed.⁴⁰ If the ALC patient provides consent, then the provisions of s. 60.1 no longer apply.⁴¹ If the patient does not consent, the following powers under s. 60.1 may be used:
- a. pursuant to s. 60.1(3)1, where an attending physician believes that an ALC patient may be eligible for admission to a long-term care home, the physician can request the placement coordinator to carry out certain actions; or
 - b. pursuant to s. 60.1(3)2, a placement coordinator may take certain steps, “with or without a request from an attending clinician.”
- [72] I pause to address the Advocacy Centre’s submission that this provision authorizes placement coordinators to determine that patients are eligible for admission to a long-term care home without an attending physician first determining that the person may be eligible for admission. I do not accept this submission. The placement coordinator’s powers can only be exercised in accordance with the “procedures, requirements, criteria, restrictions and conditions...set out in the regulations.”⁴² Subsection 240.1(5) of the applicable regulations restricts the placement coordinator’s ability to exercise the powers in s. 60.1(3)2 to situations where they receive a request from an attending clinician, or where a patient has already been determined eligible for long-term care and the question is merely whether additional homes should be added to the list.⁴³ What seems to be an unbounded discretion for the placement coordinator on the face of the *Fixing Long-Term Care Act*, is significantly and properly constrained by the regulations. The exercise of medical clinical judgment remains at the heart of the new regime.
- [73] There is no evidence in the record to suggest that anyone at a hospital has ever interpreted the provisions in the manner suggested by the Advocacy Centre. Indeed, the evidence is to the contrary. Ms. Iafrate, director of placement services for the part of the agency that covered York Region, South Simcoe County, North York, and parts of Etobicoke, testified that the program coordinator could not exercise the powers on their own because of the

⁴⁰ *Fixing Long-Term Care Act*, at s. 60.1(4).

⁴¹ *Fixing Long-Term Care Act*, at s. 60.1(6).

⁴² *Fixing Long-Term Care Act*, at s. 60.1(5).

⁴³ *General*, O. Reg. 246/22, at s. 240.1(5).

regulations and that this was consistent with the guidance documents describing the placement process.

[74] I conclude that placement coordinators may not do any of the things listed in paragraph 60.1(3)2 without a request from an attending clinician or where a patient has already been determined eligible for long-term care.

[75] To recap, if the attending physician believes that an ALC patient may be eligible for admission to a long-term care home, if the patient does not consent to be assessed or to apply to any long-term care homes, or if the patient will only apply to long-term care homes with very long waitlists, the attending physician may request that the placement co-ordinator do any of the following:

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.⁴⁴

[76] For a potential long-term care home to assess whether it will be able to care for a patient, it must receive information about the patient. To overcome the impediment of a patient refusing to consent to assessments for this purpose, the Bill 7 amendments permit certain persons to conduct assessments of the patient without that patient's consent.⁴⁵ This assessment shall be based solely on a review of existing hospital records relating to that patient.⁴⁶ Nothing in Bill 7 permits a physician or anyone else to examine physically, touch, examine, or test a patient without their consent.

[77] The placement co-ordinator will then send the applications, information, and assessment to the long-term care homes, including those (if any) selected by the patient. The

⁴⁴ Bill 7, at s. 2, adding s. 60.1(3)(2) to the *Fixing Long-Term Care Act*.

⁴⁵ *Fixing Long-Term Care Act*, at s. 60.1(3)3.

⁴⁶ *General*, O. Reg. 246/22, at ss. 240.1(6) to (9)

amendments allow persons to collect, use, and disclose personal health information, if it is necessary to carry out these actions.

- [78] Under the amendments to the *Fixing Long-Term Care Act*, the long-term care home has five days to assess the application and determine if they can safely care for the patient. If so, the long-term care home must accept the patient either directly for admission or to a waitlist.
- [79] Once the patient's admission to a long-term care home has been authorized, and an offer of a bed is made, the patient will be discharged from the hospital. A regulation under the *Public Hospitals Act* provides that discharged patients who do not leave the hospital within 24 hours shall be charged a fee of \$400 per day for every day that the patient remains in the hospital thereafter.⁴⁷
- [80] The amendments do not authorize anyone to restrain an ALC patient or to transfer an ALC patient to a long-term care home without that patient's consent.

5. The evidence on this application

- [81] The Advocacy Centre filed evidence from five fact affiants and five experts. Ontario filed evidence from four fact affiants and three experts.

A. The Advocacy Centre's fact evidence

- [82] Three of the Advocacy Centre's affiants, Norah Chaloner, Gail Herrington, and Bonny Parkinson, describe their own experiences with their family members obtaining long-term care after the passage of Bill 7. Two of the affiants, Jane Meadus and Natalie Mehra, are staff people at the Advocacy Centre and the Coalition, respectively.

(1) Norah and Richard Chaloner

- [83] Norah Chaloner is 83 years old. She affirmed an affidavit with respect to the experiences that she and her husband, Richard, had with the health care system. In November 2021, Norah and Richard applied for admission to three local long-term care homes in the Guelph area because Richard was suffering from creeping dementia and they anticipated that Richard would require more support than Norah could provide at home, even with support from the agency. Each of the three long-term care homes to which they applied had significant waitlists.
- [84] Unfortunately, Richard had a stroke on October 10, 2022, and was admitted to Guelph General Hospital. On October 17, 2022, he was transferred to St. Joseph's Health Centre for rehabilitation. Richard was not able to regain the use of his legs, which meant that Norah could not manage his care at home. At some point, Norah became Richard's substitute decision-maker.

⁴⁷ *Hospital Management*, at s. 16.

- [85] In November 2022, Jennifer Sinoulis, the placement coordinator for the agency at St. Joseph's Health Centre, contacted Norah and advised that Richard required an alternate level of care. Ms. Sinoulis suggested that Richard be transferred to a long-term care home with a shorter waitlist than the three homes that Norah had previously selected. Norah did not consider the suggested homes to be suitable and declined to apply to have Richard transferred to them. Instead, with the help of her sons, Norah began to search for other options. Ms. Sinoulis suggested considering homes outside of Guelph, including three homes in Mount Forest, which were 67 kilometers away. Norah did not find these homes suitable, because she could only drive short distances due to her macular degeneration. Norah's son located another home, called Hilltop Manor, which had an available bed, but was 35 kilometers from Guelph. Norah stated that she was contacted regularly by Ms. Sinoulis regarding her progress and was warned that Richard would be charged \$400 per day if he was not moved to a home that could accept Richard.
- [86] On November 10 and 11, 2022, Norah, Richard, and her son, met with Ms. Sinoulis to fill out the application for Richard's admission to a long-term care home. Norah selected the three homes with the long waitlists that they previously selected, the long-term care facility at St. Joseph's (which also had a waitlist), and Hilltop Manor. Norah specified that she was not consenting to applying to Hilltop Manor. On November 21, 2022, Richard was admitted to Hilltop Manor. He was transported there the next day and he continues to live there.
- [87] Norah explained that she visits Richard almost every day for two to three hours in the afternoon. She must either hire someone to drive her or rely on the goodwill of neighbours, as there is no available public transit to get her from Guelph to Hilltop Manor. She would rather have extended visits with Richard but believes that is not possible. She explained the importance of visiting Richard regularly as follows:

I visit Richard almost everyday, and believe the visits are essential to his well-being and quality of life. Richard's advancing dementia has all but completely robbed him of his situational awareness and short-term memory. This explains why most of the time Richard believes he and I are still residing at home together. Because he no longer has the use of legs, he is very dependent on assistance for most of his basic care needs, and typically calls out to me for help because he imagines that I am just in a neighbouring room. I have often been informed by staff at the long-term care home that because Richard suffers from acute anxiety, his shouting and calling for me can become incessant, and very loud. When this happens in the middle of night he is sedated, but such events can also happen during the day and I may find him too sedated when I arrive for a much of a visit. Staff also tell me that when I am able to keep up a regular schedule (uninterrupted by storms or COVID) and have longer visits, the result has a calming effect on Richard that can linger for some time.

[88] Norah stated that she has called the agency for updates regarding when Richard will be transferred to one of her preferred long-term care homes in Guelph but has received no assurances that this will happen or when it might happen. Norah concluded as follows:

Having so few publicly supported care homes and care staff has its costs. And that cost is born by those most in need of care. This is a sad situation for our province.

[89] Ontario did not cross-examine Norah on her affidavit.

(2) Gail Herrington and Rick Pinto

[90] Gail Herrington is 66 years old. She swore an affidavit about the experiences she and her husband, Rick Pinto, had with the health care system.

[91] Rick was unable to work and had mobility limitations due to a workplace accident. In 2018, he suffered a stroke. He fell at home on January 23, 2023, and was admitted to Ajax-Pickering Hospital. He stayed in the emergency department for three days before he underwent surgery for a hip replacement. Following the surgery, he was prescribed heavy painkillers and developed delirium and an infection at the site of his incision. Gail believed that Rick was not getting enough food or physiotherapy treatment in the hospital and that he was not moving around enough.

[92] On February 14, 2023, Gail met with Stephanie Topolnisky, the agency placement coordinator, Rayna Bryce, a hospital social worker, and some hospital staff. Gail learned that she would not be able to take Rick home and that they would have to apply to long-term care homes that included at least two homes with wait times of six months or less. On March 15, 2023, Ms. Bryce advised Gail that she would have to submit Rick's application for long-term care by March 22, 2023, and that two of the choices had to be long-term care homes with a wait time of less than one year. Gail stated that she was later advised that she could only apply to long-term care homes with a short waitlist.

[93] On March 15, 2023, the hospital advised Gail that Rick would be moving into a post-acute care bed at the Whitby Hospital the next day. At some point, Rick was found to be incapable for making placement decisions.

[94] On March 20, 2023, Rick was declared to be eligible for an alternate level of care and eligible for admission to a long-term care home. On March 22, 2023, Gail submitted her preference sheet that listed two long-term care homes with short waitlists as the first two preferences. Gail believes that the agency did not provide her with complete or accurate information to allow her to make decisions in Rick's best interests.

[95] On April 1, 2023, Gail became concerned about Rick's distended stomach. On April 6, 2024, Rick was taken from Whitby Hospital back to the Ajax-Pickering Hospital emergency department. He was in critical condition. It took the hospital several hours to stabilize Rick so that he could be transferred to the intensive care unit. Unfortunately, Rick died on April 7, 2024. The coroner's investigation statement said that Rick had ascites and

gastrointestinal bleeding, as well as cirrhosis of the liver. The report indicates that Rick died of sepsis related to an infection from either his catheter, his ascites, or pneumonia.

[96] In her affidavit, Gail eloquently stated many concerns she had with the care that Rick received at Ajax Pickering Hospital and Whitby Hospital. Among other concerns, she believes that Rick did not receive sufficient food, physiotherapy, rehabilitation, mobility therapy, and nursing care. She also has concerns regarding whether certain co-payments charged by the hospital were permissible in the circumstances of Rick's case. While I do not want to minimize her concerns, Gail's evidence criticizing the care Rick received at the hospitals is not relevant to the constitutionality of the statutory scheme at issue in this case.

[97] Ontario did not cross-examine Gail on her affidavit.

(3) Bonny Parkinson and Donna Smith

[98] Bonny Parkinson affirmed an affidavit about her experiences obtaining long-term care for her 94-year-old mother, Donna Smith. Bonny is the substitute decision-maker holding power of attorney for personal care for Donna.

[99] On December 9, 2020, Donna moved into a retirement home in Waterloo. On November 1, 2022, she was admitted to St. Mary's General Hospital in Kitchener with congestive heart failure.

[100] In mid-November 2022, Priscilla Schill, the agency placement coordinator, spoke to Bonny by telephone about Donna's care. Ms. Schill indicated that Donna could be discharged to Bonny's care in the community. However, Bonny felt that she was not capable of providing the necessary level of care to her mother and no medical professional had recommended at-home care to her. The other alternative was to apply for Donna to be admitted to a long-term care home. Ms. Schill stated that Donna could list as many homes as she wanted on the application but that she would have to include at least one long-term care home with a short waitlist. Ms. Schill advised that Donna would be charged \$400 per day to remain in hospital, if Bonny did not include at least one long-term care home with a short waitlist.

[101] On November 15 and 16, 2022, Ms. Schill provided Bonny with the names of a number of homes with short waitlists. Bonny indicated that homes in the Waterloo region would be preferable due to her location and the location of Donna's medical appointments. Ms. Schill then provided Bonny with the name of six homes in the Waterloo region. Bonny discussed these options with a friend who recommended that Bonny not agree to these homes because of their track record, particularly during the COVID pandemic. Bonny then asked for and received a list of homes in the Guelph area with short waitlists.

[102] On November 23, 2022, Bonny submitted Donna's application for long-term care. She listed two care homes that she preferred and very reluctantly selected a long-term care home in Fergus, which had a short waitlist, as the third option. Bonny understood that there were waitlists of between 200 and 435 people ahead of Donna at her preferred long-term care homes.

- [103] On December 21, 2022, Ms. Schill advised Bonny that Donna would be transferred to St. Joseph's Health Care in Guelph for transitional care. Bonny was pleased with the care Donna received at St. Joseph's and submitted a revised application on December 23, 2022, which moved St. Joseph's to the top of her list and continued to rank the long-term care home in Fergus as the last choice.
- [104] On December 27, 2022, Bonny was advised that the Fergus home had accepted Donna and that she would be moved there in January. However, due to an illness outbreak at Fergus, that move was delayed. In addition, Donna developed an infection that required her to remain at St. Joseph's to receive more care than could be provided at the long-term care home in Fergus. Eventually, Donna was transferred to Fergus on March 17, 2023.
- [105] Bonny described several reasons why she would prefer Donna to be residing in a different long-term care home:

22. My mother has a small private room in Caressant Care Fergus. Because of an overhang on the building it is always dark in her room. The walls are cinderblock which does not give it a welcoming or "homey" look, through [sic] we have tried as much as we can to make her room nice. There is general wear and tear throughout the building. In common areas and the elevator, there are gouges out of the walls and painting needed to be done. The dirt that was in the corners of the elevators the day I brought her there is still there.

23. The facility is also lacking parking, particularly in the winter. I need to park in the disabled parking space and have been blocked in by others parking in front of my car, for lack of space.

24. The staff at the long-term care home are well-meaning, but clearly under-resourced. There is very little in the way of programming or resources. There is no family council at Caressant Care Fergus. The physical therapist only comes in two part-time days a week, while at St. Joseph's they have a variety of physical therapists there all the time.

- [106] Bonny also noted that the long-term care home in Fergus has a number of written notices, voluntary plans of correction, compliance orders, and director's referrals.
- [107] Ontario did not cross-examine Bonny on her affidavit.

(4) Jane Meadus

- [108] Jane Meadus is a lawyer who has worked at the Advocacy Centre since 1995. In her affidavit, she described the structure and role of the Advocacy Centre and its history of involvement with issues related to long-term care in Ontario.

[109] Her affidavit describes the place of long-term care homes in Ontario’s health care system and the process of discharge from hospital to long-term care homes. In her affidavit, she described her perspective on the placement process that was in place prior to Bill 7, the impact of COVID-19 on Ontario long-term care homes, the *Fixing Long-Term Care Act*, the inspection of long-term care homes, the role and capacity of the Ontario long-term care system, and Bill 7. Ms. Meadus summarized her affidavit as follows:

In sum:

137. At one of the most difficult times in the applicant’s and their family’s lives, which is the possibility of being admitted into a long-term care home, applicants, their substitute decision-makers and families have often been coerced by various unethical and even unlawful means to accept placements in long-term care homes that are unsuitable, or unable to meet their needs.

138. The amendments to the FLTCA contained in Bill 7, along with the regulatory changes, mean that ALC patients are now faced with similar same unethical practices that have now been given the imprimatur of Parliament.

[110] Much of the affidavit contains Ms. Meadus’s opinion on domestic law and would more appropriately be included in the applicant’s factum as legal argument. I give her evidence on such matters no weight. In other parts of her affidavit, Ms. Meadus provides her opinion on how long-term care homes operate or could be improved. Some parts of her affidavit, however, are based on the unattributed hearsay evidence of her unnamed clients. Few, if any, specific examples are offered. I also find Ms. Meadus’s affidavit to be overly partisan. It is difficult to put any weight on its contents. I find the affidavit to be of little assistance to me on this application.

(5) Natalie Mehra

[111] Natalie Mehra is the Executive Director of the Coalition, a position she has held since September 2020. Although I did not grant the Coalition standing to advance this application, the Advocacy Centre may still rely on the affidavit of Ms. Mehra.

[112] With respect, Ms. Mehra’s affidavit makes clear the political nature of this application and how the arguments that lie at its heart are policy-based and not constitutional in nature. The affidavit explains that the Coalition has “worked with communities since the mid-1990s to stop hospital cuts and closures and retain and improve services.” The affidavit notes that, despite the Coalition’s successes, “the trajectory of downsizing hospitals has not been reversed.” The Coalition has published documents concluding that:

Ontario had cut more hospital beds and staff than most OECD countries, and trailed other Canadian jurisdictions in public hospital funding;

the resulting hospital bed shortage and serious overcrowding was compromising patient and staff safety; and

there was an urgent for Ontario to reopen hospital beds and restore capacity to safe levels.

[113] In her affidavit, Ms. Mehra summarized the Coalition's primary submission as follows:

It is the Coalition's contention that this hollowing out of Ontario hospital capacity is a primary cause of the acute care bed shortage that Bill 7 has ostensibly been enacted to address, but that it will do little if anything to address the problem because:

- 1) a significant proportion of ALC patients are waiting for another level of hospital care (complex continuing care, rehabilitation, palliative care or other), or
- 2) patients in ALC beds are discharged to long-term care but are too complex to be accepted for admission to long-term care homes, and
- 3) the acute shortage of long-term care home beds means there are not enough beds for the hospital crisis admissions and people waiting in the community for long-term care, meaning that ALC beds continue to fill up with people in need of care that they cannot access in long-term care.

[114] Ms. Mehra also outlined the Coalition's advocacy around long-term care issues and the COVID pandemic. She stated that it is the Coalition's position that "the Government has done very little to implement the recommendations of the [Ontario Long-Term Care COVID-19] Commission," including:

by failing to reinstate unannounced annual comprehensive inspections of every long-term care home, notwithstanding a promise by the Premier to do so;

by failing to establish a minimum care standard, but instead only a "target" of 4 hours of daily hands on care by 2025. Every target to date has been missed and staffing continues to be in crisis;

by failing to establish promised accountability measures, including fines, revocation of licenses, and criminal charges;

by allocating the majority of the new bed approvals to for-profit corporations, the majority of which are large chain companies, including those with the worst death rates during in the pandemic and terrible records of care over many years;

[115] Ms. Mehra concluded her affidavit by criticizing the process adopted by the government in passing Bill 7. Ms. Mehra stated that she sees this litigation as a substitute for the legislative committee hearings that were not held:

27. The Coalition regards Bill 7, the More Beds, Better Care Act as embodying and perpetuating this very pattern of systemic discrimination against a large group of elderly and often very ill hospital patients to deprive them of timely health care and treatment, a point the Coalition would have vigorously made and documented had the Government consulted with the public or held legislative hearings before the Bill was enacted. It [*sic*] our contention that Bill 7 will not only do nothing to create hospital or long-term care beds but will in fact have the perverse consequence of actually depriving many hospital patients of needed treatment and care, and will increase their suffering and hasten the [*sic*] deaths. The Coalition regards Bill 7 as scapegoating a cohort of the most vulnerable residents of Ontario while sidestepping the Government's responsibility for the chronic shortages in both hospital and long-term care for people who desperately need it.

28. Having been denied any opportunity to dissuade this Government from proceeding with such an extraordinary and cruel denial of fundamental rights to consent and needed care for the elderly nearly the end of their lives, the Coalition has joined with the Advocacy Centre of the Elderly as a co-applicant in these proceedings.

[116] With respect, the Coalition's unhappiness with not having the opportunity to make submissions to a legislative committee is not the basis of a sound constitutional challenge.

[117] The Coalition disagrees with Ontario's health care policies. The Coalition believes that spending on health care, including long-term health care, should be increased. The Coalition has made a series of recommendations to improve the delivery of health care in the province. The Coalition wanted the government to adopt its policy preferences instead of passing Bill 7. It is not the role of the court to express a view on this policy debate.

[118] The Coalition's policy preferences do not assist me to determine a constitutional challenge to legislation enacted by the Legislature.

B. The Advocacy Centre's expert evidence

[119] The Advocacy Centre filed five expert affidavits.

(1) Dr. Pat Armstrong

[120] Dr. Pat Armstrong is a sociologist and a distinguished research professor emeritus at York University. She was called as an expert witness and swore an affidavit dated March 13, 2023, which addressed the following topics:

- a. The change in health care services that long-term care homes are required to provide, how those changes correspond to the needs of patients in long-term care homes, and how Bill 7 may affect the ability of these homes to meet these needs.
- b. Whether Ontario's long-term care sector has the capacity to meet the needs of those seeking care in a long-term care home.
- c. The variation, if any, in the care provided by long-term care homes in Ontario, recognizing that they are all subject to the same legislation and regulatory regime, and any variability in the care provided by Ontario long-term care homes.
- d. Whether the variation in the level of care affects the ability of long-term care homes to ensure the health and safety of their residents.
- e. The preferences of those seeking admission to long-term care, the reasons for these preferences, and how these affect the waitlists for Ontario long-term care homes.

[121] Although Dr. Armstrong has an impressive list of publications, including many about health care, her peer-reviewed work cited in her affidavit does not examine the designation of ALC patients, the process of transferring those patients to long-term care homes, or Bill 7 and how it has affected the health care system.

[122] As I will explain below, I place little weight on Dr. Armstrong's evidence. Her affidavit is partisan. For example, Dr. Armstrong stated that in her opinion, "Bill 7 ignores the Government's failure to provide sufficient access to care and appropriate care staff to accommodate the increasingly complex needs of [long-term care home] residents."

[123] Dr. Armstrong also provided her opinion on matters that are not relevant to the constitutionality of the legislation. For example, she observed that "a 2021 poll indicates that nearly 75 per cent of Canadians would prefer to live in a not-for-profit [long-term care] home, while nearly 60 per [cent] of the homes are for-profit." While it is clear that Dr. Armstrong and the Coalition oppose what they see as for-profit health care, and that this appears to motivate (at least to some degree) their challenge to Bill 7, it is difficult to see the constitutional significance of this opinion.

[124] Dr. Armstrong frequently offered her opinion on domestic law, including how the statute and regulations at issue should be interpreted. Those opinions are inadmissible. Expert opinions are inadmissible when they are nothing more than the reworking of the argument of counsel participating in the case.⁴⁸ For example, Dr. Armstrong opined as follows:

31. Inspection reports, when inspections are done, also indicate a difference in the quality and nature of the care provided across the homes, regardless of ownership. Long-term care homes also differ

⁴⁸ *International Air Transport Association v. Canada (Transportation Agency)*, 2024 SCC 30, at para. 78; *Surrey Credit Union v. Willson* (1990), 45 B.C.L.R. (2d) 310 (S.C.).

in their location, connections to community, staff skills, services provided and physical structures.

32. Bill 7 ignores these differences by pressuring ALC patients to move to a home they have not willingly chosen and that may not be suitable for them, or even capable of providing appropriate care for them. In allowing actions “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,” Bill 7 ignores the fundamental right to consent. Charging \$400 a day, instead of the \$62.18 previously charged for hospital patients defined as ALC patients, is another form of coercion. Bill 7 also ignores the significant differences among care homes in terms of staffing, quality, services, physical structures and location that contribute to patients rejecting some homes and preferring others. Given that waiting lists are shortest in for-profit homes, under Bill 7 most patients are likely to end up in homes with the lowest staffing levels, the lowest quality of care and the most crowded facilities.

[125] Dr. Armstrong concluded her opinion as follows:

40. In my opinion, Bill 7 ignores the Government's failure to provide sufficient access to care and appropriate care staff to accommodate the increasingly complex needs of residents. At one time, that care was provided in extended care or other hospital settings, and the need to restore at least some of this capacity is evident, not least because such hospital care must conform with the requirements of the *Canada Health Act* while long-term care does not. Bill 7 simply ignores the fact that many homes do not have the resources or services to address continuing complex needs. It allows people in hospital to be moved to very few spaces available regardless of whether the resources and services can accommodate their needs. By doing so the “More beds, Better Care Act,” which in my opinion will provide neither, will only exacerbate the serious challenges that both the hospital and long-term care sectors now have in meeting the needs of an aging population that is no longer able to be cared for in the community or at home.

[126] I have no doubt that Dr. Armstrong sincerely believes the opinions she expressed in her affidavit. Her opinion makes a meaningful contribution to the rich policy debate surrounding health care in Ontario but is of limited assistance to me in determining the constitutional issues raised on this application.

(2) Dr. Amit Arya

- [127] Dr. Amit Arya is a palliative care physician who works in acute care hospitals, outpatient clinics, long-term care, and home care. Dr. Arya is the palliative care lead at Kensington Gardens long-term care home in Toronto and is a palliative care physician at the Freeman Centre for the Advancement of Palliative Care at North York General Hospital. Dr. Arya was called as an expert witness and swore affidavits dated March 23, 2023, and April 2, 2024. Dr. Arya's first affidavit addressed three topics.
- [128] First, Dr. Arya was asked to address the clinical characteristics and service needs of hospital patients who become designated as ALC, in particular those waiting in hospital for admission to a long-term care home, and the capacity of the current health care system, from home to institutional care, to meet their needs.
- [129] In paragraphs 5 to 24 of his affidavit, Dr. Arya explained that many of the ALC patients he sees are elderly and are living with a moderately advanced or advanced life-limiting illness that is incurable and progressive. These patients do not require immediate acute care, but a significant number of them are in the last 90 days of life. In Dr. Arya's opinion, many of these patients would benefit from palliative care even before their last 90 days of life.
- [130] Dr. Arya is of the opinion that long-term care homes require additional funding to provide recommended levels of direct hands-on care per day. This funding shortfall creates a gap in care that is filled by unpaid caregivers, usually family members. For this reason, Dr. Arya opined that proximity to family and community, along with language, religious, and cultural considerations, is often a key factor when someone chooses a long-term care home and that family caregivers provide critical assistance to aid a patient's transition to long-term care.
- [131] Dr. Arya stated that public funding for the system "falls far short of what is required to properly and safely care for a resident population of ever-increasing acuity and complexity." He offered the opinion that "there is no doubt that the quality of resident care varies considerably across Ontario, and that the reputation of certain homes for providing higher quality care accounts for the very long waitlists of those waiting to be admitted to such homes." This wide variation in care includes the provision of end-of-life care.
- [132] Second, Dr. Arya was asked to address how Bill 7 will, or is likely to, affect the health and well-being of ALC patients and their ability to access the health services and institutional care they require. To the extent that Dr. Arya offered his opinion on domestic law, I give his opinion no weight.
- [133] In paragraphs 25 to 39, Dr. Arya provided his opinion on Bill 7. Dr. Arya opined that "Bill 7 fundamentally undermines the right of ALC patients or their substitute decision-makers to provide informed consent to medical treatment" because of Bill 7's "coercive effects." Although Dr. Arya does not act as a most responsible physician for hospital in-patients, and is not responsible for writing orders discharging hospital in-patients as needing an alternate level of care, Dr. Arya offered his opinion that such doctors may face an ethical dilemma of informing their patients of the best options for long-term care homes, as well

as homes “which may be suboptimal.” Dr. Arya provided his opinion that Bill 7 undermines the hard work that he and other front-line workers do to help their patients and families make good decisions.

[134] Dr. Arya stated that Bill 7 may result in patients ending up in long-term care homes with shorter waitlists that may not be close to friends and family, where they may face language barriers, and may “share little in common with other residents in terms of their cultural or religious values.” In addition, Dr. Arya provided his opinion that there is an increased risk of re-hospitalization in order to provide palliative or end-of-life care, although he noted that transfer back to hospital is common for long-term care home residents at end of life.

[135] Third, Dr. Arya was asked to address the measures that could be implemented to better meet the health care needs of this patient cohort, and the effects of such initiatives on the capacity of hospitals to meet the needs of the communities they serve. In paragraphs 40 to 50 of Dr. Arya’s affidavit, he set out his preferred policy choices to help acute care hospitals. These include:

- a. increasing funding to home care, including home palliative care, which should include “providing front-line health care workers with fair wages and benefits and reducing wage disparities between health workers in acute care and those in home care” including that “health workers in the home care sector...be compensated fairly to travel between homes.”
- b. increasing the number of hospice beds and increasing the per bed funding for hospices;
- c. improving care, including palliative care for those living in long-term care homes by, among other things, ensuring appropriate training and educational standards of front-line health workers.

[136] Dr. Arya’s second affidavit referred to two peer-reviewed articles and one report that were relevant to the views expressed in his first affidavit. Dr. Arya elaborated on the policy preferences expressed in his second affidavit as follows:

8. As I have outlined in this responding affidavit, further investments in non-hospital palliative care options (e.g. in homecare and long-term care) will help to reduce hospitalizations, as well as prevent some of them in the first place. As originally outlined in my previous affidavit dated March 23rd, 2023, these investments would represent a far more humane and effective solution to the ALC crisis, compared to Bill 7.

[137] While I accept that Dr. Arya sincerely holds these views, his policy preferences are of limited assistance to me in determining whether the constitution prevents the Legislature from enacting Bill 7.

(3) Dr. George Heckman

- [138] Dr. George Heckman is a geriatric medicine consultant at both Grand River and St. Mary's General Hospitals in Kitchener. He supports a primary care-based shared care geriatric practice in a family health team, is the medical director in a Waterloo retirement home, and is a consultant in a Waterloo long-term care home. Dr. Heckman was called as an expert witness and swore an affidavit dated March 3, 2023. Dr. Heckman's affidavit addressed five topics.
- [139] First, Dr. Heckman was asked to describe the characteristics of older patients, including those who are designated as ALC, and how they are often affected by admission to hospital. He opined that such patients typically have multiple chronic diseases, geriatric symptoms, frailty, and delirium. Dr. Heckman stated that delirium commonly develops in older persons coming into hospital, especially if they receive care in the hospital that is not "senior friendly." He stated that up to 25 percent of hospitalized older adults acquire delirium in hospital and "are likely to have a longer stay in hospital, to suffer functional decline and disability, and as a result be designated ALC, and/or to be institutionalized, re-hospitalized or die."
- [140] Second, Dr. Heckman was asked to describe the evidence concerning effective treatment of older patients in hospital and the prevention of geriatric syndromes. Dr. Heckman provided his opinion that the Hospital Elder Life Program that focussed on reducing stressors was effective in reducing delirium, falls, and hospital and long-term care costs. Dr. Heckman provided his opinion that there should be increased funding for senior-friendly care and that hospital accreditation should include "formal measurement rates of hospital-acquired delirium and functional decline." He acknowledged that this would require system change, including support (presumably in the form of increased funding) from the Ministry of Health and the reconfiguring of electronic medical records used throughout the province:

If money was spent in providing more senior-friendly care, this would be far less expensive than dealing with the ALC 'problem' caused by neglecting senior-friendly care practices in hospitals. Better senior-friendly hospital care would free up money that could support home care, primary care, and long-term care....

Implementing senior-friendly hospitals requires system change, active support from the Ministry of Health and hospital CEOs, administrators willing and able to implement it, and support for staff in making this change. Moreover, electronic medical records must be reconfigured to make relevant information, such as pre-existing cognitive and physical function and risk factors for delirium and functional decline, more accessible to the care team in order that they may take appropriate measures to target high-risk individuals, prevent these complications and optimize the chances for the older person to return to their home.

[141] While I accept that Dr. Heckman sincerely holds these views, I do not see how his policy preferences and recommendation for widespread systemic change, including the need to increase health care spending and reconfigure the electronic medical records system, is relevant to whether the constitution prevents the government from enacting Bill 7.

[142] Third, Dr. Heckman was asked to explain the means by which clinicians and health care providers obtain consent to treatment and the anticipated effect of the Bill 7 approach on that process. Dr. Heckman provided his opinion on the scope and content of the duty to obtain informed consent. He then provided the following opinion, which did not reference any medical or other literature:

There equally cannot be any coercion when consent is obtained. A fee of \$400 per day is a significant amount of money to an older couple on a pension, since a pension payment is typically around \$1,200 per month. A \$400 daily fee would, in my view, constitute a significant amount of pressure, and thus coercion, to an older person in hospital.

[143] This opinion is not within the scope of Dr. Heckman's medical expertise and is not admissible. I give it no weight.

[144] Fourth, Dr. Heckman was asked to describe the effect of transfers from one place to another place on the health of older patients. Dr. Heckman provided his opinion that when an older adult, particularly one who is frail and may already have delirium or cognitive impairment, is moved from one place to another, there is a high likelihood that they will become delirious or that any ongoing delirium will become worse. He concluded:

The harm caused by the transfer of older adults with chronic conditions is made worse where they are transferred far away from home, particularly if their spouse is frail and cannot visit the person on a regular basis. This situation is harmful to both the patient being transferred and the spouse, and can be worsened when there are further health events in the long-term care home and there are not enough staff to deal with them. Similarly, the person may be harmed by the resulting separation from members of their extended social network.

As a result, in my experience, I have seen transitions where older people arrive in a retirement home or long-term care and they are too sick to be adequately supported in the destination setting, and are quickly returned to the hospital, where some have died.

[145] Fifth, Dr. Heckman was asked to provide available alternatives to the transfer of ALC patients from hospitals to long-term care homes. He described three options:

- a. The patient stays in the hospital, which “has the consequence of tying up a hospital bed but avoids a transfer or multiple transfers of the person.”⁴⁹
- b. Waiting in the hospital for the long-term care home that the person wants, “which would be feasible if there was sufficient funding and hiring of staff;” and
- c. Returning home and paying for care at home, which would require increasing funded home care hours by 20 to 50 percent.

[146] Dr. Heckman concluded that the preferred approach would be to “mandate senior friendly hospital practices in all hospitals” and provide “better support for primary care to prevent hospitalizations.”

[147] It is difficult to see how Dr. Heckman’s policy preferences, which would appear to involve increasing funding, changing the priorities of the Ministry of Health and hospitals, and enacting different legislation and regulations, is of meaningful assistance in determining whether the constitution prevents the Legislature from enacting Bill 7.

(4) Dr. Samir Sinha

[148] Dr. Samir Sinha is the director of geriatrics at Sinai Health System and the University Health Network. He also holds teaching appointments at the University of Toronto, Toronto Metropolitan University, and Johns Hopkins University. Dr. Sinha was called as an expert witness and swore affidavits dated March 21, 2023, and April 2, 2024. Dr. Sinha’s first affidavit addressed four topics described below.

[149] First, Dr. Sinha was asked to describe the process for designating certain hospital patients as needing an alternate level of care, including the clinical characteristics and service needs of those waiting in hospital for admission to a long-term care home.

[150] Dr. Sinha stated that the phrase “alternate level of care” was principally an administrative term, and not a precise diagnosis. It is used to indicate that a person is no longer in need of the level of care provided in the particular hospital unit or setting where they reside. Dr. Sinha expressed the opinion that the term may be applied differently in different regions and may be applied incorrectly. Indeed, Dr. Sinha was extremely critical of the designation practises in hospitals. Dr. Sinha stated that the most responsible physicians were not using the term consistently, or with precision. He stated that, in his experience, “it is not uncommon to see patients prematurely or incorrectly designated as ALC when active acute issues still require the services and care of the environment they are in.” He also stated that it “is not uncommon” for physicians not to change the patient’s designation back to requiring hospital care where the patient’s health deteriorates to the point where the patient once again requires acute care. Dr. Sinha cited pressure on hospitals to “manage the flow of patients” as leading to physicians “prematurely identifying” patients as requiring an alternate level of care before they have stabilized.

⁴⁹ I observe that Bill 7 is designed to remedy the “tying up of the hospital bed.”

- [151] On cross-examination, Dr. Sinha agreed that he does not directly admit or discharge patients at UHN Sinai Health. Dr. Sinha does not act as a most responsible physician for hospital in-patients. Dr. Sinha admitted that, as a consulting physician, it is not his role to designate a patient as an ALC patient, and he has never made such a designation at any hospital in Ontario. Dr. Sinha explained that he is a consulting physician and provides support to the most responsible physician when they are making decisions to discharge or designate patients as ALC.
- [152] Dr. Sinha's lack of hands-on experience designating patients as requiring an alternate level of care causes me to place significantly less weight on his opinion criticizing the practices of the most responsible physicians who must make the difficult decision regarding designation. Dr. Sinha did not provide a single specific example of a physician prematurely designating a patient as requiring an alternate level of care, much less a decision that was influenced by inappropriate hospital pressures. To the extent that Dr. Sinha's affidavit relies on statements from his colleagues, that evidence is unattributed hearsay on which I place no weight. I accept that Dr. Sinha is consulted by physicians who must make the challenging decisions whether to designate a patient as requiring an alternate level of care. His input is important and likely highly valued by his colleagues. The health of patients depends on his expert input into the decision-making process. However, his criticisms of the decision-making of other physicians are not grounded in his medical expertise; as a consulting physician, his criticisms are too generic to be of assistance, and are based on inadmissible hearsay.
- [153] Second, Dr. Sinha was asked to explain the capacity of the healthcare system, from home-based to institutional care, to meet the needs of this ALC patient cohort.
- [154] Dr. Sinha explained that only 40 percent of ALC patients require admission to a long-term care home. These are the patients to whom Bill 7 applies. The rest of these ALC patients are waiting for further care in other hospital units or settings for services such as inpatient rehabilitation, complex continuing care, mental health or palliative care, supportive living environments such as non-profit supportive housing settings, retirement homes, or their own homes with government-funded or private home care supports. Dr. Sinha reviewed provincial data and concluded that in January 2023, there were 1,412 ALC patients waiting for long-term care homes in acute care beds (682 patients) and post-acute care beds (730 patients). The vast majority of these patients are older persons needing highly specialized forms of long-term care because of multiple chronic conditions. Many are living with dementia and almost all have some form of cognitive impairment. Dr. Sinha recognized that such patients may deteriorate in the hospital:

Some ALC-designated patients who entered the hospital for acute treatment, having been able to previously live in the community may experience further functional deterioration during their hospital stay, because their ongoing care needs were not adequately met. These often frail and older adults have ongoing basic care needs that need to be appropriately met regardless of where they are, yet often once these patients are designated as ALC patients, they are placed in a specific lower resourced setting and receive less clinical oversight.

These patients are also at an increased risk that something bad might happen to them, especially given the high rate of recidivism typically experienced amongst older patients discharged from hospitals within 30 days after an index-hospital admission. As a consequence, a person who entered the hospital from the community may subsequently no longer remain an appropriate candidate for rehabilitation or to return home, but instead are become designated or re-designated as ALC to [long-term care] patients.

- [155] Dr. Sinha noted that hospitals are able to provide more intensive care than long-term care homes:

Unfortunately many of the [long-term care] homes to which ALC patients may be admitted are also poorly equipped to deal with their complex continuing care needs than were the hospitals that discharged them. 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.

- [156] Third, Dr. Sinha was asked to describe the effects and likely impacts of Bill 7 and how these may affect health and well-being of ALC patients, and their ability to access the health services and the ongoing home-based to institutional care they require.

- [157] Dr. Sinha expressed the opinion that Bill 7 undermined the patient's right to consent to medical treatment because under the provisions, "we no longer require their consent or their active participation in the process of discharging them from hospital to a [long-term care] home." Dr. Sinha also expressed the opinion that Bill 7 deprived ALC patients "of their right to privacy [by] removing the right to consent to the sharing of their health information." Dr. Sinha expressed the opinion that these changes may inhibit persons from attending the hospital, even when they are in need of emergency or acute care:

In my opinion, the risk of losing their right to consent to the sharing of their personal health information may actually deter some people from seeking care in hospitals if they are aware that by doing so they may ultimately lose their right to consent to future care decisions like where they may ultimately reside. I also believe this erosion of such a fundamental right will also result in additional and collateral damage for patients who can no longer trust the healthcare professionals on whom they rely to have their best interests single-mindedly at heart.

- [158] Dr. Sinha also criticized the \$400 payment that would be charged to patients who decline to move to a long-term care home that had space for them. Dr. Sinha described this payment as "another form of 'structural coercion' imposed by Bill 7 on ALC patients, their [substitute decision-makers], and families, that is neither ethical nor appropriate." It is difficult to see how these opinions falls within Dr. Sinha's expertise.

[159] Dr. Sinha expressed the opinion that there is “a large disparity in quality” among long-term care homes in Ontario and that presenting to patients that all long-term care homes “are all essentially providing a similar level of quality care is, at best, misleading.” Dr. Sinha noted that 85 percent of long-term care homes participate in accreditation programs. Dr. Sinha provided his opinion that some long-term care homes may receive additional funding, but most are underfunded and are unable to provide the necessary level of care:

45. While all [long-term care] homes across Ontario receive approximately equal levels of funding, many municipal homes and certain not-for-profit homes provide significant additional funding to support the enhanced delivery of care in their environments. However, most [long-term care] homes are underfunded and far from meeting the standard of being able to provide four hours of direct care per day that is considered necessary to ensure proper care for residents. Currently, [long-term care] homes are funded to provide only 3 hours and 15 minutes of direct care per day per resident on average across the province, with the target of funding to a 4 hour standard to be met by March 31 2025. In order to achieve this level of care, the province has stated that an additional 35,000 frontline workers will be needed to staff Ontario [long-term care] homes, notwithstanding the serious current challenge of staffing homes even to a much lower standard.

[160] Dr. Sinha also expressed concerns about “the ongoing lack of transparency about how [Bill 7] is actually being implemented.” Dr. Sinha expressed that he would like to see the province produce more and different statistics regarding the movement of ALC patients to long-term care.

[161] Dr. Sinha opined that the legislation “embodies the inherent biases of both ageism and ableism” and “treats these individuals as being less worthy than other members of society.” Dr. Sinha stated as follows:

61. I find it deeply disturbing when we start actively treating ALC patients as a problematic group and use formal legislation - rushed through without any hearings - to help ‘manage’ this problem more expeditiously. By increasingly classifying ALC patients as being less worthy than others in our society, we are essentially whittling away their rights little by little by little, so that we can ultimately regard them as being dispensable. I am increasingly finding myself repeatedly asking the question: “What’s a life worth?”

62. So a very unfortunate narrative has further arisen to gloss over what I see as fundamental violations of people’s human rights by justifying these deprivations as being for the ultimate benefit of the overall healthcare system and our society. If we accede to this

narrative, what we are fundamentally saying is simply that some human lives are not worth as much as others.

- [162] I pause to note that these opinions of Dr. Sinha, including on appropriate legislative debate, fall far outside his area of expertise. Dr. Sinha cited no literature in support of his personal views. This causes me to give his opinions on these points little weight. Moreover, his opinions are overtly partisan and not in keeping with the duty of the expert. Partisan views are of no assistance to the court. The partisan nature of his opinion causes me to place little, if any, weight on his entire affidavit.
- [163] Fourth, Dr. Sinha was asked to explain what measures he would consider available to meet the health care needs of this patient cohort and what effects such initiatives would have on the capacity of hospitals to better meet the needs of the communities they serve.
- [164] Dr. Sinha expressed the opinion that Ontario has not “right-sized our health care system, because if we had the appropriate amounts of the other forms of care in place, we would have solved the vast majority of a self-inflicted ALC patient crisis.” Dr. Sinha stated that he would prefer that Ontario provide “more robust home care and other community-based support services.” Dr. Sinha expressed the opinion that funding cutbacks, and the lack of reliable and predictable funding levels, discourage families from providing more care at home. Dr. Sinha concluded that the main problem is underfunding of the system:

The greatest need, in my view, is to actually make more appropriate and stable investments in our home and community care system. This would allow sufficient amounts of care to be provided so that people have a credible alternative to being admitted to an LTC home. I believe that many hospital discharge planners and social workers have been distressed by living with the reality for over a decade where people are going home and not getting the amount and reliability of care in the community they need. I hear regularly from my hospital colleagues that home care supports were not delivered as they and their patients and families expected they would be, and that is why the patient came back into hospital. This is why social workers, discharge planners and physicians like me are increasingly having their doubts in terms of what the home and community care sector can even do or provide, and therefore creating a greater likelihood that they will simply propose or agree that the best thing for a patient would be is to apply to a LTC home. However, again, if we simply resourced and supported the provision of home and community care properly in Ontario and we actually spent the time to think through what could best serve our patients and the taxpayers at the same time - we could help get ourselves out of the place we have now found ourselves in and hopefully never return to this place ever again.

[165] While I accept that Dr. Sinha firmly believes in his preferred policy options, they are of little assistance to me in determining whether the constitution prevents the Legislature from enacting Bill 7.

[166] Dr. Sinha provided a supplementary affidavit where he examined provincial data and noted that there has been a further increase in the number of ALC patients waiting in hospital beds over the past year and that they are waiting longer for placement into a long-term care home.

(5) Dr. Maurice St. Martin

[167] Dr. Maurice St. Martin is an attending physician at the St. Joseph's Complex Continuing Care Hospital. He is currently the medical director at both the Pioneer Manor and the St. Joseph's Villa long-term care homes in Sudbury, and he is a geriatric medicine consultant at both Grand River and St. Mary's General Hospitals in Kitchener. He supports a primary care-based shared care geriatric practice in a family health team, is the medical director in a Waterloo retirement home, and is a consultant in a Waterloo long-term care home. Dr. Heckman was called as an expert witness and swore an affidavit dated April 11, 2023. Dr. St. Martin's affidavit addressed two topics.

[168] Before turning to his evidence, it is important to note that Dr. St. Martin candidly admitted that, at the time he swore the affidavit, he had "not had any direct experience with the new powers accorded to the hospitals and HCCSS under Bill 7..." Therefore, to the extent that Dr. St. Martin identified concerns in the health care system, those concerns exist independently of, and existed prior to, the implementation of Bill 7. In my view, this significantly limits the utility of Dr. St. Martin's evidence in assessing whether the constitution prevents the Legislature from enacting Bill 7.

[169] First, Dr. St. Martin was asked to describe the process for admission of a patient to long-term care and the ability of long-term care facilities to assess whether they have the staffing and skillset to care for a patient. Dr. St. Martin provided his opinion that a significantly greater proportion of admissions to long-term care homes are coming directly from hospitals. Dr. St. Martin provided several examples where he had to block admissions because he felt he did not receive sufficient information to make an informed admissions decision. In his view, the admissions process has become less consultative, transparent, and collegial because of underfunding:

13. In my observation, the process for referring patients to long-term care has become significantly less consultative, transparent and collegial in recent years. Often, information that would allow the LTC facility to make a proper assessment of the individual is not provided and, as a result, I am often asked to make clinical decisions with little or no information.

...

16. Unfortunately, these examples reflect a broader trend where the communication and documents associated with the process of

admitting patients to LTC has become significantly less transparent and consultative. In my opinion, this trend stems from fundamental problems with the model of caring for older patients. There is a clear lack of resources for proper care in the community, which would allow older patients to remain in the community, enter LTC facilities when necessary and on the proper terms and/or to be transferred to palliative or hospice care when appropriate.

17. Instead, the health system prioritizes acute care.

...

19. In my opinion, the increased trend away from collaboration and consultation, and towards the admission of patients who are inappropriate for LTC is a result of the long-term under resourcing of chronic health care needs and the long-term care system.

[170] Second, Dr. St. Martin was asked to describe “the nature of patients being admitted to long-term care homes.” He opined that there has been an increasing trend to admit patients to long-term care homes who have greater needs than can be managed in the long-term care homes. In his view, many of the long-term care admissions are “older and frailer” than in the past and “they should [instead] have been considered for or transferred to palliative care or hospice.” He noted that hospitals and hospices have “much higher staffing levels than now exist” in long-term care homes. Dr. St. Martin opined that “the under-resourcing of the chronic care and long-term care systems” affects family members who “demand and expect the same level of care provided in the acute care setting from the...doctors and staff” in the long-term care homes.

[171] Dr. St. Martin stated that he is concerned that there is a greater number of younger, more physically able patients with psychiatric issues admitted to long-term care homes. Dr. St. Martin confirmed that, as medical director of care, he can block any admission that he does not believe is medically appropriate. At Pioneer Manor, he rejects approximately 40 applicants each year because, in his medical opinion, the long-term care home cannot provide suitable care to the applicants.

C. *Ontario’s fact evidence*

[172] Ontario filed affidavits from four fact witnesses.

(1) Dr. Rhonda Crocker Ellacott

[173] Dr. Rhonda Crocker Ellacott is the President and Chief Executive Officer of the Thunder Bay Regional Health Sciences Centre. Dr. Crocker Ellacott is a Registered Nurse and holds a Doctor of Education degree in administration. Dr. Crocker Ellacott was asked to address three topics.

- [174] First, she explained the concept of patient flow and its importance to the work of her hospital. Dr. Crocker Ellacott explained that she runs the only tertiary acute care hospital in Northwestern Ontario, which covers a geographic area larger than France. She explained that patient flow is the process of moving patients from the emergency department, into acute care beds in the hospital, to discharge or transfer to other care settings once a patient no longer requires hospitalization. She explained that patient flow frees up hospital beds so that they may be used for patients requiring acute care beds.
- [175] Second, she explained how Bill 7 has affected patient flow at her hospital. Dr. Crocker Ellacott explained that Northwestern Ontario has a significant shortage of long-term care beds. Before the implementation of Bill 7, Dr. Crocker Ellacott's hospital had a higher percentage of its hospital beds occupied by ALC patients. The "vast majority" of these patients were waiting for placement into a long-term care home. Since the passage of Bill 7, the number of ALC patients waiting in hospitals for long-term care has decreased, and the flow of patients out of the emergency department has improved. Dr. Crocker Ellacott has also observed that the hospital is able to transfer more ALC patients to the partner rehabilitation sites each day because those sites have been able to transfer patients more quickly to long-term care homes. In her hospital, "Bill 7 provides opportunity to initiate conversations and work with our partners, patients and families to identify alternative and appropriate spaces for patients who do not require the level of care provided in an acute care hospital."
- [176] Third, Dr. Crocker Ellacott explained that the hospital had to prioritize opening up acute care beds for patients who needed acute level care. She organizes her hospital "to ensure there is access to the right care, at the right place and time for all patients." Dr. Crocker Ellacott noted the potentially catastrophic outcome for a person who needs but cannot access an acute care bed:

Allocation of hospital beds is an ongoing challenge and requires system level supports to ensure bed availability meets an acuity level. Consider a patient who needs access to emergency or hospital services for an acute need and the hospital cannot accommodate their acute need due to capacity and flow challenges resulting from patients waiting for other levels of care that are available but not their choice. There are no available options for the acute care patient waiting to be admitted to hospital. This can have catastrophic implications on that acute care patient and lead to poor outcomes.

(2) Sandra Iafrate

- [177] Sandra Iafrate is a registered social worker and interim Vice-President Patient Services for the Toronto Central and Central branches of HCCSS, the provincial agency that coordinates in-home and community-based services and manages Ontario's long-term care home placement processes. She has worked for the agency and its predecessors for almost 20 years. From the passage of Bill 7 until February 2024, Ms. Iafrate was the director of placement services for the agency region that includes York Region, South Simcoe County, North York, and parts of Etobicoke. Ms. Iafrate provided evidence on two topics.

[178] First, she explained the role of a care coordinator in a hospital once a patient has been designated ALC. Ms. Iafrate explained that after a physician designates a hospital patient as ALC, a discharge planner or social worker at the hospital will refer the patient to agency care coordinators who work in the hospital. The care coordinator will then engage with the patient or their substitute decision-maker to obtain consent, assess care needs, and develop a care plan that takes into account the patient's wishes and the availability of family care.

[179] The first priority is to try and get the patient back to their home as the discharge destination. If that is not possible, or a long-term care home is the more appropriate option, the care coordinator will counsel the patient and her or his family about care options in the community, eligibility for long-term care home admissions, evaluating capacity, counselling on long-term care home choices, supporting the application process, and authorizing admission to a long-term care home. Ms. Iafrate explained the process in detail:

To break this down further, after the care coordinator completes a comprehensive assessment of the patient, they recommend all [long-term care home] choices that can meet the patient's care needs, and are within the patients preferred location(s), including homes with shorter waitlists for the patient to consider. The care coordinator will reassess the patient on an ongoing basis and review [long-term care home] choices with the goal of expediting the patient's admission to [long-term care home]. Patients and their families are encouraged to tour homes, virtually or in person. Care coordinators also provide information about wait times to assist patients and families in making informed choices. ALC patients awaiting placement in [long-term care] homes are designated as having the highest level of priority for placement: crisis level. Patients in the crisis category may apply to as many [long-term care] homes as they would like.

[180] After the passage of Bill 7, if a patient refuses to apply to a long-term care home with a reasonable wait time, the care counsellors will provide additional information to the patient in an attempt to obtain their consent to add such choices. If the patient continues to refuse, the care coordinator may select long-term care homes on behalf of the applicant that will meet their care needs, expedite admission, and enable the applicant to wait for their preferred choice of long-term care home.

[181] The care counsellors then coordinate the release of information about the patient to the long-term care homes so that the homes may determine if they can offer suitable care. This personal health information is the same whether the long-term care home receiving the information was chosen by the patient or by the care coordinator. The long-term care home then has five days to accept the patient or, if the home lacks the physical facilities or nursing experience to meet the patient's care requirements, refuse to accept the patient.

[182] Second, she explained the information that care coordinators provide to patients as part of the counselling process and when discussing long-term care options. The care coordinators provide information about the services available at various long-term care homes, the type

of beds available, and accommodation costs. They also provide information about the application and admission process.

(3) Scott Jarrett

[183] Scott Jarrett is the Executive Vice-President and Chief Operating Officer of Trillium Health Partners, a three-site hospital in Mississauga, Ontario. Mr. Jarrett addressed three topics in his affidavit.

[184] First, Mr. Jarrett explained patient flow and why it is important to his hospital. He explained that patient flow is the process of moving patients from the emergency department, into acute care beds in the hospital, to discharge or transfer to other care settings once a patient no longer requires hospitalization. He explained that patient flow is very important to the hospital to ensure that patients are in the right bed at the right time to ensure optimal access to specialized hospital services. He explained that, on average, patients designated as ALC occupy 15 percent of the beds across the three sites, which means some people needing acute care are waiting longer in the emergency room or in unconventional care spaces.

[185] Second, Mr. Jarrett explained how patient flow at his hospital had changed after the enactment of Bill 7. He stated that Bill 7 has increased the likelihood of ALC patients transitioning out of hospital care and helps staff emphasize the importance of transitioning out of the hospital once a patient's acute care needs have been addressed. He stated that Bill 7 has helped staff when they have been unsuccessful in having productive conversations with patients and family members about the transition to the most available long-term care options. He stated that while improving patient flow and wait times "cannot be solely addressed by Bill 7, it has supported the availability of some hospital beds that were otherwise used for ALC patients, who in turn benefit most from being in a [long-term care home]."

[186] Third, he explained how his hospital prioritizes acute care beds. He explained that once an ALC patient no longer needs acute care, the patient should be moved to a more suitable care environment. Until that happens, the acute care bed is occupied by a patient who does not require that level of care and is not available for a patient in the emergency department or the community who needs that bed. He concluded that Bill 7 is a useful tool to assist his hospital to manage patient flow.

(4) David Musyj

[187] David Musyj is the President and Chief Executive Officer of the Windsor Regional Hospital. Mr. Musyj provided an affidavit that addressed four topics.

[188] First, Mr. Musyj described the process for designating patients as ALC. He explained that the most responsible physician for the patient designates patients as ALC in accordance with a variety of guidelines, standards, and tools. The hospital's discharge planning policy defines an ALC patient as follows:

An ALC patient is defined as someone who occupies a bed in a hospital under the *Public Hospital's* [sic] Act and has been

designated by an attending clinician in the hospital as requiring alternate level of care because in the clinician's opinion, the person does not require the intensity of resources and/or services provided in the hospital care setting. This also allows for patients to receive those enriching services, [activities] and supports, such as social and physical activity, entertainment and organized dining that are available in long-term care settings. Those physicians work with the patient and her or his family to develop a tailored plan of care and with the utilization team to assist with patient flow and discharge. If a patient's needs change, she may be undesignated as alternate level of care.

- [189] Second, Mr. Musyj explained his concerns about patients remaining in the hospital after they are designated as ALC. Mr. Musyj explained that he has concerns both for the health care system and the patients. While in hospital, patients are exposed to increased risk of infection, decreased mobility, and a lack of enriching activities. When ALC patients remain in acute care beds, this reduces the number of hospital beds available for patients who require hospital care, harming the health care system. He put it this way:

For example, with limited beds available for acute care, [the hospital] is unable to transfer patients out of the emergency room period this, in turn, means that [the hospital] is not able to accept new patients from the waiting room or ambulances into the emergency room period when emergency medical services bring a patient requiring emergency care into the emergency room, but there is no bed available for them, the paramedics are unable to transfer the patient from their stretcher and cannot leave to attend other emergency calls. This can result in a 'code black' or 'code zero' where there are not enough emergency medical services available in the community for the number of calls being received. ...

ALC patients remaining in hospital also limit the availability of beds available for patients being moved from the intensive care unit ("ICU") into a general medicine unit, similarly limiting the ability of the ICU to accept patients. If the ICU does not have capacity to accept a patient who needs intensive care, the patient must be transferred to another facility and this introduces a level of unnecessary risk to that patient.

ALC patients remaining in hospital also limit the availability of beds required for patients to recover from surgery. This can lead to surgeries being postponed or cancelled.

- [190] Third, he explained the steps his hospital takes after a patient is designated as ALC and provided his opinion on whether Bill 7 assists in that regard. Once the most responsible physician determines that acute care is no longer required, they will issue a discharge order. The hospital will then provide information to the patient, explaining the designation and

options for next steps. If a patient is designated ALC waiting for a long-term care home, the hospital will work to assist patients and their families to apply for long-term care homes. Mr. Musyj noted that Bill 7 permitted placement coordinators to facilitate application and admission of ALC patients into long-term care homes by authorizing them to take certain steps if the patient refuses to take them. Mr. Musyj testified that the placement coordinators select long-term care homes for the application form in consideration of the patient's condition and circumstances. He stated that Bill 7 had facilitated the placement of eleven patients into long-term care homes selected by placement coordinators. He stated that the hospital preferred that the \$400 co-payment was contained in Bill 7 and its regulations, because that avoided a source of conflict with patients who thought that if a payment was just a hospital policy, it can and should be waived. He concluded that:

The changes under Bill 7 help to facilitate timely discharge of ALC patients which, in turn, helps to ensure that acute care beds remain available for individuals who require hospital level care. It minimizes confrontation between patients and staff, facilitates discussion and open dialogue, and provides incentives and eliminates barriers to transferring ALC patients into available [long-term care] placements. These changes benefit patients and staff at [the hospital], as well as the broader Windsor-Essex community.

[191] Finally, Mr. Musyj responded to some of the evidence contained in the affidavits tendered by the Advocacy Centre.

D. Ontario's expert evidence

[192] Ontario filed three expert affidavits.

(1) Dr. Travis Carpenter

[193] Dr. Travis Carpenter holds privileges at St. Joseph's Health Centre in Toronto, where he provides most responsible physician services to between 1800 and 2000 acute medical patients per year on the inpatient ward or in the emergency department. He is also the primary or co-investigator on many active research projects, including assessing health system performance and how health system strain affects quality of care. Ontario retained Dr. Carpenter to provide his opinion on six issues.

[194] First, Dr. Carpenter explained that as the most responsible physician, he admitted and discharged patients and had overall responsibility for directing and coordinating that patient's care, including whether and when to designate a patient as ALC. Over his career, he has made such decisions hundreds of times a year. He stated that most medium- and large-sized Canadian hospitals have transitioned these decisions to general internal medicine specialists, like himself. At his institution, he is supported by a team, including the charge nurse, physiotherapist, occupational therapist, speech pathologist, transition planner, social worker, and pharmacist.

[195] Second, Dr. Carpenter explained his process for designating patients as ALC (or to remove that designation). He stated that he uses team rounds to assess whether a patient is discharge

ready, so that he can benefit from the input of the entire care team. Dr. Carpenter explained that while ALC designation has a specific technical administrative and research definition, as highlighted by the Canadian Institute for Health Information, colloquially, most physicians ask the question: “Would you feel comfortable, as the most responsible physician, discharging the patient from acute care at this point in time?” The formal designation is made by the most responsible physician writing the designation order in the patient’s chart or someone doing it under the explicit direction of the most responsible physician. Dr. Carpenter emphasized that the designation decision is an exercise of professional medical judgment and any preference the hospital might have regarding designation is universally overridden in favour of a decision by the most responsible physician exercising their clinical judgment in a manner consistent with their professional responsibilities.

- [196] Third, Dr. Carpenter stated that Bill 7 has not altered his approach to designating patients as ALC and the main consideration remains whether the patient is ready for discharge:

At my hospital, Bill 7 has not noticeably altered the process for or assessment of whether a patient should be designated ALC. Discharge planning for complex and frail patients takes a significant amount of time, often many days or longer. In many cases, given handovers between prior and subsequent [most responsible physicians] week to week, a patient being presented with discharge plans (including plans made based on provisions of Bill 7) would often have been designated ALC by a different [most responsible physician]. However, as part of the typical comprehensive assessment completed by each [most responsible physician] assuming care, the main consideration remains whether the patient is “discharge ready” from a medical standpoint. This has not been altered by the implementation of Bill 7.

- [197] Fourth, Dr. Carpenter explained the scope of the problem caused to the system and to the ALC patients when they continue to occupy acute care beds when they no longer need that level of clinical care:

Most Canadian hospitals will have ALC patients occupying between 10% and 20% of their acute beds at any given time. At my hospital, our ALC rate for the internal medicine service averaged 24% of bed-days in 2021-2022 and between 16% and 22% for the final 3 months of 2023.

...

I have seen innumerable examples of direct adverse outcomes resulting from admitted patients, who are often frail and elderly, being boarded in the emergency department for prolonged periods because no hospital bed is available. These include nosocomial infections, unnecessary falls, bedsores, and delirium. In one

particularly egregious example, in a context where our own emergency department will frequently have greater than 40 or 50 patients admitted without an available bed in the main hospital, I had a patient in their late 90s spend over a week in the emergency department while awaiting a bed upstairs.

[198] Fifth, Dr. Carpenter responded to some portions of the evidence of the applicants from his perspective, as the most responsible physician who must make the difficult discharge decisions at issue in this proceeding.

(2) Dr. Abhishek Narayan

[199] Dr. Abhishek Narayan is an expert in acute and post-acute inpatient care (including assessment and treatment) and hospital administration from a medical perspective. Dr. Narayan is the Interim Program Chief and Medical Director for the Primary Care, Rehabilitation, Complex Continuing Care, Palliative Care and Seniors' Services programs at Trillium Health Partners. Dr. Narayan is responsible for the post-acute care platform, which provides oversight and care for patients who have ALC status. Dr. Narayan provided evidence in two primary areas.

[200] Dr. Narayan provided evidence regarding his role with respect to patients designated as ALC. In his role as a hospital administrator, he is responsible for patient flow from acute care into the post-acute streams of care, including high and low intensity rehabilitation, complex care, transitional care, and longer-term palliative care. In his role as most responsible physician, he is responsible for the designation and de-designation of patients as ALC. Dr. Narayan explained that the most responsible physician makes the designation decision, which is both a medical and social determination, in consultation with the care team.

[201] Dr. Narayan gave evidence that patients designated ALC occupied about 15 percent of the beds across his hospital's three sites. He explained the consequences of patients designated ALC waiting in a hospital for long-term care home placement on both the hospital and the patient as follows:

The presence of ALC patients in acute care spaces impacts all areas of the hospital. Since ALC patients occupy up to 15% of our beds, THP sees a high number of no-bed admissions (that is, patients who are admitted to hospital but who do not have a bed available for them) in the emergency department (ED). This creates risk to the patients as they are being cared for in non-traditional spaces, such as hallways and auditoriums. We are also unable to provide the supports the patients require, which can lead to further physical and cognitive decline.

Older people in hospital who are unable to mobilize are at risk of deteriorating physical condition and a loss of function and independence. It is estimated that for every 10 days spent in hospital,

people aged over 80 years can expect to lose 10% of their muscle mass, and recovering this muscle mass takes twice as long as it takes to lose it. Older adults already have less lean muscle mass and strength than younger people. A prolonged hospital stay may represent a “tipping point” from which the person never fully recovers. This decline causes longer hospitalization and increases the risk that a patient will require institutionalization that might otherwise have been avoided.

A high number of ALC patients also reduces our ability to offer surgical services, as there is a risk that elective and non-urgent procedures will be cancelled due to a lack of acute care beds.

(3) Dr. Jordan Pelc

[202] Dr. Jordan Pelc is a hospitalist at Sinai Health, with expertise in acute and post-acute inpatient care (including assessment and treatment) and hospital medical operations and administration. He acts as a most responsible physician at both Mount Sinai Hospital and its post-acute site, Hennick Bridgepoint Hospital.

[203] Dr. Pelc explained that as a most responsible physician, he writes orders to designate and de-designate patients as ALC. This designation is an administrative, not a diagnostic, term. His decision to designate a patient is informed by specific criteria, but can be summarized as asking the question, “would it be clinically appropriate to discharge a patient if there were currently a bed available for them in their next destination?” The designation depends on the context of the patient’s care needs at the next destination, be that rehabilitation or long-term care or elsewhere. Dr. Pelc confirmed that the most responsible physician makes the designation, regardless of whether that physician writes the order or gives a verbal order to another person to enter the designation in the medical record.

[204] Dr. Pelc stated that all patients designated as ALC for long-term care have the risk of deteriorating health and becoming sick again because they are generally older, frail, and at an elevated risk of becoming unwell. He observed that at his hospital, there is rapid turnover of acute-care patients who have short, focussed stays in the hospital. These patients have a high risk of returning to acute care shortly after discharge. He explained that the hospital population awaiting long-term care is different:

Patients who are awaiting long-term care are usually those who either presented with acute illness which has since resolved, or who presented with care needs that could not be met in the community. They generally are admitted to hospital for weeks, months, or longer, as teams try to develop clinically-appropriate discharge plans, work through the long-term care process, and ultimately await a bed offer for long-term care. In most cases, these patients have demonstrated exceptionally long periods of stability in hospital and do not rapidly return once discharged. As noted above, if their clinical status changes, their ALC status would be discontinued. I

am not aware of a take-back letter ever being used for a long-term care discharge for a patient under my care.

- [205] Dr. Pelc provided evidence that his hospital engages in a “continuous quality improvement process” around designating patients as ALC. One of the key purposes of this process is to promote consistency of designation and to better understand the care needs of this patient population.
- [206] Dr. Pelc explained that the process for designating patients as ALC has not changed since the enactment of Bill 7. Both before and after Bill 7, the hospital explored all non-long-term care home options, and required patients who were approved to wait in hospital for an available long-term care bed, to choose multiple long-term care home options with reasonable wait times, in order to balance patient preferences with reasonable wait times.
- [207] Dr. Pelc provided evidence that at Mount Sinai, at the time he swore his affidavit, there were 49 ALC patients out of 294 operational acute beds, and 74 alternate care patients out of 473 operational post-acute beds. He provided the opinion that this affected the hospital’s ability to provide care to patients who need a level of care that can only be provided in those beds:

We have a limited number of beds in the hospital. High ALC numbers affect our ability to provide care to patients whose care needs can only be met in the bed types we offer. Based on the most recent numbers, we have twenty-one patients admitted to Mount Sinai Hospital who do not have beds. These are patients who require admission to hospital, but are physically unable to be moved from the emergency department. I have had acutely ill patients admitted under my care who have not yet been moved from the waiting room. This is dangerous for both Emergency Department flow and for access to appropriate nursing care for admitted patients.

In addition, many other specialty services can be affected. We have at times had to cancel surgeries because there are not enough inpatient beds to offer appropriate post-operative care. We have had fewer available inpatient rehabilitation beds and at one time converted an entire inpatient rehabilitation unit to an ALC unit because of very high ALC volumes.

5. Section 7 of the Charter

- [208] The Advocacy Centre submits that Bill 7 violates section 7 of the *Charter*, which provides 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. As I will explain, I disagree.

A. Introduction: there is no Charter right to publicly funded health care

- [209] In my view, the Advocacy Centre’s submissions on s. 7 fail to account for the fact that there is no *Charter* right to publicly funded health care, much less for a person to remain in hospital once the most responsible physician has determined that the person does not require the intensity of resources or services provided by a hospital. Section 7 of the *Charter* is not a tool authorizing the courts to second-guess how the Legislature allocates scarce resources.
- [210] The Advocacy Centre relies on a string of the Supreme Court of Canada’s most important s. 7 cases: *Bedford*, *Carter*, *Chaoulli*, and *Morgentaler*.⁵⁰ The issues raised in those cases are nothing like the issues in this case. Ontario correctly points out that in each of those cases, Parliament or a legislature had enacted a penal prohibition, coupled with a fine or imprisonment for persons violating statutory prohibitions. Bill 7 does none of those things.
- [211] Bill 7 does not authorize anyone to restrain or physically transfer an ALC patient to a long-term care home without their consent. Bill 7 does not compel ALC patients to undergo physical examinations without their consent. Bill 7 does not imprison ALC patients who do not consent to selecting a long-term care home with a short waitlist.
- [212] What does Bill 7 do? It requires patients, who no longer require hospital-level care and refuse an available bed in a long-term care home because they want to remain in hospital, to pay about one-third of the cost of the care that they no longer require. This cannot violate s. 7 of the *Charter*, because the jurisprudence is clear that s. 7 does not confer a constitutional right to a certain level of funding for health or social benefits.⁵¹
- [213] Section 7 restricts the ability of the state to deprive people of their right to life, liberty, and security of the person. Section 7 does not place a positive obligation on the state to ensure that each person enjoys a particular standard of life, liberty, or security of the person, including where the government previously offered a certain level or kind of service or funding to eligible persons, and subsequently reduces or changes the benefit.⁵² Section 7 does not oblige the state to provide a certain level of funding for services, if the state chooses to provide those services. The Divisional Court recently held:

It is well-established that the protection offered by s. 7 does not “include and require provision for the economic satisfaction of basic human needs.” Nor does it include a right to access services that the state does not publicly fund. Where the state chooses to provide a service, s. 7 does not impose a required level: “[n]othing in the

⁵⁰ *Bedford v. Canada (Attorney General)*, 2013 SCC 72, [2013] 3 S.C.R. 1101; *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331; *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 S.C.R. 791; and *R. v. Morgentaler*, [1988] 1 S.C.R. 30.

⁵¹ *Deskin v. Ontario*, 2023 ONSC 5584, 544 C.R.R. (2d) 118 (Div. Ct.), at para. 92.

⁵² *Canadian Doctors for Refugee Care v. Canada (Attorney General)*, 2014 FC 651, [2015] 2 F.C.R. 267; *ETFO et al. v. Her Majesty the Queen*, 2019 ONSC 1308, 144 O.R. (3d) 347; *Canadian Snowbirds Association Inc. v. Attorney General of Ontario*, 2020 ONSC 5652, 152 O.R. (3d) 738 (Div. Ct.), at paras. 56-67.

existing jurisprudence suggests that s. 7 places a positive obligation on the state to ensure that each person enjoys life, liberty, and security of the person. Rather, s. 7 has been interpreted as restricting the state's ability to deprive people of these."⁵³

[214] Courts have repeatedly rejected claims by applicants seeking more or different government-provided funding, social, or health services. For example, in *Flora*, the Court of Appeal for Ontario upheld the province's decision not to reimburse a citizen for a life-saving liver transplant he received outside of Canada, despite the undisputed fact that the treatment was required to save the applicant's life and was not available in Ontario.⁵⁴ Section 7 does not protect a right to economic benefits, even where they will save a life. The Court of Appeal held:

In my view, on the current state of s. 7 constitutional jurisprudence, where -- as here -- the government elects to provide a financial benefit that is not otherwise required by law, legislative limitations on the scope of the financial benefit provided do not violate s. 7. On the law at present, the reach of s. 7 does not extend to the imposition of a positive constitutional obligation on the Ontario government to fund out-of-country medical treatments even where the treatment in question proves to be life-saving in nature.⁵⁵

[215] Courts have taken the same approach to the provision of social services, other than health care. For example, the Court of Appeal for Ontario dismissed a s. 7 *Charter* challenge based on the wait time for applied behaviour analysis services and the alleged lack of those services in public school settings for school-aged children with autism, because it had no reasonable prospect of success.⁵⁶

[216] As I will explain below, many of the Advocacy Centre's arguments fail because they are premised, implicitly if not explicitly, on a *Charter* right to health care and, moreover, health care at a particular level, and in a particular form.

B. *Bill 7 does not limit the right to life*

[217] The Advocacy Centre submits that Bill 7 imposes an increased risk of death on ALC patients. The Advocacy Centre submits that Bill 7 compels patients to accept beds in long-term care homes that cannot reliably provide the medical treatment and care required. It submits that there is a "substantial difference in the quality of care [long-term care homes] provide" and that the homes with the shortest waitlists are the ones with the lowest quality

⁵³ *Deskin*, at para. 94, citing *Masse v. Ontario (Ministry of Community and Social Services)* (1996), 134 D.L.R. (4th) 20 (Ont. C.J. Div. Ct.), at para. 73, *Barbra Schlifer Commemorative Clinic v. Canada*, 2014 ONSC 5140, 121 O.R. (3d) 733, at paras. 32-33, *Sagharian (Litigation guardian of) v. Ontario (Minister of Education)*, 2008 ONCA 411, 172 C.R.R. (2d) 105, at paras. 52-53, leave to appeal refused, [2008] S.C.C.A. No. 350, and *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84, [2002] 4 S.C.R. 429, at para. 81.

⁵⁴ *Flora v. Ontario (Health Insurance Plan)*, 2008 ONCA 538, 91 O.R. (3d) 412, at para. 109.

⁵⁵ *Flora*, at para. 108.

⁵⁶ *Sagharian*, at paras. 51-55.

of care. The Advocacy Centre points to studies suggesting that there is a 10 percent higher risk of death for patients in for-profit long-term care homes. The Advocacy Centre submits that Bill 7 causes patients to be “pressured or coerced” into choosing such homes.

- [218] In my view, Bill 7 is not a law or state action that imposes an increased risk of death on a person, either directly or indirectly.⁵⁷ Although the Advocacy Centre relies on *Chaoulli* and *PHS* in support of its arguments, those cases are not like this one.⁵⁸
- [219] The rights claimants in *Chaoulli* did not seek an order requiring the government to spend more money on health care, to permit them to access publicly funded hospital beds when there was no clinical need for such care, or to fund the expense of their own private health care. The rights claimants in *Chaoulli* challenged a state prohibition on them spending their own money on private health insurance. The Supreme Court agreed and held that a state prohibition on obtaining private medical insurance, when combined with the significant delays in the public health care system, breached s. 7 and was not saved by s. 1. *Chaoulli* does not stand for the proposition that the state is required to provide publicly funded health care services to a particular standard. Indeed, in *Chaoulli*, the Supreme Court of Canada categorically stated that “the *Charter* does not confer a freestanding right to health care.”⁵⁹
- [220] If Bill 7 were an analogue to the legislation in *Chaoulli*, it would prevent ALC patients from paying out of pocket to obtain access to the care setting of the patient’s choice. Indeed, Bill 7 would look more like the legislation at issue in *Chaoulli* if it prohibited patients from paying the full cost of remaining in a hospital bed while the patient waited for the long-term care home of their choice. Bill 7 does nothing of this sort. It permits ALC patients to remain in hospital, provided they contribute about one-third of the cost of that care.
- [221] In *PHS*, the Supreme Court of Canada held that the claimants’ right to life was infringed where a law prevents access to health care.⁶⁰ In that case, the Court found that the prohibition on the possession of prohibited drugs under s. 4(1) of the *Controlled Drugs and Substances Act* applied to the staff of Insite. Without an exemption from the application of the *Controlled Drugs and Substances Act*, the staff would be unable to offer medical supervision and counselling. The staff could be charged with the offence of possession of prohibited drugs. The Supreme Court held that this limitation on the s. 7 rights of staff would in turn result in limits on the s. 7 rights of clients by depriving Insite’s clients of potentially lifesaving medical care, and therefore engaged the clients’ right to life. The trial judge found that the risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals. The Supreme Court held that where a law (in that case the *Controlled Drugs and Substances Act*) creates a risk to health by preventing access to health care, that law deprives a claimant of the right to life.

⁵⁷ *Carter*, at para. 62.

⁵⁸ *Chaoulli; Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44, [2011] 3 S.C.R. 134.

⁵⁹ *Chaoulli*, at para. 104.

⁶⁰ *PHS Community Services Society*, para. 93.

[222] Bill 7 does not prevent any ALC patient from obtaining access to necessary health care. First, Bill 7 only applies to persons after the most responsible physician has determined the patient is no longer in need of hospital-level care. Second, the \$400 per day contribution towards the cost of care does not begin until a long-term care home has confirmed that it has the ability to deliver the required level of care and accepted the patient to an open bed. In no way does Bill 7 prevent any ALC patient from obtaining access to lifesaving medical care.

[223] Neither *Chaoulli* nor *PHS* supports the Advocacy Centre’s submission that Bill 7 violates the right to life by preventing access to health care. The Advocacy Centre’s submissions ultimately ask the court to find that the *Charter* requires a higher level of care to be provided at some or all long-term care homes. However, the case law is clear. The *Charter* does not provide a free-standing right to a certain level of health care.

[224] I find that Bill 7 does not infringe an ALC patient’s right to life.

C. *Bill 7 does not limit the right to liberty or security of the person*

[225] The Advocacy Centre submits that the provisions of Bill 7 violate an ALC patient’s right to liberty and security. While they are distinct interests, it is convenient to address these rights together, as they both concern the protection of individual autonomy and dignity.⁶¹

[226] The right to liberty protects the right to make fundamental personal choices free from state interference.⁶² Security of the person encompasses a notion of personal autonomy, that involves control over one’s bodily integrity free from state interference, 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.⁶³

[227] Persons have the right to direct their health care and the concept of informed consent is protected by the guarantees of liberty and security of the person. In *Carter*, the Supreme Court of Canada put it 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

⁶¹ *Carter*, at para. 64.

⁶² *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307, at para. 54.

⁶³ *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519, at pp. 587-88; *R. v. Morgentaler*; *New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, at para. 58; *Blencoe*, at para. 57; *Chaoulli*, at paras. 43, 119, 191, and 200.

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.)). As noted in *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (Ont. C.A.), the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: see, e.g., *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119 (S.C.C.); *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (Ont. C.A.); and *B. (N.) c. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (C.S. Que.).⁶⁴

[228] The Advocacy Centre submits that Bill 7 violates the right to liberty and security of the person “by depriving them of personal autonomy in their medical treatment and health care.” I disagree. I will address the Advocacy Centre’s submissions one at a time, but as an overarching comment, all of the Advocacy Centre’s submissions fail to reflect that there is no *Charter* right to health care, much less to health care spending at a particular level or in a particular setting.

(1) Placement coordinators have not usurped the role of the most responsible physician

[229] First, the Advocacy Centre submits that Bill 7 violates the right to liberty and security of the person because it authorizes a placement coordinator to act without the request of a responsible physician. I disagree with the Advocacy Centre’s interpretation of the provisions for the reasons set out in paragraphs [68] to [74] of this judgment. A placement coordinator may not do any of the things listed in paragraph 60.1(3)2 of the legislation without a request from an attending clinician or where a patient has already been determined eligible for long-term care.

(2) No right to absolute control over the sharing of personal health information

[230] Second, the Advocacy Centre submits that Bill 7 violates the right to liberty and security of the person because it permits the collection and use of an ALC patient’s medical information without the patient’s consent. The Advocacy Centre submits that this deprives ALC patients of “the right to determine whether, how, and with whom their personal health information may be shared” in breach of s. 7 of the *Charter*. The Advocacy Centre cited no authority in support of this submission, which I do not accept.

[231] Medical records are not protected by a categorical privilege like, for example documents protected by solicitor-client communication privilege.⁶⁵ While there is no doubt that patients have a strong interest in maintaining the confidentiality of their medical records, that interest is not paramount. There are many circumstances where medical information

⁶⁴ *Carter*, at para. 67.

⁶⁵ *Canada (Privacy Commissioner) v. Blood Tribe Department of Health*, 2008 SCC 44, [2008] 2 S.C.R. 574, at para. 10 (and the many cases cited therein); *M. (A.) v. Ryan*, [1997] 1 S.C.R. 157, at para. 37.

must be disclosed and shared even where the patient does not want that to happen. The statutes that provide protection for the confidentiality of medical information provide for many qualifications, exceptions, and limitations that are inconsistent with the broad right to control information asserted by the Advocacy Centre.⁶⁶ Most importantly, the *Personal Health Information Protection Act, 2004*, does not give persons an unqualified right to determine whether, how, and with whom their medical information may be shared.⁶⁷ *PHIPA* permits the disclosure of an individual's personal health information without that individual's consent in many circumstances where disclosure is necessary to facilitate the provision of health care, improve the health care system, protect the public, and allow public officials to discharge their statutory duties.⁶⁸

[232] Here, Bill 7 permits disclosure of a limited amount of personal health information to allow long-term care homes to determine whether they have the ability to provide the services the patient will need upon admission. The information, once disclosed, remains protected by *PHIPA*. It would seem perverse to allow a patient to frustrate the intent of the legislation by withholding consent to disclose personal health information except to the long-term care home of their choice, or to require long-term care homes to admit patients without knowing that it would be safe to do so. The Bill 7 disclosure provisions serve a very similar purpose to the other *PHIPA* provisions that permit the disclosure of an individual's personal health information without that individual's consent, to facilitate the provision of health care or to serve some other important societal objective.

[233] I conclude that the information disclosure provisions of Bill 7 do not infringe the right to liberty or security of the person.

⁶⁶ *Mandatory Blood Testing Act, 2006*, S.O. 2006, c. 26, at ss. 7(2), 11(1); *General*, O. Reg. 449/07, at s. 8(1)(b); *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, Schedule 2, at ss. 23(8)-(10); *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, at ss. 11(2), 39, 77.6, 77.7.1(3), and 77.8.

⁶⁷ *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A.

⁶⁸ For example, see the following sections: s. 38(1)(b) – disclosure in order for the Minister, another health information custodian or the Agency to determine or provide funding or payment to the custodian for the provision of health care; s. 39(1)(a) – disclosure for the purpose of determining or verifying the eligibility of the individual to receive health care or related goods, services or benefits provided under an Act of Ontario or Canada and funded in whole or in part by the Government of Ontario or Canada, by a municipality or by the Agency, or to receive coverage with respect to such health care, goods, services or benefits; s. 39(1)(d)(iii) – disclosure by one custodian to another who also provides health care for the purpose of activities to improve or maintain the quality of care provided to that individual or others provided with similar health care; s. 39(2) – disclosure to the Chief Medical Officer of Health or a board of health for a purpose of the *Health Protection and Promotion Act*; ss. 40(2) and (3) – disclosure to the head of a penal or other custodial institution in which the individual is being lawfully detained or to the officer in charge of a psychiatric facility within the meaning of the *Mental Health Act* in which the individual is being lawfully detained to assist an institution or facility in making a decision concerning arrangements for the provision of health care to the individual or the placement of the individual; s. 41(1)(a) – disclosure for the purpose of a proceeding or contemplated proceeding in which the custodian or the agent or former agent of the custodian is, or is expected to be, a party or witness, if the information relates to or is a matter in issue in the proceeding or contemplated proceeding; s. 41(1)(d)(i) – disclosure for the purpose of complying with a summons or order; s. 43(1)(h) – disclosure where required by law; and s. 43(1)(e) – disclosure to the Public Guardian and Trustee, the Children's Lawyer, a children's aid society, a residential placement advisory committee established under subsection 63 (1) of the *Child, Youth and Family Services Act, 2017* or a designated custodian under section 223 of that Act so that they can carry out their statutory functions.

(3) Permitting a paper-based assessment of an ALC patient does not violate any rights

[234] The Advocacy Centre submits that Bill 7 permits “a clinician to assess ALC patients’ medical condition and care needs without having to meet with or examine the patient but based only on hospital records,” in violation of the right to liberty and to security of the person. I disagree.

[235] For a long-term care home to assess whether it will be able to care for a prospective patient, it must receive information about the patient. To overcome the impediment of a patient refusing to consent to assessments for this purpose, the Bill 7 amendments permit certain persons to conduct assessments of the patient without their consent.⁶⁹ This assessment is necessary in order to determine whether a long-term care home can safely admit the patient. This assessment shall be based solely on a review of existing hospital records relating to that patient.⁷⁰ Nothing in Bill 7 permits a physician or anyone else to examine physically, touch, or test a patient without their consent.

[236] The Advocacy Centre points to the evidence of Dr. St. Martin in support of its submission that if pertinent information about a patient is not provided to a long-term care home, it may be impossible for that home to make a full assessment of the needs of a potential patient. I observe that Dr. St. Martin does not blame Bill 7 for this problem; rather, he blames underfunding:

In my observation, the process for referring patients to care has become significantly less consultative, transparent and collegial in recent years. Often, information that would allow the LTC facility to make a proper assessment of the individual is not provided and, as a result, I am often asked to make clinical decisions with little or no information.

Unfortunately, in some cases pertinent information about a patient may not be provided to the LTC home, making it impossible for it to make a full assessment of a would-be resident’s needs.

...

In my opinion, the increased trend away from collaboration and consultation, and towards the admission of patients who are inappropriate for [long-term care] is as a result of the long-term under-resourcing of chronic health care needs and the long-term care system. In the last few months, I have received admissions from [the agency] with information on a patient that is often 6 months old, and therefore of limited use in assessing the current state of frail older patients. We have been asked by [the agency] why we cannot process applications faster. When we ask for updated information,

⁶⁹ *Fixing Long-Term Care Act*, at s. 60.1(3)3.

⁷⁰ *General*, O. Reg. 246/22, s. 240.1(6) to (9).

[the agency] responds that it does not have the resources to provide that for each file, clearly reflecting a lack of sufficient resources. Yet we are not able to make proper decisions on residents to LTC without accurate information.

[237] Nowhere in Dr. St. Martin's affidavit does he say that he has encountered problems assessing whether he can admit a patient because the assessment provided to him was not based on a direct medical examination. He does not provide a single example where the reason for him not receiving pertinent information was because of a lack of a physical examination by a doctor due to the provisions of Bill 7.

[238] I emphasize that an assessment without an examination will only take place where the patient does not consent to an examination. Patient consent is necessary because nothing in Bill 7 permits anyone to restrain, touch, or physically examine a patient without their consent. It seems to me uncontroversial that it would be preferable if the patient consented to an examination and that this would lead to a superior assessment than one which is made on the paper records alone. It also seems uncontroversial that if Bill 7 authorized a physical examination without patient consent, that would be a far more serious interference with a patient's rights to liberty and security of the person than the paper-based review permitted by the legislation. It is difficult to see how a patient can both refuse consent to a physical examination and assert that an inferior assessment that respects their choice, is a violation of their right to security of the person.

[239] I find that Bill 7 does not infringe the right to liberty and security of the person by permitting a paper-based assessment in circumstances where a patient does not consent to an examination.

(4) Bill 7 does not interfere with an ALC patient's 'right' to choose where they live

[240] The Advocacy Centre submits that the provisions in Bill 7 "represent a multi-pronged assault on a patient's fundamental right...to choose where they will live in what will typically be the final months of their life." The Advocacy Centre submits that the choice of where to live is a "fundamental personal decision[] and [is] inherent in one's dignity, autonomy, and ability to make meaningful determinations about one's own life." I disagree.

[241] It seems to me that the Advocacy Centre's submissions embrace two scenarios: an ALC patient who cannot move into the long-term care home of their choice; and an ALC patient who cannot access the long-term care home of their choice and then chooses to live in a hospital.

[242] In the first scenario, the ALC patient wishes to move into a certain long-term care home, but that home does not have any available beds and may have a multi-year waitlist. This reality will interfere with the patient's ability to choose where they wish to live. However, this disappointment is not caused by Bill 7. It is caused by demand for a particular long-term care home exceeding the supply of available beds at that home. To the extent that this individual cannot choose where they will live, that disappointment is not caused by Bill 7 and is not constitutionally significant for the purposes of this case.

[243] In the second scenario, the ALC patient cannot move into the long-term care home of their choice and chooses to remain in the hospital until there is an available bed in the long-term care home of their choice, despite the availability of a bed in a long-term care home that can meet their needs. In this scenario, the legislative provisions in Bill 7 apply. The Advocacy Centre submits that Bill 7's answer to this question violates an individual's liberty and security of the person interests:

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 [long-term care] 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.

[244] I note first that none of Ms. Chaloner, Ms. Herrington, or Ms. Heckman provided any evidence regarding their family members being placed "in an environment that is discordant with their culture, language and religion." Indeed, there is no first-hand evidence on any of these issues. Instead, the applicants rely on the evidence of Dr. Arya, who is an expert witness, not a fact witness. Dr. Arya's evidence appears to rely on unidentified hearsay or, perhaps, mere speculation. In any event, as noted above, I give very little weight to Dr. Arya's evidence due to its partisan nature and his willingness to exceed the boundaries of his expertise. The lack of a factual foundation for this submission by the Advocacy Centre is problematic and is one risk of constitutional litigation advanced by organizations instead of individuals.

[245] I accept that Ms. Chaloner, Ms. Herrington, and Ms. Heckman point to the difficulties posed by their need to travel to long-term care homes to visit their loved ones that are not located close to where they themselves live. However, this inconvenience does not rise to the level of an infringement of their own s. 7 rights or those of their loved ones in long-term care. In *Tanase*, a five-judge panel of the Court of Appeal for Ontario held that requiring spouses to travel to seek medical treatment was a "minor" inconvenience, rather than an infringement of the liberty or security of the person.⁷¹ In my view, the holding in *Tanase* applies to the current situation. The possibility that a patient may be admitted to a long-term care home that requires their family members to travel to visit them, while undoubtedly sub-optimal, is an inconvenience, not an infringement of the liberty or security of the person interests of either the patient or their family members.

[246] Moreover, there is no merit to the Advocacy Centre's submission that Bill 7 infringes the "right" of an ALC patient to choose where to live. In this scenario, the most responsible physician has already determined that the patient no longer requires the level of care provided by the hospital. However, as explained in paragraphs [55] to [57], an individual

⁷¹ *Tanase v. College of Dental Hygienists of Ontario*, 2021 ONCA 482, 156 O.R. (3d) 675, at paras. 50 to 51.

has no statutory or common law right to choose to be admitted to or remain in a hospital if a clinician does not believe that individual requires the level of medical attention provided by a hospital.

[247] In my view, no one has a common law, statutory, or constitutional right to choose to live in a hospital when a responsible clinician is of the professional opinion that it is not clinically necessary for the person to be an in-patient at the hospital. Bill 7 can not interfere with such a right, because that right does not exist. Bill 7 may interfere with an ALC patient's preferences, but that interference is not constitutionally significant and is not protected by the liberty or security of the person interests guaranteed by s. 7.

[248] I wish to address one other point that the Advocacy Centre raised during oral argument, but that did not appear in their factum. The Advocacy Centre submitted that Bill 7 was unconstitutional because it altered "the leverage in the relationship" between the ALC patient and the hospital. Counsel submitted that, before Bill 7, a patient occupying a hospital bed had more leverage in discussions with the hospital and that a patient could use this leverage to compel the hospital to put in more effort to meet the patient's preferences. In the colloquy, counsel for the Advocacy Centre submitted that Mr. Chaloner might not have ended up in Hilltop Acres, a long-term care home that was undesirable for Ms. Chaloner because it was 35 kms away from her home in Guelph:

Court: Absent the Bill 7 regime, Mr. Chaloner still wouldn't be in a long-term care home in Guelph because there's no spaces.

Counsel: You're -- you're assuming that nothing would have changed had the leverage in that relationship not changed... Well, what would have happened would be that there would be that there would be -- she -- she might -- he might actually end up in Hilltop Acres. In fact, if she agreed to it, he'd never probably be able to leave there. But what would happen is a discussion with all the parties involved and instead of Ms. Chaloner having not just an incentive but being compelled to agree to something she didn't want to do -- agree to, [the agency] would have an incentive to look a little harder to see if there might be some alternative to meeting Mr. Chaloner's needs. That -- that -- that negotiating relationship meant that [the agency] had to make as much of an effort as possible as to accommodate the patient's needs. Now, there's an easy out. There's a home, Hilltop Acres, it has a very short list, probably because nobody wants to be there because it has a terrible record, not because it's in Galt.⁷²

[249] Stripped to its essence, the Advocacy Centre submits that Bill 7 is unconstitutional because it no longer allows ALC patients to hold acute care hospital beds hostage in their negotiations with the agency over access to a preferred long-term care home. Implicit in

⁷² I have edited this quote to improve readability but have not changed its meaning.

the Advocacy Centre's submission is the notion that the constitutional protection for liberty and security of the person embraces the right of an ALC patient to occupy a hospital bed that they no longer need in order to extract concessions from a hospital that needs the bed to care for a patient who needs hospital-level care. I firmly reject this troubling submission.

(5) The \$400 per day charge to remain in the hospital is not coercive

[250] The Advocacy Centre submits that the requirement under Bill 7 of a \$400 per day charge for remaining in the hospital is “coercive” and interferes with the “exercise of informed consent” because it is “a fee they can’t afford.” I disagree.

[251] In my view, the Advocacy Centre's submission on this point fails for a number of inter-related reasons that I have discussed above:

- a. there is no common law or statutory right to choose to live in a hospital where a responsible clinician is of the professional opinion that it is not clinically necessary for the person to be an in-patient at the hospital;
- b. there is no *Charter* right to publicly funded health care; and
- c. there is no *Charter* right to health care spending or social welfare spending at a particular level.

[252] Against this backdrop, the \$400 per day payment is not unlawful coercion. It simply reflects Ontario's decision regarding how to allocate health care dollars. The fact that there are economic consequences to a patient's decision does not make that consequence unlawfully coercive. As set out above, in *Flora*, the Court of Appeal for Ontario upheld the province's decision not to reimburse a citizen for a life-saving liver transplant he received outside of Canada, despite the undisputed fact that the treatment was required to save the applicant's life and was not available in Ontario.⁷³ If the *Charter* does not require Ontario to fund a life-saving liver transplant, I do not see how the \$400 per day fee breaches the *Charter*.

[253] Nothing in Bill 7 authorizes an ALC patient to be touched or forcibly transferred to a long-term care home. Nothing in Bill 7 prevents a patient from choosing to leave the hospital and go somewhere else of their choosing. If the patient refuses to move to a long-term care home that has admitted them and has an open bed, the only consequence is that the patient is required to contribute to the cost of their ongoing care at the hospital. It is notable that Bill 7 does not require the ALC patient to pay the full cost of their unnecessary stay in the hospital. The patient is only required to pay about one-third of the total daily cost. The Advocacy Centre submits that this is unconstitutional, and that Ontario should be required to pay 100 percent of the costs of care. I find that this is directly contrary to the decision of the Court of Appeal for Ontario in *Flora*. Where the government elects to provide a financial benefit that is not otherwise required by law, here a two-thirds funded hospital

⁷³ *Flora*, at para. 109.

bed, legislative limitations on the scope of the financial benefit do not violate s. 7 of the *Charter*.⁷⁴

[254] I do not accept the Advocacy Centre’s submission that requiring ALC patients to contribute to the cost of their care, where they have declined an available bed in a long-term care home that is capable of meeting their needs, violates the right to liberty or security of the person.

(6) No interference with bodily integrity or consent to medical treatment

[255] The Advocacy Centre submits that the “coercive measure that are permitted under Bill 7...negate informed consent, which is inherent in the exercise of autonomy in medical decision making.” I disagree.

[256] Nothing in Bill 7 negates the informed consent to medical treatment, because Bill 7 neither prohibits a patient from seeking or obtaining medical treatment nor requires administering medical treatment without the consent of that patient. Bill 7 enacted s. 60.1(3) of the *Fixing Long-Term Care Act*, which authorizes placement coordinators to take one or more specified actions, but none of those acts falls within the meaning of “treatment” in s. 2.1 of the *Health Care Consent*.

[257] The Advocacy Centre submits that Bill 7 operates in a similar way to the former *Criminal Code* provisions restricting access to abortion because both provisions create uncertainty with respect to medical care. With respect, this comparison is profoundly inapt. The *Criminal Code* provisions that denied women access to health care can not be meaningfully compared to any of the provisions in Bill 7. The Advocacy Centre’s reliance on *Morgentaler* is misplaced.

[258] The Advocacy Centre submits that some ALC patients have received misinformation regarding the quality of care provided in long-term care homes and when they might be relocated to their preferred long-term care home. This, the Advocacy Centre submits, interferes with patients’ abilities to consent to medical treatment. I do not accept this submission.

[259] First, the Advocacy Centre has not proved on a balance of probabilities that any such misinformation has been provided. Second, in any event, the provision of such misinformation would not render the provisions of Bill 7 an unconstitutional infringement of the right to liberty or security of the person. The improper or unlawful administration of an otherwise constitutional law does not render that law unconstitutional. A person who received misinformation may have civil remedies or, potentially, remedies under s. 24(1) of the *Charter*. However, the provision of misinformation cannot render a legislative provision unconstitutional.

⁷⁴ *Flora*, at para. 108.

[260] The Advocacy Centre submits that Bill 7 lowers the threshold for discharging ALC patients from hospital. I disagree.

[261] The discharge of patients from hospitals is regulated by s. 16 of *Hospital Management, R.R.O. 1990, Reg. 965*, which is enacted under the *Public Hospitals Act*. Section 16 reads as follows:

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.

(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.

(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.

(3.1) If a discharged patient remains in the hospital for more than 24 hours after the date set out in the discharge order, the hospital shall charge the patient a fee of \$400 for every day that the patient remains in the hospital following the expiry of that 24-hour period.

(4) Without limiting the generality of subsection (1), a patient is no longer in need of treatment in the hospital for the purposes of that subsection if,

(a) the patient is designated as an alternate level of care patient in accordance with subsection (5); and

(b) the patient's admission to a long-term care home has been authorized in accordance with section 60.1 of the *Fixing Long-term Care Act, 2021* and any applicable regulations made under that Act.

(5) An attending clinician may designate a patient of the attending clinician as an alternate level of care patient if, in the clinician's opinion, the patient does not require the intensity of resources or services provided in the hospital care setting.

(6) For the purposes of subsection (5),

“attending clinician” means a person entitled to make an order under subsection (1).

[262] In my view, s. 16 does not lower the standard for discharge. Indeed, s. 16(4)(b) imposes an additional condition that is not present for any other person being discharged from a hospital. The authorization of admission to a long-term care home, pursuant to s. 60.1 of the *Fixing Long-Term Care Act*, incorporates s. 60.1(3)4, which requires a licensee of a long-term care home to admit the approved ALC patient if they can provide care to a patient and a bed becomes available. This means that no ALC for long-term care patient can be “discharged” unless, and until, there is an appropriate long-term care bed available for them. This additional protection means that even if a patient no longer requires the intensity of resources or services provided by the hospital, they can neither be discharged nor charged the \$400 per day fee unless, and until, there is an appropriate long-term bed available for them.

[263] In conclusion, I do not accept that Bill 7 negates informed consent in a manner that infringes the right to liberty or security of the person.

D. Conclusion: Bill 7 does not limit the right to life, liberty, or security of the person

[264] For the reasons set out above, I find that none of the provisions of Bill 7, considered separately or together, violate the rights to life, liberty, or security of the person under s. 7 of the *Charter*.

[265] This finding is sufficient to dispose of the Advocacy Centre’s s. 7 challenge to Bill 7. For completeness, I will nevertheless consider whether any deprivation of the right to life, liberty, or security of the person would be in accordance with the principles of fundamental justice.

E. Any deprivation is in accordance with the principles of fundamental justice

[266] The Advocacy Centre submits that Bill 7 deprives individuals of their rights to life, liberty, and security of the person in a manner that is not in accordance with the principles of fundamental justice. It argues that when tested against its purpose, Bill 7 is arbitrary, overbroad, and grossly disproportionate. As I will explain, I disagree.

[267] The principles of fundamental justice are intended to capture and reflect Canada’s basic societal values. Those values include a commitment to legislation that is rational, comprehensible, and fair. The concepts of arbitrariness, overbreadth, and gross disproportionality have emerged and developed as examples of those fundamental societal values.⁷⁵

⁷⁵ *R. v. Brar*, 2024 ONCA 254, 171 O.R. (3d) 321, at para. 53.

[268] Laws run afoul of our basic values when the state seeks to attain its objectives through means that are arbitrary, overbroad, or have effects that are grossly disproportionate to the legislative goal.⁷⁶ The Supreme Court explained how these principles address two different evils:

The case law on arbitrariness, overbreadth and gross disproportionality is directed against two different evils. The first evil is the absence of a connection between the infringement of rights and what the law seeks to achieve — the situation where the law’s deprivation of an individual’s life, liberty, or security of the person is not connected to the purpose of the law. The first evil is addressed by the norms against arbitrariness and overbreadth, which target the absence of connection between the law’s purpose and the s. 7 deprivation.

The second evil lies in depriving a person of life, liberty or security of the person in a manner that is grossly disproportionate to the law’s objective. The law’s impact on the s. 7 interest is connected to the purpose, but the impact is so severe that it violates our fundamental norms.⁷⁷

[269] Correctly identifying the purpose of legislation is essential to a proper application of the concepts of arbitrariness, overbreadth, and gross disproportionality.⁷⁸ So, as a first step, the court must determine the law’s objective or purpose.⁷⁹

(1) The purpose of Bill 7

[270] The objective of Bill 7 is to be identified by analyzing the provision in its full context and focussing on the ends of the legislation. The goal is to articulate the objective at an appropriate level of generality and to capture the main thrust of the law in precise and succinct terms.⁸⁰ The Supreme Court of Canada explained this point as follows:

The appropriate level of generality for the articulation of the law’s purpose is also critically important. If the purpose is articulated in too general terms, it will provide no meaningful check on the means employed to achieve it: almost any challenged provision will likely be rationally connected to a very broadly stated purpose (see, e.g., *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, at para. 77). On the other hand, if the identified purpose is articulated in too specific terms, then the distinction between ends and means may be lost and the statement of purpose will effectively

⁷⁶ *Bedford*, at para. 105.

⁷⁷ *Bedford*, at paras. 108-109.

⁷⁸ *R. v. Moriarity*, 2015 SCC 55, [2015] 3 S.C.R. 485, at para. 24-27.

⁷⁹ *R. v. N.S.*, 2022 ONCA 160, 169 O.R. (3d) 401, at para. 43, leave to appeal refused, [2022] S.C.C.A. No. 281.

⁸⁰ *R. v. Moriarity*, at para. 26.

foreclose any separate inquiry into the connection between them. The appropriate level of generality, therefore, resides between the statement of an “animating social value” — which is too general — and a narrow articulation, which can include a virtual repetition of the challenged provision, divorced from its context — which risks being too specific: *Carter*, at para. 76. An unduly broad statement of purpose will almost always lead to a finding that the provision is not overbroad, while an unduly narrow statement of purpose will almost always lead to a finding of overbreadth.⁸¹

[271] Finding the purpose of Bill 7 under a s. 7 analysis engages the same exercise and statutory tools as does traditional statutory interpretation. I am to look to the words of the statute, considered in their grammatical and ordinary sense and placed in the broader context of the legislation as a whole and the related legislative history and commentary.⁸² Any statement of the legislative purpose must be firmly anchored in the legislative text, considered in its full context.⁸³

[272] The Advocacy Centre fairly notes that Bill 7 does not contain a purpose clause. The Advocacy Centre submits that the purpose of Bill 7 must be determined by examining the purposes of the *Fixing Long-Term Care Act* and the *Health Care Consent Act*, both of which were amended by Bill 7. The Advocacy Centre did not provide a succinct statement of the purpose of Bill 7. It submits that the purpose of Bill 7 is found in the purposes of the *Fixing Long-Term Care Act* and the *Health Care Consent Act*, and in the Minister’s statement that it is a priority for people to live and receive care where they can have the best possible quality of life and to receive the appropriate level of care in an appropriate setting. The Advocacy Centre put it this way:

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.” In the case of the HCCA it is “to enhance the autonomy of persons for whom admission to a care facility is proposed,” by “requiring that wishes with respect to ... admission to a care facility ... be adhered to,” and “to ensure a significant role for supportive family

⁸¹ *Moriarity*, at para. 28.

⁸² *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Directrice de la protection de la jeunesse du CISSS A*, 2024 SCC 43, at paras. 23 to 28.

⁸³ *Brar*, at para. 61; *R. v. Appulonappa*, 2015 SCC 59, [2015] 3 S.C.R. 754, at para. 33; *La Presse inc. v. Quebec*, 2023 SCC 22, 485 D.L.R. (4th) 652, at paras. 22-24; *MediaQMI inc. v. Kamel*, 2021 SCC 23, [2021] 1 S.C.R. 899, at para. 37; *R. v. N.S.*, at para. 69; and *Moriarity*, at para. 32.

members when a person lacks the capacity to make a decision about ... admission to a care facility.”

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.” and further, for ALC-LTC patients to receive “the appropriate level of care in an appropriate setting.”

- [273] In my view, the Advocacy Centre’s suggested approach and its proposed purpose pay too little attention both to the text of Bill 7 and its regulations. I have described the effect of the changes enacted by Bill 7 above, at paragraphs [67] to [80]. Those changes need to be understood in the context of the statutory and regulatory scheme that existed before Bill 7, which I described above at paragraphs [53] to [65].
- [274] The Advocacy Centre’s submission focuses solely on the ALC patient and their preferences. The Advocacy Centre’s interpretation excludes the idea that the purpose of Bill 7 might include addressing the broader needs of other patients waiting for beds, the needs of hospitals, and the needs of the health care system considered holistically. The Advocacy Centre’s proposed purpose does not account for the text of many of the provisions in Bill 7. There is nothing in the legislative text of Bill 7 that offers any support for the narrow purpose proposed by the Advocacy Centre. I do not agree that the purpose of Bill 7 can be understood as narrowly as the Advocacy Centre suggests.
- [275] While I accept that the purpose of Bill 7 must be determined in the context of the *Fixing Long-Term Care Act* and the *Health Care Consent Act*, the purposes of those Acts can not be deemed to be the purpose of Bill 7. Those Acts pre-date Bill 7, which was enacted to make changes to those Acts and how they operate. While I must remain mindful of the purpose of the other Acts, I can not allow their purpose to overwhelm the analysis of the text and effect of different legislation enacted by the Legislature, to achieve a different purpose.
- [276] Courts can look to the legislative record when determining the purpose of legislation but must do so to aid in the interpretation of the language actually used in the legislation and not as the source of a freestanding explanation for the purpose behind the legislation. The interpretive question remains to determine the purpose of the legislation as written and enacted, not what members of the government perceived the purpose to be.⁸⁴
- [277] I do not think that the extrinsic evidence cited by the Advocacy Centre concerning the purpose of Bill 7 fairly reflects the legislative record. The Advocacy Centre included the Minister’s statement that the purpose of Bill 7 is for ALC patients to “receive the appropriate level of care in an appropriate setting.” However, reading that extract in the

⁸⁴ *Brar*, at para. 77; *Frank v. Canada (Attorney General)*, 2019 SCC 1, [2019] 1 S.C.R. 3, at paras. 130-136; *MediaQMI*, at paras. 37-39; and *R. v. Sharma*, 2022 SCC 39, 165 O.R. (3d) 398, at para. 89.

context of the full quotation provides a richer understanding of the Minister's point. The Minister stated:

One of the main ways to help hospital capacity challenges is to ensure that patients are getting the appropriate level of care in an appropriate setting. There are many patients in hospitals across the province whose care needs can be better met elsewhere. These patients are often referred to as alternate-level-of-care patients, or ALC patients for short. ALC patients in hospital no longer need to be there, and many would have a much better quality of life in a long-term-care home. At the same time, moving these ALC patients out of the hospital and into long-term care obviously frees up much-needed space in hospitals for patients who require hospital treatment. [Emphasis added]

[278] I accept the purpose offered by Ontario. I find that the purpose of Bill 7 is to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care. Having considered the text, context, and scheme of the legislation, I am satisfied that this objective fairly reflects the purpose of the provisions in their full context. It properly focuses on the ends of the legislation, not just the means. In my view, this purpose is fixed at the appropriate level of generality and captures the main thrust of the legislation in precise and succinct terms.

[279] Having identified the purpose of Bill 7, I will consider the Advocacy Centre's submissions that the legislation is arbitrary, overbroad and grossly disproportionate.

(2) The legislation is not arbitrary

[280] A law is arbitrary if there is no rational connection between the object of the law and the limit it imposes on the liberty of the person.⁸⁵ A law that imposes limits on s. 7 interests, in a way that bears no connection to its objective, arbitrarily impinges on those interests.⁸⁶ An arbitrary law is one that is not capable of fulfilling its objectives.⁸⁷ This is a very high threshold.

[281] Bill 7 is not arbitrary. The provisions in Bill 7 are clearly capable of fulfilling the legislative purpose. Recall that the purpose of Bill 7 is to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care. Bill 7 enacts a series of measures rationally connected to its objective, including measures to:

⁸⁵ *Carter*, at para. 83.

⁸⁶ *Bedford*, at para. 111.

⁸⁷ *Carter*, at para. 83.

- a. encourage ALC patients to apply broadly to multiple long term care homes, including those with short waitlists;
- b. authorize the admission of patients into long-term care homes who do not respond to the encouragement to apply broadly;
- c. impose a standardized \$400 daily fee for patients who decline to move to a long-term care home that has admitted them and has a bed available to them to encourage the patient to consider accepting the offer of admission and to disincentivize remaining in a hospital bed they no longer require; and
- d. shift a portion of the cost of daily care in the hospital from the public at large to the patient who is remaining in a hospital bed the patient no longer requires.

[282] All of these measures rationally advance the objectives of Bill 7. The evidence tendered proves this to be the case.

[283] The affidavits of Ms. Chaloner and Ms. Parkinson demonstrate that the suite of measures contained in Bill 7 caused them to alter their behaviour and accept placements for their family members in long-term care homes that they would not otherwise have chosen, which in turn opened those beds for others who needed them. There is a clear connection between the effect of the law and its purpose.⁸⁸ The Advocacy Centre's own evidence demonstrates that Bill 7 is not arbitrary.

[284] The affidavits of the hospital administrators filed by Ontario also demonstrate that Bill 7 is capable of fulfilling its purpose. Each of Mr. Musyj, Mr. Jarrett, and Dr. Crocker Ellacott gave evidence that Bill 7 improved patient flow, facilitated the placement of ALC patients into long-term care homes, and allowed for faster transfers out of the hospital. All of these outcomes support maximizing hospital resources for hospital-level care. Ontario's evidence demonstrates that Bill 7 is not arbitrary.

[285] Bill 7 does not have to solve every problem related to the length of stays for ALC patients in hospital for it to be found not arbitrary. There may very well still be ALC patients who spend more time in the hospital than is optimal. However, I have no doubt that the evidence demonstrates that Bill 7 is capable of fulfilling its objectives with respect to patients who refuse to apply to long-term care homes with short waitlists or refuse an open long-term care bed and wish to wait in hospital until their preferred long-term care home has a space.

[286] The Advocacy Centre submits that Bill 7 is arbitrary because the number of ALC patients waiting for long-term care placements has increased between January 2023 and 2024. I disagree. Ontario's population is aging. The shortage of long-term care beds has not been solved. It is unsurprising that the situation continues to deteriorate. The Advocacy Centre provided no expert evidence that identifies Bill 7 as the cause of this increase. The burden is on the Advocacy Centre to prove that Bill 7 caused the increase to which it points. It has

⁸⁸ *Bedford*, at para. 119.

not done so. It is at least as likely, if not more likely, that the situation would be even more dire without Bill 7's contribution.

[287] The Advocacy Centre submits that Bill 7 will “increase the number of former ALC patients who will be readmitted to hospital because the [long-term care home] they’ve been placed in cannot properly care for them.” The Advocacy Centre did not prove that this happens. Moreover, assuming that it did happen, that would be contrary to the terms of Bill 7 and other relevant instruments. The unlawful administration of legislation does not make the legislation arbitrary or unconstitutional.

[288] I conclude that Bill 7 is not arbitrary.

(3) The legislation is not overbroad

[289] Overbreadth is a distinct principle of fundamental justice that is related to arbitrariness. The question in both cases is whether there is no connection between the effects of a law and its objective. The overbreadth principle “allows the court to recognize that the lack of connection arises in a law that goes too far by sweeping conduct into its ambit that bears no relation to its objective.”⁸⁹

[290] The Advocacy Centre submits that Bill 7 is overbroad. I disagree. Even assuming for the moment that an individual would be deprived of their liberty or security of the person by Bill 7, I do not conclude that those deprivations would not serve the purposes of Bill 7.

[291] The Advocacy Centre submits that it is “rare” for patients to engage in conduct that would bring them within the scope of Bill 7. I do not accept this submission. There are many examples of *Criminal Code* provisions that address conduct that happens only rarely. That does not make those provisions unconstitutionally overbroad. Moreover, the evidence contradicts the Advocacy Centre’s submission that such conduct is rare. Ontario correctly pointed out that of the eleven Windsor Regional Hospital patients who were moved to long-term care under Bill 7 in 2023, three had refused to apply to any long-term care homes. Those eleven placements potentially created the space for 250 other acute care patients to receive care over time.

[292] Bill 7 is narrowly tailored, not overly broad. Long-term care homes can be selected without a patient’s consent only when the agency has made reasonable efforts to obtain the patient’s consent and those efforts have failed. Patients may provide their consent at any time without having to re-start the application process. The \$400 payment only applies when a patient refuses an offer of admission to a long-term care home where there is an available bed.

[293] The Advocacy Centre submits that, instead of Bill 7, when a patient’s substitute decision-maker refuses to apply to a long-term care home, the hospital should apply to the Consent and Capacity Board for an order. This submission has no merit. Not only would such an approach tax an administrative decision-maker who has other important responsibilities, it

⁸⁹ *Bedford*, at para. 117.

would require hospitals to waste scarce public dollars on litigation that could be better spent in innumerable ways. The relevant question for the Legislature is not whether a substitute decision-maker is acting in the patient's best interests, it is how the Legislature can advance the shared interests in a better health care system within the limits imposed by the constitution.

- [294] The Advocacy Centre submits that Bill 7 could have been tailored more narrowly to apply only where there are a certain number of vacant beds. This type of micro-managing forms no part of the overbreadth analysis. It is not appropriate to tinker with legislation under the guise of the overbreadth analysis.
- [295] The Advocacy Centre submits that Bill 7 is overbroad because it relies "on an ALC designation that is vague, inconsistently applied and on occasion just wrong." Assuming for a moment that this would be relevant to an overbreadth analysis, and in my view, it is not, I do not accept the Advocacy Centre's submission on this point.
- [296] Contrary to the Advocacy Centre's submission, the evidence does not establish that clinicians are pressured by hospital administrators to discharge patients inappropriately. It was Dr. Sinha, who has never designated a patient as ALC, provided this evidence. I do not accept his evidence for the reasons set out in paragraphs [150] to [152] above. Instead, I accept the crystal-clear evidence of Dr. Carpenter, that physicians discharge their professional and fiduciary duties to their patients to the best of their abilities:

A full appreciation of the role of physicians in making ALC designations requires an understanding about the relationship between physicians and hospitals. Most physicians in Ontario practising as inpatient hospital MRPs are independent contractors and are not employees of their respective hospitals. Physicians have professional ethical and clinical responsibilities to their patients that fall outside of their responsibilities to their hospital. Similarly, physicians are subject to patient and family complaints outside of hospital jurisdiction (through the College of Physicians and surgeons of Ontario) and possible legal or financial sanction through a civil suit regarding the care that they provide.

Overall, as physicians are independent contractors, hospitals typically have insufficient levers to drive 'desirable' behavior (from their perspective) in attending physicians. Requests from the hospital will almost universally be overridden by physicians' own ethics and values, or their desire to avoid patient complaints or civil lawsuits related to the provision of potentially suboptimal care. Stated another way, potentially inappropriate discharges that are likely to result in preventable hospital readmission or an adverse event are highly undesirable professionally and personally for physicians, and a significant effort will be made to avoid such outcomes.

Operationalizing the role of the MRP in this way helps us with undesirable conflicts of interest from the physician's perspective and allows physicians to be strong advocates for their patients. For example, I am quite frequently presented with a dilemma where a hospital might prefer to avoid an 'ALC-for-LTC' designation that is likely to result in a long length of stay; however, a patient's physical or social circumstances may preclude a safe or durable discharge home. In such circumstances, I will not hesitate to indicate that I do not believe the patient should be discharged home and that an 'ALC-for-LTC' designation is appropriate.

[297] I do not accept the Advocacy Centre's submission that there is a lack of clarity or clear criteria for determining when to designate a patient as ALC. None of the Advocacy Centre witnesses are actually the ones making the decision to designate patients as ALC. In contrast, Dr. Pelc provided clear and convincing evidence that there are criteria applied when designating patients as ALC, and that when ALC designation differs from context to context, it is because of the care needs of the patient, and not because the definition changes:

Patients are not designated ALC arbitrarily. There is a specific definition and there are specific criteria which we use at my hospitals for ALC designation. These are standard and have been developed by Ontario health. 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 for them in their next destination. If the answer is yes, then in most cases the patient would be designated ALC. A copy of Ontario health's ALC reference manual is attached here too as exhibit C.

It follows from this approach that ALC designation does differ in different contexts. This is not because the definition changes, but because different hospital services are designed to meet different patient needs. Patient who is appropriate to designate ALC while awaiting transfer from an acute care facility to rehab has different care needs from a patient who is appropriate to designate ALC when they are awaiting discharge from rehab to home.

[298] Dr. Carpenter and Dr. Narayan provided evidence to similar effect. I accept their evidence and see nothing in the approach to designating patients as ALC, which has not changed under Bill 7, that would make Bill 7 overbroad. Moreover, the fact that clinicians might come to different conclusions regarding whether to designate a particular patient as an ALC patient is not even evidence that one of the doctor's is negligent, much less that Bill 7 is constitutionally infirm.

[299] I conclude that Bill 7 is not overbroad.

(4) The legislation is not grossly disproportionate

[300] The rule against gross disproportionality applies only in extreme cases where the seriousness of the deprivation of liberty is totally out of sync with the objective of the measure. The Supreme Court expressed the idea of gross disproportionality in the following hypothetical: a law with the purposes of keeping the streets clean that imposes a sentence of life imprisonment for spitting on the sidewalk.⁹⁰

[301] There is simply no evidence that comes close to establishing that Bill 7's effects are grossly disproportionate. Bill 7 imposes no punishment. Bill 7 does not prohibit anyone from doing anything. Bill 7 does not authorize anyone to touch or examine a patient without their consent. Bill 7 does not allow a hospital to physically relocate an unwilling patient to a long-term care home.

[302] Taking the Advocacy Centre's case at its highest, a patient who refuses the offer of a bed in a long-term care home that has confirmed that it can meet that patient's needs, will be asked to pay about one-third of the cost of the hospital bed they continue to occupy while waiting for their preferred long-term care home to have an opening. I do not accept that this co-payment is totally out of sync with the purpose of Bill 7 that I have described above.

[303] I conclude that Bill 7 is not grossly disproportionate.

F. Conclusion: Bill 7 does not violate s. 7 of the Charter

[304] For the reasons set out above, I find that Bill 7 does not violate an individual's right to life, liberty, or security of the person. Any deprivation would be in accordance with the principles of fundamental justice because Bill 7 is not arbitrary, overbroad, or grossly disproportionate.

[305] I dismiss the Advocacy Centre's claim that Bill 7 violates s. 7 of the *Charter*.

6. Section 15 of the Charter

[306] The Advocacy Centre submits that Bill 7 violates s. 15(1) of the *Charter* because it discriminates on the basis of age and disability. The Advocacy Centre frames its argument this way:

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,

⁹⁰ *Bedford*, at para. 120.

perpetuates and exacerbates the pre-existing disadvantages already experienced by this vulnerable group.

A. Section 15 analytical framework

[307] Section 15(1) of the *Charter* states:

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.

[308] To succeed in proving that Bill 7 breaches s. 15(1) of the *Charter*, the Advocacy Centre must meet a test with two steps. The Advocacy Centre must prove on a balance of probabilities that Bill 7:

- a. on its face or in its impact creates a distinction based on an enumerated or analogous ground (Step One); and
- b. the distinction imposes burdens or denies benefits in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage (Step Two).⁹¹

[309] The Advocacy Centre concedes that Bill 7 is neutral on its face; therefore, it must prove that Bill 7 has a disproportionate impact on members of a protected group. The Advocacy Centre submits 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).⁹²

[310] The Advocacy Centre can demonstrate a disproportionate impact in several ways, including if there are clear disparities in how a law affects the claimant’s group as compared to other comparator groups.⁹³ Where a claimant alleges indirect discrimination, the claimant will have “more work to do” at the first step.⁹⁴

B. Step One

[311] At Step One, the Advocacy Centre must prove that Bill 7 created or contributed to a disproportionate impact on the claimant group based on a protected ground. This necessarily involves drawing a comparison between the claimant group and other groups, or the general population.⁹⁵

⁹¹ *Fraser v. Canada (Attorney General)*, 2020 SCC 28, [2020] 3 S.C.R. 113, at para. 27; *Ontario v. G*, 2020 SCC 38, [2020] 3 S.C.R. 629, at paras. 40- 42; and *R. v. Sharma*, at paras. 28, 188.

⁹² *Ontario Teacher Candidates’ Council v. Ontario (Education)*, 2023 ONCA 788, 168 O.R. (3d) 721, at para. 67.

⁹³ *Fraser*, at paras. 62-63.

⁹⁴ *Withler v. Canada (Attorney General)*, 2011 SCC 12, [2011] 1 S.C.R. 396, at para. 64.

⁹⁵ *Sharma*, at para. 31, citing *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143, at p. 164.

[312] The Advocacy Centre did not specify who the proper comparator group should be for the purpose of the s. 15 analysis. The first step of the s. 15 test requires the Advocacy Centre to establish that the *Act* creates or contributes to a disproportionate impact on the basis of a protected ground. This requirement of a disproportionate impact involves some element of a comparison with others. It is virtually impossible to assess the Advocacy Centre's submissions about the protected groups without a carefully defined comparator group, because the causation analysis at Step One requires the court to compare the claimant group with some other group.⁹⁶ There is no evidence that demonstrates a clear disparity in how Bill 7 affects a protected group as compared to non-group members.

[313] All laws are expected to affect individuals, including members of protected groups. It is not sufficient for the Advocacy Centre to show merely that the law impacts groups of individuals (people "older than 75, chronically ill (most commonly with dementia) and/or terminally ill") who are protected by s. 15. Instead, the Advocacy Centre must prove on a balance of probabilities that Bill 7 created or contributed to a disproportionate impact on a protected group as compared to non-group members.⁹⁷ At Step One, causation is the central issue, and it is important to distinguish between adverse impacts caused or contributed to by the impugned law and those that exist independently of it.⁹⁸ Justice Abella explained it this way:

... [I]ntuition may well lead us to the conclusion that the provision has some disparate impact, but before we put the [government] to the burden of justifying a breach of s. 15..., there must be enough evidence to show a *prima facie* breach. While the evidentiary burden need not be onerous, the evidence must amount to more than a web of instinct.⁹⁹

[314] To prove that legislation creates or contributes to a disproportionate impact on members of a protected group, an applicant may provide evidence about the circumstances of the claimant group, as well as evidence about the results produced by the challenged law. Ideally, an applicant should provide both.¹⁰⁰ This could include statistical evidence showing a disparate pattern of exclusion or harm that is statistically significant and not simply the result of chance.¹⁰¹

[315] I am mindful that the Advocacy Centre faces hurdles to collecting data and that it has less knowledge than the state about how laws operate. However, it is essential that the Advocacy Centre meet its evidentiary burden. A sufficient evidentiary record is not "a mere

⁹⁶ *Sharma*, at para. 31.

⁹⁷ *Sharma*, at para. 40.

⁹⁸ *Symes v. Canada*, [1993] 4 S.C.R. 695, at p. 765; *Sharma*, at para. 44.

⁹⁹ *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, [2015] 2 S.C.R. 548, at para. 34.

¹⁰⁰ *Fraser*, at para. 60; *Sharma*, at para. 49.

¹⁰¹ *Ontario Teacher Candidates' Council*, at para. 54; *Fraser*, at paras. 59-60.

technicality.”¹⁰² I will follow the Supreme Court’s guidance from *Sharma* regarding the evidence at Step One of the inquiry, which includes that:

- (a) No specific form of evidence is required.
- (b) The claimant need not show the impugned law or state action was the only or the dominant cause of the disproportionate impact, they need only demonstrate that the law was a cause (that is, the law created or contributed to the disproportionate impact on a protected group).
- (c) The causal connection may be satisfied by a reasonable inference. Depending on the impugned law or state action at issue, causation may be obvious and require no evidence. Where evidence is required, courts should remain mindful that statistics may not be available. Expert testimony, case studies, or other qualitative evidence may be sufficient. In all circumstances, courts should examine evidence that purports to demonstrate a causal connection to ensure that it conforms with standards associated to its discipline.¹⁰³

[316] The Advocacy Centre submits as follows:

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

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

¹⁰² *Ontario Teacher Candidates’ Council*, at para. 81.

¹⁰³ *Sharma*, at para. 49, citing *R. v. J.-L.J.*, 2000 SCC 51, [2000] 2 S.C.R. 600, at para. 33 and *R. v. Trochym*, 2007 SCC 6, [2007] 1 S.C.R. 239, at para. 36.

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.

- [317] The Advocacy Centre has not met its burden at Step One. The Advocacy Centre has not proved that Bill 7 created or contributed to any disproportionate impact based on age or disability. The portions of Bill 7 challenged by the Advocacy Centre are not triggered by age or disability. Bill 7 affects all ALC patients the same way, regardless of age or disability. The fact that most ALC for long-term care patients are over 75 and ill, is not sufficient to meet the burden at Step One. Merely proving overrepresentation is insufficient. As noted, all laws, including Bill 7, affect individuals, including individuals within groups protected by s. 15.¹⁰⁴
- [318] What the Advocacy Centre characterizes as the burdens of Bill 7 falls only on a subset of persons designated as ALC for long-term care:
- a. individuals who refuse to include a long-term care home with a short waitlist in their application; and
 - b. individuals who decline to accept an offer of admission from a long-term care home with an available bed.
- [319] The entire group of ALC for long-term care patients fits uneasily within a traditional understanding of an enumerated or analogous group. Patients only join the group when the most responsible physician has concluded that the patient does not require the intensity of resources or services provided in the hospital care setting. Put slightly differently, a patient is only designated as ALC when the most responsible physician is satisfied that it would be clinically appropriate to discharge that patient if there is currently a bed available for them in their next destination. Moreover, if an ALC patient becomes more ill, that designation will be removed, and they will remain an in-patient.
- [320] It is difficult to find a personal characteristic of ALC for long-term care patients that corresponds with the enumerated and analogous grounds protected by s. 15. I accept that not all enumerated and analogous grounds need be immutable, but membership resting on a transient clinical designation does not fit well within a s. 15 analysis. The case becomes weaker when one recalls the subset of individuals among this group to whom the provisions will apply. An ALC for long-term care patient who accepts the available bed offered to them or consents to broaden the range of long-term care homes to which they will apply is

¹⁰⁴ *Fair Change*, at para. 383.

no longer a member of this group. Those characteristics of membership fit uneasily with the enumerated and analogous grounds that s. 15 protects from discriminatory treatment.

[321] The Advocacy Centre has not proved that Bill 7 created or contributed to any disproportionate impact based on age or disability. Consider the \$400 daily fee to which the Advocacy Centre objects. Every hospital patient, regardless of age or disability, is required by the legislation to pay the \$400 daily fee if they do not depart the hospital within 24 hours of being discharged. A young, single mother who just gave birth to a child by Caesarean section is required to pay \$400 per day if she does not leave the hospital within 24 hours of being discharged. It does not matter whether she would prefer to remain in hospital while she continues to recover from her surgery. If the most responsible physician has determined that she does not need to be in hospital, she must leave within 24 hours of the discharge order or pay the \$400 daily fee. Similarly, any person designated ALC for rehabilitation must depart the hospital within 24 hours after being offered an available bed in a rehabilitation centre.

[322] I find that the Advocacy Centre has not proved that Bill 7 created or contributed to a disproportionate impact on the claimant group based on a protected ground.

C. *Step Two*

[323] Because the Advocacy Centre failed to meet its burden at Step One, it is not necessary to consider Step Two and I decline to do so.

D. *Conclusion: Bill 7 does not violate s. 15 of the Charter*

[324] The Advocacy Centre has not proved that Bill 7 violates s. 15(1) of the *Charter* because it discriminates on the basis of age and disability. I dismiss this portion of the application.

7. Section 1 of the Charter

[325] Where a person's *Charter* right has been limited by legislation, the government may be able to justify that limitation under s. 1 of the *Charter*, which provides:

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.

[326] Although I have found that Bill 7 does not limit any of an ALC patient's rights under ss. 7 or 15 of the *Charter*, I will nevertheless consider whether any limitation would be justified under s. 1.

[327] At this stage, Ontario bears the onus of establishing on a balance of probabilities that the law is a reasonable limit on the right. A law that limits a *Charter* right will only be justified

if it meets the proportionality test first articulated in *Oakes*.¹⁰⁵ Ontario must establish that the impugned provisions have a sufficiently important objective and that the means chosen are proportional to that objective.¹⁰⁶ A law is proportionate if:

1. there is a rational connection between the means adopted and the objective;
2. it is minimally impairing in that there are no alternative means that may achieve the same objective with a lesser degree of rights limitation; and
3. there is proportionality between the deleterious and salutary effects of the law.¹⁰⁷

A. *Bill 7 has a sufficiently important objective*

[328] A law that limits a constitutional right must do so in pursuit of a sufficiently important objective that is consistent with the values of a free and democratic society.¹⁰⁸ The Court of Appeal for Ontario recently reiterated the importance of precisely and succinctly stating the purpose of the law as distinguished from the means chosen to implement it:

The Supreme Court has explained that the objective of a law must not be stated in too general terms because, otherwise, “it will provide no meaningful check on the means employed to achieve it: almost any challenged provision will likely be rationally connected to a very broadly stated purpose”: *R. v. Moriarity*, 2015 SCC 55, [2015] S.C.R. 485, at para. 28; see also *Frank v. Canada (Attorney General)*, 2019 SCC 1, [2019] 1 S.C.R. 3, at para. 46. On the other hand, an articulation that is too narrow “may merely reiterate the means chosen to achieve it”: *Frank*, at para. 46. On this basis, the Supreme Court has stated that a law’s purpose should be “both precise and succinct” and distinguished from the means chosen to implement it: *Moriarity*, at para. 29; see also *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 S.C.R. 877, at para. 23.¹⁰⁹

[329] For the reasons set out above in paragraphs [270] to [279], I found that the purpose of Bill 7 is to reduce the number of ALC patients in hospital who are eligible for admission to a long term care home in order to maximize hospital resources for patients who need hospital-level care.

¹⁰⁵ *R. v. Oakes*, [1986] 1 S.C.R. 103.

¹⁰⁶ *Carter*, at para. 94.

¹⁰⁷ *R. v. K.R.J.*, 2016 SCC 31, [2016] 1 S.C.R. 906, at para. 58.

¹⁰⁸ *K.R.J.*, at para. 61.

¹⁰⁹ *Ontario English Catholic Teachers Association v. Ontario (Attorney General)*, 2024 ONCA 101, 493 D.L.R. (4th) 195, at para. 158.

[330] The Advocacy Centre does not accept that this is a pressing and substantial objective and submits that Ontario has not provided evidence to demonstrate that this objective is pressing and substantial. I disagree. Ontario filed an overwhelming amount of evidence to demonstrate that there is a shortage of hospital beds in Ontario and that there are hospital beds occupied by ALC patients waiting for placement in a long-term care home. Ontario's factum made this point clearly and with many citations to the evidence supporting its submissions:

The consequences of a large cohort of ALC patients on access to hospital care are pronounced, resulting in direct and indirect harm to other patients.

The province tracks and reports monthly ALC numbers in Ontario hospitals. As of January 31, 2024, there were 5,140 patients designated ALC in Ontario hospitals, with 1,297 in acute care and 946 in post-acute care designated as waiting for a bed in a LTC home (2,243 ALC patients waiting for LTC in total). At any given time there are, on average, over 2000 hospital beds in Ontario that cannot be used for individuals requiring hospital-level care because they are occupied by ALC patients waiting to move to an LTC home.

Given the significant waitlists for LTC homes, patients who are ALC designated for LTC generally have longer lengths of stay than ALC patients designated to other destinations (such as rehab), which means, as a proportion of the overall available capacity, they represent a much higher usage in terms of bed days. For example, as of January 31, 2024, the 2,243 ALC-to-LTC home patients in Ontario had spent a total of 199,057 days in hospital beds. Based on an average acute care length of stay of 7 days, Ontario hospitals could have potentially served ~28,436 more patients in need of hospital-level care during that time if these beds were not occupied by individuals waiting to move to an LTC home.

If patient flow is not managed efficiently, acute care beds in the hospital continue to be occupied by patients who no longer require the services of an acute care hospital. The presence of ALC patients in acute care spaces impacts all areas of the hospital and can often lead to poor patient outcomes. For example, an acute care bed that is occupied by an ALC patient is not available for a patient waiting in the emergency department who requires admission to hospital. Hospitals are then forced to admit patients from the emergency department without a bed available for them. This creates risk to patients who must be cared for in hallways and auditoriums.

The situation has become especially dire with Canada seeing record-setting wait times for emergency care. For example, Dr. Carpenter explained that at St. Joseph's Health Centre, the emergency

department will often have 40 or 50 people admitted without an available bed in the main hospital. He recounted that, at one point, this led to a patient in their late 90s spending over a week in the emergency department waiting for a bed upstairs.

Patients boarded in the emergency department for prolonged periods of time waiting for a bed, especially those who are elderly, are at risk of direct adverse outcomes such as nosocomial infections, unnecessary falls, bedsores, and delirium. A prolonged hospital stay may represent a “tipping point” from which the person never fully recovers.

When beds are not available for patients admitted into the emergency department, this also has the further consequence of jeopardizing the availability of emergency services in the community. ALC patients remaining in hospital also limit the availability of beds available for patients being moved from the intensive care unit (“ICU”) into a general medicine unit, similarly, limiting the ability of the ICU to accept patients. If the ICU does not have capacity to accept a patient who needs intensive care, the patient must be transferred to another facility, introducing a level of unnecessary risk to that patient.

Other hospital services are affected by ALC patients remaining in hospital when they no longer need acute-level care. For example, this limits the availability of beds required for patients to recover from surgery, leading to surgeries being postponed or cancelled.

[331] In my view, Ontario has amply demonstrated on the evidence at trial that the objective of Bill 7 is pressing and substantial.

B. The impugned measures are rationally connected to Bill 7’s objective

[332] At the first step of the proportionality inquiry, Ontario must demonstrate that the means used by the infringing measures are rationally connected to the purpose they were designed to achieve.¹¹⁰ Ontario need only show on the basis of reason or logic that there is a causal connection between the infringement and the benefit sought.¹¹¹ Ontario must demonstrate that the impugned measures can be said to further in a general way an important government aim. This step is not particularly onerous.¹¹²

[333] I find that Ontario has discharged its burden. At paragraphs [280] to [299], I explained why Bill 7 was not arbitrary or overbroad. I rely on those reasons in support of my conclusion

¹¹⁰ *K.R.J.*, at para. 68.

¹¹¹ *Carter*, at para. 99.

¹¹² *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, 2000 SCC 69, [2000] 2 S.C.R. 1120, at para. 228.

that there is a rational connection between the impugned measures and the objective of Bill 7.

- [334] I observe that the affidavits of Ms. Chaloner and Ms. Parkinson demonstrate that Bill 7 is rationally connected to its legislative objective. Both women stated that they modified their behaviour and made different choices in light of the provisions of Bill 7 and that those choices resulted in their loved ones accepting an available bed in a long-term care home before a bed became available in one of their preferred homes. Therefore, the Advocacy Centre's own evidence demonstrates that there is a rational connection between Bill 7 and its legislative objective. Every time an ALC patient who is subject to the provisions of Bill 7 accepts a long-term care bed, a hospital bed is made available for someone who still requires the intensity of resources and care provided by a hospital. This is precisely the objective of Bill 7.
- [335] The Advocacy Centre submits that the measures in Bill 7 are ineffective or counterproductive. I do not accept that submission. However, even if the Advocacy Centre was correct that Bill 7 provides few benefits, that is not relevant to the rational connection stage of the proportionality analysis. A rational connection may be found on the basis of reason or logic and there is no need for direct proof of a relationship between the infringing measure and the legislative objective.¹¹³
- [336] I find that Ontario has demonstrated that there is a rational connection between the impugned measures and the objective of Bill 7, which is to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care.

C. *Bill 7 minimally impairs the rights*

- [337] At this stage of the proportionality analysis, Ontario must prove on a balance of probabilities that any limit on the right is reasonably necessary to achieve the state's goal. The court will show deference to the legislature's choices, but Ontario must still prove that the law is carefully tailored so that rights are impaired no more than necessary.¹¹⁴
- [338] However, context matters a great deal. In this case, the state is not acting as a singular antagonist to prohibit, criminalize, or punish an individual's conduct. This case is about the state allocating and distributing very scarce resources among very deserving individuals.¹¹⁵ The court must show appropriate deference to the democratically elected Legislature when it decides how to structure and fund the health care system in the interest of all Ontarians. As the Supreme Court of Canada cautioned in *Irwin Toy*,

¹¹³ *RJR-MacDonald Inc. v. Canada*, [1995] 3 S.C.R. 199, at paras. 154, 184; *R. v. Keegstra*, [1990] 3 S.C.R. 697, at p. 776; *R. v. Butler*, [1992] 1 S.C.R. 452, at p. 504; and *K.R.J.*, at para. 228

¹¹⁴ *K Mart Canada Ltd. v. U.F.C.W., Local 1518*, [1999] 2 S.C.R. 1083, at paras. 62-64; *RJR-MacDonald*, at para. 160.

¹¹⁵ *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927, at p. 994.

when striking a balance between the claims of competing groups, the choice of means, like the choice of ends, frequently will require an assessment of conflicting scientific evidence and differing justified demands on scarce resources. Democratic institutions are meant to let us all share in the responsibility for these difficult choices. Thus, as courts review the results of the legislature's deliberations, particularly with respect to the protection of vulnerable groups, they must be mindful of the legislature's representative function.

- [339] There are at least two reasons why courts should show significant deference to the Legislature regarding its decisions on health care spending.
- [340] The first reason is institutional legitimacy. Parliament and the legislatures, not the courts, have been elected to make decisions on how to best allocate scarce resources among deserving groups. No one elected the court to make the life and death trade-offs inherent in how to spend health care dollars or, for that matter, how much to spend on health care as compared to housing, education, the justice system, or social services. Elected officials are accountable to voters for these difficult decisions and courts should show deference to them.
- [341] The second reason is institutional capacity. I am hearing a single case brought by an organization on behalf of a very small group of health care users. People who were lying on stretchers in hallways of emergency departments because there was no hospital bed for them did not intervene in this case. A single case is a remarkably poor vehicle for redesigning a complex system. It is difficult to conceive of a more complicated and interconnected system than the health care system in the province of Ontario. It is difficult to imagine how I could do more damage to that system than to constitutionalize one small part of it. The courts are at a significant disadvantage compared to the Legislature and the government, who have a much better perspective on designing a health care system. As Donna Greschner and Steven Lewis observed over 20 years ago,

government departments are better equipped than courts to manage complex programs and use resources effectively. They may not always make the best use of available data and expertise, but they have far more of it than judges do, and more practice at using it. Moreover, they have the major advantage of perspective: they not only can, but must, look at the entire system. In the context of health care, they must consider the needs of all patients, compare the sometimes incommensurable, and make often tragic trade-offs. In contrast, courts run a higher risk of telescopic vision: focussing on

the case before them magnifies that case and removes other needs and problems from their field of vision.¹¹⁶

[342] I am mindful that deference must not be taken too far. Courts must also supervise policy-laden decision making.¹¹⁷ The judicial branch is justified in intervening not to assess the wisdom of the government's policy, but whether it limits an individual's rights and, if so, that limitation is justifiable under s. 1. The legislative and judicial branches each have a role. As McLachlin J. (as she then was) wrote:

[C]are must be taken not to extend the notion of deference too far. Deference must not be carried to the point of relieving the government of the burden which the *Charter* places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable. Parliament has its role: to choose the appropriate response to social problems within the limiting framework of the Constitution. But the courts also have a role: to determine, objectively and impartially, whether Parliament's choice falls within the limiting framework of the Constitution. The courts are no more permitted to abdicate their responsibility than is Parliament. To carry judicial deference to the point of accepting Parliament's view simply on the basis that the problem is serious and the solution is difficult, would be to diminish the role of the courts in the constitutional process and to weaken the structure of rights upon which our constitution and our nation is founded.¹¹⁸

[343] In a case like this one, where the applicant asserts that legislation addressing the allocation of scarce resources has limited the rights of individuals, the minimal impairment test is met if the Legislature has chosen one of several reasonable alternatives. This articulation of the test is found in the unanimous Supreme Court of Canada decision in *JTI-Macdonald*:

Again, a certain measure of deference may be appropriate, where the problem Parliament is tackling is a complex social problem. There may be many ways to approach a particular problem, and no certainty as to which will be the most effective. It may, in the calm of the courtroom, be possible to imagine a solution that impairs the right at stake less than the solution Parliament has adopted. But one must also ask whether the alternative would be reasonably effective when weighed against the means chosen by Parliament. To complicate matters, a particular legislative regime may have a number of goals, and impairing a right minimally in the furtherance of one particular goal may inhibit achieving another goal. Crafting

¹¹⁶ Donna Greschner and Steven Lewis, "Auton and Evidence-Based Decision-Making: Medicare in the Courts" (2003) 82:501 Can. Bar Rev. at 507-508.

¹¹⁷ Lorne M. Sossin and Gerard Kennedy, *Boundaries of Judicial Review: The Law of Justiciability in Canada*, 3d Ed., (Toronto: Thomson Reuters Canada Limited, 2024) at §6:9, pp. 378-385.

¹¹⁸ *RJR-MacDonald*, at para. 136.

legislative solutions to complex problems is necessarily a complex task. It is a task that requires weighing and balancing. For this reason, this Court has held that on complex social issues, the minimal impairment requirement is met if Parliament has chosen one of several reasonable alternatives: *R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713; *Irwin Toy*.¹¹⁹

[344] In my view, this case demonstrates that crafting legislative solutions to complex problems is a complex task. The Legislature chose one of several reasonable alternatives to achieve its legislative objective.

[345] The measures chosen by the Legislature limit any infringement of *Charter* rights in a number of ways. Bill 7:

- a. requires placement coordinators to attempt to obtain the consent of the ALC patients and, if the patient consents mid-way through the process, the application process need not start all over again;
- b. does not permit physicians to examine or touch patients absent their consent;
- c. does not permit anyone to touch, transfer, or remove an ALC patient without their consent; and
- d. permits ALC patients to remain in hospital to await their preferred long-term care home as long as they pay about one-third of the cost of the care they no longer require.

[346] While it is true that Bill 7 permits some administrative actions to be taken without a patient's consent, the legislative objective would be entirely frustrated if a patient could entirely avoid the operation of Bill 7 by withholding their consent to participate.

[347] For the reasons set out at a paragraph [293], I do not accept the Advocacy Centre's submission that requiring placement coordinators to apply to the Consent and Capacity Board is less minimally impairing of the right. This process would not apply unless the ALC patient had a substitute decision-maker, and the Board would not be considering or addressing the broader purposes to be obtained through the legislation. Involving the Board would not achieve the government's objective. The minimal impairment test requires only that the government choose reasonably among alternatives that are capable of achieving its objective. Less drastic means which do not actually achieve the government's objective are not considered at this stage.¹²⁰

¹¹⁹ *Canada (Attorney General) v. JTI-Macdonald Corp.*, 2007 SCC 30, [2007] 2 S.C.R. 610, at para. 43.

¹²⁰ *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37, [2009] 2 S.C.R. 567, at para. 53-55.

- [348] The Advocacy Centre submits that Bill 7 is not minimally impairing of *Charter* rights because it is overbroad. For the reasons set out at paragraphs [289] to [299], I disagree. The legislation is not overbroad.
- [349] The Advocacy Centre submits that Bill 7 is not minimally impairing because it could have been tailored to address the possibility that a clinician may err in designating a patient as ALC. I disagree. The fact that clinicians may disagree about whether to designate a patient as ALC, or that the patient's condition may change and require a reassessment, is no evidence of constitutional infirmity. Nothing in Bill 7 changes a physician's fiduciary duty to a patient to exercise their best clinical judgment in the patient's interest. I accept Ontario's evidence, tendered from doctors who actually make the difficult designation decisions, that Bill 7 has not changed their understanding of their fiduciary duties and how they must exercise them.
- [350] Finally, the Advocacy Centre submits that Bill 7 is not minimally impairing because there are other ways to achieve Ontario's goals. I note first that most of the Advocacy Centre's evidence on this point would require significant increases in public spending on health care, the alteration of priorities for the health care system, the reworking of electronic medical records, higher wages for long-term care workers, increased spending on palliative care, and increased spending on home and community care. The Advocacy Centre may wish to advance these policy proposals as part of the debate around Ontario's health care system. However, Ontario has satisfied me that it made a reasonable choice among many alternatives to address its legislative objective.
- [351] I conclude that Ontario has proved that Bill 7 is minimally impairing of any *Charter* rights that it limited. The chosen measures do not go further than necessary to achieve the legislative goal.

D. *The benefits from Bill 7 are proportionate to its deleterious effects*

- [352] The third and final step of the proportionality analysis is to determine proportionality of the effects. The final stage of the *Oakes* analysis allows for a broader assessment of whether the benefits of the impugned law are worth the cost of the rights limitation. In *Thomson Newspapers*, Bastarache J. explained:

The third stage of the proportionality analysis performs a fundamentally distinct role.... The focus of the first and second steps of the proportionality analysis is not the relationship between the measures and the *Charter* right in question, but rather the relationship between the ends of the legislation and the means employed. Although the minimal impairment stage of the proportionality test necessarily takes into account the extent to which a *Charter* value is infringed, the ultimate standard is whether the *Charter* right is impaired as little as possible given the validity of the legislative purpose. The third stage of the proportionality analysis provides an opportunity to assess, in light of the practical and contextual details which are elucidated in the first and second

stages, whether the benefits which accrue from the limitation are proportional to its deleterious effects as measured by the values underlying the *Charter*.¹²¹

[353] The first inquiry is into the benefits, or the salutary effects, associated with the legislative goal. As discussed, the legislative goal is to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care.

[354] In my view, the evidence of the benefits associated with the legislative goal are clear and obvious.

[355] First, facilitating the transfer of patients who have been found to no longer need the intensity of resources or services provided by a hospital to a long-term care home, conserves resources and opens up beds for patients who need the intensity of care that can only be provided by a hospital. Ontario filed evidence from Dr. Ellacott, Dr. Carpenter, Mr. Jarrett, and Mr. Musyj about the importance of patient flow within their hospitals. They each observed that ALC patients residing in acute care beds that they no longer required significantly affected other persons who needed the beds in the hospital. For example, Mr. Musyj provided first-hand evidence of the horrific problems that may be created when ALC patients unnecessarily occupy beds in the hospital: patients wait in the emergency room longer than necessary because there is no bed available for them; the emergency department fills up and patients cannot be accepted into the emergency department; and paramedic crews must wait to have their patients accepted into the emergency room and cannot help other people in distress. In addition, surgeries may be cancelled, and patients may not be able to move out of the intensive care unit into a general medicine unit. Mr. Musyj explained:

The health care system is impacted through decreased access to acute care hospital services for patients who truly require them. [Windsor Regional Hospital] typically has 620 beds available for patients. An average of 3.4 patients at [Windsor Regional Hospital] are newly designated ALC daily, leading to an average of approximately 105 new ALC designations every month period out of these monthly designations, only approximately 10 patients are re-designated as needing acute care following changes in their health status. The remainder of ALC patients who no longer require acute level care but continue to occupy hospital beds create a constraint on [Windsor Regional Hospital's] ability to provide acute level care to new patients who do require it.

For example, with limited beds available for acute care, [Windsor Regional Hospital] is unable to transfer patients out of the emergency room. This, in turn, means that [Windsor Regional

¹²¹ *Thomson Newspapers Co. v. Canada (Attorney General)*, [1998] 1 S.C.R. 877, at para. 125.

Hospital] is not able to accept new patients from the waiting room or ambulances into the emergency room. When emergency medical services bring a patient requiring emergency care into the emergency room, but there is no bed available for them, the paramedics are unable to transfer the patient from their stretcher and cannot leave to attend other emergency calls. This can result in a 'code black' or 'code zero' where there are not enough emergency medical services available in the community for the number of calls being received.

In the evening, [Windsor Regional Hospital] is the only option for emergency services in the Windsor and Essex County and, while construction on a new campus is set to break ground in the coming years, we are consistently at capacity and are often forced to admit patients with no beds available for them. People in the Windsor-Essex community who need hospital level now cannot wait years for the new campus to be built to receive that care.

[356] The changes enacted by Bill 7 allow for faster transfer of ALC patients from the hospital directly to a long-term care home. The benefits flowing from this change are significant and accrue to every individual in Ontario, including elderly people who themselves require the level of intense care that can only be provided by a hospital.

[357] In contrast, the harms to ALC patients caused by Bill 7 are modest. They do not affect the liberty, human dignity, equality, or autonomy of the ALC patients.¹²² At most, they require an ALC patient who wishes to remain in hospital pending an available space in their preferred long-term care home to contribute approximately one-third of the cost of that hospital bed. This is not coercive. This is a modest economic consequence of that patient's decision to occupy a hospital bed that the patient no longer requires. The consequences of Bill 7 are not serious.

[358] Bill 7 has an important social objective. This goal should not be lightly sacrificed. The evidence on this application satisfies me that Bill 7 addresses a pressing problem and will conserve health care resources and make more hospital beds available faster. The benefits of Bill 7 significantly outweigh any of the supposed limitations on rights that it imposes. Balancing the salutary and deleterious effects of Bill 7, I conclude that the impact on the ss. 7 and 15 rights of affected persons is proportionate.

E. Conclusion: any limitation on the right is justified under s. 1 of the Charter

[359] I have found that Bill 7 advances an important objective: to reduce the number of ALC patients in hospital who are eligible for admission to a long-term care home in order to maximize hospital resources for patients who need hospital-level care. I have also found that any limitations on the rights of ALC patients are rationally connected to that goal, that

¹²² Thomson Newspapers, at para. 125.

the means chosen by the Legislature to achieve the government objective meet the requirement of minimal impairment, and that any impact of the limit of those rights is proportionate.

[360] I conclude that any limit on rights would be justified under s. 1 of the *Charter*.

9. Conclusion and Costs

[361] The application is dismissed in its entirety.

[362] If the parties are not able to resolve the costs of this application, Ontario may email its costs submission of no more than three double-spaced pages to my judicial assistant on or before January 27, 2025. The applicant may deliver its responding submission of no more than three double-spaced pages on or before February 3, 2025. No reply submissions are to be delivered without leave.



Robert Centa J.

Released: January 20, 2025

CITATION: Ontario Health Coalition and Advocacy Centre for the Elderly v. His Majesty the
King in Right of Ontario, 2025 ONSC 415
COURT FILE NO.: CV-23-00698007-0000
DATE: 20250120

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

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

Respondent

REASONS FOR JUDGMENT

R. Centa J.

Released: January 20, 2025