Court File No.: CV-23-00698007-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

ONTARIO HEALTH COALITION and
ADVOCACY CENTRE FOR THE ELDERLY

Applicants

- and -

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

Respondent

FACTUM OF THE RESPONDENT

August 2, 2024

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PART I – OVERVIEW

1. This is an application for a declaration that the amendments made by the *More Beds, Better Care Act, 2022*, S.O. 2022, c. 16 to the *Fixing Long-Term Care Act, 2021*[1] and the *Health Care Consent Act, 1996*,[2] along with associated regulations (collectively, "Bill 7"), are of no force and effect because they unjustifiably infringe the *Charter* ss. 7 and 15 rights of hospital patients who have been designated as Alternate Level of Care ("ALC") patients.

2. The Respondent, His Majesty the King in Right of Ontario ("Ontario"), requests that the application be dismissed.

3. An ALC patient is someone who occupies a bed in a hospital under the *Public Hospitals Act*[3] ("PHA") 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 care setting.[4]

4. Some ALC patients are waiting in hospital for admission to a long-term care ("LTC") home. They no longer require the intensity of resources or services provided in the hospital care setting but have not yet been admitted to their preferred LTC home. Other ALC patients have not applied to any LTC homes but decline to leave the hospital for their own reasons. In the meantime, they occupy a hospital bed that they do not need, instead of a bed in an LTC home that can meet their care needs.

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[1] *Fixing Long-Term Care Act, 2021*, SO 2021, c. 39, Schedule 1. ("*FLTCA*").
[2] *Health Care Consent Act, 1996*, SO 1996, c. 2, Schedule A. ("*HCCA*").
[3] *Public Hospitals Act*, R.S.O. 1990, c. P40 ("*PHA*").
[4] *FLTCA*, at s. 60.1(1).

5. At any given time, most Canadian hospitals will have ALC patients occupying between ten and twenty percent of their acute care beds.[5] Each hospital bed occupied by an ALC patient is not available for the use of a patient who requires the level of care that only a hospital can provide. Each year in Ontario, thousands of ALC patients occupy hospital beds for many tens of thousands of hospital bed days. Since the average length of stay of an acute care patient in an Ontario hospital is seven days, a single ALC patient who occupies a hospital bed for months or years uses a hospital bed that would otherwise be available to dozens of acute care patients.[6]

6. Some LTC homes have long wait lists, and people seeking admission to these LTC homes sometimes wait for months or years to be admitted. While this result is lamentable, and efforts are underway to increase the supply of LTC beds in Ontario, the reality today is that demand for beds at some LTC homes exceeds supply. No relief sought in this application will change this reality. Nothing the Court can order will shorten any wait lists or create any new LTC beds.

7. The only question in this case is *where* ALC patients should wait while they are waiting for admission to their preferred LTC home. One option is that they can wait at home, and indeed this may be the preferred option. But not every person can be safely cared for at home, even with the home and community care services funded by the Province.

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[5] Affidavit of Dr. Travis Carpenter sworn February 21, 2024 (**"Carpenter Affidavit"**), para. 24, Joint Record (**"JR"**), Vol. V, Tab 15, p. 1774, Exhibit B, pp. 1797-1829; Affidavit of Dr. Abhishek Narayan sworn February 23, 2024, (**"Narayan Affidavit"**), para. 10, JR, Vol. V, Tab 20, p. 2136; Affidavit of Scott Jarrett sworn February 21, 2024 (**"Jarrett Affidavit"**), para. 8, JR, Vol. V, Tab 18, pp. 2000-2001; Affidavit of Dr. Jordan Pelc sworn February 23, 2024 (**"Pelc Affidavit"**), para. 23, JR, Vol. V, Tab 21, p. 2154.

[6] Cross-examination of David Musyj dated April 29, 2024 **("Musyj Cross")**, JR, Vol. VII, Tab 29, p. 2823.

8. Another option is that ALC patients can wait in a hospital bed for their preferred LTC home. But this option comes with serious drawbacks. First, it is often not good for an ALC patient's health to wait in a hospital bed for LTC home placement. A hospital is not a home, and extended hospital stays come with serious risks. Second, and more critically for this case, the purpose of a hospital bed is not to act as a waiting area for LTC home admission. The purpose of a hospital bed is to provide care for patients for whom hospital admission is a clinical necessity.[7] Hospital beds are a scarce and precious publicly funded resource, and for patients who need to be in hospital, no alternative is available.

9. The third option is that ALC patients can wait for their preferred LTC home in a different LTC home. While all LTC homes are not identical, all LTC homes in Ontario are subject to the same regulatory requirements, and no LTC home may admit a person unless they can meet the person's care requirements.[8] This is the option that Bill 7 facilitates.

10. Bill 7 was enacted to reduce the number of ALC patients waiting in hospital for LTC home admission, in order to maximize the availability of hospital beds for patients who need the level of care that only a hospital can provide. Bill 7 does so by authorizing the admission of ALC patients to LTC homes selected by a placement coordinator, if necessary, without the ALC patient's consent. While reasonable efforts must be made to obtain the consent of the ALC patient, ultimately the law does not leave it exclusively to ALC patients to decide for themselves how long they will wait in hospital for admission to their preferred LTC home. Once admission to an LTC home is authorized, a discharged ALC patient must leave hospital within 24 hours or pay a fee of $400 for each day thereafter.

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[7] *Hospital Management,* R.R.O. 1990, Reg. 965, at s. 11(2).
[8] *FLTCA*, at s. 51(7).

11. While Bill 7 authorizes the admission of ALC patients to LTC homes without the ALC patient's consent, it does not authorize any restraint, treatment or physical transfer of ALC patients without consent. No ALC patient is forced to go anywhere or do anything. Nor does Bill 7 include any prohibitions, offences or punishments. ALC patients can avoid the application of Bill 7 altogether by leaving hospital. Ultimately, Bill 7 imposes only an economic consequence on a discharged ALC patient who refuses to leave the hospital after their admission to an LTC home is authorized: they must pay a daily fee that recoups a portion of the cost imposed on the public by their medically unnecessary stay in the hospital.

12. Bill 7 does not infringe anyone's *Charter* rights. Patients do not have a *Charter* right to live in a public hospital free of charge after their attending clinician has determined that they do not require the intensity of resources or services provided in the hospital care setting. The law does not interfere with anyone's bodily integrity or consent to treatment and does not compel an ALC patient to move to an LTC home that they do not wish to move to. Nor does Bill 7 discriminate on the basis of age or disability or any other immutable personal characteristic.

13. If it were necessary to do so, Bill 7 would be justified under *Charter* s. 1. An ALC patient who has been authorized for admission to an LTC home has a place to go that can meet their care needs while they wait for placement in their preferred LTC home. A patient who requires hospital care and who is waiting for a hospital bed in an emergency room, a hallway, an ambulance or on the sidewalk has nowhere else to go. Hospital beds are scarce and precious public resources, and maximizing their availability for people who clinically require hospitalization justifies any limitation on the *Charter* rights of ALC patients who have been clinically determined not to need the intensity of resources or services provided in the hospital care setting.

14. Ontario requests that the application be dismissed.

PART II – FACTS AND STATUTORY SCHEME

A. Hospital admission and discharge

15. Admission to a public hospital is governed by the *Public Hospitals Act* ("*PHA*") and its Regulations.[9] Medical staff who are authorized to admit patients to a hospital may not do so unless, in their opinion, it is clinically necessary that the patient be admitted.[10] Hospitals are not required to admit a person who merely requires custodial care.[11]

16. Discharge of patients is similarly regulated by law. Regulation 965 under the *PHA* provides as follows:

> 16(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.

17. Despite the mandatory wording of the legislation, hospitals had to develop their own policies and measures to facilitate the timely discharge of patients and ensure limited acute care resources were directed to those who need them. Patients on waitlists for LTC homes often stayed in the hospital well beyond their discharge date, despite not requiring hospital-level care.

18. As described by David Musyj, the President and CEO of the Windsor Regional Hospital, prior to Bill 7 his hospital had a policy that a patient who had been accepted to an LTC home but refused to leave the hospital would be subject to a $600 daily rate, representing

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[9] *PHA*, R.S.O. 1990, c. P.40; *Hospital Management,* R.R.O. 1990, Reg. 965.
[10] *Hospital Management,* R.R.O. 1990, Reg. 965, at s. 11(2).
[11] *PHA,* at s. 21(b).

a contribution to the cost associated with remaining in a hospital treatment bed (approximately $1100 per day). Mr. Musyj described how front-line staff were sometimes subjected to verbal abuse by patients because of this policy.[12]

19. Dr. Jordan Pelc noted that in his hospital (Mount Sinai), prior to Bill 7, allowing a patient to wait in a hospital bed for placement in LTC required the special approval of hospital management. Where a patient remained admitted until they could be transferred, the hospital required them to choose multiple LTC home options with shorter wait times.[13]

20. Hospitals had to address the issue on an *ad hoc* basis, without the benefit of legislative or regulatory guidance. The result for patients was uncertainty and a different regime depending on the hospital involved. As described further below, this changed following the enactment of Bill 7.

B. Alternate Level of Care patients

21. An ALC patient is someone who, in the clinician's opinion, does not require the intensity of resources or services provided in the hospital setting. Most Canadian hospitals have ALC patients occupying between ten and twenty percent of their acute beds.[14] As acknowledged by the Applicants, the designation of patients as ALC did not begin with the enactment of Bill 7.[15] The term has long been used in Ontario to refer to patients who remain in hospital but do not require the intensity of resources and services provided in that setting.

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[12] Affidavit of David Musyj affirmed February 23, 2024 (**"Musyj Affidavit"**), para. 31, JR, Vol. V, Tab 19, p. 2014.

[13] Pelc Affidavit, para. 19, JR, Vol. V, Tab 21, pp. 2152-2153.

[14] Carpenter Affidavit, para. 24, JR, Vol. V, Tab 15, Exhibit B, pp. 1797-1829; Narayan Affidavit, para. 10, JR, Vol. V, Tab 20, p. 2136; Jarrett Affidavit, para. 8, JR, Vol. V, Tab 18, pp. 2000-2001; Pelc Affidavit, para. 23, JR, Vol. V, Tab 21, p. 2154.

[15] Applicant's Factum at para. 27.

There are several resources available to health care workers that provide guidance on the ALC designation.[16]

22. All the witnesses in this proceeding agree that the ALC designation is an administrative label, not a medical diagnosis. The most responsible physician ("MRP") makes the designation, but the entire medical team provides input. Dr. Carpenter described the process as follows:

> I will usually take the team rounds as an opportunity to assess whether the entire team has the consensus opinion that the patient is discharge ready. ALC status in this context does somewhat resemble a clinical syndrome like frailty: It is easy to identify on either end of a spectrum, but in the middle there will definitely be some disagreement amongst team members as to a patient's overall discharge readiness. In most cases, the determination should be the result of collective decision-making with multiple opinions for input. In my experience and as supported in previous research, health professionals tend to be risk-averse and less likely to apply an ALC designation if there are any concerns.[17]

23. A patient's ALC status may change over time. If an ALC-designated patient becomes medically unstable or requires acute care, the designation is removed. As with the initial designation, the decision is informed by consultation with the medical team, including specialists with the appropriate expertise:

> ALC designated patients continue to receive care in the hospital…Consultant services are often called for ALC designated patients, common examples being both Geriatrics and Geriatric Psychiatry. This demonstrates the expected process, namely, that when teams feel a patient (including those designated ALC) would benefit from medical reassessment, teams do indeed reassess them and offer appropriate intervention by consulting the appropriate specialty…. If it is found that a patient is no longer appropriate for discharge, their ALC designation is removed.[18]

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[16] Musyj Affidavit, Exhibit B, JR, Vol. V, Tab 19B, p. 2023; Exhibit C, Tab 19C, p. 2028; Exhibit D, Tab 19D, p. 2034.

[17] Carpenter Affidavit, para. 17, JR, Vol. V, Tab. 15, p. 1772. Dr. Pelc's evidence was similar: "*From a process perspective, decisions to designate patients ALC are made at interdisciplinary rounds. A patient is designated ALC when there is consensus that they meet ALC criteria.*", Pelc Affidavit, para. 9, JR, Vol. V, Tab 21, p. 2149.

[18] Pelc Affidavit, para. 12, JR, Vol. V, Tab 21, p. 2150. See also Cross-examination of Dr. Samir Sinha dated April 12, 2024 (**"Sinha Cross"**), qq. 25-28, JR, Vol. VII, Tab 32, pp. 3099-3100.

24. The ALC designation can be an important administrative signal to the patient's care team to take certain steps to advance the patient's interests, such as applications for rehab or home care services.[19] It also triggers a referral to Ontario Health atHome ("OHaH", formerly Home and Community Care Support Services or HCCSS), described below.[20]

C. Admission to LTC from a hospital

25. OHaH is a provincial agency that co-ordinates in-home and community-based services to support the health and well-being of Ontarians, provides access and referrals to other community services, and manages Ontario's LTC home placement process.

26. OHaH has teams of care coordinators working in each hospital in the province. The role of the OHaH care coordinator is to determine the most appropriate discharge destination for the patient. Where a patient is considered a candidate for long-term care, the care coordinator assesses their eligibility for admission to an LTC home.

27. Pursuant to the *FLTCA*, the coordinator requires the following assessments to determine eligibility to an LTC home:

> (a) An assessment of the applicant's physical and mental health, and the applicant's requirements for medical treatment and health care.
>
> (b) 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.[21]

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[19] Carpenter Affidavit, para. 19, JR, Vol. V, Tab 15, pp. 1772-1773.
[20] Affidavit of Sandra Iafrate sworn February 23, 2024 **("Iafrate Affidavit")**, para. 4, JR, Vol. V, Tab 17, p. 1964.
[21] *FLTCA*, at s. 50(4).

28. Further eligibility criteria are set out in regulation under the *FLTCA*.[22] If the patient is not eligible for admission to an LTC home, they will be advised how to appeal the decision.

29. When a patient is found to be eligible for LTC, the coordinator works with the patient, their substitute decision maker ("SDM") if any, and/or their family on the LTC home application process. The coordinator shall provide the patient with information about the length of waiting lists and approximate times to admission for LTC homes, vacancies in LTC homes, and how to obtain information from the Ministry of Long-Term Care about LTC homes.[23] Patients and their families are encouraged to tour homes, virtually or in person.

30. When a patient applies to an LTC home, the coordinator will provide the home with the patient's information and the various assessments that have been completed. The information should be no more than three months old. It is then up to the LTC home to determine if it can accept the patient (directly, or onto a waitlist). The LTC home will review the assessments and information provided, and shall approve the applicant's admission to the LTC home unless:

(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.[24]

31. It is up to the LTC home to ensure that they can meet the patient's care needs before approving their application. The Applicants' expert, Dr. Maurice St. Martin, is a Medical Director in LTC homes and acts as the MRP for patients in several LTC homes. His evidence

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[22] O. Reg. 246/22, at s. 172.
[23] O. Reg. 246/22, at s. 171(4).
[24] *FLTCA,* at s. 51(7). No regulations have been passed setting out grounds for withholding approval.

makes it clear that it is the Medical Director's responsibility to ensure that patients are not approved for admission if they cannot be provided with appropriate care. He notes that as Medical Director, he has personally intervened on a number of occasions to reject applicants in this situation.[25]

32. Once a patient has been accepted to an LTC home, they will go on the waitlist unless a bed is immediately available. When a patient receives a bed offer from an LTC home, they generally have 24 hours to decide whether to accept that offer.[26] Where the bed offer is accepted, the patient is generally expected to move into the home within five days of being advised of the availability.[27] The modifications to the LTC home admission process made by Bill 7 are described below.

D. ALC numbers and their impact on hospital capacity

33. 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.[28]

34. 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).[29] 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.[30]

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[25] Affidavit of Dr. Maurice St. Martin sworn April 11, 2023 **("St. Martin Affidavit")**, paras. 15, 20, 30, JR, Vol. IV, Tab 14, pp. 1749, 1751-1752, 1755-1756.
[26] O. Reg. 246/22, at s. 203(e).
[27] O. Reg. 246/22, at s. 203 (f).
[28] Carpenter Affidavit, para. 25, JR, Vol. V, pp. 1774-1775; Cross-examination of Dr. Travis Carpenter dated April 19, 2024 **("Carpenter Cross")**, JR, Vol. VI, Tab 24, p. 2400.
[29] Responding Affidavit of Dr. Samir Sinha sworn April 2, 2024 **("Sinha Responding Affidavit")**, Exhibit A, JR, Vol. IV, Tab 13, pp. 1706-1718.
[30] Sinha Responding Affidavit, Exhibit A, JR, Vol. IV, Tab 13, pp. 1706-1718.

35. 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.[31] 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.[32] Based on an average acute care length of stay of 7 days,[33] 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.

36. 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.[34] 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.[35] 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.[36]

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[31] Carpenter Cross, JR, Vol. VI, Tab 24, p. 2410.
[32] Sinha Responding Affidavit, Exhibit A, JR, Vol. IV, Tab 13, pp. 1706-1718.
[33] Musyj Cross, JR, Vol. VII, Tab 29, p. 2823.
[34] Affidavit of Dr. Rhonda Crocker Ellacott affirmed February 23, 2024 (**"Ellacott Affidavit"**), para. 5, JR, Vol. V, Tab 16, p. 1950; Carpenter Affidavit, para. 25, JR, Vol. V, Tab 15, pp. 1774-1775; Ellacott Affidavit, paras. 4, 13, 16, JR, Vol. V, Tab 16, pp. 1950, 1952-1953; Jarrett Affidavit, para. 15, JR, Vol. V, Tab 18, p. 2002; Pelc Affidavit, para. 24, JR, Vol. V, Tab 21, p. 2154.
[35] Carpenter Affidavit, para. 25, JR, Vol. V, Tab 15, pp. 1774-1775; Ellacott Affidavit, para. 13, 16, JR, Vol. V, Tab 16, p. 1952-1953; Jarrett Affidavit, para. 15, JR, Vol. V, Tab 18, p. 2002; Pelc Affidavit, para. 24, JR, Vol. V, Tab 21, p. 2154.
[36] Jarrett Affidavit, para. 8, JR, Vol. V, Tab 18, pp. 2000-2001; Narayan Affidavit, para. 11, JR, Vol. V, Tab 20, p. 2136.

37. The situation has become especially dire with Canada seeing record-setting wait times for emergency care.[37] 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.[38] 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.[39]

38. 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.[40] A prolonged hospital stay may represent a "tipping point" from which the person never fully recovers.[41]

39. 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.[42] 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.[43]

40. 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

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[37] Carpenter Affidavit, para. 26, JR, Vol. V, Tab 15, p. 1775.
[38] Carpenter Affidavit, para. 27, JR, Vol. V, Tab 15, pp. 1775-1776.
[39] Carpenter Affidavit, para. 27, JR, Vol. V, Tab 15, pp. 1775-1776.
[40] Carpenter Affidavit, para. 27, JR, Vol. V, Tab 15, pp. 1775-1776; Jarrett Affidavit, para. 8, JR, Vol. V, Tab 18, pp. 2000-2001; Narayan Affidavit, para. 11, JR, Vol. V, Tab 20, p. 2136.
[41] Narayan Affidavit, para. 12, JR, Vol. V, Tab 20, pp. 2136-2137.
[42] Musyj Affidavit, para. 18, JR, Vol. V, Tab 19, pp. 2011-2012.
[43] Musyj Affidavit, para. 20, JR, Vol. V, Tab 19, p. 2012.

for patients to recover from surgery, leading to surgeries being postponed or cancelled.[44] While the impact of ALC patients on hospital capacity is particularly concerning with respect to the occupancy of acute care beds, ALC patients in other hospital beds also negatively impacts hospital capacity. When it comes to patient flow, as Dr. Carpenter explained, "everything is connected", and diminished capacity in post-acute beds can interrupt movement of patients from acute to post-acute beds, which in turn can further prevent patients waiting in the emergency department from occupying acute beds.[45]

41. While construction on new hospitals is currently underway, Ontarians who need hospital level care now cannot wait years for facilities to be built to receive that care.[46]

42. It is not beneficial for ALC patients who no longer require hospital-level care to remain in a hospital. Hospital is not the most appropriate location for patients designated as ALC whose needs can be safely met in an LTC home.[47] These patients incur adverse events while waiting in an environment maladapted for their needs.[48] For example, they are at risk of infection and complications from lack of mobility.[49] ALC patients in hospital also do not have the same access to enriching services, activities or supports, such as the social and physical activity, entertainment, and organized dining, that are often available in LTC home

[44] Musyj Affidavit, para. 21, JR, Vol. V, Tab 19, p. 2012; Narayan Affidavit, para. 13, JR, Vol. V, Tab 20, p. 2137; Pelc Affidavit, para. 25, JR, Vol. V, Tab 21, p. 2154.
[45] Cross-Examination of Scott Jarrett dated April 8, 2024, qq. 10, JR, Vol. VII, Tab 28, p. 2749 and qq. 124, pp. 2783-2784; Carpenter Cross, JR, Vol. VI, Tab 24, pp. 2402-2403.
[46] Musyj Affidavit, para. 19, JR, Vol. V, Tab 19, p. 2012.
[47] Jarrett Affidavit, para. 14, JR, Vol. V, Tab 18, p. 2002.
[48] Carpenter Affidavit, para. 34, JR, Vol. V, Tab 15, p. 1779 and Exhibit K, p. 1937.
[49] Musyj Affidavit, para. 23, JR, Vol. V, Tab 19, p. 2012-2013.

settings.[50] Many of the Applicants' own witnesses gave evidence about the harms that can come from extended hospital stays, particularly for seniors.[51]

E. The changes made by Bill 7

43. Suboptimal allocation of scarce hospital capacity has led to increasing risks to the health and lives of patients, as well as increasing distress by providers that adequate care cannot be provided, resulting in stakeholders calling for practical and immediate steps to be taken at all levels of the health care system to mitigate these harms.[52]

44. These concerns all underscore the importance of a multifaceted approach to improve patient flow across the health system and ensure that individuals are placed in locations suited to their health care needs. As part of this approach, measures enacted under Bill 7, which allow for quicker and more efficient transfers into LTC homes, are an important means of supporting and improving the flow of hospital operations, creating a greater likelihood that a bed will be available to patients who do require acute hospital level care.[53]

45. The process described above for designating a patient as ALC has not changed as a result of Bill 7. Patients are designated or de-designated as ALC by their MRP, usually as part of a team discussion.[54] The criteria for ALC status and the designation process remain the same.[55]

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[50] Musyj Affidavit, para. 23, JR, Vol. V, Tab 19, pp. 2012-2013.
[51] Affidavit of Dr. George Heckman sworn March 3, 2023 (**"Heckman Affidavit"**), paras. 9-14, JR, Vol. I, Tab 8, pp. 418-420; Affidavit of Dr. Amit Arya sworn March 23, 2023 ("**Arya Affidavit**"), para. 5, JR, Vol. I, Tab 4, p. 172; Affidavit of Dr. Samir Sinha sworn March 21, 2023 **("Sinha Affidavit")**, para. 19, JR, Vol. IV, Tab 12, p. 1475; Cross-examination of Dr. George Heckman dated April 19, 2024 **("Heckman Cross")**, qq. 15-20, JR, Vol. VI, Tab 26, pp. 2579-2580.
[52] Carpenter Affidavit, para. 26, JR, Vol. V, Tab 15, p. 1775.
[53] Carpenter Affidavit, para. 28, JR, Vol. V, Tab 15, p. 1776; Musyj Affidavit, para. 24, JR, Vol. V, Tab 19, p. 2013.
[54] Pelc Affidavit, para. 17, JR, Vol 5, Tab 21, pp. 2152; Narayan Affidavit, paras. 7-8, JR, Vol. V, Tab 20, pp. 2135-2136.
[55] Carpenter Affidavit, para. 35, JR, Vol. V, Tab 15, pp. 1779-1780.

46. Furthermore, the role of physicians in the process for applying to LTC has not changed as a result of Bill 7. The administrative steps to apply for LTC home admission continue to be managed by OHaH, as they were before Bill 7.[56]

47. When an ALC designation is made and a referral is sent to OHaH, a hospital care coordinator will pick up the referral and begin the process of assessing and counselling the patient.[57] The care coordinator will engage with the patient or their SDM to obtain consent, assess the patient's care needs, and develop a plan of care that considers the patient's wishes and the family and other resources available to them. Sandra Iafrate, Interim Vice President of OHaH, described the process as "iterative", noting that it "may take several days and include multiple meetings with the patient, their family, and the care team."[58]

48. When a patient is designated as ALC-LTC, OHaH's goal "is to place the patient as quickly as possible, recognizing that patients may deteriorate rapidly as a result of an extended stay in hospital."[59]

49. ALC patients in hospital awaiting placement in LTC homes are designated as crisis level – the highest level of priority for placement.[60] The crisis designation is also appropriate to facilitate a quicker transfer, so that a hospital bed being occupied by an ALC patient can be used by a patient who requires hospital-level care.

50. After the care coordinator completes a comprehensive assessment of the patient, they recommend LTC home choices that can meet the patient's care needs and are within a specified proximity to the patient's preferred location(s), including homes with shorter

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[56] Pelc Affidavit, para. 21, JR, Vol 5, Tab 21, p. 2153; Carpenter Affidavit, para. 35, JR, Vol. V, Tab 15, pp. 1779-1780.
[57] Iafrate Affidavit, para. 4, JR, Vol. V, Tab 17, p. 1964.
[58] Iafrate Affidavit, para. 4, JR, Vol. V, Tab 17, p. 1964.
[59] Iafrate Affidavit, para. 5, JR, Vol. V, Tab 17, pp. 1964-1965.
[60] Iafrate Affidavit, para. 8, JR, Vol. V, Tab 17, pp. 1965-1966.

waitlists for the patients to consider.[61] Ideally, a patient or their SDM will consent to be assessed for eligibility for LTC home admission and, if deemed eligible, will select several LTC homes to apply to. If a patient or SDM does not consent to an assessment for LTC home admission, Bill 7 allows for these assessments to be prepared based on hospital records and information from other care providers.[62]

51. If a patient or their SDM refuses to apply to *any* LTC homes, or will only apply to homes with very lengthy waitlists, the care coordinator is authorized, pursuant to changes made by Bill 7, to select LTC homes for an ALC patient that will meet their care needs and enable them to wait for their preferred choice outside of the hospital.[63] The care coordinators may only proceed if reasonable efforts have been made to obtain the consent of the patient or their SDM.[64]

52. In selecting potential LTC homes for an ALC patient, the care coordinator must consider the patient's condition and circumstances, the class of accommodation they have requested, if any, and the proximity of the home to the patient's preferred location.[65] Care coordinators remain mindful of ethnocultural preferences and travel distance of caregivers[66] and may only select an LTC home that is within a 70 km radius from the patient's preferred location, or 150 km radius if the patient's preferred location is in the area of the North East LHIN or the North West LHIN. Ms. Iafrate's evidence was that the average distance between

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[61] Iafrate Affidavit, para. 8, JR, Vol. V, Tab 17, pp. 1965-1966.
[62] *FLTCA*, at s. 60.1 and O. Reg 246/22, at s. 240.1(5)-(10); Carpenter Affidavit, para. 36, JR, Vol. V, Tab 15, p. 1780.
[63] Iafrate Affidavit, para. 11, JR, Vol. V, Tab 17, p. 1967; See also *FLTCA*, at s. 60.1.
[64] *FLTCA*, at s. 60.1(4); Iafrate Affidavit, para. 11, JR, Vol. V, Tab 17, p. 1967; Iafrate Affidavit, Exhibit A, JR, Vol. V, Tab 17, pp. 1975-1976, 1978.
[65] O. Reg 246/22, at s. 240.2(5) and (7).
[66] Iafrate Affidavit, para. 11, JR, Vol. V, Tab 17, p. 1967.

an LTC home selected by a coordinator and the patient's top choice of preferred LTC home is 13.7 km.[67]

53. Once a patient has selected which LTC homes they will be applying to (or once the care coordinator selects additional homes), the care coordinator sends the information about the patient, including their assessments, to the LTC homes to determine whether they can offer the patient a suitable placement.[68] As Ms. Iafrate notes: "The personal health information provided to LTC homes is the same regardless of whether the home is chosen by the patient or applied to by the care coordinator without the patient's consent."[69]

54. LTC homes have 5 days to assess applications and to make a determination whether to accept an applicant.[70] They will only accept a patient if they can safely care for them.[71]

55. Once a patient has been accepted to an LTC home they will go on the waitlist unless a bed is immediately available. If the patient agrees to be moved to a care coordinator selected home, they will maintain their crisis-level priority status for any other LTC homes they selected, up to a maximum of five homes.[72]

56. When an ALC patient receives a bed offer from an LTC home and is discharged, Bill 7 requires hospitals to charge a standardized rate of $400 for each day that the patient chooses to remain in hospital instead of moving to the LTC placement, following the expiry of a 24-hour waiting period.[73] This represents a contribution to the cost associated with remaining in a hospital treatment bed (approximately $1100 per day) when acute hospital

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[67] Cross-examination of Sandra Iafrate dated April 15, 2024 **("Iafrate Cross")**, Questions Taken Under Advisement During the Cross-Examination, JR, Vol. VII, Tab 35C, p. 3185.
[68] Iafrate Affidavit, paras. 11-13, JR, Vol. V, Tab 17, pp. 1967-1968.
[69] Iafrate Affidavit, para. 12, JR, Vol. V, Tab 17, pp. 1967-1968.
[70] Iafrate Affidavit, para. 13, JR, Vol. V, Tab 17, p. 1968; *FLTCA*, at s. 51(7).
[71] St. Martin Affidavit, paras. 15, 20, 30, JR, Vol. IV, Tab 14, pp. 1749, 1751-1752, 1755-1756.
[72] O. Reg 246/22, at s. 240.3(3); Musyj Affidavit, para. 35, JR, Vol. V, Tab 19, p. 2015.
[73] Musyj Affidavit, para. 29, JR, Vol. V, Tab 19, p. 2014.

treatment services are no longer required.[74] As Mr. Musyj, President of Windsor Regional Hospital, explained: "The standardized rate acts as an incentive for ALC patients to accept LTC placements available to them, thereby freeing up an acute care bed for another patient."[75]

57. The measures under Bill 7 provide opportunity to work with patients and families to identify alternative and appropriate care settings for patients who do not require the level of care provided in an acute care hospital.[76] They enable the system to flow patients to the most appropriate care setting.[77]

58. For example, by empowering OHaH care coordinators to apply to LTC homes without patient consent, Bill 7 has facilitated the placement of eleven ALC patients from Windsor Regional Hospital into LTC homes.[78] Two of these patients who identified preferred homes subsequently moved to those preferred homes, and three declined an offer to move to their preferred homes, choosing instead to stay in the ones selected for them by the OHaH care coordinators.[79] These eleven placements alone potentially created space for 250 other acute care patients to receive care at Windsor Regional Hospital.[80]

F. The Applicant's Evidence

59. The Applicants rely on the evidence of four physicians (Drs. Arya, Heckman, St Martin and Sinha), none of whom acts as a Most Responsible Physician for hospital in-patients and none of whom is responsible for writing orders designating hospital in-patients

[74] Musyj Affidavit, para. 30, JR, Vol. V, Tab 19, p. 2014.
[75] Musyj Affidavit, para. 31, JR, Vol. V, Tab 19, p. 2014.
[76] Jarrett Affidavit, paras. 11-16, JR, Vol. V, Tab 18, pp. 2001-2002.
[77] Jarrett Affidavit, paras. 11-16, JR, Vol. V, Tab 18, pp. 2001-2002; Ellacott Affidavit, para. 14, JR, Vol. V, Tab 16, p. 1952.
[78] Musyj Affidavit, para. 8, JR, Vol. V, Tab 19, p. 2009; Musyj Cross, JR, Vol. VII, Tab 29, pp. 2823-2827, Exhibit 1, p. 2851.
[79] Musyj Cross, Exhibit 1, JR, Vol. VII, Tab 29, p. 2851.
[80] Musyj Affidavit, para. 8, JR, Vol. V, Tab 19, p. 2009; Musyj Cross, JR, Vol. VII, Tab 29, pp. 2823-2827, Exhibit 1, p. 2851.

as ALC.[81] They offer a number of speculative apprehensions or criticisms about the decisions of other, unnamed doctors who designate patients as ALC.

60. The Respondent, by contrast, relies on the evidence of three physicians (Drs. Carpenter, Narayan and Pelc), each of whom acts as Most Responsible Physician for many hundreds of hospital in-patients in Ontario each year and each of whom is responsible for designating and de-designating patients as ALC. To the extent that there is a difference of opinion about the ALC designation process between the Applicants' physician experts and the Respondent's physician experts, the Court should prefer the evidence of the latter, as these physicians actually discharge the important responsibility of admitting and discharging hospital patients and are actually responsible for designating or de-designating patients as ALC.

61. The Applicants also rely on the expert evidence of Dr. Armstrong, a sociologist. Dr. Armstrong has no role in designating hospital patients as ALC, discharging patients from hospitals, or admitting patients into LTC homes.[82] The publications cited by Dr. Armstrong do not examine the designation of ALC patients[83] or the process of transferring ALC patients from hospital to LTC homes[84] or refer to Bill 7 or its impacts.[85] Dr. Armstrong agreed that she not in a position to disagree with any clinical decision to admit or deny patients admission to an LTC home.[86]

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[81] Cross-examination of Dr. Amit Arya dated April 26, 2024 (**"Arya Cross"**), qq. 7-8, JR, Vol. VI, Tab 23, pp. 2390-2391; Sinha Cross, qq. 21-22, 123, JR, Vol. VII, Tab 32, pp. 3098, 3138-3140; Heckman Affidavit, para. 4, JR, Vol. I, Tab 8, p. 416; Affidavit of Dr. Maurice St. Martin sworn March 3, 2023 (**"St. Martin Affidavit"**), paras. 2-7, JR, Vol. IV, Tab 14, pp. 1745-1747.

[82] Cross-examination of Dr. Pat Armstrong dated April 16, 2024 (**"Armstrong Cross"**), qq. 27-29, JR, Vol. VI, Tab 22, pp. 2352-2353.

[83] Armstrong Cross, qq. 104, 144, JR, Vol. VI, Tab 22, pp. 2367, 2376.

[84] Armstrong Cross, qq. 107, 145, JR, Vol. VI, Tab 22, pp. 2368, 2376-2377.

[85] Armstrong Cross, qq. 111, 143, JR, Vol. VI, Tab 22, pp. 2369, 2376.

[86] Armstrong Cross, qq. 111, 143, JR, Vol. VI, Tab 22, pp. 2369, 2376.

62. The Applicants also rely on the affidavit of Jane Meadus, a lawyer for one of the Applicants. Her views about the merits of the law that her client is challenging are not evidence but really legal argument in the form of an affidavit.

PART III – ISSUES

63. Ontario submits that the issues on this application are as follows:

a) Does Bill 7 infringe the rights of ALC patients under *Charter* s. 7?

b) Does Bill 7 discriminate against ALC patients contrary to *Charter* s. 15?

c) If the answer to either of these questions is yes, is Bill 7 justified under *Charter* s. 1?

64. Ontario submits that Bill 7 does not infringe any *Charter* rights. In the alternative, any infringement is justified as a reasonable limit under *Charter* s. 1.

PART IV – LAW AND ARGUMENT

A. No infringement of *Charter* s. 7

65. The analysis under s. 7 of the *Charter* proceeds in two stages. The first question is whether the impugned law deprives the claimant of their life, liberty, or security of the person. If the answer to that question is "yes", the second question is whether the infringement is in accordance with the principles of fundamental justice.[87] If the claimant cannot meet the first part of the test, the "analysis stops there."[88] The claimant bears the onus at both steps.[89]

[87] *Carter v Canada (Attorney General)*, 2015 SCC 5 at para. 71 [*Carter*]; *Canada (Attorney General) v Bedford*, 2013 SCC 72 at para. 93 [*Bedford*].
[88] *Blencoe v British Columbia (Human Rights Commission)*, 2000 SCC 44 at para. 47. [*Blencoe*].
[89] *Carter,* at para. 55.

i. The importance of taking a system perspective

66. Ontario denies that the impugned legislation deprives anyone of life, liberty or security of the person and, in any event, denies that any deprivation is contrary to the principles of fundamental justice. But more generally, Ontario submits that the framework of individual *Charter* s. 7 rights is a poor lens through which to view the intractable problem of resource allocation that lies at the heart of this case.

67. Bill 7 is concerned with the optimal allocation of a scarce, finite and precious public resource: public hospital beds. It is incontrovertible that the demand for hospital beds in Ontario exceeds the current availability of these beds. It is similarly indisputable that the demand for LTC home beds currently exceeds the supply, with some LTC homes experiencing waitlists that are months or even years long. While efforts are underway to increase the supply of both hospital beds and LTC home beds, such efforts take time and cannot match the unmet demand immediately.

68. The reality is that no relief sought on this application and nothing that the Court can order will create more hospital beds or decrease waitlists for LTC homes. The Court, no less than the Legislature or the Government, must take the reality of the situation as it is when considering resource distribution questions such as how the existing and finite supply of hospital beds can be allocated fairly, who must wait to be admitted to a hospital bed or LTC home, and where those people should wait for their preferred care placement.

69. The *Charter* s. 7 rights of individuals shed no light on this intractable problem of how to allocate these scarce and finite public resources. Of course, ALC patients have a *Charter* s. 7 right to life, liberty, and security of the person, to "medical autonomy" and to make "fundamental personal choices". But so too do the patients who are waiting in the emergency department or in hospital hallways for admission to a hospital bed. The patient

waiting in the emergency room has the same constitutional right to "medical autonomy" as the ALC patient waiting for an LTC home in a hospital bed that they no longer need. The LTC home resident who has already been admitted to a popular LTC home has identical *Charter* rights to the ALC patient who will wait years on a wait list for admission, and identical *Charter* rights to the person who is waiting for their preferred LTC home at home instead of in a hospital bed.

70. The *Charter* s. 7 rights of individuals cannot assist in allocating the scarce and finite supply of health care resources, because all of the individuals who seek access to those resources have identical s. 7 rights. Giving priority to the "fundamental personal choice" of an ALC patient who wishes to wait in a hospital bed for their preferred LTC home over the wishes of a patient in the emergency department who requires admission to that bed to receive hospital care does nothing to advance *Charter* rights, because doing so merely substitutes the interests of one *Charter* rights-holder for those of another person with the same *Charter* rights.

71. The implacable reality is that allocating existing finite health care resources is a literally zero-sum situation: either an ALC patient can wait in a hospital bed for placement in their preferred LTC home, or a hospital patient can be admitted to that hospital bed instead. But both *Charter* rights-holders cannot occupy the same bed at once, no matter what their "medical autonomy" or "fundamental personal choice" is. It follows that any attempt to invoke *Charter* s. 7 to promote the priority of some individuals to stay in hospital instead of others is misguided.

72. The *Charter* s. 7 cases relied on by the Applicant – including *Bedford*, *Carter*, *PHS*, *Chaoulli,* and *Morgentaler*[90] – all arose in a very different context. Each of those cases involved a penal prohibition coupled with a penalty of a fine or imprisonment. In such circumstances, the state acts as "singular antagonist"[91] against the individual by imposing prohibitions and the threat of punishment, and so of course the rights of individuals to liberty, security, autonomy, and fundamental personal choices are implicated.

73. By contrast, Bill 7 imposes no prohibitions and creates no offences or punishments. Under Bill 7, an ALC patient is free to leave hospital at any time, free to decline any medical treatment (including a physical examination to determine eligibility for admission to an LTC home), and free to decline to move to an LTC home. Nothing in Bill 7 authorizes any person to restrain an ALC patient or to physically transfer an ALC patient to an LTC home without their consent. The consequence for an ALC patient who refuses to leave hospital despite being discharged is purely economic: they must pay a portion of the cost of the publicly funded hospital bed that they have chosen to occupy. And unlike a person whose life, liberty or security of the person is engaged by the prohibitions at issue in *Carter*, *Bedford*, *PHS*, *Chaoulli,* or *Morgentaler*, an ALC patient is free to opt-out of the application of Bill 7 at any time by leaving the hospital.

74. In this context, the state is not acting as "singular antagonist" by prohibiting and punishing the conduct of individuals. Rather, it is concerned with the "reconciliation of claims of competing individuals or groups or the distribution of scarce government resources."[92] As

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[90] *Bedford; Carter; Canada (Attorney General) v. PHS Community Services Society*; 2011 SCC 44, [2011] 3 S.C.R. 134 [*PHS*]; *Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35 [*Chaoulli*]*; R. v. Morgentaler*, 1988 1 SCR 30 [*Morgentaler*].
[91] *Irwin Toy Ltd. v. Quebec (Attorney General)*, 1989 1 S.C.R. 927, at p. 994 [*Irwin Toy Ltd.*].
[92] *Irwin Toy Ltd.*, at p. 994.

the Supreme Court has noted, courts have no superior expertise or legitimacy as compared to the elected branches of government in making such decisions:

> 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.[93]

75. Indeed, courts are at a disadvantage compared to elected governments in assessing the trade-offs that must inevitably be made when a system attempts to balance and reconcile the diverse and deserving needs of multiple groups all seeking access to the same finite and scarce public resources. As Professors Greschner and Lewis explain:

> 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.[94]

76. In this case, the risk of "telescopic vision" is great. The Applicants advance the perspective of a single group of health care system users: ALC patients who are waiting in hospital for an LTC home. They rely on evidence from three individuals, Ms. Chaloner, Ms. Parkinson and Ms. Herrington, each of whom had a loved one in sympathetic circumstances waiting in hospital for a placement in their preferred LTC home.

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[93] *Irwin Toy Ltd.*, at p. 993.

[94] D. Greschner & S. Lewis, "Auton and Evidence-Based Decision-Making: Medicare in the Courts" (2003) 82 Can. Bar Rev. 501, at p. 507-508.

77. If the only issue in this case was deciding what was in the best interests of these three patients, the decision might be easy. But Ontario's health care system must reconcile the legitimate needs of all patients, including the needs of patients who are not before the court. In that balance, the interests of these three individuals cannot assume priority over countless other patients merely because these three have sworn affidavits in a court case. Bill 7 is a response to a system-wide issue, and the Court must approach it with a system perspective, rather than viewing the issue solely through the eyes of the claimant group.

ii. No *Charter* s. 7 right to choose to live in a hospital without charge

78. What is really sought in this challenge is the right of ALC patients to remain in hospital while they wait for their preferred LTC home placement to become available, even though they do not require the intensity of resources or services provided in the hospital care setting. No such right is protected by *Charter* s. 7.

79. The Applicants assert that Bill 7 deprives ALC patients of their autonomy "to choose where they live in what will typically be the final months of their life"[95] and of their "fundamental rights to informed consent to where they live".[96] The Applicants argue that the "intensely personal considerations that often inform an individual's decision as to where to live" fall within the "irreducible sphere of personal autonomy" protected under *Charter* s. 7.[97] But no individual has a *Charter* s. 7 right to choose to live in a public hospital free of charge.

80. There is no *Charter* right to publicly funded health care.[98] Section 7 does not protect the right to state funding for even life-saving medical treatment.[99] It would therefore be

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[95] Applicant's Factum at para. 96.
[96] Applicant's Factum at para. 128.
[97] Applicant's Factum at para. 91.
[98] *Chaoulli*, at para. 104.
[99] *Flora v. Ontario Health Insurance Plan*, 2008 ONCA 538 at para. 101.

anomalous if a patient had a *Charter* s. 7 right to choose to remain in a public hospital free of charge even after they no longer require the intensity of resources or services provided in the hospital care setting.

81. No-one has an "autonomy" right to make the "fundamental personal choice" to live in a hospital bed. A patient cannot, by exercise of fundamental personal choice, choose to admit themselves to hospital. Indeed, no person may be admitted to a public hospital unless a clinician with the privilege to do so concludes that "it is clinically necessary that the person be admitted" and writes an order to that effect.[100] Equally, once the patient is no longer in need of treatment in the hospital, the responsible clinician must order them discharged, and the patient "shall leave the hospital on the date set out in the discharge order."[101]

82. Public hospital beds, like courtrooms or classrooms, are special-purpose public amenities. They are made available for eligible persons to use for a particular purpose, and when that purpose is served, the person must relinquish their use so that someone else may use them in turn. A hospital is not anyone's home, and a law that states that persons who no longer require the intensity of resources or services provided in the hospital care setting must either leave the hospital or pay a portion of the cost associated with their stay does not deprive anyone of any interest protected by *Charter* s. 7.

83. The Applicants argue that Bill 7 deprives ALC patients of liberty because it "compel[s] them to apply and accept admission to LTC homes that may isolate [them] 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."[102] Bill 7 does no such thing. Under Bill 7, ALC patients are free

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[100] *Hospital Management*, RRO 1990, Reg 965, at s. 11.
[101] *Hospital Management*, RRO 1990, Reg 965, at s. 16.
[102] Applicant's Factum at para. 92.

to apply to any LTC home they wish, and free to accept or not to accept any offer of admission that they receive. An ALC patient who wishes to apply and accept admission to an LTC home of their choice is entirely free to do so.

84. Equally, no ALC patient may be restrained or physically transferred to any LTC home without their consent. While Bill 7 allows a placement coordinator to *authorize* an ALC's patient's admission to an LTC home, it does not allow anyone to compel the patient to move to an LTC home or indeed anywhere else. Bill 7 imposes no constraints on where a patient may go upon leaving hospital.

85. For an ALC patient who chooses not to leave hospital despite having been admitted to an LTC home, the consequences are purely economic: they must pay a portion of the cost associated with their daily hospital stay. The Applicants say this charge is "a fee they can't afford",[103] which may or may not be true depending on the means of the patient and the length of their hospital stay. But in any event, *Charter* s. 7 does not immunize individuals from the economic consequences of their own choices. An ALC patient who wishes to avoid the daily fee can make alternate arrangements to live elsewhere.

86. The Applicants argue that "generally a great deal of thought is put into [a patient's] choice of a LTC home where the patient will likely spend the rest of their lives" and that such decisions frequently include considerations such as whether the candidate LTC homes are "close to family and friends, meet specific ethno-cultural needs or care needs, and that have a good reputation for providing quality care."[104] They note that not all LTC homes are the same, and that patients and their SDMs generally "make rational decisions about choosing homes they wish to spend their final days in."[105]

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[103] Applicant's Factum at para. 94.
[104] Applicant's Factum at paras. 51-62.
[105] Applicant's Factum at para. 66.

87. No one disputes these propositions, but ultimately, they are beside the point. ALC patients are free under Bill 7 to apply to and accept admission to their preferred LTC homes. But when an ALC patient is *not* admitted to their preferred LTC home but instead placed on a wait list, the question remains: where should they wait – in a hospital bed or in another LTC home? Simply repeating the factors that led the ALC patient to choose their preferred home (proximity to family, cultural care needs, good reputation, etc.) is of no assistance if admission to their preferred LTC home is unavailable for months or years. A hospital bed is an unsuitable place for an ALC patient to wait for their preferred LTC home, no matter how desirable that LTC home is or how reasonable are the factors that led the patient to prefer that LTC home.

iii. No interference with bodily integrity or consent to medical treatment

88. There is no doubt that *Charter* s. 7 protects "control over one's bodily integrity free from state interference."[106] But Bill 7 does not interfere with anyone's bodily integrity. Unlike the laws at issue in *Carter* or *Morgentaler*, Bill 7 does not prohibit anyone from seeking or obtaining any medical treatment. Nor does Bill 7 authorize anyone to administer treatment to an ALC patient without their consent.

89. The list of actions that may be performed without the ALC patient's consent is set out in s. 60.1(3) of the *FLTCA*. These actions may only be taken if reasonable efforts have been made to obtain the consent of the ALC patient or their SDM. None of these actions is "treatment" within the meaning of the *HCCA*.[107]

90. A placement coordinator, who does not provide health care to the ALC patient, may take certain administrative steps, including determining the ALC patient's eligibility for admission to an LTC home and authorizing that patient's admission. These are all

[106] *Carter*, at para. 64.
[107] *HCCA,* at s. 2(1).

administrative acts that do not involve laying hands on or otherwise interfering with the patient's body at all. Neither the placement coordinator nor anyone else is permitted to restrain the patient or to compel the patient to undergo any treatment.

91. A hospital clinician is permitted to "conduct an assessment of the ALC patient for the purpose of determining the ALC patient's eligibility for admission to a long-term care home",[108] because such an assessment is necessary in order to determine whether an LTC home can safely care for the patient.[109] But where the patient does not consent to this assessment, "the person conducting the assessment shall base their assessment solely on a review of existing hospital records relating to that patient."[110] No one may restrain, lay hands on or otherwise interfere with the body of a patient who does not consent to the assessment.

iv. No deprivation of the "right to control personal health information"

92. The Applicant asserts that Bill 7 deprives ALC patients "of the right to determine whether, how, and with whom their personal health information may be shared."[111] No such unqualified right is protected by *Charter* s. 7, and none of the cases relied on by the Applicants supports the existence of such a right.

93. At common law, there is no categorical or absolute privilege associated with a patient's medical information, and medical information "may be required to be disclosed, notwithstanding the high interest of the plaintiff in keeping it confidential."[112] Courts may order parties to submit to physical and mental examinations, both under the Rules and as a

[108] *FLTCA*, at s. 60.1(3)(3).
[109] Iafrate Affidavit, para. 9, JR, Vol. V, Tab 17, p. 1966.
[110] General, O Reg 246/22, at s. 240.1(8).
[111] Applicant's Factum at para. 114.
[112] *M. (A.) v. Ryan*, 1997 1 SCR 157 at para. 37.

matter of their inherent jurisdiction,[113] and such examinations may become part of the trial record and thus open to public inspection. A purported constitutional right "to determine whether, how, and with whom [a person's] personal health information may be shared" would be inconsistent with all of these longstanding practices.

94. In Ontario, the rules governing the collection, use and disclosure of personal health information are mostly statutory and are subject to many qualifications, limitations, and exceptions. For example, the *Mandatory Blood Testing Act, 2006*,[114] the *Regulated Health Professions Act, 1991*,[115] and the *Health Protection and Promotion Act*[116] all authorize disclosures that are inconsistent with a person's purported ability "to determine whether, how and with whom" their personal health information may be shared. No court has ever found that these provisions violate any *Charter* s. 7 right.

95. The point is not that the privacy of a person's personal health information is unimportant; the point is that an individual's control over the disclosure of their personal health information sometimes gives way in law to other compelling interests, including facilitating the provision of health care, improving the health care system, protecting the public, assisting in the administration of justice, and allowing public officials to discharge their statutory duties. The assertion that individuals have a right "to determine whether, how and with whom their personal health information may be shared" is simplistic, unrealistic, and inaccurate in light of the complex regulatory framework for the protection of personal health information in Ontario.

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[113] See *Rules of Civil Procedure*, RRO 1990, Reg 194, at Rule 33.01 and *Courts of Justice Act*, RSO 1990, C.43, at s. 105; See also *Ziebenhaus (Litigation Guardian of) v. Bahlieda*, 2015 ONCA 471.
[114] S.O. 2006, c. 26, at ss. 7(2) and 11(1); O. Reg. 449/07 at s. 8(1)(b).
[115] 1991, S.O. 1991, c. 18, Schedule 2, at ss. 23(8)-(10).
[116] R.S.O. 1990, c. H.7, at ss. 11(2), 39, 77.6, 77.7.1(3), and 77.8.

96. The most important Ontario statute regulating the collection, use and disclosure of personal health information is the *Personal Health Information Protection Act, 2004* ("PHIPA"). *PHIPA* contains many protections for the privacy of a person's personal health information, but it does not give individuals an unqualified right "to determine whether, how and with whom their personal health information may be shared."[117] *PHIPA* expressly permits disclosure of personal health information without the person's consent in a variety of contexts, including: to the Chief Medical Officer of Health or a board of health for a purpose of the *Health Protection and Promotion Act*;[118] so that the Minister can provide funding or payment for provision of health care;[119] to the head of a penal or other custodial institution or officer in charge of a psychiatric facility to assist an institution or a facility in making a decision concerning or arrangements for the provision of health care to the individual or the placement of the individual;[120] for determining or verifying an individual's eligibility for health care or related benefits or services;[121] by one health information custodian who has provided or assisted in providing health care to an individual to another, for purpose of improving quality of care to individual or to others who have received similar care;[122] for purposes of a legal proceeding;[123] to comply with summons/court order;[124] where disclosure is permitted or required by law;[125] and to the Public Guardian and Trustee, the Children's Lawyer, or a Children's Aid Society so that they can carry out their statutory functions.[126]

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[117] *Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Schedule. A. [*PHIPA*]
[118] *PHIPA*, at s. 39(2); See also *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7 at s. 2. [*HPPA*]
[119] *PHIPA*, at s.38(1)(b).
[120] *PHIPA*, at s. 40(2)-(3).
[121] *PHIPA*, at s. 39(1)(a).
[122] *PHIPA,* at s. 39(1)(d)(iii).
[123] *PHIPA*, at s. 41(1).
[124] *PHIPA*, at s. 41(1)(d)(i) and (ii).
[125] *PHIPA*, at s. 43(1)(h).
[126] *PHIPA*, at s. 43(1)(e).

97. Under Bill 7, personal health information about an ALC patient may be disclosed to LTC homes for the purpose of assessing whether the patient may be safely admitted to those homes. An LTC home is only permitted to admit a resident if the LTC home can meet the person's care requirements, and so the LTC home must be provided with information about the person's health in order to satisfy this requirement. The information that a placement coordinator may provide to an LTC home without the ALC patient's consent is identical to the information that a patient provides when they apply to an LTC home of their choice. If an ALC patient could veto the disclosure of this information, they could prevent an LTC home from assessing their eligibility for admission and thereby frustrate the purpose of the statute.

98. While a placement coordinator may provide an LTC home with the ALC patient's personal health information under Bill 7 without the patient's consent, it is important to note that the other protections of *PHIPA* continue to apply. Placement coordinators and LTC homes may not collect, use or disclose personal health information if other information will serve the purpose, and must not collect, use or disclose more personal health information than is reasonably necessary to meet the purpose. They are also subject to the same controls respecting security and further disclosure as any other health information custodian.

v. No inconsistency with fundamental justice

99. In the alternative, Ontario submits that any deprivation is in accordance with the principles of fundamental justice. Given the purpose underlying the impugned provisions, the law is not arbitrary, overbroad, or grossly disproportionate.

i) The purpose of Bill 7

100. Whether the law accords with the principles of fundamental justice can only be assessed with a clear and precise articulation of the purpose of the provisions at issue. The

Applicants' approach, which relies on the general purposes of the *FTLCA* and the *HCCA*, is erroneous because it ignores the specific purpose of the challenged provisions.[127]

101. The Supreme Court has held that a challenged law's objective should be articulated "at an appropriate level of generality" which "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."[128] Instead, the objective should be both precise and succinct.[129]

102. The purpose of the amendments made by Bill 7 is to reduce the number of ALC patients in hospital who are eligible for LTC home admission in order to maximize hospital resources for patients who need hospital-level care. This precise and succinct statement of the legislative purpose is supported by the law itself, its context, and the legislative history. Statements by the Minister during the legislative debates strongly support this purpose:

> 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.[130]

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[127] *R. v. Moriarity*, 2015 3 S.C.R. 485 at para. 24, [*Moriarity*]; *R. v. Safarzadeh-Markhali*, 2016 1 S.C.R. 180 at para. 24, [*Safarzadeh-Markhali*]; *R. v. Ndhlovu*, 2022 SCC 38 at para. 61. [*Ndhlovu*].

[128] *Moriarity,* at para. 28; *Safarzadeh-Markhali*, at para. 27; and *Ndhlovu*, at para. 62.

[129] *Moriarity*, at para. 29, *Safarzadeh-Markhali,* at para. 28; and *Ndhlovu*, at para. 62.

[130] Ontario, Legislative Assembly, Official Report of Debates (Hansard), 43rd Parl, 1st Session, No. 8 (August 23, 2022) p. 327 (Paul Calandra). See also comments of the Minister's Parliamentary Assistant, John Jordan who stated: "These proposed legislative amendments will, if passed, reduce ALC patient volumes and support their movement out of hospitals now and in the future. This change is crucial because it would help ensure that patients who need hospital treatment can get the emergency treatment, surgeries and other hospital services they need when they need them. At the same time, it would make sure the ALC patients receive care in a more suitable setting that will offer a better quality of life while they wait for their preferred long-term-care home." (p. 332 John Jordan)

ii) The impugned provisions are not arbitrary

103. A law will be arbitrary where it has no connection to its objective.[131] There must be a rational connection between the law's purpose and the limits it imposes on life, liberty, or security of the person.[132]

104. The measures enacted under Bill 7 have a clear and direct connection to the purpose of reducing the number of ALC patients in hospital in order to maximize hospital resources for patients who need hospital-level care. The law facilitates the movement of ALC patients into LTC homes by encouraging ALC patients to apply broadly to multiple LTC homes and by authorizing their admission when they do not. The imposition of a daily fee for ALC patients who refuse an LTC home offer while awaiting their preferred LTC home creates a financial deterrent against waiting in a hospital bed rather than in an LTC home. It also partly recoups the costs borne by the public from the ALC patient's choice to stay in hospital instead of accepting an offer of LTC home admission.

105. The Applicants argue that the law is arbitrary because data from Ontario Health indicates that the number of ALC patients waiting for LTC home placement has increased between January 2023 and January 2024. They argue that this fact demonstrates that Bill 7 is ineffective and thus arbitrary. The Court should reject this argument.

106. First, in identifying that the number of ALC patients in Ontario has grown over time, the Applicants do not account for the fact that the population of the province has also grown over this period. Moreover, this data cannot tell us how many ALC-LTC patients would be waiting in hospital today had Bill 7 not been enacted.

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[131] *Bedford,* at para. 111.
[132] *Bedford,* at para. 111.

107. In any event, the evidence of the hospital administrators contradicts the Applicants' argument that the ALC situation in the province has only worsened since Bill 7. This evidence demonstrates the connection between Bill 7's measures and its underlying purpose. David Musyj of Windsor Regional Hospital notes:

> Bill 7 assists in transferring ALC patients out of hospital and into community care because it helps open discussion…
>
> …The changes under Bill 7 allow for faster transfer of ALC patients from the hospital directly into an LTC placement by other means, as well.
>
> For example, it is now easier for HCCSS placement coordinators to facilitate application and admission of ALC patients into LTC homes by authorizing them to take certain steps that previously could not be taken without patient consent.
>
> … In 2023, the changes under Bill 7 facilitated the placement of [11] WRH ALC patients into HCCSS selected LTC homes.[133]

108. The evidence of Scott Jarrett, Executive Vice President and Chief Operating Officer of Trillium Health Partners, also explained the positive impact of Bill 7:

> 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 LTC setting.
>
> Bill 7 has been used to select LTC homes for patients/SDMs who are unable or unwilling to make LTC choices that have a reasonable wait time. THP's standard work to engage in early discharge planning has resulted in over 240 discharges of ALC patients from hospital to LTC in the last 3 months. LTC home choices by HCCSS under the provisions of Bill 7 are infrequent, but have been helpful when THP teams have been unsuccessful in having productive conversations with families/SDMs about the most available LTC options.
>
> In the absence of Bill 7, I expect patient flow would decrease, as more acute beds would be occupied by patients who do not require acute care, leading to more patients waiting for a bed.[134]

109. Dr. Rhonda Crocker Ellacott, President and Chief Executive Officer of Thunder Bay Regional Health Sciences Centre, also gave evidence that, since the implementation of Bill 7,

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[133] Musyj Affidavit, paras. 27, 32-34, JR, Vol. V, Tab 19, pp. 2013-2015.
[134] Jarrett Affidavit, paras. 11-13, JR, Vol. V, Tab 18, pp. 2001-2002.

the number of ALC patients waiting in hospital have decreased and there has also been an improvement in patient length of stay related to better flow out of and shorter stays in the emergency department.[135]

110. Mr. Musyj's evidence about the impact of the $400/daily fee is also noteworthy. Mr. Musyj explained the positive change experienced in his hospital since the daily fee became a mandatory province-wide measure. He noted that prior to Bill 7, he would often be contacted by ALC patients objecting to charges imposed by hospital policy, and that front-line staff were sometimes subjected to verbal abuse by families of ALC patients who refused to pay. These complaints have generally stopped since Bill 7. Instead of requiring each hospital to determine how to deal with ALC patients who decline an LTC bed offer, creating an inconsistent and *ad hoc* approach, ALC patients in the province under Bill 7 "are subject to the same rate, which cannot be waived or amended by individual hospitals. The standardized rate acts as an incentive for ALC patients to accept LTC placements available to them, thereby freeing up an acute care bed for another patient."[136] Far from being arbitrary, this is a rational measure aimed at achieving its legislative purpose.

iii) The impugned provisions are not overbroad

111. Overbreadth arises when a law has some applications that are connected to its objective, but some applications that are not so connected.[137] In this way, an overbroad law is arbitrary in part.

112. The Applicants argue that Bill 7 is overbroad because it is rare for an ALC patient to unreasonably refuse to apply or be admitted to an LTC home, and when this does occur,

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[135] Ellacott Affidavit, paras. 9-10, JR, Vol. V, Tab 16, p. 1951.
[136] Musyj Affidavit, para. 31, JR, Vol. V, Tab 19, p. 2014.
[137] *Bedford*, at para. 112.

Ontario could seek an order from the Consent and Capacity Board.[138] They also argue that the law could have been crafted more narrowly to apply only where a patient refuses to select a stipulated number of homes, or where there are a certain number of vacant LTC beds, or no crisis patients waiting at home.[139] They also argue that the designation by doctors of ALC patients is "vague, inconsistently applied and on occasion just wrong."[140] Each of these claims must be rejected based on the evidence.

113. Whether or not it is "rare", the evidence demonstrates that some ALC patients in Ontario do refuse to be assessed for LTC home placement or refuse to apply to LTC homes.[141] For example, of the eleven Windsor Regional Hospital patients who were moved to LTC under Bill 7 in 2023, three had refused to apply to *any* LTC home. The evidence also showed that some ALC patients refuse a bed offer and remain in a hospital bed for lengthy periods of time.[142]

114. The Applicants' claim that Ontario could seek an order from the Consent and Capacity Board to address these concerns are addressed at paragraphs 147-148.

115. The Applicants argue that the provisions are overbroad because they apply to all ALC patients. However, the key provisions – those allowing for selection of LTC homes without ALC patient consent and the charging of a $400 daily rate to remain in hospital – only apply when a patient refuses to apply to additional LTC homes or refuses an offer of admission and is discharged from hospital. Selection of LTC homes without consent may only take place

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[138] Applicant's Factum at paras. 122-123.
[139] Applicant's Factum at paras. 124-125.
[140] Applicant's Factum at para. 126.
[141] Musyj undertakings show that of 11 patients moved to LTC under Bill 7 as of date of affidavit, 3 had refused to select any LTC homes to apply to. See also Jarrett Affidavit, para. 10, JR, Vol. V, Tab 18, p. 2001.
[142] Cross-examination of Dr. Jordan Pelc dated April 11, 2024 **("Pelc Cross")**, qq. 81-88, JR, Vol. VII, Tab 31, pp. 3052-3055.

when reasonable efforts to obtain consent have been made.[143] Patients may also choose to consent at any point without having to start the application process from the beginning.[144] The provisions of Bill 7 only have a real impact on ALC patients who refuse to consent to some part of the LTC home assessment, application, or admission process.

116. Finally, contrary to the Applicants' assertions, the ALC designation is not vague or arbitrary, and there is no evidence that it is inconsistently applied. It is true, as the Applicants note, that the designation will depend on the individual patient and the nature of the care that can be provided in a particular hospital setting.[145] Nevertheless, all the physicians in this proceeding who are responsible for designating patients as ALC had the same understanding of its meaning.

117. For example, Dr. Carpenter noted that while the term has a specific technical definition, in practical terms the relevant question for a physician is "Would you feel comfortable as the MRP discharging the patient from acute care at this point in time?"[146] Dr. Carpenter also noted that the assessment involved in determining whether a patient is ALC has not been altered by Bill 7.

118. Dr. Jordan Pelc provided a definition of ALC that is very similar to Dr. Carpenter's: "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

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[143] *FLTCA,* at s. 60.1(4). See also Iafrate Cross, q. 11, JR, Vol. VII, Tab 27, pp. 2608-2609; Iafrate Affidavit, Exhibit A, JR, Vol. V, Tab 17, pp. 1975-1976, 1978.

[144] Iafrate Affidavit, Exhibit A, JR, Vol. V, Tab 17, p. 1978.

[145] Dr. Pelc's evidence states that the ALC designation does differ in different contexts, not because the definition changes, but "because different hospital services are designed to meet different patient needs. A 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." (Pelc Affidavit, para. 8, JR, Vol. V, Tab 21, p. 2149).

[146] Carpenter Affidavit, para. 16, JR, Vol. V, Tab 15, pp. 1771-1772.

cases the patient would be designated ALC."[147] Dr. Narayan's evidence similarly noted that while "the process for designating patients ALC is not standardized across the sector, general principles of medical stability and consideration of whether one requires specialized hospital care or supports apply broadly."[148]

119. The ALC designation simply indicates that a patient no longer requires hospital care. It is a determination made by clinicians with the appropriate expertise. The fact that some clinicians may disagree about a particular patient's ALC status, or even that they may occasionally err in making a designation, has no impact on the constitutionality of the impugned provisions.

120. The Applicants' expert, Dr. Samir Sinha, does not act as an MRP and does not make ALC designations. In his affidavit, he claimed that patients are often designated ALC inappropriately.[149] However, on cross-examination, Dr. Sinha acknowledged that his experience is largely confined to the most complex patients and cases.[150] He described his own experience with ALC patients as that of a consultant, not an attending MRP, and stated that if he or his geriatrician colleagues raise concerns about an ALC designation with the MRP, those concerns will be considered and addressed, and the patient may be de-designated as ALC where appropriate.[151] This reflects the system working as it should.

121. The provisions enacted under Bill 7 are not overbroad. Rather, they are carefully tailored measures aimed at achieving the legislative objective of reducing the number of ALC-LTC patients in hospital, in order to maximize hospital resources for patients who require hospital-level care.

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[147] Pelc Affidavit, para. 7, JR, Vol. V, Tab 21, pp. 2148-2149.
[148] Narayan Affidavit, para. 8, JR, Vol. V, Tab 20, p. 2136.
[149] Sinha Affidavit, para. 7, JR, Vol. IV, Tab 12, pp. 1471-1472.
[150] Sinha Cross, q. 49, JR, Vol. VII, Tab 32, p. 3107.
[151] Sinha Cross, qq. 43-46, JR, Vol. VII, Tab 32, pp. 3104-3106.

iv) The impugned provisions are not grossly disproportionate

122. The rule against gross disproportionality "only applies in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure":

> This idea is captured by the hypothetical of a law with the purpose of keeping the streets clean that imposes a sentence of life imprisonment for spitting on the sidewalk. The connection between the draconian impact of the law and its object must be entirely outside the norms accepted in our free and democratic society.[152]

123. Bill 7 does not begin to approach the "draconian impact" of a law that imprisons people for life for spitting on the sidewalk. Bill 7 does not prohibit anything or punish anyone, and it does not authorize any restraint, involuntary treatment or physical transfer of ALC patients. An ALC patient who declines to leave hospital despite being admitted to an LTC home faces only financial consequences.

124. It would trivialize the important protections of the *Charter* to conclude that a law is "grossly disproportionate" because it does not allow a patient who no longer needs a hospital to remain in a hospital bed indefinitely until they decide to leave. Indeed, five other provinces similarly require patients awaiting LTC home placement to wait in an interim placement setting rather than in hospital.[153]

B. No infringement of *Charter* s. 15

125. The two-part test under *Charter* s. 15(1) is:

> (1) Does the law create a distinction based on enumerated or analogous grounds, on its face or in its impact; and
>
> (2) Does the distinction impose a burden or deny a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage?[154]

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[152] *Bedford*, at para. 120.
[153] Carpenter Affidavit, paras. 30-31, JR, Vol. V, Tab 15, pp. 1777-1778, Exhibits F-J, pp. 1852-1936.
[154] *R. v. Sharma*, 2022 SCC 39 at para. 28. [*Sharma*].

126. A claimant must satisfy both steps of the test to establish a breach of *Charter* s. 15(1).[155] In this case, the Applicants cannot demonstrate that either step of the test is satisfied.

127. The Applicants have failed to demonstrate a distinction under the first step of the test. Bill 7 does not draw any distinctions on the basis of enumerated or analogous grounds. Nor have the Applicants met the evidentiary burden to show that the Act creates an adverse impact based on age or disability. As the Court of Appeal for Ontario recently affirmed in rejecting a *Charter* s. 15(1) challenge, a sufficient evidentiary record is not a "mere technicality" but is instead "essential" for an Applicant to lead.[156]

128. In *Sharma*, the Supreme Court clarified the proper application and burden of proof in adverse impact cases, where the impugned law is facially neutral and it is alleged that the law has a disproportionate impact based on a protected ground.[157] At step one of the test for discrimination, the burden is on the claimant to show not only that there is a disproportionate impact on a protected group, but to demonstrate through evidence that the impugned law *created* or *contributed to* that disproportionate impact.[158]

129. In this case, there is no evidence that the Act causes an adverse impact based on age or disability. The impugned measures under Bill 7 are not triggered based on an individual's age or disability, but rather apply to individuals designated as ALC who make choices to lengthen their hospital stay.

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[155] *Sharma,* at para. 38.

[156] *Ontario Teacher Candidates' Council v. Ontario (Education)*, 2023 ONCA 788 at para. 81 [*Ontario Teacher Candidates' Council*], citing *MacKay v. Manitoba*, [1989] 2 SCR 357 at p. 366. See also: *Ernst v. Alberta Energy Regulator,* 2017 SCC 1 at para. 22; *Boone v. Kyeremanteng*, 2020 ONSC 198 at para. 15.

[157] I.e., members of a group protected on the basis of an enumerated or analogous ground. See also *Sharma,* at para. 29.

[158] *Sharma*, at para. 44.

130. ALC designation is not an immutable personal characteristic like the enumerated and analogous grounds. Rather, it is a point-in-time and individualized assessment of the care needs of a particular patient. If a patient's care needs change such that they require hospital-level care, they are no longer ALC under Bill 7, and their ALC designation will be removed by the responsible clinician.

131. Moreover, an ALC patient who chooses to leave hospital, for example by accepting an offer of admission to an LTC home, ceases to be subject to the provisions of Bill 7 authorizing LTC home selection and to the daily hospital fee. The decision to stay in a hospital bed despite having been discharged by the hospital and admitted to an LTC home is not an immutable personal characteristic. All hospital patients, whether or not designated ALC and whatever their age, are required to be discharged once they are no longer in need of treatment in the hospital and are subject to a $400/day charge if they remain in hospital for more than 24 hours after the date in their discharge order.

132. The Applicants argue that Bill 7 has a disproportionate effect on the basis of age and disability because most ALC patients are over the age of 75 and are chronically or terminally ill.[159] But this fact alone cannot establish that the Act is discriminatory. All laws, including Bill 7, are expected to impact individuals, including members of protected groups.[160] Any law directed at hospital patients will mostly affect people who are older or ill, because those are mostly the people who are patients in hospitals.

133. It is not sufficient for the Applicants to simply show that the law impacts groups of individuals protected by section 15. At step one of the test for discrimination, causation is the

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[159] Applicant's Factum para. 141.
[160] *Fair Change v. His Majesty the King in Right of Ontario*, 2024 ONSC 1895, at para. 383. [*Fair Change*]

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.[161]

134. The causation analysis at step one necessarily involves drawing a comparison between the claimant group and other groups.[162] The Applicants have not provided any evidence to show that Bill 7 has a disproportionate impact on a protected group as compared to non-group members.[163] They have presented no evidence demonstrating "clear disparities in how [Bill 7] affects the claimant's group as compared to other comparator groups."[164] Indeed, Bill 7 does not have a different impact depending on the age or disability of the persons it applies to: all ALC patients are treated identically by Bill 7 no matter what their age or disability. Simply demonstrating that older disabled persons are overrepresented among ALC patients as compared to the general population is insufficient to demonstrate that Bill 7 disadvantages older or disabled ALC patients more than other ALC patients to whom it applies.[165]

135. The key provisions of Bill 7 apply equally to all patients in hospital who do not require hospital-level care, who may require LTC, and who make decisions that lengthen their hospital stay. The Act does not draw a distinction or create an adverse impact on the basis of any protected grounds. The Applicants have failed to meet their burden at step one of the s. 15 discrimination test.

136. Even if the Applicants could satisfy step one, they have also failed to adduce any evidence to demonstrate that step two of the test is met. There is no evidence that the Act reinforces, exacerbates or perpetuates any historic or systemic disadvantage. Bill 7 does not

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[161] *Fair Change*, at para. 383; See also *Symes v. Canada*, 1993 CanLII 55 (SCC), [1993] 4 S.C.R. 695*,* at p. 765; *Sharma*, at para. 44.

[162] *Fair Change*, at para. 383; *Sharma*, at para. 32, citing *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143 at p. 164 [*Andrews*].

[163] *Fair Change*, at para. 383; *Sharma*, at para. 40.

[164] *Ontario Teacher Candidates' Council*, at para. 67.

[165] *Fair Change*, at para. 352.

function by stereotyping, which is the application of presumed group characteristics to individuals. Rather, it requires an individualized assessment by an attending clinician of whether the patient does not require the intensity of resources or services provided in the hospital care setting and whether the patient may be eligible for admission to an LTC home. Such individualized decision-making on clinical grounds is "the antithesis of the logic of the stereotype, the evil of which lies in prejudging the individual's actual situation and needs on the basis of the group to which he or she is assigned."[166]

C. In the alternative, any limit on *Charter* rights is justified under s. 1

137. If this Court finds that the impugned provisions breach ss. 7 or 15(1) of the *Charter,* Ontario submits that those breaches are reasonable and demonstrably justified under *Charter* s. 1.

138. As set out in *R v Oakes*,[167] to establish that a law is justified under section 1, Ontario must show that the impugned provisions have a pressing and substantial objective and that they do not disproportionately interfere with *Charter* rights in furtherance of that objective. Ontario must demonstrate that the infringement is rationally connected to the objective, that the means chosen to further the objective interfere as little as reasonably possible with the rights at issue, and that the benefits of the infringing measures outweigh its negative effects.

139. As set out above at paras. 74-77, this is a case in which the Court ought to accord significant deference under section 1. The policy choices necessary to allocate scarce health care resources require the elected branches to mediate between competing interests and choose among deserving claimants for scarce public resources.[168] In these circumstances, the

[166] *Winko v. British Columbia (Forensic Psychiatric Institute)*, 1999 2 SCR 625 at para. 88.
[167] *R. v. Oakes*, [1986] 1 S.C.R. 103.
[168] *Irwin Toy Ltd.,* at pp. 993-4.

Court should take care not to usurp the role of the Legislature in crafting appropriate policy responses to complex and multi-faceted issues.

i. The impugned provisions have a pressing and substantial objective

140. As set out above, Bill 7's purpose is to reduce the number of ALC patients in hospital in order to maximize hospital resources for patients who need hospital-level care. There can be no doubt that protecting the availability of hospital resources for people who require hospitalization is a critically-important objective. As Dr. Crocker Ellacott explained:

> 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.[169]

ii. The impugned measures are rationally connected to the objective

141. To establish a rational connection, the government "must show that it is reasonable to suppose that the limit may further the goal, not that it will do so."[170] This test is "not particularly onerous."[171] As long as the challenged limit "can be said to further in a general way an important government aim it cannot be seen as irrational."[172]

142. The impugned law meets this low threshold. There is an evident connection "on the basis of reason or logic"[173] between the law's effects and its purpose of reducing the number

[169] Ellacott Affidavit, para. 16, JR, Vol. V, Tab 16, p. 1953.
[170] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 2 SCR 567 at para. 48 [*Hutterian*].
[171] *Mounted Police Association of Ontario v. Canada (Attorney General)*, 2015 1 S.C.R. 3*,* at para. 143 [*MPAO*].
[172] *Canada (Human Rights Commission) v Taylor,* 1990 3 SCR 892 at pp. 925-926.
[173] *RJR-MacDonald Inc. v. Canada (Attorney General)*, 1995 3 SCR 199 at para. 153 [*RJR-MacDonald Inc*].

of ALC patients waiting in hospital for LTC home placement. Each ALC patient who leaves hospital under Bill 7 releases a hospital bed that can thereafter be used to care for a patient who requires a hospital level of care.

iii. The impugned measures are minimally impairing

143. At the minimal impairment stage, the "government is not required to pursue the least drastic means of achieving its objective, but it must adopt a measure that falls within a range of reasonable alternatives."[174] A measure of deference is appropriate at this stage:

> 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…Crafting 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.[175]

144. The impugned law falls within the range of reasonable alternatives. As Dr. Carpenter explained, five other provinces similarly require patients awaiting LTC home placement to wait in an interim placement setting rather than in hospital.[176]

145. The measures also go no further than necessary to achieve the legislative goal. The actions that may be taken without an ALC patient's consent are administrative in nature and can only be taken where reasonable efforts have been made to obtain the patient's consent. These actions are justified by the need to facilitate the transfer of ALC patients to a more appropriate care setting. If the consent of the ALC patient was required, each individual ALC

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[174] *MPAO*, at para. 149.
[175] *Canada (Attorney General) v JTI-Macdonald Corp*, 2007 SCC 30 at para. 43.
[176] Carpenter Affidavit, paras. 30-31, JR, Vol. V, Tab 15, pp. 1777-1778, Exhibits F-J, pp. 1852-1936.

patient would have a veto over their discharge from hospital, defeating the purpose of the legislation.

146. The scheme contains several safeguards so that there is as little interference as possible with any *Charter* rights. No involuntary treatment, restraint or physical transfer is permitted under Bill 7. Placement coordinators are expected to continue to seek consent throughout the process, and a patient who chooses to consent at a late stage is not required to restart the application process. There are also geographic limits on how far away patients can be placed. Where a patient is admitted to an LTC home selected by a placement coordinator, they maintain their crisis priority status for all other LTC homes to which they have applied. Ultimately, an ALC patient who refuses to leave hospital after being admitted to an LTC home faces only a financial consequence.

147. The Applicants suggest that the scheme would be less restrictive of *Charter* rights if placement coordinators took matters to the Consent and Capacity Board ("CCB") in those cases where a patient's SDM refuses to apply to LTC homes. This alternative would not realize the legislative objective and should therefore be rejected.

148. First, CCB review of an SDM's decisions would apply only to patients with an SDM. It could have no application to capable patients who are making their own decisions about placement in an LTC home. Second, SDMs are legally limited in their ability to depart from a patient's prior capable wish.[177] Finally, the issue to be addressed by the CCB is solely whether an SDM is acting in the patient's best interests, while the measures enacted under Bill 7 are intended to consider the interests of the broader population of hospital users, including patients who are waiting in an emergency department or a hospital hallway for a hospital bed to become available.

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[177] *HCCA,* at s. 53(3).

149. The minimal impairment test "requires only that the government choose the least drastic means *of achieving its objective*. Less drastic means which do not actually achieve the government's objective are not considered at this stage."[178] The Applicants' proposed alternative, "instead of asking what is minimally required to realize the legislative goal, asks the government to significantly compromise it."[179]

iv. The benefits of the infringing measure outweigh its negative effects

150. Finally, Ontario submits that the benefits of the infringing measures outweigh any deleterious effects. At this stage of the analysis, the court must consider the impact of Bill 7 on other users of the health care system. Facilitating the transfer of patients who no longer need the services of a hospital helps to alleviate the pressure on hospital resources.

151. Mr. Musyj, Mr. Jarrett, and Dr. Ellacott all noted the improvements to patient flow in their hospitals following the measures introduced by Bill 7.[180] ALC patients that occupy acute care beds have significant impacts on other hospital users. As Mr. Musyj notes:

> …with limited beds available for acute care, WRH is unable to transfer patients out of the emergency room. This, in turn, means that WRH 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 not 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, WRH 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

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[178] *Hutterian,* at para. 54.
[179] *Hutterian*, at para. 60.
[180] Musyj Affidavit, paras. 27, 32-34, JR, Vol. V, Tab 19, pp. 2013-2015; Jarrett Affidavit, paras. 11-13, JR, Vol. V, Tab 18, pp. 2001-2002; Ellacott Affidavit, paras. 9-10, JR, Vol. V, Tab 16, p. 1951.

> hospital level now cannot wait years for the new campus to be built to receive that care.[181]

152. Mr. Musyj also notes that ALC patients remaining in hospital limit the availability of beds for patients moving from the intensive care unit into a general medicine unit. This may mean transferring an ICU-bound patient to another facility and introducing unnecessary risk to the patient. There is also an impact on patients who require a hospital bed in which to recover following surgery. Where these beds are not available, surgeries may be postponed or cancelled.[182]

153. The same elderly and vulnerable people represented by the Applicants can benefit from Bill 7's measures when they are the ones seeking hospital care. This was highlighted in Dr. Carpenter's evidence:

> 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. [183]

154. The bottom line is that an ALC patient waiting in hospital for their preferred LTC home can receive the level of care they require in a different LTC home. By contrast, a person seeking acute care from a hospital has nowhere else to go. Given these competing priorities, Ontario made a reasonable policy decision to incentivize ALC patients to wait for their preferred LTC home outside of the hospital. To the extent this limits anyone's *Charter* ss. 7 or 15(1) rights, it is reasonable and demonstrably justified.

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[181] Musyj Affidavit, paras. 18-19, JR, Vol. V, Tab 19, pp. 2011-2012.
[182] Musyj Affidavit, paras. 20-21, JR, Vol. V, Tab 19, p. 2012.
[183] Carpenter Affidavit, para. 27, JR, Vol. V, Tab 15, pp. 1775-1776.

PART V – ORDER REQUESTED

155. Ontario respectfully requests that this application be dismissed with costs.

156. Alternatively, in the event that this Court finds that Bill 7 unjustifiably infringes the *Charter*, Ontario submits that the appropriate remedy would be a suspended declaration of invalidity for a period of 1 year to allow the Ministry the opportunity to remedy any constitutional wrong.[184] A suspended declaration would avoid "the harmful and undesirable consequences of an immediate declaration"[185] and would respect that it is for the legislature, not the courts, to develop policy and legislation that serves the public interest and respects the constitutional boundaries delineated by the judiciary.[186] Failure to suspend would create uncertainty and complexities in relation to LTC home placements and waitlists. A suspension would also promote legal certainty and the rule of law.[187]

ALL OF WHICH IS RESPECTFULLY SUBMITTED

August 2, 2024

S. Zachary Green, Cara Zwibel and Emily Owens
Of counsel for the Respondent,
His Majesty the King in Right of Ontario

[184] *Schachter v Canada*, 1992 2 SCR 679 at p. 715-717, 719; *Ontario (AG) v G*, 2020 SCC 38 at para. 139 [*Ontario (AG) v G*]; *R v Ndhlovu*, 2022 SCC 38 at paras. 139, 142 (12 mos.); *Reference re Code of Civil Procedure, art. 35*, 2021 SCC 27 at paras. 154–155 (12 mos, plus 12 mos extension); *TL v BC (AG)*, 2023 BCCA 167 at para. 279 (12 mos); *Luamba v AG of Que.*, 2022 QCCS 3866 at paras. 857-858 (six mos); *R v Gorman*, 2022 NLSC 67 at para. 62 (12 mos); *R v Kloubakov*, 2022 ABQB 21 at para. 68 (30 days); *Adams v Nova Institution*, 2021 NSSC 313 at para. 161 (six mos); *Centre for Gender Advocacy v AG of Que.*, 2021 QCCS 191 at paras. 191, 210, 284 (approx. 10 mos).

[185] *Ontario (AG) v G*, at paras. 83, 126, 129.

[186] *Reference re Code of Civil Procedure, art. 35,* at paras. 154–155.

[187] *Ontario (AG) v G*, at para. 131.

SCHEDULE A - CASELAW

1.	*Carter v. Canada (Attorney General)*, 2015 SCC 5
2.	*Canada (Attorney General) v. Bedford*, 2013 SCC 72
3.	*Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44
4.	*Canada (Attorney General) v. PHS Community Services Society,* 2011 SCC 44
5.	*Chaoulli v. Quebec (Attorney General)*, 2005 SCC 35
6.	*R. v. Morgentaler*, 1988 1 SCR 30
7.	*Irwin Toy Ltd. v. Quebec (Attorney General),*1989 1 S.C.R. 927
8.	*Flora v. Ontario Health Insurance Plan*, 2008 ONCA 538
9.	*M. (A.) v. Ryan*, 1997 1 SCR 157
10.	*Ziebenhaus (Litigation Guardian of) v. Bahlieda*, 2015 ONCA 471
11.	*R. v. Moriarity,* 2015 3 S.C.R. 485
12.	*R. v. Safarzadeh-Markhali,* 2016 SCC 14
13.	*R. v. Ndhlovu,* 2022 SCC 38
14.	*R. v. Sharma,* 2022 SCC 39
15.	*Ontario Teacher Candidates' Council v. Ontario (Education),* 2023 ONCA 788
16.	*MacKay v. Manitoba*, 1989 2 SCR 357
17.	*Ernst v. Alberta Energy Regulator,* 2017 SCC 1
18.	*Boone v. Kyeremanteng,* 2020 ONSC 198
19.	*Fair Change v. His Majesty the King in Right of Ontario,* 2024 ONSC 1895
20.	*Symes v. Canada,* [1993] 4 S.C.R. 695
21.	*Andrews v. Law Society of British Columbia,* 1989 1 S.C.R. 143
22.	*Winko v. British Columbia (Forensic Psychiatric Institute)*, 1999 2 SCR 625
23.	*R. v. Oakes*, 1986 1 S.C.R. 103

24.	*Alberta v. Hutterian Brethren of Wilson Colony*, 2009 2 SCR 567
25.	*Mounted Police Association of Ontario v. Canada (Attorney General),* 2015 1 S.C.R. 3
26.	*Canada (Human Rights Commission) v. Taylor,* 1990 3 SCR 892
27.	*RJR-MacDonald Inc. v. Canada (Attorney General),* 1995 3 SCR 199
28.	*Canada (Attorney General) v. JTI-Macdonald Corp*, 2007 SCC 30
29.	*Schachter v. Canada*, 1992 2 SCR 679
30.	*Ontario (AG) v. G,* 2020 SCC 38
31.	*Reference re Code of Civil Procedure art. 35*, 2021 SCC 27
32.	*TL v. BC (AG)*, 2023 BCCA 167
33.	*Luamba v. AG of Quebec,* 2022 QCCS 3866
34.	*R v. Gorman,* 2022 NLSC 67
35.	*R v. Kloubakov,* 2022 ABQB 21
36.	*Adams v. Nova Institution,* 2021 NSSC 313
37.	*Centre for Gender Advocacy v. AG of Quebec,* 2021 QCCS 191

Other

Ontario, Legislative Assembly, Official Report of Debates (Hansard), 43rd Parliament, 1st Session, No. 8 (August 23, 2022)

SCHEDULE B – LEGISLATION

[*Fixing Long-Term Care Act*, 2021, S.O. 2021, c.39, Schedule. 1]

***Fixing Long-Term Care Act*, 2021, S.O. 2021, c.39, Schedule. 1, ss. 1, 51(5), 60.1.**

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

(…)

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

(…)

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

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

(b) has been designated by an attending clinician in the hospital as requiring an alternate level of care because, in the clinician's opinion, the person does not require the intensity of resources or services provided in the hospital care setting. 2022, c. 16, s. 2.

Definitions
60.1(2) For the purposes of this section,
"ALC patient" means a person described in subsection (1); ("patient en NSD")
"attending clinician" means a person who is authorized under the *Public Hospitals Act* to issue a discharge order for the ALC patient. ("clinicien traitant") 2022, c. 16, s. 2.

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

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

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

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

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

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

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

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

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

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

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

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

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

   A. the placement co-ordinator has determined the patient's eligibility for admission to the home,

   B. a bed becomes available, and

   C. the placement co-ordinator has authorized the patient's admission to the home.

5. A person with authority to carry out an action listed in paragraph 1, 2, 3 or 4, a hospital within the meaning of the *Public Hospitals Act* or any other person prescribed by the regulations may collect, use or disclose personal health information if it is necessary to carry out an action listed in paragraph 1, 2, 3 or 4. 2022, c. 16, s. 2.

Limitation, reasonable efforts to obtain consent required
60.1(4) The actions listed in subsection (3) may only be performed without consent if reasonable efforts have been made to obtain the consent of the ALC patient or their substitute decision-maker. 2022, c. 16, s. 2.

Actions to be performed in accordance with regulations
60.1(5) Subject to subsection (6), sections 49 to 54 do not apply to the actions listed in subsection (3), and instead the actions shall be performed in accordance with the procedures, requirements, criteria, restrictions and conditions, if any, that are set out in the regulations. 2022, c. 16, s. 2.

If consent provided
60.1(6) An ALC patient or their substitute decision-maker may provide their consent to any stage of the process described in this section and, if the consent is provided, the relevant portions of sections 49 to 54 and the regulations apply to the stages of the process to which they have consented, subject to any modifications or exemptions set out in the regulations. 2022, c. 16, s. 2.

Limitation
60.1(7) Nothing in this section authorizes any person to restrain an ALC patient to carry out the actions listed in subsection (3) or to physically transfer an ALC patient to a long-term care home without the consent of the ALC patient or their substitute decision-maker. 2022, c. 16, s. 2.

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

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

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

***Health Care Consent Act, 1996*, S.O. 1996, c. 2, Schedule. A, ss. 2(1), 53.**

Interpretation
2 (1) In this Act,
"attorney for personal care" means an attorney under a power of attorney for personal care given under the *Substitute Decisions Act, 1992*; ("procureur au soin de la personne")

"Board" means the Consent and Capacity Board; ("Commission")

"capable" means mentally capable, and "capacity" has a corresponding meaning; ("capable", "capacité")

"care facility" means,

(a) a long-term care home as defined in the *Fixing Long-Term Care Act, 2021*, or

(b) a facility prescribed by the regulations as a care facility; ("établissement de soins")

"community treatment plan" has the same meaning as in the *Mental Health Act*; ("plan de traitement en milieu communautaire")

Note: On a day to be named by proclamation of the Lieutenant Governor, subsection 2 (1) of the Act is amended by adding the following definition: (See: 2017, c. 25, Sched. 5, s. 55 (1))

"confining in a care facility" and related expressions when used in this Part and Part III.1 have the meaning or meanings provided for in the regulations; ("confinement dans un établissement de soins")

"course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; ("série de traitements")
"evaluator" means, in the circumstances prescribed by the regulations,

(a) a member of the College of Audiologists and Speech-Language Pathologists of Ontario,

(b) a member of the College of Dietitians of Ontario,

(c) a member of the College of Nurses of Ontario,

(d) a member of the College of Occupational Therapists of Ontario,

(e) a member of the College of Physicians and Surgeons of Ontario,

(f) a member of the College of Physiotherapists of Ontario,

(g) a member of the College of Psychologists of Ontario, or

(h) a member of a category of persons prescribed by the regulations as evaluators; (“appréciateur”)

“guardian of the person” means a guardian of the person appointed under the *Substitute Decisions Act, 1992*; (“tuteur à la personne”)

“health practitioner” means a member of a College under the *Regulated Health Professions Act, 1991* or a member of a category of persons prescribed by the regulations as health practitioners; (“praticien de la santé”)

“hospital” means a private hospital as defined in the *Private Hospitals Act* or a hospital as defined in the *Public Hospitals Act*; (“hôpital”)

“incapable” means mentally incapable, and “incapacity” has a corresponding meaning; (“incapable”, “incapacité”)

“mental disorder” has the same meaning as in the *Mental Health Act*; (“trouble mental”)
“personal assistance service” means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; (“service d’aide personnelle”)

“plan of treatment” means a plan that,

(a) is developed by one or more health practitioners,

(b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person’s current health condition, and

(c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person’s current health condition; (“plan de traitement”)

“psychiatric facility” has the same meaning as in the *Mental Health Act*; (“établissement psychiatrique”)

“recipient” means a person who is to be provided with one or more personal assistance services,

(a) in a long-term care home as defined in the *Fixing Long-Term Care Act, 2021*,

(b) in a place prescribed by the regulations in the circumstances prescribed by the regulations,

(c) under a program prescribed by the regulations in the circumstances prescribed by the regulations, or

(d) by a provider prescribed by the regulations in the circumstances prescribed by the regulations; (“bénéficiaire”)

“regulations” means the regulations made under this Act; (“règlements”)

“treatment” means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include,

(a) the assessment for the purpose of this Act of a person’s capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person’s capacity to manage property or a person’s capacity for personal care, or the assessment of a person’s capacity for any other purpose;

Note: On a day to be named by proclamation of the Lieutenant Governor, the definition of “treatment” in subsection 2 (1) of the Act is amended by striking out “admission to a care facility” in clause (a) and substituting “admission to or confining in a care facility”. (See: 2017, c. 25, Sched. 5, s. 55 (2))

(b) the assessment or examination of a person to determine the general nature of the person’s condition,

(c) the taking of a person’s health history,

(d) the communication of an assessment or diagnosis,

(e) the admission of a person to a hospital or other facility

Note: On a day to be named by proclamation of the Lieutenant Governor, the definition of “treatment” in subsection 2 (1) of the Act is amended by adding the following clause: (See: 2017, c. 25, Sched. 5, s. 55 (2))

(e.1) a person’s confining in a care facility,

(f) a personal assistance service,

(g) a treatment that in the circumstances poses little or no risk of harm to the person,

(h) anything prescribed by the regulations as not constituting treatment. (“traitement”) 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, ss. 10 (1, 2); 2009, c. 33, Sched. 18, s. 10 (1); 2021, c. 39, Sched. 2, s. 9 (1, 2).

(…)

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

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

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

Notice to substitute decision-maker
53.(1) 1.1 If the person responsible for authorizing admissions to the care facility intends to apply under subsection (1), the person shall inform the substitute decision-maker of his or her intention before doing so. 2000, c. 9, s. 39 (2)

Parties
53.(2) The parties to the application are:

1. The substitute decision-maker.

2. The incapable person.

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

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

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

Public Hospitals Act, R.S.O. 1990, c. P40

***Public Hospitals Act*, R.S.O. 1990, c. P40, s.21.**

Refusal of admission

21 Nothing in this Act requires any hospital to admit as an in-patient,

(a) any person who is not a resident or a dependant of a resident of Ontario, unless by refusal of admission life would thereby be endangered; or

(b) any person who merely requires custodial care. R.S.O. 1990, c. P.40, s. 21; 2006, c. 4, s. 52 (8)

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

R.R.O. 1990, Reg. 965: Hospital Management, ss. 11, 11(2), 16.

Admission to Hospital
11. (1) No person shall be admitted to a hospital as a patient except,

(a) on the order or under the authority of a physician who is a member of the medical staff;

(a.1) on the order or under the authority of a registered nurse in the extended class who is a member of the extended class nursing staff;

(b) on the order or under the authority of an oral and maxillofacial surgeon who is a member of the dental staff;

(b.1) if the person is being admitted for treatment by a dentist who is a member of the dental staff other than an oral and maxillofacial surgeon, on the joint order of the dentist and a physician who is a member of the medical staff; or

(c) on the order or under the authority of a midwife who is a member of the midwifery staff. O. Reg. 761/93, s. 4; O. Reg. 346/01, s. 2 (1); O. Reg. 216/11, s. 3 (1); O. Reg. 159/17, s. 2.

11. (2) No physician, registered nurse in the extended class, dentist or midwife shall order the admission of a person to a hospital unless, in the opinion of the physician, registered nurse in the extended class, dentist or midwife, it is clinically necessary that the person be admitted. O. Reg. 216/11, s. 3 (2).

11. (3) No person shall be registered in a hospital as an out-patient except,

(a) on the order or under the authority of a member of the medical staff, midwifery staff or extended class nursing staff;

(b) on the order or under the authority of a member of the dental staff who is an oral and maxillofacial surgeon

(b.1) in the case of a person who is an out-patient solely for the purpose of attending a dental clinic in a hospital, on the order or under the authority of a member of the dental staff; or

(c) Revoked: O. Reg. 64/03, s. 7 (2).

(…)

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

1. The attending physician, registered nurse in the extended class or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.

2. A member of the medical, extended class nursing, dental or midwifery staff designated by a person referred to in paragraph 1. O. Reg. 346/01 s. 4; O. Reg. 216/11, s. 5; O. Reg. 159/17, s. 2.

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

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

(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. O. Reg. 486/22, s. 1.

16.(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. O. Reg. 485/22, s. 1.

16. (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. O. Reg. 485/22, s. 1.

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

"attending clinician" means a person entitled to make an order under subsection (1). O. Reg. 485/22, s. 1.

O. REG. 246/22: GENERAL

O. REG. 246/22: GENERAL, ss. 171(4), 172, 203(e), 203(f), 240.1(5-10), 240.2(5)(7).

Information to be provided by placement co-ordinator

171. (4) When a person is determined eligible for admission, the placement co-ordinator shall provide the person with information about,

(a) the length of waiting lists and approximate times to admission for long-term care homes;

(b) vacancies in long-term care homes; and

(c) how to obtain information from the Ministry about long-term care homes.

(…)

Eligibility for Admission

Criteria for eligibility, long-stay

172. (1) A placement co-ordinator shall determine a person to be eligible for long-term care home admission as a long-stay resident only if,

(a) the person is at least 18 years old;

(b) the person is an insured person under the *Health Insurance Act*;

(c) the person,

(i) requires that nursing care be available on site 24 hours a day,

(ii) requires, at frequent intervals throughout the day, assistance with activities of daily living, or

(iii) requires, at frequent intervals throughout the day, on-site supervision or on-site monitoring to ensure their safety or well-being;

(d) the publicly-funded community-based services available to the person and the other caregiving, support or companionship arrangements available to the person are not sufficient, in any combination, to meet the person's requirements; and

(e) the person's care requirements can be met in a long-term care home.

(2) In this section,

"nursing care" means nursing and other personal care given by or under the supervision of a registered nurse or a registered practical nurse.

(…)

Authorization of admission
203. (1) The appropriate placement co-ordinator shall authorize the admission of an applicant to the long-term care home only if,

(…)

(e) within 24 hours of being informed by the placement co-ordinator of the availability of accommodation in the home, the applicant consents to being admitted to the home; and

(f) in the case of an applicant who is applying for authorization of their admission to the home as a long-stay resident or an interim bed short-stay resident, the applicant agrees with the licensee of the home that,

(i) the applicant will move into the home before noon of the fifth day following the day on which they are informed of the availability of accommodation in the home, unless the applicant and the licensee agree to the applicant moving in at a later time on the fifth day,

(ii) the applicant will pay the accommodation charge that is required under subsections 94 (1) and (3) of the Act, for each of the five days provided for in subclause (i), whether or not the applicant moves into the home, and

(iii) if the applicant moves into the home on the day the applicant is informed of the availability of accommodation, the applicant will pay the accommodation charge that is required under subsections 94 (1) and (3) of the Act for that day.

(…)

ALC patients being considered for long-term care home admission
240.1 (1) This section and sections 240.2 and 240.3 apply in the special circumstances of processing the admission of an ALC patient to a long-term care home for a long-stay bed, in accordance with section 60.1 of the Act. O. Reg. 484/22, s. 2.

(…)

240.1 (5) Where a placement co-ordinator receives a request from an attending clinician to determine an ALC patient's eligibility for admission to a long-term care home or the ALC patient has already been determined eligible for long-term care home admission and the ALC patient's applying to additional homes is being considered, the placement co-ordinator shall,

(a) meet with the patient or the patient's substitute decision-maker, if any;

(b) provide information to the patient or their substitute decision-maker, if any, about the long-term care home placement process under section 60.1 of the Act and related regulations, and the admission process under sections 49 to 54 of the Act and related regulations;

(c) where applicable, ask the patient or their substitute decision-maker, if any, whether they will submit an application for determination of eligibility for admission to a long-term care home in accordance with subsection 50 (1) of the Act;

(d) where applicable, inform the patient or their substitute decision-maker, if any, that if they do not consent to submit an application for a determination of eligibility that,

(i) the placement co-ordinator shall proceed to determine eligibility, and if eligible, identify a home or homes for the patient, and

(ii) the patient or the substitute decision-maker may choose to participate in the admissions process at any stage;

(e) where applicable, inform the patient or their substitute decision-maker, if any, of the implications of a choice described in subparagraph (d) (ii);

(f) provide the patient or their substitute decision-maker, if any, with information about a resident's responsibility for payment for charges for accommodation and the maximum amounts that may be charged by a licensee for accommodation; and

(g) advise the patient or their substitute decision-maker, if any, that a resident may apply to the Director for a reduction in the charge for basic accommodation and that a resident who makes such an application may be required to provide supporting documentation including,

(i) the resident's Notice of Assessment issued under the *Income Tax Act* (Canada) for the resident's most recent taxation year,

(ii) the resident's proof of income statement (option "C" print) from the Canada Revenue Agency for the resident's most recent taxation year, or

(iii) the resident's written authorization to electronically obtain income information for the resident's most recent taxation year from the Canada Revenue Agency. O. Reg. 484/22, s. 2.

240.1 (6) Where the ALC patient or their substitute decision-maker, if any, refuses to apply for a determination of eligibility, the placement co-ordinator shall make a determination of eligibility for admission to a long-term care home based on as much information as is available in the circumstances about the patient's,

(a) physical and mental health;

(b) requirements for medical treatment and health care;

(c) functional capacity;

(d) requirements for personal care; and

(e) behaviour. O. Reg. 484/22, s. 2.

240.1 (7) The placement co-ordinator may request that an assessment of the matters described in clauses (6) (a) to (e) be conducted by a physician, a registered nurse in the extended class or a registered nurse on the staff of the hospital for the purpose of determining the ALC patient's eligibility for admission to a long-term care home. O. Reg. 484/22, s. 2.

240.1 (8) Where a placement co-ordinator requests an assessment of an ALC patient under subsection (7) in a situation where the patient or their substitute decision-maker, if any, does not consent to the patient being assessed for the purpose of determining their eligibility for admission to a long-term care home, the person conducting the assessment shall base their assessment solely on a review of existing hospital records relating to that patient. O. Reg. 484/22, s. 2.

240.1 (9) In addition to an assessment conducted under subsection (7), the placement co-ordinator may collect the information referred to in subsection (6) about an ALC patient through any or all of the following:

1. Consultation with,

   i. the attending clinician and any other member of the hospital staff who has directly been involved in providing care to the patient while in hospital,

   ii. a primary health care provider of the patient,

   iii. a home and community care services provider who provided home and community care services to the patient immediately before the patient was admitted to hospital, or

   iv. an application entity or service agency as defined in the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*.

2. Review of records of personal health information relating to the patient that are held by the hospital or by a primary health care provider, a home and community care services provider or an application entity or service agency referred to in subparagraph 1 ii, iii or iv. O. Reg. 484/22, s. 2.

240.1 (10) The following persons are prescribed for the purposes of paragraph 5 of subsection 60.1 (3) of the Act as persons who are authorized to collect, use and disclose personal health information about an individual, where the collection, use or disclosure, as the case may be, is necessary to determine an ALC patient's eligibility for admission to a long-term care home or to effect the admission of a patient to a home in accordance with section 60.1 of the Act and the regulations:

1. A home and community care services provider.
2. A primary health care provider.
3. An entity that provides community mental health and addiction services.
4. An application entity or service agency as defined in the *Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*. O. Reg. 484/22, s. 2.

(…)

Application for authorization of admission, ALC patients
240.2(5) In selecting a long-term care home for the ALC patient, the placement co-ordinator shall consider,

(a) the patient’s condition and circumstances;

(b) the class of accommodation requested by the patient, if any; and

(c) the proximity of the home. O. Reg. 484/22, s. 2.

(…)

240.2 (7) The placement co-ordinator shall only select a long-term care home for the ALC patient,

(a) that is within a 70 kilometre radius from the patient’s preferred location; or

(b) that is within a 150 kilometre radius from the patient’s preferred location, if the patient’s preferred location is in the area that was, immediately before the *Local Health System Integration Act, 2006* was repealed, the geographic area of the North East Local Health Integration Network or the North West Local Health Integration Network under that Act. O. Reg. 484/22, s. 2; O. Reg. 247/24, s. 3.

R.R.O. 1990, Reg. 194: *RULES OF CIVIL PROCEDURE*

R.R.O. 1990, Reg. 194: *RULES OF CIVIL PROCEDURE*, Rule 33.01.

MEDICAL EXAMINATION OF PARTIES

Motion for Medical Examination
33.01 A motion by an adverse party for an order under section 105 of the Courts of Justice Act for the physical or mental examination of a party whose physical or mental condition is in question in a proceeding shall be made on notice to every other party. R.R.O. 1990, Reg. 194, r. 33.01.

Courts of Justice Act, R.S.O. 1990, c. C.43

***Courts of Justice Act*, R.S.O. 1990, c. C.43, s.105.**

Physical or mental examination
Definition
105. (1) In this section, "health practitioner" means a person licensed to practise medicine or dentistry in Ontario or any other jurisdiction, a member of the College of Psychologists of Ontario or a person certified or registered as a psychologist by another jurisdiction. R.S.O. 1990, c. C.43, s. 105 (1); 1998, c. 18, Sched. G, s. 48.

Order
105. (2) Where the physical or mental condition of a party to a proceeding is in question, the court, on motion, may order the party to undergo a physical or mental examination by one or more health practitioners.

Same
105. (3) Where the question of a party's physical or mental condition is first raised by another party, an order under this section shall not be made unless the allegation is relevant to a material issue in the proceeding and there is good reason to believe that there is substance to the allegation.

Further examinations
105. (4) The court may, on motion, order further physical or mental examinations.

Examiner may ask questions
105. (5) Where an order is made under this section, the party examined shall answer the questions of the examining health practitioner relevant to the examination and the answers given are admissible in evidence. R.S.O. 1990, c. C.43, s. 105 (2-5).

Mandatory Blood Testing Act, 2006, S.O. 2006, c. 26

***Mandatory Blood Testing Act,* 2006, S.O. 2006, c. 26, ss. 7(2), 11(1).**

Obligations re taking and analysing sample
7(2) An analyst who receives a blood sample for analysis under section 3 or pursuant to an order of the Board under section 5;

(a) shall ensure that the sample is not used for any purpose other than its analysis in accordance with the regulations and the reporting of results as required by and in accordance with the regulations and as described in clause 5 (2) (c);

(b) shall not release the sample to any person other than in accordance with the regulations, or for the purpose of having a person acting on behalf of the analyst retain the sample as long as no person other than the analyst has access to the sample; and

(c) despite the *Personal Health Information Protection Act, 2004*, shall not disclose the results of the analysis of the blood sample to any person other than in accordance with the regulations and the order. 2006, c. 26, s. 7 (2); 2019, c. 1, Sched. 7, s. 7.

(…)

Regulations
11 (1) The Minister may make regulations,

(0.a) prescribing anything that is referred to in this Act as prescribed;

(a) prescribing diseases that are listed communicable diseases for the purposes of this Act;

(a.1) prescribing laboratories for the purpose of the definition of "analyst" in section 1;

(b) defining "victim of a crime" for the purpose of paragraph 1 of section 2;

(c) prescribing classes of persons for the purpose of paragraph 3 of section 2;

(d) prescribing circumstances and activities for the purpose of paragraph 4 of section 2;

(e) governing an application to a medical officer of health under section 2 and the actions taken by a medical officer of health pursuant to an application;

(f) prescribing other evidence of seropositivity respecting the listed communicable diseases that may be provided pursuant to a request made by a medical officer of health under section 3 and governing the obtaining and provision of that evidence;

(f.1) establishing and governing the process for an applicant to withdraw his or her application for the purposes of subsection 3 (4).

(g) governing the taking and analysis of blood samples pursuant to a request made by a medical officer of health under section 3 or an order of the Board under section 5, including requiring reports on the taking of blood samples and on the analysis and governing the reports;

(h) governing the physician report required by clause 5 (1) (e), including prescribing the classes of physicians or qualifications of physicians who may prepare the report, prescribing the examination and testing, including base line testing, and counselling and treatment that the physician must or may conduct to prepare the report and prescribing the information that the report must or may contain;

(i) prescribing classes of persons for the purpose of clauses 5 (2) (a) and 6 (2) (a);

(j) governing the reports and notices required pursuant to an analysis of a blood sample obtained under section 3 or pursuant to an order of the Board under section 5, including prescribing the information that such reports and notices must or may contain;

(k) specifying restrictions or conditions on the use that any person may make of the blood sample provided pursuant to a request made by a medical officer of health under section 3 or an order of the Board under section 5, on the release of the blood sample and on the use or disclosure of any information derived from the blood sample;

(l) prescribing rules governing when an application is deemed to be received by a medical officer of health or the Board;

(m) REPEALED: 2019, c. 1, Sched. 7, s. 9 (5).

O. Reg. 449/07: GENERAL

O. Reg. 449/07: GENERAL, s. 8(1)(b)

Request for voluntary compliance
8. (1) When making a request under section 3 of the Act that a respondent voluntarily provide a blood sample or other evidence of their seropositivity respecting the listed communicable diseases, the medical officer of health shall

(…)

(b) disclose the details of the occurrence, as described in the applicant and physician reports, to the respondent, without disclosing the applicant's personal information.

Regulated Health Professions Act, 1991, S.O. 1991, c. 18, Schedule 2

***Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, Schedule 2, ss. 23(8)-(10).**

Same, personal health information
23(8) The Registrar shall not disclose to an individual or post on the College's website information that is available to the public under subsection (5) that is personal health information, unless the personal health information is that of a member and it is in the public interest that the information be disclosed. 2007, c. 10, Sched. M, s. 28.

Restriction, personal health information
23(9) The Registrar shall not disclose to an individual or post on the College's website under subsection (8) more personal health information than is reasonably necessary. 2007, c. 10, Sched. M, s. 28.

Personal health information
23(10) In subsections (8) and (9), "personal health information" means information that identifies an individual and that is referred to in clauses (a) through (g) of the definition of "personal health information" in subsection 4 (1) of the *Personal Health Information Protection Act, 2004*. 2007, c. 10, Sched. M, s. 28.

Health Protection and Promotion Act, R.S.O. 1990, c. H.7

***Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, ss. 11(2), 39, 77.6, 77.7.1(3), 77.8.**

Report

11(2) The medical officer of health shall report the results of the investigation to the complainant, but shall not include in the report personal health information within the meaning of the *Personal Health Information Protection Act, 2004* in respect of a person other than the complainant, unless consent to the disclosure is obtained in accordance with that Act. 2004, c. 3, Sched. A, s. 86.

(…)

Confidentiality

39 (1) No person shall disclose to any other person the name of or any other information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, a disease of public health significance, a virulent disease or a reportable event following the administration of an immunizing agent. R.S.O. 1990, c. H.7, s. 39 (1); 2017, c. 25, Sched. 3, s. 1 (3).

Exceptions

39 (2) Subsection (1) does not apply,

(0.a) where the disclosure is authorized under this Act or the *Personal Health Information Protection Act, 2004*;

(a) in respect of an application by a medical officer of health to the Ontario Court of Justice that is heard in public at the request of the person who is the subject of the application;

(b) where the disclosure is made with the consent of the person in respect of whom the application, order, certificate or report is made;

(c) where the disclosure is made for the purposes of public health administration;

(d) in connection with the administration of or a proceeding under this Act, the *Regulated Health Professions Act, 1991*, a health profession Act as defined in subsection 1 (1) of that Act, the *Public Hospitals Act*, the *Health Insurance Act*, the *Canada Health Act* or the *Criminal Code* (Canada), or regulations made thereunder; or

(e) to prevent the reporting of information under section 125 of the *Child, Youth and Family Services Act, 2017* in respect of a child who is or may be in need of protection. R.S.O. 1990, c. H.7, s. 39 (2); 1998, c. 18, Sched. G, s. 55 (5); 1999, c. 2, s. 36; 2002, c. 18, Sched. I, s. 9 (5); 2007, c. 10, Sched. F, s. 12; 2017, c. 14, Sched. 4, s. 17 (2).

(…)

Order to provide information
77.6 (1) Subject to subsections (2) and (3), if the Chief Medical Officer of Health is of the opinion, based on reasonable and probable grounds, that there exists an immediate and serious risk to the health of persons anywhere in Ontario, he or she may issue an order directing any health information custodian indicated in the order to supply the Chief Medical Officer of Health or his or her delegate with any information provided for in the order, including personal health information. 2009, c. 33, Sched. 18, s. 12 (6).

Restriction
77.6 (2) The Chief Medical Officer of Health may only make an order under subsection (1) if he or she is of the opinion, based on reasonable and probable grounds, that the information is necessary to investigate, eliminate or reduce the immediate and serious risk to the health of any persons, and the information supplied must be no more than is reasonably necessary to prevent, eliminate or reduce the risk to the health of persons anywhere in Ontario. 2009, c. 33, Sched. 18, s. 12 (6).

Further restriction
77.6 (3) The Chief Medical Officer of Health may use or disclose the information provided to him or her under subsection (1) only for the purpose of investigating, eliminating or reducing the risk to the health of persons anywhere in Ontario and for no other purpose. 2009, c. 33, Sched. 18, s. 12 (6).

Restriction on recipient
77.6 (4) Any person to whom the Chief Medical Officer of Health discloses the information pursuant to subsection (3) may use or disclose that information only for the purpose of investigating, eliminating or reducing the risk to the health of persons anywhere in Ontario and for no other purpose. 2009, c. 33, Sched. 18, s. 12 (6).

Prevail over other provisions
77.6 (5) Subsections (3) and (4) prevail despite anything in,

(a) the *Freedom of Information and Protection of Privacy Act*;

(b) the *Municipal Freedom of Information and Protection of Privacy Act*; and

(c) the *Personal Health Information Protection Act, 2004*. 2009, c. 33, Sched. 18, s. 12 (6).

Comply with order
77.6 (6) A health information custodian that is served with an order under subsection (1) shall comply with the order within the time and in the manner provided for in the order. 2009, c. 33, Sched. 18, s. 12 (6).

Definitions
77.6 (7) In this section,

"health information custodian" means a health information custodian within the meaning of the *Personal Health Information Protection Act, 2004*; ("dépositaire de renseignements sur la santé")

“personal health information” means personal health information within the meaning of the *Personal Health Information Protection Act, 2004*. (“renseignements personnels sur la santé”) 2009, c. 33, Sched. 18, s. 12 (6).

(…)

Personal information, personal health information
77.7.1(3) A health care provider or health care entity, in complying with an order under subsection (1), shall not include personal health information within the meaning of the *Personal Health Information Protection Act, 2004* or personal information within the meaning of the *Freedom of Information and Personal Protection Act* when supplying information to the Minister or his or her delegate. 2017, c. 25, Sched. 3, s. 11

May collect specimens, etc.
77.8 (1) Subject to subsection (2), if the Chief Medical Officer of Health is of the opinion, based on reasonable and probable grounds, that there exists an immediate and serious risk to the health of persons anywhere in Ontario, he or she may, as he or she considers reasonably necessary for the purpose of investigating, eliminating or reducing the risk to the health of persons anywhere in Ontario,

(a) collect previously collected specimens and information respecting the analysis of previously collected specimens; and

(b) order any person to provide previously collected specimens or information respecting the analysis of previously collected specimens to the Chief Medical Officer of Health. 2009, c. 33, Sched. 18, s. 12 (8).

Restriction
77.8 (2) The Chief Medical Officer of Health may use, provide or disclose the previously collected specimens or information only for the purpose of investigating, eliminating or reducing the risk to the health of persons anywhere in Ontario and for no other purpose. 2009, c. 33, Sched. 18, s. 12 (8).

Restriction on recipient
77.8 (3) Any person to whom the Chief Medical Officer of Health discloses or provides previously collected specimens, or information respecting the analysis of previously collected specimens may use, provide or disclose them only for the purpose of investigating, eliminating or reducing the risk to the health of persons anywhere in Ontario and for no other purpose. 2009, c. 33, Sched. 18, s. 12 (8).

Prevail over other provisions
77.8 (4) This section prevails despite anything in,

(a) the *Freedom of Information and Protection of Privacy Act*;

(b) the *Municipal Freedom of Information and Protection of Privacy Act*; and

(c) the *Personal Health Information Protection Act, 2004*. 2009, c. 33, Sched. 18, s. 12 (8).

Comply with order
77.8 (5) A person that is served with an order under clause (1) (b) shall comply with the order within the time and in the manner provided for in the order. 2009, c. 33, Sched. 18, s. 12 (8).

Restriction re individuals
77.8 (6) Nothing in this section permits the Chief Medical Officer of Health to compel an individual to provide a bodily sample or submit to tests without the individual's consent. 2009, c. 33, Sched. 18, s. 12 (8).

Personal information
77.8 (7) For the purposes of this section, the Chief Medical Officer of Health has the power to collect, use, retain and disclose personal information, including personal health information. 2009, c. 33, Sched. 18, s. 12 (8).

Definitions
77.8 (8) In this section,

"personal health information" means personal health information within the meaning of the *Personal Health Information Protection Act, 2004*; ("renseignements personnels sur la santé")

"personal information" means personal information within the meaning of the *Freedom of Information and Protection of Privacy Act*; ("renseignements personnels")

"specimens" includes specimens from any person, animal or plant, living or deceased or from any other thing. ("échantillons") 2009, c. 33, Sched. 18, s. 12 (8).

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

***Personal Health Information Protection Act*, 2004, S.O. 2004, c. 3, Schedule. A, ss. 38(1)(b), 39(1)(a), 39(1)(d)(iii), 39(2), 40(2)-(3), 41(1), 43(1)(e),43(1)(h).**

Disclosures related to providing health care
38 (1) A health information custodian may disclose personal health information about an individual,

(…)

38(1)(b) 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; or

(…)

Disclosures for health or other programs
39 (1) Subject to the requirements and restrictions, if any, that are prescribed, a health information custodian may disclose personal health information about an individual,

39(1)(a) 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;

(…)

39(1)(d) where, (…)

39(1)(d) (iii) the disclosure is for the purpose of activities to improve or maintain the quality of care provided by the receiving custodian to the individual to whom the information relates or individuals provided with similar health care. 2004, c. 3, Sched. A, s. 39 (1); 2006, c. 4, s. 51 (3); 2007, c. 10, Sched. H, s. 14; 2009, c. 33, Sched. 18, s. 25 (4); 2016, c. 30, s. 43 (3); 2019, c. 5, Sched. 3, s. 17 (5, 6); 2020, c. 13, Sched. 3, s. 8 (15, 16).

Same
39(2) A health information custodian may disclose personal health information about an individual,

(a) to the Chief Medical Officer of Health or a medical officer of health within the meaning of the *Health Protection and Promotion Act* if the disclosure is made for a purpose of that Act or the *Immunization of School Pupils Act*;

(a.1) to the Ontario Agency for Health Protection and Promotion if the disclosure is made for a purpose of the *Ontario Agency for Health Protection and Promotion Act, 2007*; or

(b) to a public health authority that is similar to the persons described in clause (a) and that is established under the laws of Canada, another province or a territory of Canada or other jurisdiction, if the disclosure is made for a purpose that is substantially similar to a purpose of the *Health Protection and Promotion Act* or the *Immunization of*

School Pupils Act. 2004, c. 3, Sched. A, s. 39 (2); 2007, c. 10, Sched. K, s. 32; 2020, c. 5, Sched. 6, s. 5.

(…)

Disclosures related to care or custody

40 (2) A health information custodian may disclose personal health information about an individual 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 for the purposes described in subsection (3). 2004, c. 3, Sched. A, s. 40 (2).

Same

40 (3) A health information custodian may disclose personal health information about an individual under subsection (2) to assist an institution or a facility in making a decision concerning,

(a) arrangements for the provision of health care to the individual; or

(b) the placement of the individual into custody, detention, release, conditional release, discharge or conditional discharge under Part VI of the *Child, Youth and Family Services Act, 2017*, the *Mental Health Act*, the *Ministry of Correctional Services Act*, the *Corrections and Conditional Release Act* (Canada), Part XX.1 of the *Criminal Code* (Canada), the *Prisons and Reformatories Act* (Canada) or the *Youth Criminal Justice Act* (Canada). 2004, c. 3, Sched. A, s. 40 (3); 2017, c. 14, Sched. 4, s. 28 (2).

Disclosures for proceedings

41 (1) A health information custodian may disclose personal health information about an individual,

(a) subject to the requirements and restrictions, if any, that are prescribed, 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;

(b) to a proposed litigation guardian or legal representative of the individual for the purpose of having the person appointed as such;

(c) to a litigation guardian or legal representative who is authorized under the Rules of Civil Procedure, or by a court order, to commence, defend or continue a proceeding on behalf of the individual or to represent the individual in a proceeding; or

(d) for the purpose of complying with,

(i) a summons, order or similar requirement issued in a proceeding by a person having jurisdiction to compel the production of information, or

(ii) a procedural rule that relates to the production of information in a proceeding. 2004, c. 3, Sched. A, s. 41 (1).

Disclosure by agent or former agent
41 (2) An agent or former agent who receives personal health information under subsection (1) or under subsection 37 (2) for purposes of a proceeding or contemplated proceeding may disclose the information to the agent's or former agent's professional advisor for the purpose of providing advice or representation to the agent or former agent, if the advisor is under a professional duty of confidentiality. 2004, c. 3, Sched. A, s. 41 (2).

(…)

Disclosures related to this or other Acts
43 (1) A health information custodian may disclose personal health information about an individual,

(…)

43(1)(e) 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;

(…)

43(1)(h) subject to the requirements and restrictions, if any, that are prescribed, if permitted or required by law or by a treaty, agreement or arrangement made under an Act or an Act of Canada. 2004, c. 3, Sched. A, s. 43 (1); 2005, c. 25, s. 35; 2006, c. 34, Sched. C, s. 26; 2007, c. 10, Sched. H, s. 15; 2017, c. 14, Sched. 4, s. 28 (3).

Health Protection and Promotion Act, R.S.O. 1990, c. H.7

***Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, s. 2.**

Purpose

2 The purpose of this Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario. R.S.O. 1990, c. H.7, s. 2.

Court File No. CV-23-00698007-0000

ONTARIO HEALTH COALITION and ADVOCACY CENTRE FOR THE ELDERLY -and- **HIS MAJESTY THE KING IN RIGHT OF ONTARIO AS REPRESENTED BY THE ATTORNEY GENERAL OF ONTARIO et al**

Applicants **Respondent**

ONTARIO
SUPERIOR COURT OF JUSTICE (DIVISIONAL COURT)

Proceedings commenced at Toronto

FACTUM OF THE RESPONDENT

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