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Limits of the Law: Legal Challenges to the Health Services Restructuring Commission

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CHAPTER 7

Limits to the Law:
Challenging the Health Services Restructuring Commission in Court*

Joan M. Gilmour

INTRODUCTION

A key element in Wellesley Central Hospital’s Staying Alive campaign was its legal challenge to the Health Services Restructuring Commission’s (HSRC) Directions, requiring it to transfer its programs and services to St. Michael’s Hospital and cease operations. This chapter describes those legal proceedings, and analyzes them in the larger context of the restructuring process the government instituted. Part I explains the legal background underlying the litigation. It outlines the basis for and extent of government control over hospitals in Ontario, and the legal constraints on it when undertaking hospital restructuring, especially hospital closure. This part explains how the legislation governing both public hospitals and the Ministry of Health was amended by the Conservative government shortly after it assumed power in the mid-1990s, to remove many of those constraints and expand government’s power to reconfigure the public hospital system. At the same time, it eliminated ways that government could be held accountable by transferring responsibility for making changes to a newly created body, the Health Services Restructuring Commission. Parts II and III review and assess the outcome of the government’s approach, and the attempts by hospitals and citizens to contest it in court. Part II focuses on the HSRC’s Directions to the Wellesley Central and the lawsuit the hospital launched in response. Part III reviews other hospitals’ legal challenges to the HSRC and their results. Part IV analyzes the role of the courts, and reflects
more generally on the utility of the litigation strategies adopted by Wellesley Central and other hospitals in their attempts to alter the government’s course, given the legal framework and political climate in which the restructuring process took place.

PART I: HOSPITALS, RESTRUCTURING AND THE LAW

Although hospitals in Ontario are for the most part non-profit institutions rather than government-operated facilities, nonetheless, government provides the bulk of their funding, and they are subject to extensive government regulation. Even though hospitals’ share of the health care dollar has been shrinking for several years, hospitals remain the largest single item of health care spending in Canada. As a result, when governments seek to constrain health care costs, the hospital sector is an obvious target. In doing so, however, governments must abide by the law—the common law, statutes and regulations that govern not only hospitals, but government itself. Legal frameworks limit the changes that can be made and how they can be implemented. In the field of health care, government has traditionally been accorded significant leeway in policy-making. Decisions about the overall shape of the publicly funded health care system—what level of funding will be provided to hospitals, what types of services will be insured, and so on—have generally been considered to be policy decisions properly made by government, at least at a macro level. Once these policies and funding decisions have been set, the many institutions and providers in the system then work to provide care within the government’s framework and in keeping with their own policies.

Beginning in the late 1970s and continuing to the mid-1990s, the government’s primary means of attempting to constrain hospital costs in Ontario was to cut hospital budgets. For the most part, decisions to do so were considered to be beyond the supervisory power of the courts. For example, in Re Metropolitan General Hospital and the Minister of Health (1979), the application for judicial review seeking to compel the Minister of Health to remedy a claimed emergency situation at a Windsor hospital and reinstate 25 beds and the attendant funding for them, failed. Although the evidence established that the hospital was below the Ministry’s own target of beds-to-population ratio in the area, the court held that, provided the Minister was acting in accordance with his duties, departmental expenditures were within his discretion. Under the Ministry of Health Act, the Minister’s duties included
governing hospitals and assessing the revenues required for that purpose. The statute directed the Minister to determine the hospital facilities required to meet the public’s health needs, and to promote the development of adequate health resources. Nonetheless, the court held that the Minister was not required to spend money allocated to his department in a particular way or at all, nor did he owe the applicant hospital a legal duty to do so. The court concluded that “the wisdom of the decision can never be the subject of judicial review. It is a political and not a judicial problem” (Re Metropolitan General Hospital and the Minister of Health, 1979, at 705).

It would seem to follow from such an expansive view of government’s discretion that decisions about hospital restructuring would be largely unassailable in court, essentially giving the Minister of Health a free hand to re-shape the system. Ministerial power, however, is not unlimited. Courts exercise a supervisory role through judicial review to ensure that even at the ministerial level, government acts according to law. In this way, judicial review can serve as an important constraint on government action. Even Ministers are not permitted to exceed their jurisdiction, act in unauthorized and procedurally unfair ways or contravene constitutional rights. These constraints have limited government’s power over public hospitals in important ways. In Re Doctors Hospital and the Minister of Health (1976), the court upheld a challenge to the Cabinet’s decision to close Doctors Hospital in Toronto and others by revoking their approval under the Public Hospitals Act. The government had decided to close these hospitals in order to save money. The court held that, having regard to the history and content of the Act, it was regulatory in nature and meant to deal only with managerial, staffing and operational matters. Consequently, it was not sufficiently broad to allow government to close hospitals for financial reasons or budgetary constraints. These were extraneous considerations when government acted under this statute, and it had no jurisdiction to take them into account. Consequently, its decision was void. The court’s interpretation of the purpose and policy underlying the Public Hospitals Act meant that government could not rely on it to close hospitals for financial reasons. In the result, while government could cut hospitals’ funding, it was very difficult to force a hospital to close, at least by executive order.

The landscape for hospital planning and restructuring changed abruptly when the Conservatives were elected in Ontario in 1995, promising a “Common Sense Revolution” that would shrink the role of government, reduce government expenditures and financial commitments and lower taxes. In January 1996, the Conservative government swiftly passed and proclaimed in force the Savings
and Restructuring Act, 1996 (the “SRA”), omnibus legislation that brought sweeping change to many areas, including the governance of the health care system. A striking feature common to many of these changes was the elimination of traditional ways to hold government accountable. In particular, the SRA limited or denied access to the courts to challenge government actions, often by removing rights of appeal. As John Evans (now Mr. Justice Evans) noted in commenting on this legislation, by insulating the exercise of government power from the influence of concerned citizens, Ontario was introducing “government by management-style command and increasing the province’s democratic deficit” (Evans, Canada Watch, 1996, at 65).

The SRA significantly augmented the government’s ability to reconfigure the public hospital system, and to do so for a greatly expanded variety of reasons. It amended the Public Hospitals Act (PHA) to give the Minister of Health broad powers to direct changes in the operations of public hospitals, including the ability to require hospitals to close, amalgamate, or alter the type, level and volume of services provided, if the Minister considered it in the public interest to do so (PHA, s.6). A broad definition of “public interest” was also added to the statute—essentially, it encompassed any matter the Minister regarded as relevant, including the “proper management of the health care system in general” and “the availability of financial resources” to manage the system and deliver services (PHA, s.9). Companion amendments to the Ministry of Health Act (MHA) allowed Cabinet to create the Health Services Restructuring Commission (HSRC) for a limited term and assign it duties and powers in connection with the development and restructuring of the health care system (MHA, s.8). In March 1996, the Minister’s newly expanded powers over hospitals were delegated to the HSRC by regulation (O.Reg. 87/96, made under the PHA; O.Reg. 88/96, made under the MHA). Ontario already had some experience with health planning bodies prior to the SRA: District health councils had been established, with regional planning and advisory responsibilities. Delegation of responsibility to them had, however, been limited; they were seen as primarily advisory, and subject to significant Ministry direction and control (Fierlbeck, 2001, 147). Unlike the district health councils, the HSRC could require change. There was no appeal from its decisions to a court or any other body. The Commission was given four years, until March 2000, to complete its work.

The HSRC was delegated extensive powers to restructure public hospitals, but received little direction from the Ministry about what the health care system should look like or what level of services would be appropriate, other than a
requirement that it have regard to district health council reports for affected communities (MHA, s.8(8)). The Commission characterized its task as threethread (HSRC, 2000, p. 11):

1. To make binding decisions about hospital restructuring;

2. To make recommendations about the restructuring of other sectors of the health system, including reinvestment needed in hospitals and elsewhere; and

3. To foster the creation of an integrated health services system.

Despite the broad grant of power, it was still subject to legal and practical limits. While hospitals were required to implement its restructuring decisions, it had only advisory power with respect to other elements in the health services system. Further, authority over funding remained with the Ministry of Health. And finally, the SRA did not exclude the possibility of judicial review (although as it turned out, with only one exception, courts rejected all substantive challenges to its decisions).

In its final report on its activities, the HSRC asserts that from the outset, Commission members believed that in order to develop a truly effective health services system, restructuring should begin with primary care and community services systems rather than with hospitals, the “institutions of last resort” (HSRC, 2000, p. 13). In contrast, from the government’s point of view, the Commission’s “prime mandate” was hospital restructuring. Despite members’ views about what would be required to achieve genuine reform, they accepted their appointments and proceeded with the government’s agenda (ibid.).

The HSRC insisted throughout that it had not been charged with cutting costs (HSRC, 2000, p. 1). As even it acknowledged, however, the government’s announcement in December 1995 that hospital budgets would be reduced by 18 percent over the coming three years did lead to “cynicism about restructuring and create the strong perception that the HSRC was simply an agent of the government mandated to ‘manage’ hospital budget reductions” (HSRC, 2000, p. 12). That perception was understandable. Not only was the government slashing hospital budgets from the outset of the hospital restructuring process, but the HSRC itself was created pursuant to a statute, the SRA, the full title of which was: An Act to Achieve Fiscal Savings and to promote Economic Prosperity through Public Sector Restructuring, Streamlining and Efficiency and to implement other aspects of the government’s economic agenda (S.O. 1996, c.1). There is not one word in the lengthy title of that statute about improving the health care
system or anything else, except finances. The focus was economics and the explicit aim was saving money.

The government was keenly aware that cutting costs in the health care system, especially by closing hospitals, would provoke strong opposition and exact heavy political costs. Hospitals are intricately intertwined with the communities in which they are situated, and fill a host of important roles. Rather than take on hospital restructuring directly, then, the government set out to shift decision making to the newly created HSRC, expecting that in this way, it could absolve itself of responsibility for these decisions and distance itself from the blame and criticism that were sure to follow (Cohn, 2001). The HSRC and those involved in its operations clearly recognized that it was meant to be a political buffer. In reporting at the conclusion of its term, it noted that among the government and hospital staff, Commission members and staff, and others whom it had canvassed about its operations, the “resounding response” was that “the Health Services Restructuring Commission did a job that could not have been done by the MOHLTC [Ministry of Health and Long Term Care], the Government of Ontario, or the hospital community, individually or collectively.” One respondent added that the greatest risk to continued restructuring was “government’s inability to make the tough decisions” (HSRC, 2000, pp. 161–62). The government’s approach to hospital restructuring was to try to depoliticize decision making about health care services by removing it from the realm of political contestation. One crucial element it used in advancing this agenda was to shield the restructuring process from legal scrutiny or challenge (see generally Gilmour, 2002, pp. 286–92). Examining the legal proceedings in the Wellesley Central and other challenges to the HSRC’s decisions will provide a basis on which to assess the government’s efforts.

PART II: WELLESLEY CENTRAL HOSPITAL IN COURT

i) Wellesley Central Hospital and the Health Services Restructuring Commission’s Directions

Despite the lack of ground rules or guidelines, the HSRC began work as soon as the regulations were in place and appointments to the Commission were finalized in April 1996. It adopted three highly generalized evaluative criteria to guide the restructuring process: quality, accessibility, and affordability (HSRC, 2000, pp. 16–18). The terms were appealingly “common sense,” but were obviously
open to widely varying interpretations and emphases. Still, who could object to these as goals for the hospital system? The devil, of course, was in the details, and in what the criteria, admirable as they appeared, left out.

The Commission began its review of Metropolitan Toronto hospitals a few months into its mandate, in June 1996. Previously, the Metropolitan Toronto District Health Council had recommended in its final report on hospital restructuring in Toronto, released in September 1995, that services be consolidated in fewer locations and significantly curtailed at The Wellesley Hospital. It had not, however, recommended doing away with a role for the hospital entirely, nor changing its ownership (Wellesley Central Hospital v. Ontario (H.S.R.C.), hereafter “Wellesley,” para. 11). Following release of that report and in an effort to forestall its implementation, Wellesley had voluntarily amalgamated with the Central Hospital to create the Wellesley Central Hospital Corporation, and then entered into an alliance with Women’s College Hospital (the “alliance”) that the partners projected would realize savings of $51 million annually (Wellesley, para. 12).

The HSRC released its initial report on hospital restructuring in Metropolitan Toronto on March 6, 1997. It included Notices of Intention to Issue Directions to a number of area hospitals, including Wellesley Central. It proposed to require Wellesley Central and St. Michael’s Hospital to develop and implement a plan whereby Wellesley Central would relinquish the ownership, operation, management and control of its programs, services, buildings and assets to St. Michael’s by August 31, 1997. Wellesley Central was to cease operation as a public hospital (HSRC, 2000, p. 112). The HSRC’s Notice of Intention to Issue Directions to Wellesley’s alliance partner, Women’s College Hospital, would require it to amalgamate with Sunnybrook Health Sciences Centre and the Orthopaedic and Arthritic Hospital. The bulk of programs and services were to be provided at the Sunnybrook site, although ambulatory women’s health care programs would be retained in downtown Toronto. Prior to the issuance of the Notices, Wellesley Central had understood from its meetings with Commission staff that the HSRC viewed the new initiative it had undertaken with Women’s College in forming the alliance favourably—indeed, that the two should “go as far and as fast as you can” to implement it (Burnham Affidavit). When the Notices of Intention to Issue Directions were released, however, the HSRC gave no effect to the alliance at all. The Commission allowed the hospitals affected by these Notices the minimum 30 days required by law in which to respond (PHA, s.6 (5))—that is, until April 7, 1997.
ii) Wellesley Central Hospital v. Ontario (Health Services Restructuring Commission): The Litigation

Although the SRA and the regulations delegating power to the HSRC had not included any provision for appeal from its decisions, the Wellesley Central Board of Directors was determined to fight the Directions in court. To that end, by late March 1997, it had changed the hospital’s legal representation and retained a new law firm, Fasken Martineau, with instructions to mount the strongest legal case that would protect the hospital and its assets, and that would also establish what would be lost if the hospital was closed. The latter point was especially important to Wellesley Central, given that it was implicit in the HSRC’s intended Directions that it considered the two hospitals to be essentially interchangeable in terms of their ability to offer services — i.e., that St. Michael’s, a Roman Catholic institution, could simply step into Wellesley Central’s shoes, despite the particular characteristics and needs of the population Wellesley Central served, and the nature of the care and programs it provided. At the same time, given the short deadlines the Commission had imposed for responses, Wellesley Central also had to take every opportunity to make its case within the HSRC’s processes and try to convince the Commission that the hospital should remain open. Even after requesting an extension of time in which to respond from the HSRC, it was only given a few more weeks, first until April 18 and then until May 2, 1997 (Wellesley, para. 13). Its lawyers scrambled to prepare submissions to the Commission as well as the case to be argued in court, and at the same time, advise the hospital and its directors about the myriad legal issues raised by both the legal challenge and the HSRC’s Directions if, in the end, they had to be implemented (personal communication, Robert Cosman, Fasken Martineau, July 2003). Consideration had to be given to employment issues, directors’ duties, insurance, expenditures, confidentiality of patient records, ownership of Wellesley Central’s land and buildings, the legality of the Directions requiring the transfer of assets and other matters. Time was short, and the hospital had to act on multiple fronts simultaneously.

Wellesley Central was not the only hospital that had decided to contest the HSRC’s Directions in court. Several hospitals in Toronto and elsewhere in the province faced the prospect of being shut down or having their services severely curtailed. Losing institutions that not only ministered to a community’s health needs, but were also embedded in its social and economic life understandably aroused strong and heated opposition. While the HSRC’s Directions could not be appealed, the legislation and regulations did not preclude judicial review.
TWCH Board of Directors engaged in legal action in the summer of 1997 to set aside the hospital's closure. The key legal arguments focused on expropriation of the hospital's assets, the possibility of bias on the part of decision-makers and the violation of rights of individuals under the Canadian Charter of Rights and Freedoms. Pictured above, Fasken Martineau lawyers, Bob Cosman and Kelly McKinnon, prepare for the court case. (Source: Wellesley Central Health Corporation, Archives.)

With their very existence at stake, mounting a legal challenge seemed to be one of the few avenues remaining open to hospitals that had the potential to force the HSRC to back down. Sudbury General Hospital, the Brockville, London and Lakehead Psychiatric Hospitals, and Pembroke Civic Hospital had already begun proceedings seeking judicial review of the Commission's Directions. In Toronto, Wellesley Central, as well as Women's College Hospital (Wellesley's alliance partner) and the Doctors Hospital commenced applications for judicial review, while others considered doing so too.

Wellesley presented its submissions to the HSRC objecting to its proposed Directions at the beginning of May 1997. It also filed its application for judicial review, seeking to prevent the Commission from implementing them—specifically, it sought an order quashing the Notice of Intention and prohibiting the Commission from issuing Directions in the same or similar terms. The HSRC responded with a motion to quash the application for judicial review on the ground that it was premature, since the Commission had not made any final decision yet. The two motions were argued before the Divisional Court on June 25, 1997. The court allowed the HSRC's motion and dismissed Wellesley Central's application for judicial review as premature ([1997] O.J. No. 2752). In its judgment, it noted that the Commission's procedures allowed those affected by the Notices to respond, and that such submissions might influence
its final decisions. Experience with the HSRC’s processes was still limited at that point, and the tenacity with which it would adhere to the plans it announced in its Notices of Intention was not yet apparent. In light of this, it is perhaps understandable that the court characterized the Notice of Intention to Wellesley Central as “essentially an invitation to concerned persons to carry on a dialogue” with the Commission; the Notice was no more than the Commission’s “present inclination” (ibid., para. 3). Although it did not grant the relief the hospital sought, the court did note that Wellesley Central had serious concerns about the Commission’s jurisdiction, composition and procedures, adding that it could raise these with the Commission, and if it still objected after the Commission finalized its decisions, in court (ibid., para. 4).

The HSRC issued its final Directions to Metropolitan Toronto hospitals and Advice to the Minister of Health one month later, on July 23, 1997 (HSRC, “Metropolitan Toronto Health Services Restructuring Report”). The broad outlines of its Directions to Wellesley Central remained unchanged—it was to relinquish the operation and management of its programs and services to St. Michael’s Hospital. The HSRC had, however, taken account of the argument made by counsel for Wellesley Central and some of the other hospitals that, in the absence of statutory authorization, requiring them to transfer ownership of hospital buildings and assets constituted unlawful expropriation. The final HSRC Directions required Wellesley Central to develop a plan with St. Michael’s to transfer the operation and management of its services and programs, but it no longer had to relinquish its buildings and assets to St. Michael’s. It did, however, still have to allow temporary use of its premises by St. Michael’s as needed for patient care, education and research (with payment of appropriate compensation). The two hospitals were also directed to develop a plan (i) for a new Sherbourne Hospital Corporation to establish, own and govern an ambulatory care centre at the Central Hospital site; and (ii) to provide for the transfer of ownership of the buildings and assets at the Central site to the new corporation (with compensation). The Wellesley Central Board was also directed to make recommendations to the Minister of Health for the disposal of the hospital’s land, buildings and assets at the Wellesley Street site once all programs had been transferred.

Two days after the HSRC issued its final Directions for Metropolitan Toronto, on July 25, 1997, the Divisional Court released its judgment in Pembroke Civic Hospital v. Ontario (Health Services Restructuring Commission). This was the first case to address challenges to the HSRC’s processes, composition, mandate and powers on substantive grounds. Earlier challenges to HSRC
processes and jurisdiction had been disposed of on procedural grounds. Pembroke Civic Hospital, located in Renfrew County north of Ottawa, had sought judicial review of Directions the HSRC had issued in February 1997, requiring it to close and transfer its programs and services to the Pembroke General Hospital, a Roman Catholic institution in the same town.

The court dismissed the Civic’s application and upheld the decision of the HSRC. In what became a recurring theme in these cases, Mr. Justice Archie Campbell stressed the restricted role of the court in reviewing decisions of the Commission:

The court’s role is very limited in these cases. The court has no power to inquire into the rights and wrongs of hospital restructuring laws or policies, the wisdom or folly of decisions to close particular hospitals, or decisions to direct particular hospital governance structures. It is not for the court to agree or disagree with the decision of the Commission. The law provides no right of appeal from the Commission to the court. The court has no power to review the merits of the Commission’s decisions. The only role of the court is to decide whether the Commission acted according to law in arriving at its decision. (Pembroke Civic Hospital, 1997, p. 44)

The court rejected all the Civic’s arguments—that it had been denied procedural fairness by the HSRC because of bias, prejudgment or failure to provide adequate opportunity to make submissions; that the Commission had erred in accepting a continuing role for denominational governance in the health care system; and that residents’ rights under the Canadian Charter of Rights and Freedoms to freedom of religion and conscience, to equality, and to life, liberty and security of the person had been infringed by the Commission’s selection of a Roman Catholic hospital over the secular Civic as the only public hospital remaining in the community. The Civic immediately sought leave to appeal from this decision and a stay of the court’s order until the appeal could be heard, since otherwise, the HSRC Directions would require its emergency department to close almost immediately. The Civic was granted a stay pending determination of the application for leave to appeal, but the application for leave itself was dismissed by the Court of Appeal on September 10, 1997 ([1997] O.J. No 3603). The decision in Pembroke Civic proved highly influential on later courts in the legal challenges to the HSRC that followed.

Within a week of the release of the HSRC’s final Directions for Metropolitan Toronto, on July 31, 1997, Wellesley Central and three individuals who relied
on the hospital for health care commenced an application for judicial review. It sought to quash the Directions on the grounds that

1. The Commission did not have the authority to compel a public hospital to divest itself of its assets or otherwise interfere with its property rights;

2. The Directions were void for uncertainty;

3. The Commission exercised its discretion unreasonably by taking into account or according excessive weight to an irrelevant consideration, namely, the interest of a Catholic health care provider in not having its religious governance diluted;

4. The Commission violated its duty of procedural fairness;

5. The Commission was inappropriately influenced by the government;

6. Past associations of Commission members and staff gave rise to a reasonable apprehension of bias; and

7. The Directions violated rights guaranteed under the *Canadian Charter of Rights and Freedoms* to (i) freedom of religion, (ii) equality and (iii) liberty and security of the person.

Women’s College Hospital (Wellesley’s erstwhile alliance partner) and Doctors Hospital also brought applications for judicial review. Time was of the essence, since the HSRC required hospitals to implement its Directions in short order. Arrangements were quickly finalized with the court and counsel for all parties in these cases to hear the applications (and potentially, one by the Orthopaedic and Arthritic Hospital) during the week of August 25, 1997. In early August 1997, Wellesley Central and the HSRC consented to a motion by St. Michael’s Hospital seeking leave to intervene on specified grounds in the Wellesley Central proceedings.

Wellesley Central’s application for judicial review was heard August 27 and 28, 1997, immediately following that brought by Doctors Hospital. Women’s College had reached an agreement with Sunnybrook and the Orthopaedic and Arthritic Hospital, and did not proceed with its application. In judgments released September 15, 1997, the Divisional Court dismissed both Wellesley Central’s and Doctors’ applications with costs, upholding the HSRC’s Directions. Wellesley Central’s counsel drafted the documents required to seek leave to appeal this decision, which argued that the court had erred in concluding the HSRC had not unlawfully expropriated Wellesley Central’s property. Since negotiations with St. Michael’s, and then with the government, did progress, however, it did not proceed with that application.
From the outset, Wellesley’s counsel had considered one of its strongest arguments to be that the Directions affecting Wellesley’s assets and property were in reality an unlawful expropriation (taking of its property) (personal communication, Robert Cosman, July, 2003). The HSRC had directed Wellesley Central to develop a plan with St. Michael’s Hospital to (i) allow the latter temporary use of some of its facilities while needed for patient care, research and education; and (ii) transfer ownership of its buildings and assets, as well as programs and services at the Central Hospital site to St. Michael’s and the new Sherbourne Hospital Corporation; further, the Wellesley Central Board had been directed to (iii) make recommendations to the Minister of Health to dispose of the land, buildings and assets at the Wellesley site. The common law is clear that the power to expropriate must be specifically conferred by statute. Adopting the reasoning in the companion Doctors Hospital case, the court held, however, that since use of the Wellesley site was only temporary, and was needed in order to transfer programs and services (something the HSRC was authorized by statute to require), then the Direction was merely ancillary to the HSRC’s power under the Public Hospitals Act to “make any other direction related to a hospital that the Minister considers in the public interest” (PHA s.6(6)), and thus did not contravene the law (Wellesley, para. 21; Doctors Hospital, 1997, para. 33). It concluded that the Direction regarding the Central Hospital site only ordered the parties to negotiate toward a particular goal. This, too, was unobjectionable, because merely anticipating agreement was not expropriation. It added that if the parties were not able to agree, “the matter may then require legislation, a regulation under [the PHA] or the use of the court to adjudicate on the then outstanding issues” (Wellesley, para. 24). Thus, the court acknowledged that in the event of deadlock, neither the HSRC nor the Minister would necessarily be able to require implementation of the HSRC’s plans for the Central site without further authorization. Finally, with respect to the Direction that the Wellesley Central Board formulate and recommend a plan to dispose of the property at the Wellesley site, the court concluded that because the HSRC had not actually directed the hospital to dispose of the land, and it had not done so yet (not surprisingly, since Wellesley was challenging the legality of this Direction in court), this could not be said to constitute an expropriation either (Wellesley, para. 25). The Divisional Court’s reasoning in Wellesley Central and Doctors Hospital is marked by a formalistic reading of both the common law on expropriation and the practical effect of the HSRC’s Directions. It coupled this with a large and liberal reading of the HSRC’s statutory power, to support its conclusion that requiring these
hospitals to make arrangement to dispose of and transfer their property did not constitute expropriation.

Wellesley Central also argued that the HSRC had ordered it to transfer assets and programs rather than merge or amalgamate with St. Michael's because the Commission had acceded to Roman Catholic health care providers' demands for continued denominational control of their governance structures despite restructuring, and in so doing, had given excessive weight to private sectarian interests. The Divisional Court rejected this argument too. Relying on Pembroke Civic Hospital, it noted that it was for the Commission to decide whether to take the role of Roman Catholic hospitals in Ontario into account, and whether to consider representations from them. It concluded that there was no evidence the HSRC had given the private interests of Roman Catholic health care undue weight to preserve the purity of St. Michael's governance structure (Wellesley, para. 36). Evidence of pronouncements by the Catholic Health Association of Ontario that denominational control of governance structures was a "deal breaker" was not enough to convince the court otherwise (Wellesley, para. 33).

As in Pembroke Civic, the court characterized the Commission's role, powers and functions as close to the political/legislative rather than judicial end of the spectrum, meaning that it had the widest area of non-reviewable discretion. It rejected Wellesley's arguments that Commission members' past associations with health care and other organizations gave rise to a reasonable apprehension of bias. The court considered it an advantage and indeed, in the public interest, that as a "policy making and implementation body," its members be experienced and knowledgeable people. Nor had the Commission denied Wellesley Central procedural fairness in not adopting more adversarial procedures, given the nature of its task; Wellesley had been given sufficient opportunity to state its case and knew the case it had to meet (Wellesley, paras. 40, 43).

The court's unwillingness to engage in any close review of the Commission's decisions extended to arguments that its Directions breached the Canadian Charter of Rights and Freedoms as well. Again, it relied heavily on the analysis in Pembroke Civic. In both cases, secular hospitals had been directed to transfer programs and services to Roman Catholic institutions and to cease operations themselves. Relative to Wellesley Central, one effect of the HSRC Directions would be to eliminate access to a number of reproductive health care services previously available at the Wellesley when programs were transferred to St. Michael's. Physicians granted privileges at St. Michael's were required to sign an acknowledgement of their willingness to abide by the principles in the Catholic Health Care Ethics Guide.\footnote{Abortion, vasectomies, tubal ligation as}
a form of birth control, birth control counselling, artificial insemination and
in vitro fertilization involving unmarried persons were among the services that
would no longer be offered (Wellesley, para. 60). Wellesley Central had served
a high-needs, low-income population, with a high incidence of gay and lesbian
patients and patients infected with HIV/AIDS. Wellesley and the individual
applicants objected to programs and services being transferred to an institution
that adhered to the moral precepts of the Roman Catholic Church, which
condemns homosexuality and prohibits a range of reproductive and other
services. As the court noted, “the Catholic health care mission, which is a
guiding principle of CHAO members [Catholic Health Association, which
included St. Michael’s] encompasses the Catechism of the Catholic Church....
The catechism presents homosexual acts as ‘immoral,’ ‘evil,’ ‘depraved,’ and
‘disordered’” (Wellesley, para. 60).

Wellesley Central and the individual applicants argued that the result of the
HSRC’s Directions would be to violate patients’ rights to freedom of conscience
and religion, to equality and to security of the person, all protected under the
Charter of Rights and Freedoms. They asserted that the right to freedom of
religion includes a right to be free from religion, that the right to security of the
person includes the right to be free from the threat to security that would result
from the increased difficulty that women in Wellesley’s catchment area would
have in accessing reproductive services (in particular, abortion), and that the
individual applicants’ equality rights would be breached because they would have
to obtain health care services in a hostile climate that would reasonably be
perceived as discriminatory (Wellesley, paras. 61, 62).

The Charter challenges all failed, primarily because in the court’s view,
women and those personal applicants who were gay, lesbian or HIV+ had
other options—they would not be compelled to receive treatment at St.
Michael’s. The court did not even call on the HSRC or St. Michael’s to respond
on the Charter issues (Wellesley, para. 63). Nowhere does the court—or the
HSRC, whose decision it was reviewing—explicitly consider the implications
of a public hospital deciding not to offer certain reproductive health care
services, not on the basis of resource availability, but rather as the result of a
moral judgment that those services (which are for the most part publicly insured
and therefore by definition medically necessary) are wrong. The court adopted
the reasoning in Pembroke Civic, in which Archie Campbell J. concluded: “The
silent presence of crucifixes does not constrain the chosen religious practices
of those exposed to them and does not compel or coerce them to engage in
religious practices or observances which they would not freely choose”
I SURVIVAL STRATEGIES (Pembroke, para. 56) That observation does not, however, address the crux of the Charter claims being advanced. The Charter claims in Wellesley Central and Pembroke Civic were about access to health care and the conditions under which that would occur, not about patients being compelled to "engage in religious observances." As I have argued elsewhere (Gilmour, 2002, 288–89):

The institutional policies dictated by adherence to the Catholic faith are in themselves coercive, because they prohibit the provision of certain types of health care on the basis that a particular religion condemns them as morally wrong. They carry with them an inherent judgment, the judgment of a publicly funded institution charged with carrying out government policy to provide comprehensive health care, that those seeking such services—primarily women—are also morally in the wrong, or at best misguided. That is not a silent presence but an active judgment with real consequences and ramifications, particularly when other hospitals and health care are not easily accessed, either because of geography or owing to lack of individual resources or institutional capacity.

These policies restrict decisions about patients' health care to those dictated by religious belief, rather than encompassing the range appropriate to the health needs of the person concerned. The restrictions are exacerbated if accompanied by limitations on ready referrals and comprehensive, open counselling.

The court in Wellesley Central accepted the HSRC's argument that Toronto's large size meant that access would not be affected. When cross-examined on his affidavit filed on behalf of the HSRC in the Wellesley Central proceedings, Mark Rochon, CEO of the HSRC, stated that the Commission had considered accessibility of services, and that in addition to Wellesley Central and St. Michael's, it had directed the Toronto Hospital and Mt. Sinai Hospital to determine which of the Wellesley's services should be relocated there. He added that the services at issue were already available in other Toronto hospitals, and that in any event, many could be provided outside the hospital setting in doctors' offices or clinics. As for people living with HIV/AIDS, the HSRC concluded and the court accepted that they, too, could obtain health services elsewhere in Toronto (Wellesley, paras. 64–66). Since there was no compulsion, the court held that the Charter-protected right to freedom of conscience and religion would not be breached (Wellesley, 729).

The HSRC's assertion (echoed in the litigation by the intervenor, St. Michael's Hospital) that services eliminated at the Wellesley could simply be accessed
elsewhere merits closer examination. With respect to reproductive services, even prior to the hospital restructuring process, research had indicated that despite the Supreme Court of Canada’s 1988 decision in *R. v. Morgentaler*, access to abortion was limited and controversial in many areas (Ferris et al., 1998; 1995). Indeed, in the *Pembroke Civic* litigation, the Pembroke obstetrician/gynaecologist whose affidavit the Roman Catholic Pembroke General filed as part of its case had stated on cross-examination that, although abortions were performed at the Ottawa Civic Hospital, there was too little operating room time available, and as a result, most women in Pembroke needing abortions went to the Morgentaler clinic in Montreal. Montreal is more than 300 kilometres from Pembroke.

In issuing its Directions to Toronto hospitals, the HSRC does not seem to have concerned itself with the effects its decisions would have on women’s access to these services, although both their contentious nature and still fragile presence in the health care system were well known. There is no indication the HSRC took existing research into account or made its own assessment in this regard, beyond noting that there were facilities in Toronto performing abortions, and calling for the establishment of a Women’s Health Council. Nor is there an indication in its reports that it actually made a determination on evidence that other facilities could or would replace the services lost. Yet in a 1994 survey of Ontario hospitals performing abortions, providers noted limits on ability to book operating room time, lack of availability of beds and too few physicians with appropriate training as factors limiting hospitals’ capacity (Ferris, 1998). These findings make the HSRC’s assumption that hospitals and clinics that had been performing abortions would simply be able to absorb the demand that had been met at the Wellesley questionable. It was not at all clear that other facilities would or could do so, or whether this would increase delay in accessing these services.

Mr. Justice Adams had commented some years earlier in *Ontario (A.G.) v. Dieleman*:

> Public hospitals have not always given priority to the interests of women seeking access to abortion services.... The need for free-standing clinics in Ontario is pronounced because of the politics which pervade the abortion issue and the impact of political forces on hospitals throughout the province.... In effect, the free-standing clinics are a response to the uncertain delivery of abortion services at Ontario’s public hospitals notwithstanding that hospitals provide the greatest protection against the harmful effects of protest activity.” (1994, pp. 315–16)
Ensuring women’s ability to access abortion services has remained a struggle, both in the courts, given some provincial governments’ refusal to allow or fund this type of care (see e.g., Morgentaler, 1993; Lexogest, 1993; Morgentaler, 1995; Jane Doe, 2004), and in the less obviously political realm of local hospitals’ decisions. When abortion access is considered as a matter of health care administration, then denials of access are characterized as local governance issues; the gendered nature and discriminatory effects of those decisions are obscured (Gilmour, 2002; Lessard, 1997).

From the beginning, although courts took a limited view of their role, they recognized that they still had to determine “whether the Commission acted according to the law in arriving at its decision” (Pembroke, p. 44). Yet in every challenge to the HSRC except one, courts were decidedly deferential in doing so. They repeatedly resisted efforts to have them delve into the bases for the HSRC’s decisions or query them closely. Administrative law scholar David Mullan has summarized the experience in the HSRC litigation: “the opportunities left open by the concept of ‘act[ing] according to the law’ proved ... to be quite limited” (Mullan, 1999, p. 353). That was certainly true in Wellesley Central. The court’s broad reading of the Commission’s policymaking function and the scope of its discretion led it to decline to scrutinize the relevance or weight of factors the Commission took into account, such as the role and impact of denominational governance, or consider the significance of matters it omitted.

PART III: OTHER LEGAL CHALLENGES TO THE HEALTH SERVICES RESTRUCTURING COMMISSION

There were few legal challenges to the HSRC after those from Toronto. With one exception, all of them met the same fate as Wellesley Central’s.

i) Russell v. Ontario (Health Services Restructuring Commission) (1998)

In Russell v. Ontario (Health Services Restructuring Commission), decided in 1998, the Divisional Court was faced with the reverse situation to that in Wellesley Central. The HSRC had directed the Roman Catholic Hotel Dieu Hospital in Kingston to cease operating as a public hospital and relinquish operation and management of its programs and services to the secular Kingston
General Hospital (KGH), with provision for temporary use of the Hotel Dieu buildings and assets by KGH for patient care. The Directions also called for the establishment of an ambulatory care centre at the site of the Kingston psychiatric Hospital (a move dependent on both Ministerial approval and planning permission), and required KGH to offer the religious order that operated the Hotel Dieu the opportunity to manage both the new ambulatory care centre and the transitional services at the Hotel Dieu site—in other words, a continuing role in acute health care (Russell, 1998, para. 3). Prior to the HSRC process, area hospitals had already voluntarily engaged in a process of rationalizing services, so that even before the Commission issued its Directions, Hotel Dieu had limited its services to ambulatory care with limited walk-in emergency services and acute inpatient mental health beds. Most inpatient acute care services and all rehabilitation care had been consolidated elsewhere (Russell, 1998, para. 6). Hotel Dieu and the individual members of the religious order that operated it asserted that the Directions infringed their Charter-protected right to religious freedom, which they argued included the ability to continue the mission of their order, ministering to the sick poor. They also argued that the Directions were patently unreasonable and premature, since the hospital would have to close before either the planning authority or the ministry could decide whether the psychiatric hospital site would be approved for ambulatory care, and that the HSRC had failed to take relevant planning considerations into account.

In a decision affirmed on appeal, the court rejected all these arguments (Russell, Ont. C.A., 1999). Relying on Wellesley Central, it noted that if the HSRC had to resolve implementation issues before issuing Directions, it would never make any progress at all. It added that the HSRC was not required to consider matters beyond its mandate, such as planning considerations, although it was free to do so. As it pointed out, if the necessary planning and ministerial approvals were not forthcoming, the HSRC could amend or revise its Directions.

The Divisional Court disposed of the applicants’ Charter arguments by noting that, since there was no constitutional entitlement to funding for denominational hospitals in the first place, there was no constitutional impediment to withdrawing funding. The religious order was still free to continue its mission to minister to the sick poor in other ways, but “[n]ever ... has it been suggested that freedom of religion entitles one to state support for one’s religion.”
ii) *Douglas Memorial Hospital v. Ontario (Health Services Restructuring Commission)* (1999)

The reluctance to intervene in the HSRC's decisions is also apparent in *Douglas Memorial Hospital v. Ontario (Health Services Restructuring Commission)*, a decision of the Superior Court dismissing the hospital's application for judicial review. The HSRC issued its Restructuring Report for the Niagara Region and Directions to the nine area hospitals, including the applicant, in March 1999. Douglas Memorial Hospital, a rural public hospital located in Fort Erie, was directed to amalgamate with the eight other hospitals in the region to form the Niagara Health Care System. The affected hospitals would lose their independent governance, although standing committees for each of the rural communities affected would have limited power to refuse approval of decisions to eliminate local inpatient or emergency services. The governance structure that the HSRC directed these hospitals to adopt differed from Ministry of Health policy, set out in a framework and guidelines for rural and northern health care that it had developed in 1997. Douglas Memorial, concerned that it would be absorbed by the larger hospitals, challenged the Directions on two grounds: First, that the HSRC was bound by the Ministry's framework (under which rural hospitals were to be left to determine their own governance arrangements); and second, that the Directions were discriminatory because they did not treat it in the same way as other rural hospitals that had not been the subject of HSRC Directions.

The court would not consider the merits of the HSRC's decision. In dismissing the application, Hambly J. stated, "the governance structure recommended by the Commission may or may not be in the public interest. The Commission, after far greater deliberation than I am able to give the matter and with far greater knowledge of the issues than I have, decided that it is" (para. 17). Even though the Ministry had developed policy to guide the Commission in its work in this sector, the court held that its framework and guidelines were not binding on the HSRC. Provided the Commission had exercised its mandate in good faith, its decisions about restructuring in the Niagara Region, and at Douglas Memorial in particular, could not be considered discriminatory (para. 25).

The government was caught by its own decision to create an independent commission to restructure hospitals. When it tried to impose a solution that would be more acceptable to rural and northern areas (where it relied on strong political support), it found that it could not do so. As the decision in *Douglas Memorial* demonstrated, its commission was not required to follow its orders. That situation was, however, short-lived. Within a month of the release of the
SRC's Niagara area report in March 1999, the government put regulations in place revoking the HSRC's decision-making powers and making its role advisory (O. Regs. 272/99 and 273/99).

i) Lalonde v. Ontario (Health Services Restructuring Commission) 1999

Only one hospital successfully challenged the HSRC's Directions. In February 1997, the Commission released its initial Ottawa Health Services Restructuring Report and Notices of Intention to issue Directions to public hospitals in the Ottawa area. It proposed to direct Hôpital Montfort to close as a public hospital and amalgamate with three other hospitals in the area to form a single corporation providing services at two sites. Montfort was a francophone institution, providing health care services to the public and training for medical professionals in French. As such, it filled an important role both practically and symbolically in the Franco-Ontarian community in the region and beyond. The threat of closure generated tremendous public protest from the community, as well as from federal, Quebec and some Ontario politicians. In August 1997, the Commission reconsidered its original plan and issued a second report, with revised Directions to the Montfort. It concluded the hospital should remain open and retain its own governance, but that it would become primarily a centre for ambulatory care, with a reduced budget and number of beds that would support limited day surgery, limited obstetrics and acute and longer term mental health beds (Lalonde, 1999, para. 30). The revised Directions also included provisions to strengthen the bilingual nature of services offered at other area institutions being reconfigured. Montfort and the francophone community were of the view that the modified Directions would destroy the francophone nature of services and training. The hospital and individual applicants sought judicial review to have the Directions quashed and to prevent their re-introduction.

Montfort asserted:

1. The Directions violated the Charter's guarantee of equality rights by discriminating against Franco-Ontarians.

2. The Commission violated administrative law principles in issuing the Directions, as (i) they were patently unreasonable, and (ii) the Commission had exceeded its jurisdiction by taking irrelevant considerations into account (specifically, the possibility of an anglophone backlash).
3. The Directions failed to effectively protect the francophone minority, one of the country’s founding cultures, and therefore violated a fundamental organizing principle underlying the Canadian constitution, the protection of minorities.

As noted previously, in April 1999 the government had revoked the Commission’s authority to issue Directions to public hospitals in place of the Minister and made its role advisory only (O. Regs. 272/99 and 273/99). The Divisional Court heard the Montfort’s application for judicial review in June 1999, and released its decision in November of that year (Lalonde v. Ontario (Health Services Restructuring Commission, 1999).

The court quashed the Commission’s Directions. It held that by focusing on restructuring hospital services without taking into account the Montfort’s broader institutional role in promoting and enhancing Franco-Ontarians as a cultural/linguistic minority, the HSRC had violated the unwritten constitutional principle requiring that minorities be respected and protected. The HSRC, in keeping with provincial policy, had focused on the bilingual provision of services. In doing so, the court concluded, it had ignored Montfort’s broader institutional role, and had not considered the need for unilingual francophone institutions. The decision was affirmed by the Ontario Court of Appeal in December 2001 (Lalonde, 2002). It held that the Commission’s Directions were inconsistent with the purpose and objectives of Ontario’s French Language Services Act (FLSA), which had been put in place to enhance the equality and use of French. The HSRC had failed to take all reasonable measures to comply with that statute (Lalonde, 2002, paras. 164–65). Further, in determining the public interest, as the Commission was required to do in restructuring the hospital system under the PHA, it must have regard to the fundamental constitutional principle of respect for and protection of minorities (Lalonde, 2002, para. 180). It had not done so. Justifications based on “administrative convenience and vague funding concerns” did not suffice to displace these statutory and constitutional imperatives (Lalonde, 2002, para. 168). The court remitted the question of restructuring health services at the Montfort to the Minister for reconsideration in light of its conclusions. Under intense political pressure, the government decided not to seek leave to appeal to the Supreme Court of Canada.

_Lalonde_ stands in striking contrast to the other legal challenges to the HSRC. Unlike _Russell_, in which the court left the HSRC to decide for itself whether to consider matters not central to its mandate (in that case, the Planning Act and planning considerations raised by its restructuring plan for Kingston area hospitals), in _Lalonde_, the court circumscribed the Commission’s power to
interpret its mandate. It held that the unwritten constitutional principle requiring respect for and protection of minorities imposed a substantive legal obligation on the HSRC to advance the protection of francophone minorities in formulating its Directions. This was reinforced by the FLSA. Unlike the Planning Act, the HSRC was not free to ignore this statute. Since it had failed to take either into account, its Directions could not stand.

Other than Lalonde, courts had refused to examine the merits of HSRC Directions or question its processes. The tone was set from the outset in Pembroke Civic: The HSRC had the widest area of non-reviewable decision making. Its decisions were allowed to stand even when they contravened the government’s own policy (as in Douglas Memorial), or presumed on the approval of other, unrelated government authorities (as in Russell). Only in Lalonde was the court prepared to hold that the Commission had not “acted according to law,” and then only when it failed to adhere to a constitutional principle, the protection of minorities. Once that threshold had been crossed, however, the court did not hesitate to scrutinize the evidence, substitute its own assessment of the facts (in particular, what the effect of losing the Montfort as a unilingual health care and training facility would be, and the inadequacy of the HSRC’s bilingual alternative) and pointedly outline the solution it had concluded was needed, a unilingual facility at least as strong as currently existed.

Both levels of court in Lalonde obviously considered it to be a different kind of case than the others, justifying a more interventionist approach and a higher level of scrutiny. Presumably, this was because it raised questions of constitutional rights. Deference to the Commission was neither required nor appropriate on issues of constitutional interpretation. Applicants had, however, raised constitutional claims in other cases, including Wellesley Central, and they had lost. In those cases, courts had declined to inquire into the HSRC’s fact-gathering or decision-making processes, leaving its exercise of discretion untouched, even when deciding Charter claims. Perhaps taken aback by the magnitude and seemingly intractable nature of soaring health care costs, or reluctant to interfere with the government’s policy agenda, courts in those cases had held that because any constitutional violations were only prospective, applicants had to meet a high threshold of proof and show substantial evidence of the anticipated Charter violations (Wellesley, 1997, para. 67; Gilmour, 2002, 291). When coupled with courts’ refusal to scrutinize the evidence the HSRC had taken into account or query its assertions that its restructuring plans best met its criteria of quality, accessibility and affordability of health care services, these Charter challenges had little chance of success.
PART IV: REFLECTIONS ON THE HOSPITAL RESTRUCTURING PROCESS

In reflecting on the restructuring process in general, it is clear that the courts were not prepared to stand in the way of government's determination to move ahead with its policy agenda decisively and quickly. For the most part, they treated the restructuring decisions as outside their area of expertise. As the Divisional Court noted in rejecting Montfort's administrative law claims in Lalonde, "The Commission's decisions are fundamentally matters of judgement ... reasonable people can differ on the solutions" (Lalonde, 1999, para. 97). Both the Commission and the courts treated restructuring as a technical matter, with decisions left to administrators and experts charged with the theoretically neutral task of rationalizing the public hospital system (Gilmour, 2002, p. 291). The result was essentially unchallengeable HSRC decisions.

Characterizing the HSRC Directions in this way ignored their qualitative dimensions and obscured their political character. With the exception of Lalonde, the HSRC successfully concentrated the courts' (and its own) attention on the technical aspects of the hospital restructuring decisions in Wellesley Central and the other decisions. The courts, for their part, gave short shrift to arguments about the systemic effects that HSRC decisions would have on the care particular groups would receive. In Wellesley Central, the patient groups who would be disproportionately affected by the decision to close the hospital were not powerful people. They were poor people, people with HIV/AIDS, women, and gays and lesbians. These groups' Charter claims had so little purchase with the court that it did not even call on the respondents to address those issues (Wellesley, 1997, para. 63). Unlike the Catholic Health Association of Ontario (which, as Mark Rochon, CEO of the HSRC, pointed out when cross-examined on his affidavit in the Pembroke Civic proceedings, was consulted because it spends in excess of one billion dollars a year of public funds, and so, is a very significant presence in the hospital system), members of these groups are frequently marginalized, and are seldom decision-makers when it comes to the health services available to them. Instead, they are most often the objects of solutions that have been developed by experts in the policy-making process and then applied to them. In contrast, the constitutional claim based on linguistic/cultural rights carried the day in Lalonde, and the court imposed a remedy that substantially narrowed the policy choices open to government in restructuring this hospital, all but directing the outcome.

By creating the HSRC and delegating to it the power to make decisions
about closing public hospitals and transferring services, the government aimed to insulate itself from political and legal accountability. As Daniel Cohn has pointed out, however, it is difficult for government to depoliticize tough restructuring issues or deflect blame from itself when it not only sets the Commission’s mandate and the length of its term, and appoints its members, but also retains the power to change all of that by regulation (Cohn, 2001). As discussed previously, the HSRC saw itself as essential to pushing through difficult but necessary decisions (HSRC, 2000). Despite the numerous speeches and presentations HSRC members and staff gave and the countless meetings they held, however, it never attained popular legitimacy. Given its task, that may have been an impossible goal. The public remained sceptical about its priority-setting process and hostile to many of its Directions. The public was not convinced that its decisions were the necessary result of an objective, technical assessment, conducted by an independent body applying its expertise to difficult issues. The extent of public opposition was remarked on by the courts in several of the challenges to the Commission’s Directions (see, for example, Pembroke and Lalonde), and was evident in the public campaigns for change to them, such as Wellesley Central’s Staying Alive, and that mounted by the Friends of Women’s College Hospital. Indeed, the government itself was unconvinced by the HSRC, and would not follow the expert advice of its own Commission when it came to northern and rural restructuring (HSRC, 2000, p. 81)! Hospital restructuring could not be reduced to a matter of technical expertise, without also factoring in qualitative considerations and the many other crucial characteristics of the hospitals’ place in the community and the health care system. In the end, government’s strategy to offload decision making to the HSRC did not shelter it from blame or the political fallout from hospital restructuring. It was unable to distance itself from responsibility for the decisions that “its” Commission made.

As for the hospitals, in hindsight, did litigating make sense? With the exception of the Montfort, all of them lost in court. Litigation takes tremendous resources—not just money, but time and energy as well. Hospitals, though, were faced with closure or a substantial reduction in the services they could provide. While the costs of litigation were high, so were the stakes—hospitals were fighting for their very existence. Even though the legislation and regulations had been drafted to shield the restructuring process from legal scrutiny, it could be expected that, faced with oblivion as the alternative, hospitals would oppose the Directions however they could, and they had the financial resources to do so. Unlike the alternatives—persuasion, pressure or politics—judicial review was one of the few
ways that the Commission might be forced to change its decisions. Courts offered the possibility of altering the distribution of power as between the HSRC and the hospitals. And at the outset, no one knew that courts would take such a limited view of their role, or such an expansive view of the Commission’s powers. Deciding to challenge the HSRC’s Directions in court made sense.

The hospitals, though, were not able to convince the courts there were grounds to intervene. With respect to the Wellesley Central and Pembroke Civic Hospitals in particular, the courts’ failure to appreciate the consequences of these decisions for marginalized groups, or to accurately understand the constitutional dimension of their claims is a stark reminder of how easily these groups are excluded from constitutional protection. The contrast with the treatment of language and cultural rights in Lalonde is notable. The losses, however, do not mean that nothing was achieved. Litigation can serve important functions even when unsuccessful. In the HSRC cases, it acted as an important focal point for community organizing in opposition to government action. Further, the lawsuits undoubtedly made the HSRC’s restructuring decisions more public. As a result, the process itself was opened to greater public scrutiny and assessment. The litigation also exposed the nature of the process and the issues and decisions at stake. It became apparent that hospital restructuring was not an apolitical issue, nor one that could be solved by applying neutral, objective criteria to arrive at uncontested answers, the “right” solution. As this became increasingly clear, the continued litigation intensified the political pressure on government to acknowledge and resume its responsibility for hospital restructuring and ensuring access to health care services.

Hospital restructuring remains a never-ending story in Ontario. Some resisted the HSRC’s Directions and seem to have met with some success through inertia (see for example, Lukits, 2003). With the defeat of the Conservatives in the last election in Ontario, the new Liberal government is permitting others to withdraw from or alter the amalgamations the HSRC imposed and enter into different alignments. (In 2005, Georgetown Hospital withdrew from the William Osler Health Centre, where it had been one of three campuses, and joined with other area hospitals.) Government continues efforts to rein in hospital spending and reconfigure the organization of hospitals and the health care system through different initiatives. The 2004 Commitment to the Future of Medicare Act would allow it to require accountability agreements from health care institutions and exact financial penalties from hospital administrations and senior executives that fall short of fiscal goals. Most recently, Ontario has introduced its version of regionalization, Local Health Integrated Networks. As this initiative is just
being implemented at the time of writing, it is too new to assess its impact.

Returning to a final comment on Wellesley Central and its decision to litigate, the hospital lost; its application for judicial review was dismissed. In that, it met the same fate as all the other hospitals that challenged the HSRC’s decisions in court, with the exception of Montfort. Yet by refusing to accept the Commission’s Directions, the Wellesley Central also made substantial gains. First, it established that neither the Commission nor the government could simply require it to relinquish its property, nor to do so without appropriate compensation. Second, rather than St. Michael’s governing and operating the Sherbourne ambulatory care centre alone, it ultimately gained its independence. It has now become an independent entity. More importantly, the litigation forced not only St. Michael’s to negotiate with it, but brought the government to the table as well, rather than Wellesley Central simply being left to implement the HSRC’s Directions. The result was that at the end of the day, Wellesley Central emerged reconfigured, and having retained funds to continue its urban health initiatives in a community and for people who had great need of such services. Wellesley Central was not able to preserve the hospital, but it did preserve an ability to act to further that mission.

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**Limits to the Law**


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O.Reg. 88/96 and 273/99, made under the **Ministry of Health Act,** R.S.O. 1990, c.M.26, as am.

**ENDNOTES**

1. Although the HSRC did release a draft vision statement in January 1997, it considered this a work in progress, and its final vision statement was not released until January 2000, after it had completed its work (HSRC, 2000, p. 32).


4. Test of irreparable harm on application for stay not met—**Connelly v. Ontario (Health Services Restructuring Commission)** [1997] O.J. No. 129 (Div. Ct.) (Sudbury General Hospital, Jan. 1997; Application for judicial review unnecessary as all parties agreed Directions to provincial psychiatric hospitals were beyond the jurisdiction of the HSRC—**OPSEU v. HSRC** [1997] O.J. No. 2144 (Div. Ct.) (Brockville, London and Lakehead Psychiatric Hospitals, April 1997).
5. Transcript of the Cross-Examination of O’Neill on Affidavit filed in support of St. Michael’s Application for Leave to Intervene in Wellesley Central Hospital v. Ontario (Health Services Restructuring Commission), August 15, 1997, Q&A 203, p. 50–51.

6. Affidavit of Mark Rochon, para. 44, p. 10

7. Transcript of the Cross-Examination of Dr. Sharma on Affidavit filed in support of Pembroke General Hospital, Pembroke Civic Hospital v. Ontario (Health Services Restructuring Commission), Q and A 129–30, p. 27.


10. The other unwritten principles underlying the constitution are federalism, democracy, and constitutionalism and the rule of law.

11. The Montfort’s other claims failed. The court held that equality rights protected by section 15 of the Charter could not be used to enhance language rights that were otherwise constitutionally protected. As for its administrative law claims, the court concluded that the Directions were neither “patently unreasonable” nor based on irrelevant considerations. The court accepted that the Commission had acted on the evidence in applying its policy criteria (quality, accessibility, affordability of health services in the region).

12. Cross Examination of Rochon, pp. 29–30, Q & A 114).