Court of Queen's Bench of Alberta

Citation: Elder Advocates of Alberta Society v. Alberta, ABQB 490

Date: 20080814
Docket: 0503 13196
Registry: Edmonton

Between:

Elder Advocates of Alberta Society and James O. Darwish, Personal Representative of the Estate of Johanna H. Darwish, Deceased

Plaintiffs

- and -

Her Majesty the Queen In Right of Alberta, Aspen Regional Health Authority, Calgary Health Region, Capital Health, Chinook Regional Health Authority, East Central Health, Northern Lights Health Region, Palliser Health Region, Peace Country Health

Defendants

Reasons for Judgment
of the
Honourable Madam Justice S.J. Greckol

I. Introduction

[1] The Plaintiffs, the Elder Advocates of Alberta Society (the EAAS) and James O. Darwish in his capacity as the personal representative of the estate of Johanna H. Darwish (Darwish), bring this application for certification pursuant to the *Class Proceedings Act*, R.S.A. 2000 c. C-16.5 (*CPA*). The EAAS is a non-profit society. Darwish is the son of Johanna H. Darwish, who was a resident in the Lynwood Nursing Home from March 1994 until her death on February 22, 2006. Darwish was his mother's guardian and trustee and is now the executor of her estate. The Lynwood Nursing Home is operated by the Defendant, Capital Health, through its agent, the Capital Care Group, which is a wholly-owned subsidiary health corporation of Capital Health.

[2] The Defendants, Her Majesty the Queen in Right of Alberta (the Government) and the nine Regional Health Authorities (RHAs), including Aspen Regional Health Authority, Calgary Health Authority, Capital Health, Chinook Regional Health Authority, David Thompson

Regional Health Authority, East Central Health, Northern Lights Health Region, Palliser Health Region, and Peace Country Health, administer and operate a regime for the provision of health care services to Alberta residents pursuant to the *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20 (*AHCIA*), the *Nursing Homes Act*, R.S.A. 2000, c. N-7 and the *Hospitals Act*, R.S.A. 2000, c. H-12.

[3] The Government funds health care services by providing global, population-based funding to the RHAs, all of which are bodies corporate and have been established pursuant to the *Regional Health Authorities Act*, R.S.A. 2000, c. R-10 (*RHAA*). In turn, the RHAs are responsible for the planning and delivery of health care services in hospitals, long-term care facilities (LTCFs), community health services and public health programs to the residents of each respective region. The RHAs deliver health care services directly or indirectly through either wholly-owned subsidiary health corporations or private operators who have entered into nursing home contracts with the RHAs pursuant to s. 2 of the *Nursing Homes Act.*

[4] One of the core services delivered by the RHAs to each region is residential long-term care, in nursing homes and auxiliary hospitals. The RHAs determine how much health care funding is to be directed to these LTCFs. The LTCFs are required to provide nursing home care to eligible residents and to operate their facilities in accordance with the applicable legislation and regulations: see the *Nursing Homes General Regulation*, Alta. Reg. 232/85, ss. 2, 4.

[5] The Plaintiffs led evidence establishing that the RHAs fund nursing homes and auxiliary hospitals in the same way, and that this funding essentially comes from two different streams of income: one is the global health care funding provided from the Government, the other is money paid by residents as an accommodation charge (Accommodation Charge). For the fiscal year ending March 1, 2005, approximately $577.7 million in funding for LTCFs came from the global health care funding stream and approximately $206.5 million from the Accommodation Charge stream.

[6] The Plaintiffs bring this action on behalf of a proposed class of "all Residents of Long-Term Care Facilities and patients in general hospitals in Alberta who have been assessed as requiring auxiliary hospital or nursing home level care, and the estates of such persons who, since August 1, 2003, have been charged the Accommodation Charge, save and except for all such persons, who at any time since August 1, 2003, have received:

(a) Assured Income for the Severely Handicapped (AISH);

(b) Supports for Independence (SFI);

(c) the full Supplementary Accommodation Benefit;

(d) benefits to pay the Accommodation Charge from the Worker's Compensation Board, the Department of Veteran Affairs (Canada), the Department of National Defence (Canada), the First Nations and Inuit Branch of Health Canada, and the Royal Canadian Mounted Police;

> (e) a waiver, in its entirety, of the Accommodation Charge increase which took effect August 1, 2003 pursuant to AR 260/2003, for reasons of financial hardship."
>
> (the Proposed Class)

[7] The definition of "accommodation charge" is provided in the *Nursing Homes Act*, while the maximum amount of the charge is set out in s. 3(1) of the *Nursing Homes Operation Regulation*, Alta. Reg. 258/85. On August 1, 2003, pursuant to Alta. Reg. 260/2003, the maximum Accommodation Charge was increased to the following rates:

> (a) $39.62 per day for residents of standard wards;
>
> (b) $42.00 per day for residents in semi-private rooms; and
>
> (c) $48.30 per day for residents in private rooms.

[8] The Plaintiffs allege that the Accommodation Charge increases were not fair, reasonable or justified, and were not in the best interests of the members of the Proposed Class. The Plaintiffs contend the Defendants have breached their fiduciary duty and duty of care owed to the members of the Proposed Class. Finally, the Plaintiffs maintain that the Accommodation Charge charged constitutes a breach of contract, an unjust enrichment calling for restitution, an *ultra vires* action, an *ultra vires* tax, and a violation of the rights of the members of the Proposed Class pursuant to s. 15(1) of the *Canadian Charter of Rights and Freedoms.*

[9] The EAAS commenced this action. The Defendants have agreed that adding Darwish as a Plaintiff has cured, *nunc pro tunc*, the alleged defect that the EAAS was not a member of the class when it did so. The Plaintiffs have reserved the right to apply to add a new Plaintiff should that be necessary to assert a s. 15 *Charter* right.

II. Legislation

A. Class Proceedings Legislation

[10] The requirements for certification are set out in s. 5(1) of the *CPA*, which provides as follows:

> 5(1) In order for a proceeding to be certified as a class proceeding on an application made under section 2 or 3, the Court must be satisfied as to each of the following:
>
> (a) the pleadings disclose a cause of action;
>
> (b) there is an identifiable class of 2 or more persons;

(c) the claims of the prospective class members raise a common issue, whether or not the common issue predominates over issues affecting only individual prospective class members;

(d) a class proceeding would be the preferable procedure for the fair and efficient resolution of the common issues;

(e) there is a person eligible to be appointed as a representative plaintiff who, in the opinion of the Court,

(i) will fairly and adequately represent the interests of the class,

(ii) has produced a plan for the proceeding that sets out a workable method of advancing the proceeding on behalf of the class and of notifying class members of the proceeding, and

(iii) does not have, in respect of the common issues, an interest that is in conflict with the interests of other prospective class members.

[11] The Plaintiffs must establish each of these requirements before the action can be certified. Once the Court is satisfied that each of the requirements has been met, certification is mandatory: *CPA*, s. 5(3).

[12] Section 8 of the *CPA* refers to specific circumstances which are not, in themselves, a bar to certification:

> 8. In determining whether a proceeding is to be certified as a class proceeding, the Court is not to refuse certification by reason only of one or more of the following:
>
> (a) the relief claimed includes a claim for damages that would require individual assessment after determination of the common issues;
>
> (b) the relief claimed relates to separate contracts involving different prospective class members;
>
> (c) different remedies are sought for different prospective class members;
>
> (d) the number of prospective class members or the identity of each prospective class member has not been ascertained or may not be ascertainable;

(e) the class includes a subclass where the prospective subclass members have claims that raise common issues not shared by all the prospective class members.

[13] In determining whether an action should be certified as a class proceeding, the Court must strike a balance between efficiency and fairness: ***Western Canadian Shopping Centres Inc. v. Bennett Jones Verchere***, 2001 SCC 46, [2001] 2 S.C.R. 534 at para. 44.

[14] As stated in ***Ayrton v. PRL Financial (Alta.) Ltd.,*** 2006 ABCA 88 at para. 14, 384 A.R. 1, the *CPA* "supports a purposive approach and provides for extensive flexibility in terms of procedures available to certification judges to deal with class actions as they unfold."

[15] The certification stage is not meant as a test of the merits of the action. The issue is not whether the claim is likely to succeed, but whether it is appropriately prosecuted as a class action: ***Hollick v. Toronto (City)***, 2001 SCC 68 at para. 16, [2001] 3 S.C.R. 158.

[16] Nevertheless, the Court must assess, although not determine, the merits of the action in order to identify the common issues, define the class and address the criteria in s. 5(1) of the *CPA*: ***Windsor v. Canadian Pacific Railway Ltd.***, 2006 ABQB 348 at para. 48, 402 A.R. 162, var'd slightly 2007 ABCA 417, A.R. 200. The merits of the action also are relevant in determining whether a class proceeding is the preferable procedure for the fair and efficient resolution of the common issues: ***T.L. v. Alberta (Director of Child Welfare)***, 2006 ABQB 104 at para. 36, 395 A.R. 327.

[17] A certification motion is not the appropriate place for deciding difficult questions of fact or law, but there is little point in certifying the class proceeding if the action appears doomed to fail: ***T.L.*** at para. 36.

[18] The proposed class representative must show some basis in fact to support the certification order. This is not to say there must be affidavits from members of the class or there should be any assessment of the merits of the claims of other class members. However, the class representative must show some basis in fact for each of the certification requirements set out in s. 5(1) of the *CPA*, but need not establish that the pleadings disclose a cause of action, as that requirement is governed by the rule that a pleading should not be struck for failure to disclose a cause of action unless it is "plain and obvious" that no claim exists: ***Hollick*** at para. 25.

[19] This minimum evidentiary requirement does not involve the weighing of evidence, but instead calls for some factual basis to be shown for each of the requirements in s. 5(1) other than the need for the pleadings to disclose a cause of action: ***Windsor*** , 2006 ABQB 348 at paras. 42 and 50.

[20] The affidavit evidence presented in support of certification must provide sufficient information, particulars and specificity with respect to the requirements for certification. Those who oppose certification must put forward their supporting evidence: ***Condominium Plan No. 0020701 v. Investplan Properties Inc.***, 2006 ABQB 224 at para. 53, 57 Alta. L.R. (4th) 310.

B. Legislative Scheme for the Provision of Health Care Services

[21] In general, provincial legislation governs the scheme by which health care is funded and administered, although federal legislation sets certain prerequisites for federal health care transfer payments. In Alberta, public health care funding is largely provided via the provincial public insurance apparatus in the *Alberta Health Care Insurance Act*.

[22] The Plaintiffs wish to represent persons they describe as being residents of LTCFs; that is, residents of nursing homes and auxiliary hospitals, as well as some residents of hospitals who are chronically ill. These institutions are governed by the *Nursing Homes Act*, the *Hospitals Act,* and their regulations.

[23] The Plaintiffs advance two primary arguments in relation to the legislative scheme addressing the provision of long-term care. First, they submit that the Accommodation Charge prescribed by s. 3(1) of the *Nursing Homes Operation Regulation* is permissive and discretionary, and not fixed and mandatory. Section 3(1) of the Regulation provides that an operator "may" charge an accommodation charge and that the accommodation charge "shall not exceed the specified amounts." The Plaintiffs contend the permissive and discretionary nature of the Accommodation Charge is confirmed by s. 3(5) of the *Nursing Homes Operation Regulation*, which states: "The amounts prescribed under subsection (1) are the maximum amounts that an operator may charge an eligible resident..." (emphasis added). The Plaintiffs allege that the Defendants informed the public the charges were mandatory and implemented them as mandatory rather than as discretionary.

[24] Second, the Plaintiffs note the LTCFs are required to provide the "basic care" services listed in s. 2 of the *Nursing Homes General Regulation*, but are permitted to charge the Accommodation Charge for accommodation and meals. The Plaintiffs take the position that the exemption for "accommodation and meals" means the cost of rent for personal space and the cost of food (but not of meal preparation). They maintain the LTCFs are responsible for paying for all other items listed in s. 2 of the *Nursing Homes General Regulation*. The Plaintiffs allege the members of the Proposed Class are being charged for services that the Government should be providing free of charge.

[25] In response, the RHAs submit that there is no requirement under the *Nursing Homes Act* that an operator of a nursing home must charge less than the maximum allowable rates. The RHAs submit the phrase "in respect of," as used in the definition of "accommodation charge" in the *Nursing Homes Act*, should be give the broadest possible interpretation. They point out there are no definitions of the terms "accommodation" and "meals" found in any of the statutes or regulations pled, nor is there any regulatory or administrative scheme that would suggest the term "accommodation" should be narrowly construed to mean the square footage occupied "for personal space" or that the word "meals" should be defined as "food" but not its preparation.

1. Federal Health Legislation

[26] The *Canada Health Act*, R.S.C. 1985, c. C-6 requires that the provinces operate health care insurance plans that meet its program criteria in order to qualify for funding (s. 7).

[27] To satisfy the "comprehensiveness" criterion, the insurance plan must insure all "health services" provided by "hospitals" (s. 9).

[28] A "hospital" is defined in s. 2 of the Act as including any facility that provides hospital care, including acute, rehabilitative or chronic care, but not including "a facility... that provides nursing home intermediate care service or adult residential care services..." (s. 2).

[29] "Hospital services" means medically necessary services provided to patients at a hospital, including "accommodation and meals at the standard or public ward level ...;" and services provided by "persons who receive remuneration therefor from the hospital..." (s. 2).

[30] For a province to qualify for a full cash contribution by Canada, user charges must not be permitted under the provincial health care insurance plan. However, user charges are permitted "for accommodation or meals provided to an in-patient who... requires chronic care and is more or less permanently resident in a hospital or other institution" (s. 19).

[31] Accommodation and meals to a standard or public ward level must be provided to patients who are in hospitals. People in LTCFs are excluded from the Act and are not affected by the prohibition against user charges for accommodation and meals. People who are chronic patients resident in hospitals or other institutions may be subject to user charges for accommodation or meals. In Alberta, these two categories of people fall under separate legislative schemes.

2. Alberta Legislation - *Alberta Health Care Insurance Act* and Subordinate Regulations

[32] In Alberta, the *AHCIA* authorizes the provincial health insurance plan required by the *Canada Health Act*. Pursuant to s. 16(a) of the Act, the Lieutenant Governor in Council may make regulations authorizing or requiring the Minister, or any other person, to do anything for the purpose of having the Plan meet the criteria prescribed under the *Canada Health Act*.

[33] The general purpose of the legislation and the required benefits under the health insurance system are set out in s. 3, which states:

> 3(1) The Minister shall, in accordance with this Act and the regulations, administer and operate on a non-profit basis a plan to provide benefits for basic health services to all residents of Alberta.
>
> (2) The Minister shall, in accordance with the regulations, provide extended health services to a resident and the resident's dependants if

> (a) the resident or the resident's spouse or adult interdependent partner is 65 years of age or older, or
>
> (b) the resident is receiving a widow's pension. [Emphasis added.]

[34] Thus, the province must provide "basic health services" for all residents, with those over 65 receiving an additional set of "extended health services." Basic health services are defined in the *AHCIA* and regulations, while extended health services are set out in the regulations.

[35] The province must pay “benefits in respect of health services provided to residents,” unless exempted by the Act or regulations (*AHCIA*, s. 4(1)).

[36] Section 43 of the *AHCIA* allows the province the option of providing financial assistance in special circumstances:

> 43(1) The Lieutenant Governor in Council may establish a program to provide financial assistance in cases where, because of the sickness or disability of a resident or dependant, the resident is faced with expenses that could not reasonably be foreseen and guarded against and that place an undue burden on the financial resources of the resident.
>
> (2) The program may specify the types of expenses in respect of which assistance may be given and the portion of the expense that is to be borne by the resident.

[37] The *AHCIA* provides a very broad and discretionary authority for the Lieutenant Governor in Council and the Minister to make regulations that affect the provision of health services:

> 16. The Lieutenant Governor in Council may make regulations
>
> ...
>
> (c) prescribing classes of goods and services as basic health services or extended health services;
>
> ...
>
> (f) subject to section 4(2), providing for procedures for the review of any decision or the settlement of any question pertaining to the determination of
>
> (i) the amount of benefits payable for a particular service,

(ii) whether any service is a health service or not,

(iii) whether any service provided by a physician is medically required or not, or

(iv) any other matter that affects the entitlement to benefits;

(g) providing, for the purpose of removing doubt, that

(i) any service is or is not a basic health service, extended health service or insured service, or

(ii) any particular service that may be provided by a physician is or is not medically required;

...

(l) requiring practitioners to file with the Minister the kinds of information that the regulations prescribe for the purpose of facilitating the handling, assessing and payment of claims for benefits;

(m) prescribing the times by which or the circumstances under which practitioners are required to file information pursuant to the regulations under clause (l);

...

17. The Minister may make regulations

(a) respecting the rates of benefits in respect of basic health services or extended health services;

(b) respecting the manner in which benefits are to be paid and the persons to whom benefits are to be paid, the conditions of payment and the information required to be submitted in connection with claims for benefits;

(c) specifying, within the classes prescribed by the Lieutenant Governor in Council, the goods and services that are basic health services or extended health services for the purpose of the Plan.

[38] Basic health services are not specified by the regulations. Rather, various kinds of health care are carved out of that category. Certain of these exceptions are found in the *AHCIA*, the

Chiropractic Benefits Regulation, Alta. Reg. 82/2006, *Podiatric Benefits Regulation*, Alta. Reg. 87/2006 and the *Podiatric Surgery Benefits Regulation*, Alta. Reg. 137/2006. For example, the *Medical Benefits Regulation*, Alta. Reg. 84/2006, sets out the amount that may be claimed by a physician for a particular medical service pursuant to a master "Schedule of Medical Benefits." Certain services, such as plastic surgery, are generally excluded. Notably, "insured medical services" are defined as "all services provided by physicians that are medically required."

[39] Extended health services are listed in the *Extended Health Services Benefits Regulation*, Alta. Reg. 83/2006, and generally include a range of dental and optical goods and services.

[40] The Government may declare services which have been classified as “basic health services” by regulation to be insured services for the purposes of the Plan.

3. Alberta Legislation - *Nursing Homes Act* and Subordinate Regulations

[41] Care provided in nursing homes and auxiliary hospitals is provided for under the *Nursing Homes Act*, the *Hospitals Ac*t and their regulations.

[42] The *Nursing Homes Act* and its subordinate regulations do not identify a global purpose for the legislation, or any general principles under which the Act is to operate.

[43] A RHA may enter into a contract with a nursing home operator for the provision of nursing home care to those who are eligible. Operations and financing of nursing homes are regulated by the *Nursing Homes Act*. A “nursing home” is defined as "... a facility for the provision of nursing home care."

[44] Under the *Nursing Homes Act*,

> 1. ...
>
> (c) “basic care” means the types and levels of basic services prescribed in the regulations to be provided to residents;
>
> (d) "benefits" means the amounts payable under this Act in respect of the cost of nursing home care provided to eligible residents.
>
> (e) "nursing home care” means basic care and care provided under an approved program.

[45] The *Nursing Homes General Regulation* prescribes the types and levels of basic services to be provided to residents, including:

> (a) accommodation and meals;

(b) facilities services;

(c) necessary nursing services;

(d) personal services;

(e) therapeutic and special diets as required;

(f) drugs and medicine specified by the Minister for use on a routine or emergency basis as prescribed by a physician;

(g) routine dressings as required; and

(h) life enrichment services. [Emphasis added.]

[46] Nursing home funding has two sources: the Alberta government (typically via an RHA) and the nursing home residents themselves. Section 8(2) of the *Nursing Homes Act*, set out below, limits the financial contribution of nursing home residents to the Accommodation Charge:

> 8(2) Subject to the regulations, an operator shall not charge an eligible resident for nursing home care in excess of the amount prescribed in the regulations for the accommodation charge.

[47] Section 24(g) of the Act provides that the Minister may make regulations "respecting the determination of accommodation charges."

[48] The term "accommodation charge" is defined in s. 1(a) of the *Nursing Homes Act*.

> s. 1(a) "accommodation charge" means the charge in respect of nursing home care payable by a resident for accommodation and meals in a nursing home or an approved hospital referred to in s. 2 [a hospital that provides nursing home services]

[49] The maximum amount that can be charged is found in the *Nursing Homes Operation Regulation*:

> s. 3(1) An operator may charge a resident an accommodation charge and the accommodation charge shall not exceed the following:
>
> (a) for each resident day of accommodation in a standard ward, $39.62;
>
> (b) for each resident day of accommodation in a semi-private room, $42.00;

(c) for each resident day of accommodation in a private room, $48.30.

...

(5) The amounts prescribed under subsection (1) are the maximum amounts that an operator may charge an eligible resident as his accommodation charge for the applicable types of accommodation...
...

(7) Notwithstanding subsection (1), if a resident is admitted to a nursing home for the purpose of receiving palliative care or sub-acute care the operator shall not charge that resident an accommodation charge.

[50] Certain state funding is mandatory:

10(1) Subject to this Act and the regulations, benefits shall be paid in respect of an eligible resident in an operator's nursing home in the amounts and in the manner determined in accordance with the regulations. [Emphasis added.]

[51] There are no such regulations.

[52] The *Nursing Homes Act* specifies the criteria by which a person may qualify for "benefits" (basic care and approved programs). To receive paid benefits, a person must be an Alberta resident, and meet three criteria:

9(2) Benefits may be paid in respect of a resident

(a) who has been found by an assessment committee appointed pursuant to the regulations to require nursing home care,

(b) who is a resident of Alberta and has resided in Alberta for the period prescribed by the regulations, and

(c) who meets other requirements or conditions prescribed by the regulations.

[53] A number of categories of residents are not necessarily eligible for benefits:

9(3) Benefits may not be paid in respect of a resident

(a) if payment for the resident's nursing home care is the responsibility of

(i) The Workers' Compensation Board,

(ii) the Department of Veterans Affairs (Canada),

(iii) the Department of National Defence (Canada), or

(iv) the Medical Services Branch of Health Canada, or is provided for under any other statute;

(b) if the assessment committee finds that the resident is no longer in need of nursing home care or that the resident no longer meets other requirements or conditions prescribed by the regulations. [Emphasis added.]

[54] Subsections 9(2) and 9(3) speak of "residents," while s. 10(1) mandates payment to "eligible residents." These two terms are linked via the definition of an eligible resident in the *Nursing Homes Act*:

1. In this Act, ...

(g) "eligible resident" means a resident in respect of whom benefits are payable under section 9.

[55] Combining ss. 9 and 10, benefits shall be paid in respect of an eligible resident as determined by regulation (s.10(1)), although there is no such regulation in place at present. The RHA may enter into an agreement with the board of an approved hospital (under the *Hospitals Act*) for "the provision of nursing home care to eligible residents in the hospital and for the payment of benefits to the board in the amounts agreed to and to authorize the board to charge eligible residents the accommodation charge" (s. 10(2)). Benefits may be paid in respect of an Alberta resident found by an assessment committee to require nursing home care, who meets the conditions prescribed by regulation (s. 9 (2)). Benefits may not be paid if payment is the responsibility of other named entities, or if the committee finds the person is no longer in need of nursing home care (s. 9(3)).

[56] The *Nursing Homes General Regulation* and *Nursing Homes Operation Regulation* include provisions that are relevant to identifying eligible residents. The "assessment committee" referred to in ss. 9(2)(a) and 9(3)(b) of the *Nursing Homes Act* is mentioned in both regulations. The *Nursing Homes Operation Regulation* sets out the composition, function and operations of the assessment committee. Under the terms of the *Nursing Homes Operation Regulation*, an operator shall admit a person referred by the assessment committee if there is a bed available:

5(1) Subject to

(a) an operator having an available bed, and

(b) the procedure referred to in section 6(3),

> an operator shall admit to his nursing home for the provision of nursing home care a person referred to him by the assessment committee for admission to his nursing home as a resident.
>
> ...
>
> (3) No person shall be admitted to a nursing home within the district
>
> (a) until the person has been assessed and approved in accordance with the assessment procedures referred to in section 6(3), and
>
> (b) unless the person has had a complete medical examination within 3 months prior to his application for admission and the results of the medical examination have been made available for review by the assessment committee. [Emphasis added.]

[57] The guidelines applied are created by the district board and subject to approval by the Minister (*Nursing Homes Operation Regulation*, s. 6(3) and (4)).

[58] The minimum requirements for residency (*Nursing Homes Act*, s. 9(2)(b)) are laid out in s. 3 of the *Nursing Homes General Regulation*:

> 3. The period during which a resident of Alberta must reside in Alberta for the purposes of section 9(2)(b) of the Act is
>
> (a) the year immediately preceding the application for benefits, if he has been a resident of Canada for a period of at least 10 years, or
>
> (b) 3 consecutive years at any time preceding the application for benefits.

[59] The procedure by which a resident may be designated as no longer requiring nursing care (and the consequential funding) is outlined in the *Nursing Homes Operation Regulation*:

> 11(1) Subject to subsection (2), the operator or the Minister may declare that a resident is no longer in need of basic care and is eligible for transfer or discharge.
>
> (2) A declaration under subsection (1) shall be based on the following:
>
> (a) in the case of the operator,
>
> (i) on consultation with the resident's attending physician, and
>
> (ii) on the recommendation of the assessment committee;

(b) in the case of the Minister, on a report of the attending physician and on the records of the nursing home.

4. Alberta Legislation - *Hospitals Act* and Subordinate Regulations

[60] In Alberta, long-term health care and accommodation in auxiliary hospitals is governed by the *Hospitals Act* and its regulations. The Act distinguishes between hospitals, auxiliary hospitals and nursing homes:

1. In this Act,

...

(c) "auxiliary hospital" means a hospital for the treatment of long-term or chronic illnesses, diseases or infirmities;

...

(h) "hospital" means an institution operated for the care of diseased, injured, sick or mentally disordered people;

...

(m) "nursing home" means a nursing home as defined in the *Nursing Homes Act*;

[61] In certain instances, admission to a hospital and obtaining medical services may involve a person paying "proper charges." These charges cover goods and services that are not covered by health insurance, or are specific user payments that are enumerated in the statute:

30(3) In this section, "proper charges" means the charges for services not provided as insured services under Part 3 or charges for the payment of which patients are liable pursuant to Part 3 or the regulations.

[62] Proper charges may be recovered from a patient, persons with authority over the patient, the patient's adult interdependent partner or spouse, persons who sign the hospital admission form, or persons identified as liable by the court (*Hospitals Act*, s. 30(1)).

[63] Generally, persons attending Alberta hospitals are not liable for insured services. Under s. 37(1) of the *Hospitals Act*, the insured services to be provided to a person shall be those furnished:

(a) by an approved hospital of the patient's choice, and

(b) by any other institutions or persons that are prescribed in the regulations.

[64] Insured services always include standard ward hospitalization, and other additional services that may be prescribed by regulation (*Hospitals Act*, s. 37(2)).

[65] Standard ward hospitalization is defined in s. 36(j) of the *Hospitals Act* as:

> 36. In this Part,
>
> ...
>
> (j) "standard ward hospitalization" means the following services to in-patients:
>
> (i) accommodation and meals at the standard or public ward level;
>
> (ii) necessary nursing services;
>
> (iii) laboratory, radiological and other diagnostic procedures, together with the necessary interpretation, for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability;
>
> (iv) drugs, biologicals and related preparations when administered in a hospital, as specified in the Agreement;
>
> (v) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies, where available;
>
> (vi) routine surgical supplies;
>
> (vii) use of radiotherapy facilities, where available;
>
> (viii) use of physical therapy facilities, where available;
>
> (ix) services rendered by persons who receive remuneration for those services from the hospital. [Emphasis added.]

[66] Pursuant to s. 41 of the *Hospitals Act*, the portion of hospital costs that is to be paid by a patient is set by regulation, and these costs are part of the "proper charges" defined in s. 30(3):

> 41. Approved hospital operating costs shall be shared between the patients and the Government of Alberta on a basis that is to be set out in the regulations.

[67] Further details as to the parties who are to bear the costs of health services and procedures are found in the subordinate *Hospitalization Benefits Regulation*, Alta. Reg. 244/90. Certain additional costs are designated as insured:

> 4(1) The following goods and services, in addition to standard ward hospitalization, are included in insured services under Part 3 of the Act:
>
> (a) to in-patients,
>
> (i) a semi-private or private room, where a patient's medical condition makes it necessary;
>
> (ii) private nursing care for a patient where ordered by the attending physician and approved in accordance with the hospital's by-laws;
>
> (iii) subject to subsection (2)(f) and (g), drugs, biologicals and related preparations when administered in a hospital, unless they are enhanced goods and services referred to in section 5.2;
>
> (iv) pacemakers, steelplates, pins, joint prostheses, valve implants and any other goods approved by the Minister, unless they are enhanced goods and services referred to in section 5.2;
>
> (v) transportation in Alberta, whether by ambulance or other commercial vehicle, to transport a patient in the circumstances described in section 6;
>
> (vi) goods and services included in an approved hospital program or a specific program but not included in subclauses (i) to (v), unless they are enhanced goods and services referred to in section 5.2;
>
> (vii) enhanced goods or services provided under section 5.2(2);
>
> (b) to out-patients, any medically necessary goods and services that may be provided on an out-patient basis, including goods used in a medical procedure but excluding goods provided to a patient for use after discharge from an approved hospital or facility.

[68] Other services are excluded by legislation and these exclusions parallel those of the *AHCIA* and its subordinate regulations.

[69] As can be seen, the *Hospitals Act*, and the *Hospitalization Benefits Regulation* by reference, include accommodation and meal costs as specific insured benefits. However, following the *Canada Health Act* exception for persons who require chronic care and are effectively permanent residents in a hospital, the *Hospitalization Benefits Regulation* excludes Accommodation Charges for chronic care, permanent residents:

> 5(1) A resident of Alberta who is admitted as an in-patient to an approved hospital shall be required to pay authorized charges at the following rates:
>
> ...
>
> (d) in an auxiliary hospital, where a patient has been assessed as requiring chronic care and is more or less a permanent resident in the auxiliary hospital, the patient will be responsible for accommodation charges for standard ward accommodation, semi-private room accommodation or private room accommodation at the same rates as are prescribed in section 3(1) of the *Nursing Homes Operation Regulation* (Alta. Reg. 258/85). [Emphasis added.]

[70] An exception is made for those persons who are receiving palliative or sub-acute care services:

> 5(1.1) Notwithstanding subsection (1), a resident of Alberta who is admitted to an auxiliary hospital as an in-patient for the purpose of receiving palliative care or sub-acute care services shall not be required to pay an accommodation charge.

[71] A second instance where legislation allows for a user charge that relates to accommodation is where a patient has been assessed as properly requiring treatment at an auxiliary hospital or nursing home level, but cannot be accommodated in those facilities. In that case, the patient is again assessed fees for accommodation:

> 5(8) In a general hospital, authorized charges in respect of standard ward accommodation, semi-private room accommodation or private room accommodation may be made for a patient who has been assessed as requiring auxiliary hospital or nursing home level care at the same rates as are prescribed in section 3(1) of the *Nursing Homes Operation Regulation* (Alta. Reg. 258/85). [Emphasis added.]

> (9) The charges set out in subsection (8) commence on the day the patient is assessed as requiring auxiliary hospital or nursing home level care and apply only to patients who are assessed after January 31, 1988.

[72] In both instances, semi-private and private room costs may only be charged where those facilities are requested by the patient:

> 5(10) A patient
>
> (a) in an auxiliary hospital, or
>
> (b) in a general hospital who has been assessed as requiring auxiliary hospital or nursing home level care under subsection (8) shall not be charged for a private room unless the patient has requested a private room and if the patient is occupying a private room but has not requested a private room, the patient may be charged not more than the semi-private room accommodation charge.

[73] A second fee recovery system is specified by the regulation, and provides for "enhanced goods and services:"

> 5.2(1) In this section,
>
> (a) "good or service" does not include accommodation;
>
> (b) "hospital" means an approved hospital located in the region of the regional health authority.
>
> (2) A regional health authority may determine
>
> (a) whether or not hospitals may charge a person who requests and receives an enhanced good or service the cost of the enhanced good or service, and
>
> (b) the amount that hospitals may charge for an enhanced good or service, but in no case may the charge exceed the actual cost of the good or service plus a reasonable administrative allowance.
>
> (3) If, due to a medical necessity as determined by the patient's attending physician, a patient requires an enhanced good or service, the patient is not responsible for the cost of that enhanced good or service.

[74] The legislation does not particularize these "enhanced goods and services."

[75] Under s. 5(1)(d), a chronic care permanent auxiliary hospital resident "will be responsible" for Accommodation Charges "at the same rates" as prescribed by s. 3(1) of the *Nursing Homes Operation Regulation*. In contrast, under s. 5(8), for a general hospital patient who is assessed as requiring a lower level of care but who has remained in a general hospital,

“authorized charges ... may be made” “at the same rates” as prescribed by 3(1) of the *Nursing Homes Operation Regulation*.

[76] The charges permitted under ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulation* are "accommodation charges." This term is not defined in the *Hospitals Act* and its regulations. Under the *Nursing Homes Act*, this term means a charge "… payable by a resident for accommodation and meals." "Authorized charges," including those under ss. 5(1)(d) and 5(8), enter specific revenue streams with much broader potential applications.

[77] Certain funds collected via s. 5(8) and all of the authorized charges required by s. 5(1)(d) enter a general revenue stream. These are considered "offset revenue:"

> 1(1) In this Regulation,
>
> …
>
> (s) "offset revenue" means revenue from
>
> (i) preferred accommodation charges up to the aggregate amount collected from that source during the 1982/83 fiscal year,
>
> ...
>
> (iv.1) on and from July 4, 1991 the amount from each daily authorized charge collected pursuant to section 5(8) that is equivalent to the amount chargeable under section 5(8) in respect of standard ward accommodation,
>
> (v) authorized charges under section 5(1)(d). [Emphasis added.]

[78] Other kinds of offset revenue include payments for non-insured health care services (s. 1(1)(s)(vii.1)), income from enhanced goods and services (s. 1(1)(s)(vii.2)), equipment and space rental fees (s. 1(1)(s)(viii)), and goods and services provided by the hospital to non-patient third parties (s. 1(1)(s)(ix)). Offset revenue is pooled with Government operating grants to form operating revenue:

> 1(1) In this Regulation,
>
> …
>
> (u) "operating revenue" means operating grants granted for the fiscal year and offset revenue earned for the fiscal year, but does not include discretionary revenue. [Emphasis added.]

[79] Operating revenue is used to fund the hospital as a whole. When operating revenue is insufficient to cover a hospital's costs, a "hospital operating deficit" exists, and certain administrative consequences follow. When operating revenue exceeds a hospital's financial requirements, a "hospital operating surplus" exists, and the surplus must first be applied to repay transfers and duplicate payments from the Minister (s. 17(2)), then cover deficits (s. 17(3)). Any funds that remain may be used by a hospital board for any purpose that benefits the hospital (s. 17(1)):

> 17(1) Hospital operating surpluses and discretionary revenue remaining after a board complies with subsections (2) and (3) may be used
>
> (a) for any purpose within the authority of the board that will benefit the hospital, and
>
> (b) if the hospital has a foundation, for transfers to the foundation.
>
> (2) Hospital operating surpluses shall be returned to the Minister to the extent that they are attributable to a reduction or transfer of services, programs or activities that have not been approved by the Minister or to duplicate payments or overpayments made by the Minister.
>
> (3) Discretionary revenue and hospital operating surpluses, other than those that must be returned to the Minister under subsection (2), may be retained by the board and shall be used to offset hospital operating deficits and deficits for programs other than approved hospital programs.
>
> (4) The board of an approved hospital may not make an appropriation or disposition from hospital operating surpluses or discretionary revenue under this section without the written approval of the Minister.

[80] Where a resident who is in hospital, but is assessed as requiring auxiliary or nursing home level care, choses a more private form of accommodation and pays an additional cost for that preferred accommodation, the extra cost (the cost over the "standard ward accommodation") becomes part of a hospital's "discretionary income" (*Hospitalization Benefits Regulation,* ss. 1(1)(m), 1(1)(s)).

> 1(1) In this Regulation,
>
> …
>
> (m) "discretionary revenue" means revenue received by a hospital board from the following sources:
>
> (i) the following charges:

(A) in a general hospital

(I) preferred accommodation charges in excess of the aggregate amount collected from that source during the 1982/83 fiscal year, up to the aggregate amount collected from that source at rates not exceeding $8 per day for semi-private room accommodation or $16 per day for private room accommodation,

...

(IV) from July 1, 1990 to July 3, 1991 the amount in excess of $16 from each daily authorized charge collected pursuant to section 5(8), and

(V) on and from July 4, 1991 the amount from each daily authorized charge that is in excess of the amount chargeable under section 5(8) in respect of standard ward accommodation. [Emphasis added.]

[81] All fees collected under s. 5(1)(d) of the *Hospitalization Benefits Regulation* are first used to offset the general cost of hospital operations, then applied to repay the Minister and cover other hospital program deficits. Section 5(8) fees are split, with most of the money immediately being applied to cover hospital costs, while any remaining portion for preferred accommodation is used to off-set hospital program deficits. In both cases, surpluses that are not required to cover general and program specific hospital deficits become funds that the hospital board may use at its discretion.

[82] A broad general authority is delegated to both the Lieutenant Governor in Counsel and to the Minister under the *Hospitals Act*:

28(1) The Lieutenant Governor in Council may make regulations

...

(l) concerning any other matters that in the opinion of the Lieutenant Governor in Council are necessary in order to carry out the purposes of this Act.

...

(2) The Minister may, by order,

...

(b) direct, regulate and control any other matters that may be required by this Act or the regulations.

[83] Specific authority to regulate charges, services and goods that are associated with charges, and the manner in which charges are determined, collected, and distributed falls to the Lieutenant Governor in Counsel:

43. The Lieutenant Governor in Council may make regulations

...

(b) prescribing the goods and services for the purpose of section 37(2)(b);

(c) prescribing the institutions and persons for the purpose of section 37(1)(b);

...

(h) prescribing the basis on which approved operating costs and capital costs of hospitals are determined;

(i) prescribing the rates and manner of payment by the Minister of the Minister's share of the operating and capital costs of hospitals and the manner of accounting by hospitals for those payments;

...

(k) defining "authorized charges";

(l) respecting the basis of sharing the operating costs of hospitals between the Minister, patients and other persons using hospital facilities, the assessment and collection of authorized charges and charges for accommodation and meals where hostel accommodation is provided, and exemptions from those charges;

(m) providing for the payment by the Minister of all or any part of the authorized charges on behalf of patients suffering from specific diseases or conditions;

...

(q) concerning any other matter considered necessary to carry out the purposes and objects of this Part.

[84] As noted above, the RHAs have an exclusive role in regard to enhanced goods and services as a significant exception to this allocation of authority.

[85] The *Hospitals Act* allows for inspections by the Government and requires financial reporting:

> 26. The Minister and employees of the Government authorized by the Minister for the purpose may make all necessary inquiries into the management and affairs of hospitals, may visit and inspect hospitals and may examine hospital records for the purpose of verifying the accuracy of reports and ensuring that this Act and the regulations are adhered to.
>
> ...
>
> 56(2) At the end of the fiscal year a foundation shall prepare and submit to the Minister an annual report that shall include the audited financial statements and any other statements and reports that the Minister may require.

5. Alberta Legislation - *Regional Health Authorities Act* and Subordinate Regulations

[86] The RHAs have been created under the *RHAA* to administer the health regions. They have the following authority:

> 5. Subject to this Act and the regulations, a regional health authority
>
> (a) shall
>
> (i) promote and protect the health of the population in the health region and work toward the prevention of disease and injury,
>
> (ii) assess on an ongoing basis the health needs of the health region,
>
> (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly,
>
> (iv) ensure that reasonable access to quality health services is provided in and through the health region, and

> (v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region,
>
> and
>
> (b) has final authority in the health region in respect of the matters referred to in clause (a).

[87] Tom Mills, Executive Director of Policy, Strategic Directions Division, Alberta Health and Wellness, asserts that the RHAs are responsible for the planning and delivery of health care services in the regions. One of the core services to be delivered in each region is residential continuing care (i.e. nursing homes and auxiliary hospitals).

[88] Under the general supervisory role of the Minister, a significant element of policy decision-making is delegated to these RHAs. Where a duty to fund or supervise exists for the Minister, a concomitant duty exists for any relevant RHA.

[89] Management of health care is attained by creation and application of a "health plan." Funds to implement the health plan and fund subordinate organizations such as nursing homes and hospitals are funnelled through the RHA, with the RHA delegated authority to administer and distribute those funds (*RHAA*, s. 20):

> 20. Notwithstanding any other enactment, where an enactment provides that the Minister shall or may provide grants or payments of any kind to any person including, without limitation, an existing health authority, the Minister may instead provide those grants or payments to a regional health authority and, subject to any terms and conditions the Minister considers appropriate, delegate to the regional health authority the Minister's power in respect of the provision of the grants or payments.

[90] Although the RHAs have broad powers, the Minister retains a significant capacity to oversee their operations. The Minister has the authority to dismiss those persons who have not properly exercised powers or completed duties. RHAs are responsible to audit subordinate organizations, and report in turn to the Minister. A similarly broad authority for inspection is retained by the Minister. Both the Lieutenant Governor in Counsel and the Minister may make regulations under the *RHAA*, although authority to provide directions concerning operations and finances more generally falls to the Minister.

[91] Section 9 of the *Regional Health Authorities Regulation*, Alta. Reg. 15/1995 provides that: “A regional health authority shall comply with all directives.” The term “directive” is defined in s. 1(a) of the regulation as meaning: “a written policy, rule, direction or guideline issued by the Minister.”

6. *Directive D-317*

[92] *Directive D-317*, a Ministerial Directive dated August 30, 1991 and addressed to administrators of LTCFs, stated that it was developed to clarify "which services facility operators are expected to provide at no charge to residents and what items are the responsibility of the individual resident." The Directive specified that administrators were to ensure by October 1, 1991 that the practices in their facility were in full compliance with the intent of the instructions in the Directive. The Directive indicated that operators were to provide at no charge to residents "all services required by legislation including supplies and equipment required for residents as specified in the *Nursing Homes Act* and Regulations and the *Hospitals Act* and Regulations," including among other services and supplies:

> 1. Services defined as "basic care" for nursing homes and services defined as "standard ward hospitalization" services and "insured services" in auxiliary hospitals.

[93] *Directive D-317* required that residents assume responsibility for the costs of certain items, including:

> 1. Accommodation charges as outlined in the *Nursing Homes Operation Regulation* and the *Hospitalization Benefits Regulations*.
>
> ...
>
> 7. Professional health care services to the extent that they are not fully covered by AHCIP or Blue Cross such as dentistry, optometry, chiropody or special equipment as provided thought the AADL program. [Emphasis in the original.]

[94] The health service standards and accommodation standards for LTCFs were outlined in two documents issued in May 2006: *Continuing Care Health Service Standards* and *Long-Term Care Accommodation Standards*.

III. Facts

A. Affidavits of Plaintiffs

1. Elder Advocates of Alberta Society

(a) Ruth Maria Adria

(i) *Affidavit Filed February 28*, 2006

[95] Ruth Adria is the President of the Elder Advocates Of Alberta Society (EAAS), which is a non-profit society incorporated pursuant to the *Societies Act*, R.S.A. 2000, c. S-14.

[96] EAAS has a board of seven people with advocates in Rocky Mountain House, Calgary, Lethbridge, Red Deer, Ft. McMurray and other locations. Many of them drive to Edmonton and other centers for various tasks such as giving presentations, testifying, and advocating for the elderly.

[97] Ms. Adria asserts that the residents of nursing homes in Alberta are frail and vulnerable members of our society; that most are dependent adults who have no voice; that they rely completely on others to provide them with the basic necessities of life, comfort, companionship and medical care; that in many cases they have no family or peer-group support; and that their needs are quite complex.

[98] EAAS has been functioning since 1993. The trade name declaration for EAAS was filed with the Registrar of Corporations on February 18, 1993.

[99] Ms. Adria relies on the *Report of the Auditor General on Seniors Care and Programs*, dated May 2005 (the *Report*), as support for the position that publicly funded institutions are not providing proper care for the elderly, and her view that the ideal of a "properly monitored cohesive regime of care and medical treatment" is more a myth than a reality.

[100] She relies on the following comments made by the Auditor General at p. 15 of the *Report*:

> The Department [of Health and Wellness] does not have an adequate system to monitor long-term care facilities' compliance with Basic Standards..
>
> The Department currently lacks information to assess the quality and cost-effectiveness of services in long-term care facilities...
>
> The Department has not identified the information that it requires from the facilities to enable it to monitor their compliance with the legislation.

[101] Ms. Adria also relies on p. 69 of the *Report*, where the Auditor General writes as follows with respect to long-term care facilities:

> ... we conclude that there is a strong likelihood of non-compliance against many Basic Standards in facilities across Alberta, with a resulting risk of diminished quality of care. Further, we conclude that Department and Authority systems at the program delivery level relative to the Basic Standards are not effective.

[102] She also cites the following passage from p. 71 of the *Report*:

> Only 7 of 25 facilities fully met Basic Standards relative to the provision, administration and management of medication to residents. We witnessed unlocked and unattended medication carts, inconsistent recording of medication

outcomes, frequent inadequate reporting and follow-up of medication errors, and staff completing medication administration procedures that did not comply with professional practice standards.

(ii) *Affidavit Filed June 5, 2006*

[103] Ms. Adria filed a supplemental affidavit on June 5, 2006 in support of the certification application. In it, she asserts that approximately 14,400 seniors in Alberta reside in about 200 LTCFs, representing about 4.4 percent of Alberta's seniors and only 0.44 percent of Alberta's entire population.

[104] Ms. Adria further deposes that the case mix of nursing home patients continues to increase in complexity because of hospital "rapid discharge" policies, and that many patients now in nursing homes would have been hospitalized in the past. She notes that hospital patients are not required to pay for accommodation and meals.

(b) James Darwish

(i) *Affidavit Filed February 27, 2006*

[105] Mr. Darwish, who articled with the Provincial Auditor, is a chartered accountant. He has worked as an auditor with Revenue Canada and was the chief financial analyst for the Alberta Securities Commission for 11 years. He then held various senior positions with the Alberta Government, including Superintendent of Insurance and Real Estate, and Assistant Deputy Minister in the Department of Consumer and Corporate Affairs, where he was in charge of the audit section.

[106] He makes the following assertions:

(a) The Accommodation Charge increase took effect August 1, 2003. In the year following the Accommodation Charge increase (i.e. the fiscal year ended March 31, 2004), health care funding to the Regions increased by 5.26%. At the same time, health care funding to the Continuing Care Facilities decreased by 5.35%. This is a dramatic reduction in health care funding for residents of nursing homes.

(b) From the year ended March 31, 2002 to the year ended March 31, 2005, health care funding from the Province to the Health Authorities increased by 27% (from $4,169,939 to $5,299,508). During the same period of time, health care funding to the Continuing Care Facilities remained essentially flat (there was an insignificant increase of .58% from $574,365 to $577,699), showing a disregard for the frail and infirm elderly, who in many cases have no one to speak on their behalf.

[107] Mr. Darwish contends that at the same time health care funding to the LTCFs remained essentially flat (and in one year substantially decreased), the Government unilaterally imposed a huge Accommodation Charge increase of 40 percent on the residents of nursing homes.

[108] Mr. Darwish wrote a letter to the Government dated September 26, 2003, in which he posed a number of questions concerning the Accommodation Charge increase and health care costs. Two cabinet ministers responded: Gary Mar, then the Minister of Health and Wellness, and Stan Woloshyn, then the Minister of Seniors.

[109] Mr. Mar stated the following in his letter to Mr. Darwish, dated October 23, 2003:

> The base rates for long-term care accommodation charges were set in 1994 and have not kept up with the actual costs of providing room and board services. In January 2002, long-term care accommodation charges increased 14 per cent to offset inflation. The August 2003 increase was necessary to ensure long-term care operators can provide quality room and board services and improve the living environment in their facilities.
>
> The new accommodation charges were determined based on actual operating costs for room and board services over the past nine years. Operating costs for nursing home and auxiliary hospitals administered by health regions, nursing homes operated by voluntary societies and private companies, lodges administered by Alberta Seniors and building upgrade and maintenance programs paid by Alberta Infrastructure were all considered to determine the real costs to provide accommodation services. Separate rates were set to reflect the cost difference to operate private rooms compared to semi-private or standard rooms.
>
> ...
>
> Your mother's monthly accommodation payments are not used to pay the facility's health care staff. Rather, the accommodation charges go directly to the facility operator, who uses the money to fund room and board services.

[110] In his October 28, 2003 letter to Mr. Darwish, Mr. Woloshyn indicated that:

> In 1999, the government completed extensive consultations with medical professionals, geriatric specialists, seniors and their families. At that time, it was suggested that government adopt a new vision for continuing care that included a recommendation to separate housing and health services in long-term care. Included in this separation was a decision to increase the contribution of residents to the costs of their accommodation. This allows the government to devote health funding to care rather than to accommodation and basic services.

> Responsibility for accommodation services has been transferred to the Ministry of Seniors. Alberta Health and Wellness continues to be responsible for ensuring standards of care and staffing are met in each facility.
>
> ...
>
> The monthly accommodation rate paid by long-term care residents represents daily living expenses similar to those paid by Albertans living at home. Included in this amount are a resident's room, meals, nutritional supplements, housekeeping services, laundering of linens, utilities, cable television charges, wander guard, incontinence supplies, routine building maintenance, and improvements to the facility (paint, carpet, furnishings).

[111] Mr. Darwish interpreted these letters as suggesting that the Province had *bona fide* reasons for raising the Accommodation Charge, and that the Accommodation Charge increase could be supported by verifiable cost data.

[112] Mr. Darwish points to the following excerpt from p. 15 of the *Report*:

> The Department currently lacks information to assess the quality and cost-effectiveness of services in long-term care facilities. The Department obtains some information from Authorities about wait lists and certain financial information. However, this information is not sufficient to allow the Department to assess the effectiveness of services provided in long-term care facilities. Nor is this information sufficient for making funding decisions, setting accommodation rates, or assessing policy changes.

[113] And from p. 37:

> The Department also does not have a policy on the portion of accommodation costs that are the responsibility of the resident, what accommodation costs should consist of, or how to calculate the accommodation rate.

[114] Mr. Darwish formed the conclusion that the rationale for the Accommodation Charge increase that had been presented by Ministers Mar and Woloshyn was misleading and incorrect.

[115] After reading the Auditor General's *Report*, Mr. Darwish contacted EAAS and they took steps to commence the present law suit. Mr. Darwish advances the following reasons for his assertion that residents of nursing homes have been taken advantage of by the Government:

(a) In the News Release dated June 17, 2003, the Province stated:

> "Accommodation rates in Alberta's long-term care facilities will increase August 1, 2003 <u>to improve the quality of resident care and services.</u>" [Emphasis added.]

"The increase will give operators an additional $58 million a year to improve the living environment for residents." [Emphasis added.]

(b) These representations are false. In fact, the residents of the Lynnwood Nursing Home have seen no improvement in their living environment or the quality of resident care and services as a result of paying a higher accommodation charge. I am unaware of any additional staff being hired.

(c) At the same time that health care funding to the Continuing Care facilities was trending down, and indeed reduced, accommodation charges increased dramatically, resulting in accommodation charges subsidizing the shortfall in health care funding.

(ii) *Affidavit Filed June 5, 2006*

[116] Mr. Darwish's mother, Johanna Darwish, was admitted to the Capital Care Lynnwood nursing home in March 1994.

[117] Mr. Darwish states that when his mother was admitted to the nursing home, she was suffering from dementia and paranoia, a form of mental illness. She was not able to live safely on her own and required 24-hour per day supervision. She could not manage her own affairs and Mr. Darwish became her guardian and trustee. After being admitted to Lynnwood, she continued to deteriorate. Eventually, she did not recognize her son, or talk or communicate. She could not feed, bathe or clothe herself. She had serious diabetes problems. She wore diapers. She was totally dependent on others for everything.

[118] Mrs. Darwish was in a semi-private room which she shared with another person. Pursuant to the General Admission Agreement, Mr. Darwish was responsible for paying "the accommodation charge approved by Alberta Health" for a semi-private room. No one explained what the "accommodation charge" was composed of or how it was calculated. He understood that his mother was moving into a facility that was like a hospital and unlike a private home or a hotel.

[119] The maximum daily Accommodation Charges in effect at Lynnwood during that period are set out below:

Type of Accommodation	34424	37256	37833
Standard	$24.75	$28.22	$39.62
Semi-Private	$26.25	$29.93	$42.00
Private	$28.60	$32.60	$28.30

[120] On January 1, 2002, the Accommodation Charge increased by about 15 percent. On August 1, 2003, the Accommodation Charge increased by a further factor of 40 to 48 percent, depending on the type of accommodation.

[121] Mr. Darwish asserts that, to the best of his knowledge, there was never an attempt on the part of the RHAs or the operators of any of the nursing homes to fine tune or adjust the Accommodation Charge for individual residents. All residents were charged the same rate, and it was the maximum rate, depending on whether the room was standard, semi-private or private. Subsidies were available through the Alberta Seniors Benefit (ASB).

[122] He notes that, according to the Auditor General's *Report* at p. 19, there were 14,065 beds in LTCFs as of February 2005. *Continuing Care Health Service Standards*, published by Alberta Health and Wellness in May 2006, indicated there were about 14,400 people living in approximately 200 long-term care facilities at that time. Mr. Darwish does not know if either of these numbers include Laurier House Lynnwood and Laurier House Strathcona in Edmonton.

[123] Mr. Darwish points out that s. 1(k) of the *Nursing Homes Act* defines "nursing home care" as "basic care and care provided under an approved program" and that "basic care" is defined in s. 2 of the *Nursing Homes General Regulation* as:

> (a) accommodation and meals;
>
> (b) facilities services;
>
> (c) necessary nursing services;
>
> (d) personal services;
>
> (e) therapeutic and special diets as required;
>
> (f) drugs and medicine specified by the Minister for use on a routine or emergency basis as prescribed by a physician;
>
> (g) routine dressings as required;
>
> (h) life enrichment services.

[124] He asserts that operators of nursing homes are required to provide these services to residents, as indicated in *Information for Residents - Medical Expense Deductions* and *Care Component of Monthly Resident Fees for 2005*, documents provided to him by the Capital Care Group.

[125] He contends that while the residents are responsible for paying for "accommodation and meals," which is the Accommodation Charge referred to in the General Admission Agreement, Alberta Health and Wellness is responsible for paying for everything else.

[126] He indicates that he has reviewed the financial statements for the Capital Care Group going back to 1999 and there is no expense item or schedule for "accommodation," a surprising deficiency since the residents are held responsible for this expense.

[127] Mr. Darwish contends that this deficiency in the financial statements supports the Auditor General's conclusion (at p. 37 of the *Report*) that the Department "does not have a policy on the portion of accommodation costs that are the responsibility of the resident, what accommodation costs should consist of, or how to calculate the accommodation rate."

[128] Mr. Darwish asserts that, in 2005, his mother was paying a monthly Accommodation Charge of $1,260.00 (for a 30 day month). The Capital Care Group advised him that $834.00 of that amount was the care component. The care component, according to the Capital Care Group, did not include the cost of food, personal space rent, or common area costs. The breakdown of the care component was provided to Mr. Darwish to use as a deduction for medical expenses for income tax purposes, as indicated in the documents *Information for Residents - Medical Expense Deductions* and *Care Component of Monthly Resident Fees for 2005*.

[129] Mr. Darwish concluded from the information provided by the Capital Care Group that the cost of the non-care component, which amounted to $426 (the difference between $1,260 and $834), represented the cost of accommodation and meals to his mother.

[130] While his mother was at Lynnwood, he observed staff reductions and was told that this was done to cut expenses. The professional staff also were downgraded. Registered nurses were replaced with licensed practical nurses, who were replaced in turn by personal care attendants.

[131] Mr. Darwish concluded that the public representations made by the Government of Alberta concerning the Accommodation Charge increase were not true.

[132] He asserts that the residents of long-term care facilities (nursing homes and auxiliary hospitals) suffer from a variety of physical and mental infirmities. They have chronic and complex health needs. They are frail and vulnerable. They do not have the resources or the mental or physical ability to bring their own separate actions. They do not have meaningful access to justice.

[133] Mr. Darwish contends that it is not efficient for 14,000 residents of nursing homes to bring their own separate lawsuits. Enormous time and resources will be saved if the 14,000 claims are brought under the umbrella of one lawsuit.

(iii) *Affidavit Filed November 30, 2006*

[134] Mr. Darwish states that he is unaware of any prospective class members who have expressed an interest in prosecuting separate individual actions. He deposes he is unaware of any similar claims which are, or which have been, the subject of other proceedings.

[135] Mr. Darwish is primarily concerned that the Government is not following its own legislation and regulations with respect to the provision of long-term care services. He asserts that the Government has issued confusing and contradictory documents and correspondence that he believes conflict with the legislation and regulations, and that this confusion is deliberate. In particular, he is concerned with the confusion surrounding the definition and calculation of "accommodation and meals," for purposes of s. 2(a) of the *Nursing Homes General Regulation,* and identification of those services that properly fall under the umbrella of "basic care," which are provided to the residents at no cost.

[136] Mr. Darwish maintains that the RHAs do not check to ensure that the money paid by the residents for Accommodation Charges is used solely to pay for accommodation and meals. He relies on a letter dated March 26, 2002, sent by Vivien Lai, Senior Policy Advisor in the Strategy Development Branch of Alberta Health and Wellness, to Wendy Armstrong of the Consumers' Association of Canada (Alberta), which stated:

> Based on this direction, long-term care operators would not be able to use the revenue from the accommodation charge, including any additional revenue generated by the recent 14 per cent increase in these charges, to cover any of the costs of providing the services outlined above that they are expected to provide to the resident free of charge.
>
> Rather, the revenue generated by the charges would be applied to the cost of providing the accommodation portion of care. The *Nursing Home Act* defines the accommodation charge as nursing home care payable by a resident for accommodation and meals, however, what would be included in the cost of providing these services is not explicitly defined. Hence accommodation costs can only be defined by excluding those costs related to the services to be provided at no cost to the client, and those out of pocket expenses for which the resident is directly responsible.

[137] Mr. Darwish states that he is unaware of any case in Alberta where the Accommodation Charge has been specifically tailored to match the actual cost of accommodation and meals for the individual resident. The Accommodation Charge, on a dollar basis, is the same across the province, except in a few cases of financial hardship.

(iv) *Affidavit Filed September 17, 2007*

[138] Mr. Darwish filed a supplemental affidavit on September 17, 2007 in support of the proposed amendments to the Amended Fresh Statement of Claim. This affidavit seems to have been in response to the Supreme Court of Canada's decision in ***Kingstreet Investments Ltd. v. New Brunswick (Finance)***, 2007 SCC 1, [2007] 1 S.C.R.

[139] Mr. Darwish asserts that the operators of LTCFs co-mingle the funds they receive from residents through the Accommodation Charge with the funds they receive from the RHAs. He

further alleges that the Defendants have not determined the cost of accommodation and meals. Mr. Darwish claims that the non-care component of $426 per month, which he had calculated in his June 6, 2006 affidavit as representing the cost of accommodation and meals to his mother, demonstrates that there is no reasonable nexus between the true cost of accommodation and meals and the amount his mother was actually charged ($1,260 per month).

(v) *Affidavit Filed January 22, 2008*

[140] Mr. Darwish filed his affidavit of January 22, 2008 to address issues raised during the cross-examination of Mr. Petherbridge, the Chief Financial Officer of East Central Health. In particular, Mr. Darwish asserts that Mr. Petherbridge allocated housekeeping, plant operation, plant maintenance, laundry and linens, patient food services, building depreciation and administration costs to "housing costs" as opposed to "health costs" and, in doing so, has improperly downloaded these costs onto the residents with the result that the residents are subsidizing the Defendants' obligation to pay for health care.

[141] Mr. Darwish notes that Mr. Petherbridge, during cross-examination on October 18, 2006, testified that he was aware that the Government of Alberta had classified institutional laundry as part of "facilities services," which is one of the components of "basic care." Mr. Petherbridge also testified that residents of the nursing homes in East Central Health were not charged for institutional laundry. Mr. Darwish points out that Mr. Petherbridge has since contradicted this statement as he has deposed in his most recent affidavit, filed November 30, 2007, that he classified "laundry and linen" as a "housing" cost as opposed to a "health" cost.

[142] Using the Tofield Health Centre's figures for the annual cost of food, supplies and kitchen maintenance, Mr. Darwish calculated that each resident's monthly portion of those costs was $220. He then calculated the square footage of the private rooms at the Tofield Health Centre and compared it to the rent of a high-end apartment in Edmonton in order to estimate the average monthly cost per resident for accommodation and meals. He came up with a total of $465 as a "goalpost" to estimate what the correct amount of the Accommodation Charge should be and to show that there is large discrepancy between this "correct" amount and the amount actually charged by the facility operators.

[143] Mr. Darwish claims that there is a significant discrepancy between the true cost of accommodation and meals and the Accommodation Charge actually paid by the residents. He further maintains that the excessive Accommodation Charge benefits the Defendants by allowing them to avoid having to incur health care expenses that they otherwise would have to pay as required by the legislation.

(vi) *Cross-examination on Affidavits*

[144] During cross-examination, Mr. Darwish stated that Ms. Adria, a friend of his aunt's, called him to discuss the condition of nursing homes and to ask him to consider being a plaintiff in this lawsuit. He also stated that he had always felt that the Government could not charge an accommodation fee, because his mother was in a hospital setting and that health care, including

hospital stays, is "supposed to be free in Alberta." However, when asked whether he expected rooms to be provided for free or whether he had always understood that there would be a cost associated with the accommodation, Mr. Darwish stated as follows:

> A: Yeah, you know what, in my mind, I suppose it's fair, in my mind, my mother and people in nursing homes are an inch away from a hospital. Some of them actually are moved over from a hospital into a nursing home, and they don't have to pay anything.
>
> Q: Right, but in the context of a nursing home?
>
> A: But in a - well, I am just telling you that it should be a fair amount, and it should be based on the space they are paying for, and that's it. That's what it should be based on.

[145] Mr. Darwish stated that the Government documents discussing the increase in the Accommodation Charge (i.e. the *News Release*, *Backgrounder*, and Fact Sheet implied that facility operators could not charge less than the maximum Accommodation Charge set by the Government.

[146] When asked if one of the initial reasons why he did not want to pay the increased Accommodation Charge was because of his mother's financial hardship, Mr. Darwish stated that while hardship made it difficult to pay, the reason that he did not want to pay it was because he did not think that the increase was justified. Although he did pay the increased amount, he did so under protest. His first payment of the Accommodation Charge after the rate increase was on August 12, 2003.

[147] Mr. Darwish admitted that Lynnwood renovated his mother's unit within the first year of their admission to the facility. The renovations included painting and remodelling of the little kitchen area. He stated that there were no changes to the services or meals provided by the facility.

B. Affidavits on behalf of the Defendants

1. Alberta Heath and Wellness

(a) Tom Mills

(i) *Affidavit Filed September 11, 2006*

[148] In his affidavit of September 11, 2006, Tom Mills, the Executive Director of Policy, Strategic Directions Division for Alberta Health and Wellness, provides statistical information concerning the status of people in the Proposed Class. He cites spring 2006 data as showing approximately 12,551 persons residing in nursing homes or receiving long-term care in auxiliary hospitals, not including those receiving sub-acute, palliative, psychogeriatric and respite care.

For the purposes of statistics and funding decisions, the practice of the Government is to group those living in nursing homes or receiving long-term care in auxiliary hospitals as long-term care residents.

[149] Individuals who have been assessed as requiring nursing home or auxiliary hospital care but are in a general hospital awaiting placement; those who have been assessed as requiring chronic care and are more or less permanently resident in an auxiliary hospital; and those residing at the Raymond Care Centre (a diagnostic and treatment centre under the *Mental Health Act*) are charged the same Accommodation Charge as set under the *Nursing Homes Act*.

[150] According to spring 2005 classification data cited by Mr. Mills, 92.9 percent of long-term care residents are seniors. There is an annual turn-over rate that is about 18 percent.

[151] Among long-term care residents eligible for the ASB, the income levels in June 2006 were: up to $10,000 (324 people); $10,000 - $15,000 (936); $15,001 to $20,000 (5112); and over $20,000 (1479).

[152] About 70 percent of long-term care residents receive ASB, AISH or SFI.

[153] Mr. Mills asserts that long-term care residents have differing capacities for the activities of daily living and require differing levels of continuing care. Some residents are subject to public or private guardianship orders, while others have trustees or persons with power of attorney or enduring power of attorney.

[154] The nine RHAs are responsible for the services provided in LTCFs.

[155] LTCFs are operated by: (1) RHAs (Public Facilities), (2) corporations or individuals under contract to the RHAs (Private Facilities), or (3) voluntary, cultural or faith-based organizations under contract to RHAs (Voluntary Facilities). The relative proportions of public, private and voluntary facilities vary from region to region.

[156] Mr. Mills deposes that there are presently 103 active registered nursing homes and 100 active registered auxiliary hospitals. There are 21 facilities with active registrations on both lists, yielding 182 presently operating separate institutions that may have to be examined as part of this proceeding.

[157] There is a great variation between LTCFs. Some are large (more than 100 residents), while others are small (less than 20). Some are in rural areas, whereas others are urban. Some are close to acute care facilities, while others are more distant.

[158] Contracts or agreements between LTCFs and RHAs vary.

[159] The Government provides operational funding to RHAs to provide acute and ambulatory care, continuing care, home care, health protection, disease prevention and health promotion

within their regions. Some of this funding is provided to LTCFs to provide personal services and health care services to long-term care residents.

[160] Until 2006/2007, approximately 90 percent of this funding was allocated by the Government to RHAs using a population-based formula, and the other 10 percent was allocated for specific purposes or to compensate when there was insufficient data on which to make a population allocation. For the 2007-2008 fiscal year, a new formula was used.

[161] RHAs have discretion in terms of how they fund LTCFs. The May 2005 *Report* noted (at p. 36) that facility funding levels differ among the RHAs by up to $10,000 per year per bed.

[162] According to Mr. Mills, the *Nursing Homes Act* and regulations and the *Hospitals Act* and regulations define the services to which long-term care residents are entitled without cost and how these can be augmented by the RHAs. The precise level of service each resident receives will depend on the assessed needs of the individual as determined by the RHA.

[163] Mr. Mills refers to *Directive D-317*, dated August 30, 1991, which provides clarification as to which services are the financial responsibility of the LTCF and which are the responsibility of the resident. He also points to a 1995 document, entitled *Basic Service Standards for Continuing Care Centres*, which was issued in conjunction with the delegation of authority to the RHAs to clarify expectations and to help smooth the transition to regional service delivery. It cites statutes, regulations, directives and policies that describe the requirements and expectations of Alberta Health and Wellness in relation to the provision of long-term care. This document was rescinded and replaced by the May 2006 *Continuing Care Health Service Standards and Long-Term Care Accommodation Standards*, which came into effect on April 1, 2007.

[164] Mr. Mills states that RHAs have the discretion to augment the publicly funded health care services as they deem appropriate.

[165] LTCFs make their own decisions on capital improvements and day-to-day management decisions on matters such as staffing and meal selection, within the limits of the law.

[166] Mr. Mills asserts that there is a tremendous variation over time and location in the expenditure accounts reported annually by RHAs.

[167] He believes that if this class action proceeds, the financial records of each individual facility would have to be reviewed in order to determine how funds are actually being allocated among the various components of nursing home or auxiliary hospital care, as the Government does not maintain such records.

[168] Mr. Mills states that LTCFs receive funding from RHAs for certain services, and also receive revenue from the Accommodation Charge paid by long-term care residents. In addition, LTCFs charge residents for certain additional goods and services, such as:

(a) hair salon services;

(b) private telephones and internet access in resident rooms;

(c) personal laundry services, including dry-cleaning pick-up, delivery, labelling and minor repairs;

(d) services not otherwise covered by other programs or insurance, such as dentistry and optometry;

(e) personal use goods and services requested by the resident, such as personal clothing and footwear, confectioneries, toiletries other than the brand provided by the LTCF, cosmetic supplies, newspapers, magazines, tobacco and alcohol;

(f) transportation and related costs for recreation outside the LTCF.

[169] Mr. Mills asserts that the Government sets the maximum Accommodation Charge for nursing home accommodation. LTCFs may charge less. Section 3(1) of the *Nursing Homes Operation Regulation* prescribes maximum daily amounts for each of standard ward, semi-private, and private accommodation.

[170] Section 5 of the *Hospitalization Benefits Regulation* draws a distinction between an in-patient admitted to an auxiliary hospital for the purpose of receiving palliative care or sub-acute care services, on the one hand, and "a patient. . . assessed as requiring chronic care and [who] is more or less a permanent resident in the auxiliary hospital," on the other. The Regulation provides that the latter is responsible for Accommodation Charges at the same rates as prescribed in s. 3(1) of the *Nursing Homes Operation Regulation*.

[171] Subject to availability, residents can choose from three types of rooms: standard, semi-private, or private. As of 2003, there were 742 standard beds, 8797 semi-private beds, and 3934 private beds in Alberta. Residents who need a semi-private or private room for medical reasons as prescribed by a physician are only required to pay the standard ward Accommodation Charge.

[172] Mr. Mills notes that people admitted to a LTCF for the purpose of receiving sub-acute care are exempt from paying Accommodation Charges. Sub-acute care is provided to individuals who are recovering from an acute illness, injury or surgical procedure, and who require additional medically necessary, professional health services. Sub-acute care may include convalescence, IV therapy, complex wound care and rehabilitation services. The policy rationale for the exemption is that individuals receiving sub-acute care in a LTCF are expected to be discharged home, and therefore still need to maintain their own home.

[173] He also notes that people admitted to a LTCF for the purpose of receiving palliative care are exempt from paying Accommodation Charges since the services are deemed medically necessary. If a resident, who is already in a LTCF and paying the Accommodation Charge,

requires palliative care, the fee continues to be charged because the facility is the resident's home and the resident essentially is being cared for "at home."

[174] Individuals admitted to a LTCF for respite care pay a *per diem* fee for services that may be lower than the Accommodation Charge.

[175] The 2003 increase in maximum Accommodation Charges that could be charged by LTCFs was implemented effective August 1, 2003.

[176] Mr. Mills states that public announcements on the 2003 increase were effected though a *Media Notice*, dated June 16, 2003, regarding a press conference to discuss the changes; a June 17, 2003 news release; and a June 17, 2003 *Backgrounder*. A letter dated June 17, 2003 also was sent to LTCFs for distribution to long-term care residents. Additional letters discussing the increase were sent to RHAs and LTCFs on August 1 and August 20, 2003.

[177] The June 17, 2003 letter to long-term care residents from Alberta Seniors was sent for the stated purpose of informing residents of changes to long-term accommodation rates. The letter indicated that "[a]ccommodation rates have not kept pace with actual costs of providing room, board and housekeeping services." It advised that rates would increase to help facility operators maintain and improve accommodation and services. Included with the letter was a *Backgrounder*, which advised that services/products funded though accommodation charges included: food; nutritional supplements; meal preparation and meal service; extra baths when required; incontinence supplies including disposable diapers when required; wander guard bracelet with batteries; cable television connection to room; housekeeping services; utilities; routine maintenance; and improvements to facility décor.

(ii) *Information on Alberta Seniors Benefit*

[178] The ASB is an income-based program that provides cash benefits to eligible seniors. Seniors are eligible to receive a portion of the maximum ASB benefit if they are over 65 and receive the full amount of Old Age Security benefit. Seniors not receiving Old Age Security benefits are eligible to receive the ASB at a reduced rate. The amount of the ASB benefit received by a senior depends on income, Old Age Security eligibility, marital and cohabitation status, and residence type. The lower a senior's income, the higher their benefits will be, up to the maximum.

[179] The amount of this benefit has changed over time. Starting in July 2003, long-term care residents receiving ASB received a monthly supplementary accommodation benefit in addition to their regular monthly cash benefit to help lessen the impact of the anticipated August 1, 2003 increase in the maximum Accommodation Charge.

(iii) *Information on Assured income for the Severely Handicapped*

[180] The amount of the AISH benefit also has changed over time. Prior to August 2003, AISH recipients in long-term care received a living allowance of up to $175 plus the cost of their Accommodation Charge. After the Accommodation Charge increased in 2003, AISH clients still received a maximum living allowance of $175 and accommodation funding at the semi-private room rate.

(iv) *Information on Supports for Independence /Alberta Works*

[181] The SFI/Alberta Works benefit is available to certain low-income individuals. The amount of this benefit has changed over time.

[182] According to Mr. Mills, the Government asked RHAs, operators and ministry staff to work together to resolve situations where the new rates caused individuals financial hardship on a case-by-case basis.

(v) *Cross-Examination on Affidavit*

[183] During cross-examination, Mr. Mills stated that *Directive D-317* was given to the RHAs sometime in 1994 and 1995, when the RHAs were first brought on board under the *Regional Health Authorities Act.* It was his understanding that the purpose of the Directive was to govern the RHAs' conduct and the way they were to treat the costs associated with LTCFs, and that the RHAs were expected to comply with the terms of the Directive. He further stated that to the best of his knowledge, the Directive was not repealed and was in effect during the time period relevant to this action.

[184] New Directives, effective May 3, 2006, were issued to the RHAs, which required them to take all necessary steps to implement and comply with the standards set out in the *Continuing Care Health Service Standards* (which replaced the *Basic Service Standards for Continuing Care Centres*, released April 1995) and the *Accommodation Standards - Long-Term Care Facilities*, both of which were released in May 2006. The new Directives also required the RHAs to prepare quarterly progress reports from June 30, 2006 until March 31, 2007, to be submitted to the Government and to include the following information:

(a) a description of the RHA's implementation plans;

(b) a description of the steps that have been taken by the RHA and its continuing care health services operators and providers/LTCF operators to implement the plans; and

(c) the anticipated date of full implementation of the standards and compliance with the Directives.

[185] During cross-examination, Mr. Mills confirmed that the Minister funds RHAs, which then provide funding to nursing homes and auxiliary hospital operators, and that the Minister does not directly fund nursing homes or auxiliary hospitals.

[186] Although the contracts between the LTCFs and the RHAs may vary significantly in terms of their details, Mr. Mills confirmed that every operator is required to comply with the relevant statutes and regulations and that no operator is exempted from the legislation. The contracts mentioned in Mr. Mills' affidavit all required the LTCF operators to provide the RHAs with information, records and reports, including financial information.

[187] Mr. Mills also confirmed that LTCFs receive funding from two sources: the RHA and fees paid by long-term care residents.

[188] He agreed that the Government developed a system to classify long-term care residents according to a number of factors relating to the level of care they required. The functional care assessment is a measure of the care needs of each individual resident of a LTCF based on four functions of daily living (eating, toiletting, transferring and dressing), two behaviour indicators (potential for injury to self or others, and ineffective coping), continence indicators (urinary and bowel), and based on a scale from "A" to "G." He stated that the functional care assessment of a particular resident was not a factor which influenced how much that resident would be charged for accommodation and meals and that the Government has never told the RHAs to adjust the Accommodation Charge for reasons related to an individual resident's functional care assessment.

[189] Mr. Mills stated that, to the best of his knowledge, the Government has not developed a classification system, similar to that used to assess care needs, to measure the cost of accommodation and meals required by individual residents in LTCFs, nor a classification system at the provincial level to measure the amount of food consumed by long-term care residents. He admitted that when the Province increased the Accommodation Charge in 2003, it did not have information about the quantity or cost of food consumed by residents of LTCFs on an individual basis. He confirmed that the Government has not developed any system to measure the amount of living space occupied or utilities consumed on an individual basis by residents of LTCFs, and did not have information about the amount of living space occupied or the cost of utilities consumed by residents on an average or province-wide basis when the Accommodation Charge was increased.

[190] Mr. Mills recalled that the background material accompanying the June 17th media package was drafted by staff in the Policy and Communications Branches of Alberta Health and Wellness, in consultation with staff from Alberta Seniors.

[191] In his affidavit, Mr. Mills quotes the Auditor General's *Report* for the proposition that funding levels vary by up to $10,000.00 per bed per year. He clarified in cross-examination that it was his understanding that those funding levels relate to the basic care obligations set out in items (b) through (h) of the "basic care" definition in the *Nursing Homes General Regulation*, and that funding for those obligations comes from the RHAs, which in turn receive block

funding from the Government. He confirmed that the basic care obligations are not the responsibility of the long-term care residents, except for item (a) of the "basic care" definition, relating to accommodation and meals, which is to be paid by the residents as the Accommodation Charge. According to Mr. Mills, the Auditor General's observation is a reflection of the variability of the needs of the residents and the care provided to them in accordance with their needs. He admitted that the variability of the funding levels for the basic care needs of residents did not change or affect in any way the Accommodation Charge that was levied or paid by the residents.

[192] Mr. Mills confirmed that when setting the Accommodation Charge in 2003, the Government did not distinguish between auxiliary hospital residents and nursing home residents. He also confirmed that the following factors do not affect the Accommodation Charge residents are required to pay: (a) whether a facility is in a rural area as opposed to an urban area; (b) the size of the LTCF; (c) the LTCF's proximity to acute care facilities; (d) the ownership of the facility: (e) the age of the resident; (f) the income level of the resident; (g) the resident's functional capacity; or (h) the resident's legal status. He did not know of any cases where the Accommodation Charge was influenced by expenditures on capital improvements or management decisions relating to staffing and meal selection. He admitted that he had no knowledge of whether variations over time or in terms of location in the expenditure accounts were factors which influenced how much individual residents actually were charged for accommodation and meals.

[193] Mr. Mills stated that facility services include housekeeping, institutional laundry and linen services, preventative maintenance, paint and carpet renewal, and other building-related services that "would go to keeping the lights on, the heat on and the building in a good state of repair."

[194] Although he could not speak to the technical details of how the ASB or other income supplements work, Mr. Mills indicated that he had been advised by his colleagues at Alberta Seniors and Community Supports that the ASB is a subsidy available for long-term care residents who qualify. The Accommodation Charge, which is the same for all long-term care residents, is paid in full by the resident or the person with guardianship or trusteeship authority on behalf of a resident, and the resident in turn will receive the benefit from the relevant Government department providing income support.

2. Regional Health Authorities

[195] Representatives of the various RHAs depose that the RHAs have been evolving their approach to elder care and have been attempting to reduce facility care for elders and expand other programming that is both more appropriate and cost-effective. They assert that, although there has been a steady increase in funding for the care component of elder care since the increases in the maximum Accommodation Charges, the number of residents in facility care and auxiliary hospital care in the Regions has decreased.

[196] The representatives of the RHAs state that the costs of providing long-term care have increased but that the RHAs did not claw back any of the increase in the Accommodation Charge by reducing the care portion of their budgets. They depose that the RHAs do not have any "rapid discharge" policies.

[197] Many of the representatives state that the Accommodation Charge is just a small portion of the actual cost of maintaining a resident in long-term care. They explain that the RHAs do not receive funding from the Province explicitly for long-term care. Instead, each RHA receives provincial funding in a global amount out of which it is expected to provide long-term care services. The RHA then determines how much of the funding received from the Province will be allocated to the LTCFs to fulfill the care requirements.

[198] The RHA deponents assert that the Accommodation Charges have not kept pace with the cost of providing room, board and housekeeping services to residents in facility care. They depose, without attribution, that it was recognized that this was putting a substantial strain on the budgets of the RHAs and the viability of the independent operators.

[199] Most of the RHA representatives deposed that they were unaware of any situations where the RHAs had moved long-term care residents because of the increase in the Accommodation Charges (exceptions are discussed below). They stated that most of the increases were covered by reciprocal increases in subsidies, the instigation of hardship policies and the flexibility of the RHAs to deal with individual cases as circumstances arose.

[200] According to a number of the RHA deponents, the funding formulas that apply to continuing care and related programs are complex. Individuals in continuing care have different levels of acuity, financial resources, family support, and complicated medical conditions. The amount of funding for individual residents varies substantially given the individual choices of the residents. The deponents state that mandatory staffing ratios make small rural facilities substantially more expensive on a per resident basis.

[201] Certain of the RHA representatives note that the care requirements for long-term care residents vary both within the Regions and across the Province. Facilities are subject to a classification process set out in the Alberta Health and Wellness *Preliminary Resident Classification Results* for the Regions. The facilities are classified using the case mix index (CMI) and case mix measure (CMM), each classification attracting a different level of resource allocation. The CMI and the CMM are reflections of a person's care needs based on activities of daily living, behavioural components, and continence.

(a) Brenda Huband - Calgary Health Region

[202] Brenda Huband is the Vice President of the Calgary Health Region (CHR), South East Community Portfolio. In an affidavit filed September 29, 2006, she asserts that the CHR delivers long-term care using a different model than most other RHAs. The CHR has consolidated and delivers public sector, urban, long-term care through its wholly-owned subsidiary, Carewest. The CHR directly provides long-term care in the rural areas of the Region. The CHR, however,

continues to be responsible for all long-term care services provided not only by Carewest and itself, but also all other LTCF operators under contract to the CHR.

[203] Ms. Huband deposes that LTCF's care requirements for residents vary both within CHR and across the province. Facilities are subject to a classification process, the results of which determine the resources allocated to each nursing home by the CHR.

[204] The Alberta Health and Wellness *Preliminary Resident Classification Results* for the CHR shows that the CMI for the thirty-eight facilities in the Region varied from a low of 81.79 to a high of 125.75.

[205] Ms. Huband refers to a number of exhibits discussing the increase in the Accommodation Charge, including a letter from the Minister for Alberta Seniors, Stan Woloshyn, to the President and Chief Executive Officer of the CHR, Jack Davis, setting out the government's expectations; correspondence and background information forwarded by Alberta Health and Wellness with regard to the increase in Accommodation Charges, which contains information on comparable rates in other provinces; a letter from the CHR to its facility operators setting out the increase in the Accommodation Charges; and a copy of Carewest's *Newsletter* of April 16, 2004, which includes an editorial prepared by Ms. Huband during her tenure as the Executive Director with Carewest.

[206] Ms. Huband states that the CHR had a hardship policy until June 1, 2006, and intervened from time to time to assist those residents who, for a variety of reasons, were unable to pay the Accommodation Charge. As each resident has difference sources of income and subsidy to assist in paying the Accommodation Charge, each hardship case was reviewed individually to determine the degree to which the Accommodation Charge was subsidized. The assistance provided under the program was tailored to the individual financial needs of the resident. Given the complexity of the subsidy system and the individual circumstances of each resident, the program was tailored to deal with any number of situations.

[207] The CHR and its contract providers have experienced some instances of bad debt due to unpaid Accommodation Charges. In the most recent five years, Carewest's bad debts due to unpaid Accommodation Charges amounted to $235,000.00, not including sums written-off by the CHR-operated rural LTCFs or other contract providers.

[208] As part of her affidavit, Ms. Huband included a sample of reports submitted by various CHR facility operators to Alberta Seniors. These reports outline the impact of the August 1, 2003 increases to the Accommodation Charges. Each operator and facility forwarded these reports to the Government. The reports indicate that much of the increase in funding paid for improvements to capital projects, such as the replacement of equipment, renovations and upgrades to electrical and ventilation systems.

[209] Ms. Huband asserts that there has been an increase in complex presentations in LTCFs, which is the result of increasing chronicity (chronic conditions), the aging nature of the

population and the significant effort made to divert those who would do better in other programs from going into long-term care.

[210] Ms. Huband asserts that long-term care residents typically are transferred to a hospital to receive acute care. There is a substantial difference in the cost and amenities between a bed in a continuing care facility and one in an acute care unit, as a resident approved for a continuing care bed receives care from health professionals with expertise and/or experience in the area of gerontology and, therefore, care specific to their needs, which may not be available or available to the same extent in an acute care facility.

[211] Ms. Huband notes that there are situations where clients are assessed, approved and waiting in acute care for placement in a LTCF. These residents occupy less than two percent of the acute care beds. The CHR is working on programs to help people obtain placement in the LTCF of their choice, where possible. The wait time for a care center admission is very short and has rarely been as high as two weeks.

[212] In the cross-examination on her affidavit, Ms. Huband confirmed that the CHR uses the same funding formula for all long-term care facilities, regardless of whether they are auxiliary hospitals or nursing homes. She indicated that there are two income streams: first, funds that come into the facility from the CHR by way of operating grants; and second, funds that come from the residents by way of the Accommodation Charge. However, she was not sure if the funding is broken down specifically by each stream of revenue or whether it is received in some consolidated fashion.

[213] Ms. Huband stated that applicants for admission to a LTCF typically undergo a process which includes the involvement of a physician. She referred to a CHR policy, entitled *Transition and Admission to Continuing Care Facilities: 'No Preference Admission'*, which sets out the admission process. The stated purposes of this policy are:

> (a) to ensure that the care requirements of individuals are met in the most appropriate facility or location;
>
> (b) to facilitate the timely transition to a continuing care facility for individuals who no longer require care in an acute care facility, a rehabilitation and recovery unit, or who can no longer be supported on Home Care; and
>
> (c) to facilitate the efficient use of limited health system resources.

[214] The first step in the process is to have the responsible physician carry out a clinical assessment of the individual's care needs to determine whether that individual is a candidate for transition to another level of care. Once an individual is assessed as being eligible for continuing care but remains in a hospital or a rehabilitation and recovery bed beyond the clinically required period as determined by the responsible physician, the individual will be charged for accommodation in accordance with s. 5 of the *Hospital Benefits Regulation* at the

Accommodation Charge authorized by the Minister. The underlying principle of the policy is "no preference for immediate admission."

[215] Despite the differences among long-term care residents in terms of their level of acuity, financial resources, family support and medical conditions, Ms. Huband confirmed that all residents in LTCFs need unscheduled professional nursing care as well as assistance in some aspects of daily living, such as toiletting, bathing or eating.

[216] Ms. Huband stated that she was unaware of any cases where the Accommodation Charge was adjusted to reflect circumstances unique to a particular long-term care resident. To the best of her knowledge, the CHR has never attempted to quantify or analyze the needs of the individual residents in terms of their accommodation and meals. The CHR did not conduct any analysis regarding the cost of accommodation and meals. When asked whether the CHR has reviewed or analyzed the records and financial information coming from the LTCF within the CHR to determine whether the funds collected from the residents through the Accommodation Charge were used exclusively to pay for accommodation and meals, Ms. Huband responded that the CHR did not collect that level of detail. She also stated that Carewest would not collect this level of detail either. In addition, neither the CHR nor Carewest ever made a determination as to which housekeeping services were for resident rooms and which were for common areas.

[217] She confirmed that Carewest charged the maximum Accommodation Charges for semi-private and private rooms.

[218] Ms. Huband explained that the hardship funding program is used as bridge funding, most likely until benefits available through Alberta Seniors and other programs come into effect. There were 36 long-term care residents who made use of the hardship program in 2004-2005, 39 in 2005-2006, and 19 from 2006 to the date of the cross-examination. The bridge funding or temporary assistance was used for an average of five months in 2004-2005, 2.2 months in 2005-2006, and 2.5 months in 2006-2007. The hardship program, which is available to all residents in LTCFs in the CHR, has also been used to assist residents who do not qualify for the ASB. In 2004-2005, it was used five times, and in 2005-2006 it was used three times for such residents.

(b) Norm Petherbridge - East Central Health

[219] Norm Petherbridge is the Chief Financial Officer of East Central Health ("ECH"). He has been a chartered accountant since 1971 and the Chief Financial Operator for ECH since November 1994. He has also been a member of the Alberta Health and Wellness Funding Methodology Working Group since approximately 1997.

[220] In his affidavit of September 29, 2006, he attests to his understanding that the 2003 increases in the Accommodation Charges were largely the result of lobbying by the Alberta Long-Term Care Association (the "ALTCA"), which consulted with representatives of the Alberta Government (ECH is not a member of ALTCA). With the exception of an inflationary increase in January 2002, the Accommodation Charges had not changed since 1994.

[221] Mr. Petherbridge refers to a report entitled *Healthy Aging: New Directions for Care*, which was produced in November 1999 by Alberta Health and Wellness' Policy Advisory Committee on Long-Term Care, chaired by David Broda (the *Broda Report*). The *Broda Report* reviewed the state of long-term care in Alberta and made recommendations for the future.

[222] Mr. Petherbridge asserts that, except for situations of hardship, the source of the long-term care residents' income for payment of the Accommodation Charge is not the business of ECH. The mandate of the ECH is to ensure that sufficient funds are paid for the health care component of the facility's funding to provide appropriate services. Mr. Petherbridge believes that it was commonly understood that the health care component of the funding subsidized accommodation costs up until the increase of August 1, 2003. He also believes that people involved in health care funding are of the view that this subsidy still continues to some extent.

[223] Mr. Petherbridge deposes that the ECH's current average cost for the health care portion of long-term care funding is $132.71 per resident day. The lowest cost per resident day is $120.48. However, there are small facilities in rural settings where the cost of care per day is $231.44 per resident. Mr. Petherbridge asserts that this is a very substantial increase in costs that ECH incurs to support the care of the residents living in their own communities and close to their families.

[224] Mr. Petherbridge states that ECH did have a hardship policy for seniors who required private rooms but who were not receiving sufficient income from the ASB to cover this cost. In these cases, ECH would subsidize the shortfall. This policy is no longer in effect as Alberta Seniors raised the subsidy levels. Although ECH was not advised of this increase in subsidy until after May 1, 2006, ECH has made no attempt to claw back the payments of the subsidies received by the long-term care residents.

[225] Mr. Petherbridge indicates that ECH has had to write off significant sums of bad debt for unpaid Accommodation Charges each year.

[226] According to Mr. Petherbridge, studies done by ECH indicate that individuals over the age 65 years constitute 15.4 percent of the population served by ECH and consume an estimated 62.7 percent of the budget. All reports indicate that this ratio will grow.

[227] He asserts that health care regions have subsidized the elders' non-health related costs for some time and still do to some extent. He contends that the Accommodation Charges have not kept pace with the cost of providing room, board and housekeeping services and this was putting a substantial strain on the budgets of the RHAs and the viability of the independent LTCF operators. In making these assertions, Mr. Petherbridge relies on a letter from Paul Rushforth, President of ACTLA, dated July 23, 2003, which includes submissions made by ACTLA to Alberta Health and Wellness that recommended an Accommodation Charge of $52.21 per day for a semi-private bed.

[228] Mr. Petherbridge states that in 2002-2003, ECH had 985 beds and the total funding (which does not include funds recovered by facilities for Accommodation Charges) was $39,806,157.00.

In 2006-2007, ECH had 924 beds with annualized projected funding of $44,309,431.00, representing an accumulative increase in costs of 18.7 percent in that five-year period. In 2003, the average resident cost per day for ECH was $112.06, with a low of $96.44 and a high of $244.08. In 2006, the regional average resident cost per day was $132.71, with a low of $120.48 and a high of $231.44.

[229] Mr. Petherbridge asserts that at no time after the August 2003 increase in Accommodation Charges did ECH attempt to reduce its funding. He denies that elder care has gotten worse and that no expenditures are being made to improve continuing care facilities.

[230] Mr. Petherbridge swore a subsequent affidavit, filed on November 30, 2007. He appears to have sworn this affidavit in response to the Plaintiffs' application to have a new plaintiff, who was a resident of Tofield Health Centre, added to the action. The application was withdrawn as the proposed new plaintiff passed away before the application could be heard.

[231] Mr. Petherbridge states that the Tofield Health Centre is a multi-purpose facility in the ECH region, which means that the facility operates as both an acute care hospital and a LTCF. Mr. Petherbridge has access to its financial statements and costs records, and plays an on-going role in monitoring the financial operation of the facility.

[232] According to Mr. Petherbridge's calculations, which are based on the audited financial systems of ECH, the total amount of the Accommodation Charges collected from the residents of the Tofield Health Centre from April 1, 2006 to March 31, 2007 was $795,722.00. This total does not take into account the subsidies that some residents received from the Alberta Government through various programs. Mr. Petherbridge states that ECH and the facility do not generally have information regarding which of their residents receive subsidies, nor the amounts of any subsidies received.

[233] Mr. Petherbridge calculates the LTCF's costs from April 1, 2006 to March 31, 2007 as totalling $4,127,214.00. Deducting the Accommodation Charges from the total costs, the net cost of operating the LTCF was $3,331,443.00.

[234] Mr. Petherbridge has divided the Tofield Health Centre's costs between the costs associated with health care and those associated with housing. He categorizes the following services as falling under the housing category: housekeeping, plant operation, plaint maintenance, laundry and linen services, patient food services, and building depreciation. He admits that some costs are not easily allocated between health and housing, such as administrative costs. Accordingly, he has applied different percentages of those services to health and housing. Based on his calculations, the housing costs portion of the LTCF costs totals $1,246,309.00, and the housing cost per resident day equals $70.35. Given that the average daily Accommodation Charge is $44.92, Mr. Petherbridge asserts that ECH pays the remaining housing cost of $25.43 per resident per day, which adds up to $450,537.00 for the year.

[235] Mr. Petherbridge further states that while specific numbers vary across the LTCFs in ECH, he would expect to find similar funding and cost patterns in other facilities, which would

show that Accommodation Charges collected do not pay for all housing related expenses and do not subsidize the health care costs. In addition, given that the maximum Accommodation Charge is set by regulation and the facility costs are subject to increase, Mr. Petherbridge claims that the percentage of overall LTCF costs that are paid for by the Accommodation Charges will vary.

[236] As mentioned above, Mr. Darwish takes great issue with the items that Mr. Petherbridge claims fall under the "housing" portion of facility costs.

[237] During cross-examination on his affidavits, Mr. Petherbridge confirmed that the ECH does not make a distinction between for-profit and non-profit facilities in terms of allocating funding to those facilities. When the ECH requests funding from the province, it does so based on a global number without explicitly setting out a specific breakdown for LTCFs.

[238] Mr. Petherbridge indicated that, as far as he knew, all residents in LTCFs in the ECH are charged the maximum Accommodation Charge. There has never been an effort or attempt made to fine-tune or adjust the Accommodation Charge for reasons that were unique or peculiar to an individual resident. The ECH has not carried out any analysis to determine the actual costs of accommodation and meals, although it considered doing so when it received the package of materials from the ALTCA. According to Mr. Petherbridge, the ECH has never looked at its own financial data to determine what the proper Accommodation Charge should be because the Region does not set the Accommodation Charges. However, he admitted that ECH has the discretion to charge less than the maximum rate, but has chosen not to do so.

[239] Mr. Petherbridge stated that the ECH pays for all the care services necessary to provide the basic services that are listed. The prescribed rents are collected and the ECH does not delineate the costs of the common areas or nursing areas to rent or care.

[240] In terms of the Tofield Health Centre, Mr. Petherbridge confirmed that this facility is registered as both an auxiliary hospital and a nursing home. There are a total of 50 long-term care beds in the facility and no distinction is drawn between auxiliary hospital beds and nursing home beds. They are treated the same in terms of the ECH's financial analysis. Services such as meal preparation, laundry, housekeeping, plant maintenance, and administration are all performed by persons who receive remuneration for those services from ECH. The staff employed at the Tofield Health Centre are employees of ECH.

(c) Robert Stratychuk - Chinook Health Region

[241] Robert Stratychuk is the Chief Operating Officer of the Chinook Health Region (Chinook). He has been the Chief Operating Officer or Vice-President of Chinook since January 2, 1995.

[242] In an affidavit filed on September 28, 2006, Mr. Stratychuk states that the increase in Accommodation Charges for Chinook-operated beds caused a few long-term care residents to request a move away from privately-operated facilities because they did not want to pay the higher rates. These individuals were allowed to stay in their private rooms at a semi-private rate

until a semi-private room became available. According to Mr. Stratychuk, no one was moved from their site over this issue. Chinook's contracted operators who had no semi-private rooms agreed to reduce the private room rate from $48.30 to $44.00 to accommodate low income seniors and prevent residents from having to move. Chinook attempted to negotiate an increased subsidy with AISH for their clients to allow them to stay in private rooms with these contracted operators, but Chinook was not successful. As a result, some AISH clients chose to move to the one privately-operated facility with semi-private and ward rooms in the City of Lethbridge. The number of those who chose to move was fewer than five.

[243] According to Mr. Stratychuk, the Chinook's average cost for the care portion of the funding, as of September 2006, was $126.32 per resident per day, with residents in the lowest cost facility receiving care funding of $119.52 per day, and those in the highest cost facility $142.64 per resident per day. He refers to the *Alberta Health and Wellness Preliminary Resident Classification Results* and notes that each of the 11 facilities in Chinook has different numbers of residents with different care mixes, which results in different funding levels based on each facility's CMI.

[244] In Chinook, any person who requires care in a private room by virtue of their condition and/or care requirements is accommodated at the semi-private room rate of $42.00. Chinook has a hardship policy to help low income people who are not eligible for the ASB, AISH or disability benefits. According to Mr. Stratychuk, no one is discriminated against on the basis of income or the ability to pay. In situations in which the Accommodation Charges are not paid, Chinook employs social workers to attempt to assist the family to access the appropriate programs.

[245] Mr. Stratychuk asserts that Chinook has bad debts that must be written off annually. In the fiscal year prior to September 2006, bad debts due to unpaid Accommodation Charges were $12,182.07.

[246] Mr. Stratychuk notes that seniors' care has been the focus of substantial change. Chinook was able to reduce its facility care residential population by 12.3 percent, notwithstanding an expanding geriatric population. It has also increased its supported housing beds from 0 to 244, excluding enhanced lodge beds.

[247] Studies done by Chinook indicate that seniors comprise 13 percent of the population served by Chinook. However, this segment of the population absorbs approximately 60 percent of Chinook's budget. In a funding comparison based on 100 beds of continuing care with a CMI of 100, the Chinook costs would have grown from $3,912,767.00 in 2002-2003, to $4,803,593.00 in 2006-2007, an increase of 22.76 percent over four years. Mr. Stratychuk asserts that Chinook basically incurred the same percentage cost increase in their own facilities.

[248] During cross-examination on his affidavit, Mr. Stratychuk drew a distinction between public LTCFs that are operated directly by the RHA, facilities that are run by private operators under contract to the RHA, and those that are run by "voluntaries." He stated that Chinook's responsibility changes depending on who owns and operates the facility, but not in the matter of the outcomes of the organizations. For example, where the facility is owned and operated by the

RHA, Chinook is responsible for staff scheduling, but a privately owned facility is responsible for its own operations. That said, the overall outcomes of the delivery of care services provided by each facility is the responsibility of the RHA, regardless of private or public ownership.

[249] Mr. Stratychuk stated that the funding formula was developed by the Government and that he does not have knowledge of the original design of the formula, despite his efforts to search for that information. He believed that the formula itself was developed by committee members from different hospitals prior to the creation of the RHAs. He relied on a letter dated April 7, 1995, from the then Health Minister, Shirley McClellan, requesting the RHAs to use the funding formula as a guideline for funding nursing homes and auxiliary hospitals. According to Mr. Stratychuk, there have been material changes in the funding methodology since 2003, the most significant of which was the increase in the multiplier, which is the number of paid hours for direct nursing care per resident. When the formula originally came out, the multiplier was 2.81. The Minister of Health directed an increase in the multiplier used to determine direct care nursing to 3.6 as of October 1, 2006. In its funding formula, Chinook uses 3.6 for direct care nursing and therapeutics and has stayed at 3.1 for the remainder of the funding formula. Hospitality services, which Mr. Stratychuk understood to include maintenance, housekeeping and laundry, are still part of the funding formula.

[250] Mr. Stratychuk confirmed that there is no material distinction between auxiliary hospitals and nursing homes in terms of funding, budget documentation provided to the Province, or in allocating money to the various facilities. Although Mr. Stratychuk acknowledged that there is a legislative difference between nursing home patients and auxiliary hospital patients, the two have melded together over time so that no distinction is made in how the patients are treated from an operational or practical point of view. Both types of patients are required to pay the Accommodation Charge.

[251] During cross-examinations, Mr. Stratychuk indicated that although there is a single point of admission for the Region which applies to everyone, he was not aware of the specific admission requirements, policies or criteria in assessing whether an individual qualifies for long-term care. Chinook's policy document entitled *Referral of Clients who Require Institutional Continuing Care* implies that physician consultations are part of the community care assessment process in reviewing the medical condition of prospective residents.

[252] According to Mr. Stratychuk, individuals in nursing homes require 24-hour supervision by a registered nurse and unscheduled care while those in designated assisted living may still require professional care provided by a registered nurse but this care can be provided on a scheduled basis.

[253] Mr. Stratychuk admitted that Chinook has not attempted to adjust the Accommodation Charge for individual residents based on the actual cost of that Resident's accommodation and meals. Chinook has not developed a classification system to measure the actual cost of accommodation and meals required by individual residents in LTCFs.

[254] Mr. Stratychuk noted that not all Chinook residents in LTCFs were charged the maximum Accommodation Charge. At one of the facilities, St. Mike's Health Centre, there were a number of people who did not want to stay in a private room and pay the increased Accommodation Charge. However, St. Mike's Health Centre only has private rooms. Immediately following the rate increase, St. Mike's continued to charge the lower rate to these residents. Over a period of time, these residents chose to move to semi-private rooms in other facilities in Lethbridge because they could not afford or did not want to pay the maximum rate for a private room, which St. Mike's eventually implemented. Mr. Statychuk confirmed that the situation at St. Mike's was the only exception to the maximum Accommodation Charge being applied and involved less than five residents.

[255] After the increase in the Accommodation Charges, Chinook did not undertake any analysis or conduct any financial audits or reviews to determine if residents of LTCFs should be charged something less than the maximum amount or to examine the basis for the Accommodation Charges levied by the private operators.

[256] Mr. Stratychuk confirmed that private operators and voluntaries that are under contract with Chinook to provide long-term care services are required to report financial information to the region on an annual basis. Chinook reviews this information as part of its stewardship responsibilities to deliver health services to the Region.

[257] According to Mr. Stratychuk, Chinook has not audited its own records and financial statements with respect to the public LTCFs in the region to determine whether the money collected from the residents for the Accommodation Charge was used solely to pay for accommodation and meals. Chinook has not requested any audits of either the public or private operators. Chinook has not performed any reviews or analyses of the financial records and statements of either the public or private facilities to determine whether the funds from the Accommodation Charges are used exclusively to pay for accommodation and meals.

[258] Mr. Stratychuk admitted that Chinook has not determined what the housekeeping costs were for resident rooms and common areas as opposed to the facility as a whole. Chinook does not track the housekeeping or laundry expenses to ensure that such costs are paid out of the funds Chinook has allocated to the facility and not out of money collected from the residents.

(d) Linda Metz - Northern Lights Health Region

[259] Linda Metz is the Vice President of Corporate Services of the Northern Lights Health Region ("NLHR") and has been in this position since December 16, 1999.

[260] According to Ms. Metz in her affidavit, filed on September 29, 2006, the NLHR administers only four units and the Region has a younger demographic than most of the southern regions in Alberta. According to Ms. Metz, the CMI for the NLHR varies from a low of 69.46 to a high of 89.47. The funding for long-term care for the NLHR was 7.35 percent of the population-based funding in 2003-2004, 8.03 percent in 2004-2005, and 8.88 percent in 2005-2006.

[261] Ms. Metz refers to Statistics Canada's *Residential Care Facilities Survey*, which she asserts indicates that revenue from fees and charges has fallen each year since 2003-2004. However, the *Survey* shows that the revenue collected from the residents in the NLHR was $419,178.00 in 2003-2004, $438,919.00 in 2004-2005, and $416,560.00 in 2005-2006. According to the *Survey*, the number of beds staffed and in operation remained constant throughout this period, with an insignificant variation in the average number of residents.

[262] Ms. Metz asserts that in the spring of 2005, there were 64 people in residence in the NLHR, and in 2006, there were 61. However, Ms. Metz notes that the cost of those residents has continued to rise.

[263] Ms. Metz deposes that because the Region has a younger demographic and Alberta's lowest CMI, the NLHR does not have any residents who require significant acute care.

[264] During cross-examination on her affidavit, Ms. Metz confirmed that all of the LTCFs in the region were owned and operated by the NLHR. In terms of funding, the NLHR does not make any distinction between residents in nursing homes and those in auxiliary hospitals. All residents of LTCFs undergo the same process in order to be admitted to the facility. Care needs are provided by the RHA regardless of the level of an individual's specific care needs.

[265] Ms. Metz confirmed that the NLHR's admission procedure includes physician involvement. The NLHR's admissions policy states as follows:

> The Alberta Assessment and Placement Instrument (A.A.P.I.) is used as the basic tool for determining eligibility for admission to Continuing Care. It is completed by Home Care prior to admission.
>
> This (A.A.P.I.) application must include a medical completed by the resident's physician within the past twelve (12) months.

[266] Ms. Metz recalled that the NLHR received the same package of information as the other RHAs when the increase in the Accommodation Charge occurred. She confirmed the residents of the NLHR were charged the maximum rates as set out in the Regulation.

[267] Ms. Metz admitted that the NLHR has not conducted any review or analysis to determine what the Accommodation Charge should be for its residents. She did not know specifically how the money that was collected from the residents was spent and on what items.

[268] Ms. Metz admitted that the NLHR did not make any calculations as to what portion of housekeeping costs related to resident rooms and common areas. She did not know why the residents were told that they would be paying for bed linens, towels and costs associated with facility management and administration when these items were paid for by the NLHR out of its budget.

(e) Seamas O'Fuarthain - Palliser Health Region

[269] Seamas O'Fuarthain has been the Chief Financial Officer of the Palliser Health Region ("Palliser") since June 12, 2006.

[270] In his affidavit, filed on September 29, 2006, Mr. O'Fuarthain states that Palliser must work individually with certain residents and their families to ensure that Accommodation Charges are paid, but its primary mandate is to ensure that sufficient funds are allocated to provide appropriate care services. He deposes that it is his understanding that Palliser's hardship policy for residents who require private rooms is that if the resident is receiving the ASB, the resident is charged at the semi-private accommodation rate.

[271] When asked during cross-examination on his affidavit whether Palliser's responsibility for services provided by LTCFs changes depending on whether the facility is public, private or voluntary, Mr. O'Fuarthain replied that Palliser's responsibility in terms of its own facilities is direct and operational, while it is a contracted responsibility with respect to facilities operated by third parties. Palliser's mandate is to ensure that the services that are required by legislation to be delivered are in fact delivered by third parties under contract to the region.

[272] Mr. O'Fuarthain confirmed that it is within Palliser's discretion to allocate its global funding as it sees fit. Palliser uses a funding formula to allocate funds to the LTCFs. The formula is the same regardless of whether the facility is a nursing home or an auxiliary hospital. The funding formula has changed since 2003 in terms of the multipliers used, but the categories of which services are funded and which are not have not changed.

[273] Palliser has admission criteria for long-term care in Medicine Hat. Two of the requirements are that the applicant receive a minimal score of a "D" or greater in terms of the Alberta Residential Classification program, and that the applicant have a physician who practices at the facility of admission (or accepts a specific designated doctor).

[274] Mr. O'Fuarthain was unsure whether long-term care residents typically are charged less than the maximum Accommodation Charge. He was aware of one Palliser LTCF, the Brooks Health Centre, which charged the semi-private rate of $42.00 for a private room if the resident was receiving the ASB, based on a direction given to Palliser by the Government. In his Answers to Undertakings, Mr. O'Fuarthain provided the following responses from the third party contractors in terms of what these LTCFs were charging as an Accommodation Charge:

(a) South Ridge Villa: charged the maximum for their beds in the main building (50 beds) and $45.00 per day for the cottage beds (30 beds).

(b) Sunnyside Nursing Home: charged $45.00 for private rooms that were not newly constructed and charged the maximum for all other rooms.

(c) CPL - Riverview Care Centre: charged $45.00 for private rooms and charged the maximum for semi-private rooms.

(d) Valleyview Nursing Home and Orchard Manor: charged the maximum for all rooms.

(e) Club Sierra: was not open before August 1, 2003.

[275] Mr. O'Fuarthain stated that Palliser has never made an effort to fine-tune or adjust the Accommodation Charge for reasons that are unique or peculiar to an individual resident. Palliser has not determined the actual costs of accommodation and meals for Palliser residents in facilities owned and operated by the Region. It has not performed any kind of analysis or conducted any kind of financial review to determine if residents should be charged less than the maximum Accommodation Charge. Mr. O'Fuarthain had no knowledge of whether the third party contractors have conducted any such analyses or reviews. He confirmed that Palliser did not review its financial records to determine whether the funds collected from residents for the Accommodation Charge was used exclusively to pay for accommodation and meals.

(f) Lynne Mansell - Capital Health

[276] Lynne Mansell is the Director of Planning, Community Care, Rehabilitation and Geriatrics of Capital Health. She has been employed by Capital Health since November 2000 and has held the position of Director since November 2004.

[277] According to Ms. Mansell, in her affidavit filed September 26, 2006, Capital Health delivers public sector long-term care through its wholly owned subsidiary, The Capital Care Group. In addition, Capital Health itself provides long-term care in two rural sites. She asserts that Capital Health is responsible for administering the contracts with and providing oversight for services provided by voluntary and private LTCF operators who are under contract to Capital Health. Ms. Mansell deposes that the CMI for the thirty-eight facilities in Capital Health varied from a low of 75.75 to a high of 113.83.

[278] Ms. Mansell deposes that payment of the Accommodation Charge is the responsibility of the individual resident. Since the increase in the Accommodation Charges, Capital Health has implemented an informal hardship program and has responded to requests from time to time to assist those residents who, for a variety of reasons, are unable to pay. As each resident has different sources of income and subsidies to assist in payment of the Accommodation Charge, each hardship case is reviewed individually to determine the degree to which the Accommodation Charge is subsidized and tailored to the individual financial needs of the resident.

[279] Although the Accommodation Charges imposed by the independent operators are not set by Capital Health, Ms. Mansell is aware of at least one facility that charges $45.00 per day for some private rooms that have shared bathrooms, as opposed to the legislated maximum rate for private rooms of $48.30.

[280] According to reports submitted to the Government by operators of LTCFs in the Capital Health Region, some of the 2003 increase in the Accommodation Charges has paid for the purchase and replacement of equipment and furniture, renovations, and improvements to meals

and housekeeping services. In its Report dated February 13, 2004, the Capital Care Group stated that:

> This increase [to Accommodation Charges] has enabled us to pay for services that are provided at this time. Prior to this increase, and in order to maintain services with available resources, we reduced management, cut service hours of staff and delayed routine maintenance.

[281] This Report also indicated that the Capital Care Group, as the public provider for continuing care residents, had a higher proportion of residents who could not pay the private room rate, and expected to subsidize Accommodation Charges for residents in private rooms who could only pay at the semi-private room rate, at an annual cost of $350,000.00.

[282] Ms. Mansell asserts that for the first year that the new Accommodation Charges were in effect (2003-2004), Capital Health adjusted funding to reduce the general administration portion of facility funding by 4.62 percent. In the same year, overall facility funding increased per bed and funding with regard to care has increased every year since.

[283] Ms. Mansell denies that residents of LTCFs have seen no improvement in their living conditions since the increase in the Accommodation Charges. She believes that long-term care administration, service delivery and provision of amenities have improved and are still improving.

[284] During cross-examination on her affidavit, Ms. Mansell confirmed that, apart from donations, the two major sources of funding for LTCFs are the grants from Capital Health and the Accommodation Charges paid by the long-term care residents.

[285] The amount of money Capital Health spends on LTCFs is based on historical funding patterns with adjustments for new programs, services, beds, and similar items. Capital Health undergoes a budget review process to set its annual budget and the amount allocated to LTCFs is part of this budgeting process. In order to allocate funds to each specific facility, Capital Health uses a classification process based on the CMI, the CMM, and a funding formula. The funding formula used by Capital Health to fund LTCFs does not change, regardless of whether the facility is public, private or voluntary. Ms. Mansell stated that the original version of the funding formula was developed by Alberta Health and Wellness.

[286] According to Ms. Mansell, the operators of the LTCFs and auxiliary hospitals are required to report back to Capital Health on a quarterly basis and to provide independently audited annual statements. Neither the quarterly reports nor the annual statements provide enough information to allow Capital Health to determine whether funding has been used in accordance with *Directive D-317.* The reports do not permit Capital Health to check whether the Accommodation Charges accord with actual accommodation expenses.

[287] According to Ms. Mansell, individuals applying for admission to the LTCFs all go through the same assessment process, which requires physician input. The primary criterion

common to those in long-term care is the need for unscheduled professional nursing care; individuals who have personal care needs but do not require unscheduled professional nursing care may be able to receive services through another option like supported living. Residents of nursing homes may also require assistance in terms of the factors giving rise to the CMM, such as functions of daily living (eating, toiletting, transferring, dressing) and continence indicators. The responsibility for providing long-term care, regardless of whether an individual's needs are fairly basic or complex, is that of Capital Health for its own facilities or the owners of other facilities under contract to Capital Health.

[288] Ms. Mansell admitted that Capital Health has never attempted to fine-tune or adjust the Accommodation Charge for reasons that are unique or peculiar to an individual resident. Capital Health has not developed any classification system to measure the cost of accommodation and meals required by individual residents in LTCFs.

[289] Ms. Mansell confirmed that, although Capital Health was asked to address questions or concerns raised by residents or their family members, it did not check to ensure that residents were paying only for personal laundry service, which is the resident's responsibility, and not for linens and towels, which are to be provided by the facility. Capital Health did not perform any kind of analysis, review or audit to determine who was paying for basic facility services, defined by the Government as housekeeping, laundry and linen services, and preventative maintenance.

[290] The Capital Care Group, a subsidiary of Capital Health, charges all of its long-term care residents the maximum Accommodation Charge. To Ms. Mansell's knowledge, neither the Capital Care Group nor Capital Health have done any kind of financial analysis to determine whether residents should be charged less than the maximum rate or to justify charging the maximum. Capital Health has not received any financial analysis from any operators in terms of the Accommodation Charge. Capital Health does not check to see if the Accommodation Charges match up with actual accommodation expenses, as the reports received from the facility operators do not permit this type of analysis.

[291] In terms of Capital Health's hardship policy, Ms. Mansell advised that there were 39 individuals receiving financial assistance from 2003 to 2006, for a total amount of $69,748.00. It was noted that few residents who received funding in 2006 continue to do so, as other funding sources are in now place, including the 2006 funding increase to the ASB and disability benefits.

(g) Shelly Pusch - Aspen Regional Health

[292] Shelly Pusch is the Vice President of Corporate Services for Aspen Regional Health ("Aspen"). She has served in that position since April 2003, and prior to that was the Chief Financial Officer for Aspen since May 1997. Before May 2007, she also filled various facility management and finance roles in the Barrhead Healthcare Centre.

[293] Ms. Pusch provided a copy of audited financial information, which compares Accommodation Charges with housing expenses for Aspen's independent continuing care facilities. The financial information demonstrates that the amounts collected in Accommodation

Charges do not cover the housing expenses required to operate the facilities and that the deficit for each facility ranges from $251,298.00 to $317,702.00. It is to be noted that the subcategories under the heading “Support/Housing Services” include food services, laundry/linen services, housekeeping services, plant maintenance and operation, rent, and utilities. Some of these subcategories are in dispute in terms of whether they fall under the statutory definition of “accommodation and meals.”

[294] In her affidavit, filed September 28, 2006, Ms. Pusch deposes that, as of September 2006, the Region’s average cost for the care portion of funding was $121.81 per day, with a low of $106.75. There were small units in rural settings in which the cost of care per day was $173.25 per resident. The CMI for Aspen’s 20 facilities ranged from a low of 81.51 to a high of 113.23.

[295] Aspen, like other RHAs, has a hardship policy for long-term care residents who require private rooms. Ms. Pusch states that Aspen planned to eliminate the hardship policy effective January 2007, since the shortfalls are now covered by Alberta Seniors. Aspen has no plans to claw back the payments of the additional subsidy received by the residents.

[296] Ms. Pusch deposes that in 2004-2005, Aspen wrote off $22,877.79 in uncollectible bad debts due to unpaid Accommodation Charges.

[297] Aspen’s minimum staffing requirements, based on the Region’s standards and union contracts, provide for one registered nurse per unit, 24 hours per day, 365 days per year. Two nursing assistants are on during the day and evenings, and one is on during the night. The requirements remain the same regardless of the number of beds in the unit.

[298] Ms. Pusch notes that accommodations are made to take into account local conditions and desires of local residents to remain in the community. She cites the example of a special high-needs client who had been residing in a special unit in Capital Health before being admitted to a facility in Aspen in order to provide closer access to family. Ms. Pusch asserts that Aspen had to add substantial additional staffing hours to accommodate this high needs client.

[299] According to Ms. Pusch, studies done by Aspen indicate that, as of September 2006, the senior’s population (residents over 65 years of age) made up 10.79 percent of the population served by Aspen and that this segment of the population absorbed 50.94 percent of Aspen’s in-patient budget, not including direct continuing care.

[300] Ms. Pusch asserts that Aspen’s Accommodation Charge revenues are 26 percent of the overall cost of long-term care. In 2002-2003, Aspen had 872 beds and its total funding, not including funds recovered by facilities for Accommodation Charges, was $27,984,000.00. In 2005-2006, Aspen had 825 beds and its funding was $28,915,000.00. The accumulative increase in costs covering that three-year period was 9.21 percent. In 2003, the average cost per resident per day was $87.92, with a low of $80.53 and a high of $159.90. The regional average cost was of September 2006 was $121.81 per day.

[301] During cross-examination, Ms. Pusch confirmed that Aspen's mandate is to ensure that sufficient funds are paid for the care component of the facilities' funding to provide appropriate services and that this mandate is the same regardless of whether the facilities are public, private or voluntary. While the actual delivery of the services may be in the hands of a third party, the overall responsibility for the services remains with the RHA.

[302] Of a total of approximately 825 residents in LTCFs, Ms. Pusch was aware of only two cases where the actual Accommodation Charge had been lowered so that the resident was charged the semi-private rate for a private room. These two adjustments were made based on a hardship assessment of the individual residents. Otherwise, every long-term care resident in Aspen is charged the maximum Accommodation Charge.

[303] Ms. Pusch admitted that Aspen did not conduct any financial analysis or audits to determine if its residents in LTCFs should be charged less than the maximum Accommodation Charge. Aspen does not track what the money collected from the residents is used for, where it goes or how it is applied.

(h) Sean Chilton - Peace County Health

[304] Sean Chilton has been the Corporate Business Officer of Peace Country Health ("PCH") since February 2004.

[305] Mr. Chilton asserts in an affidavit filed on September 28, 2006 that in 2005-2006 the average cost for direct nursing per resident day in PCH facilities was $125.54, not including costs for therapy, support services or administration. In one independent facility in PCH, the average cost per resident day was $101.72 for direct nursing and high-cost drugs.

[306] There are eleven facilities in the PCH Region, including one independent operator. In 2006, the CMM varied from a low of 83.66 to a high of 104.73.

[307] Mr. Chilton states that PCH has a hardship policy which accounts for a number of challenges that individual long-term care residents may face, and allows for discretionary decision-making for PCH administrators to address unique situations. According to the policy, financial hardship will only be recognized after eligibility for all other provincial, federal and personal (3rd party) funding services has been eliminated through a financial status review by a PCH social worker.

[308] Mr. Chilton asserts that PCH writes off bad debts due to unpaid Accommodation Charges. In 2004-2005, the total amount of unpaid Accommodation Charges was $32,032.57. In 2005-2006, it rose to $33,414.95.

[309] According to Mr. Chilton, in the Peace River (Sutherland Place) and Manning Continuing Care Centres, where there are no semi-private rooms, the PCH accommodates residents requesting a semi-private room by subsidizing those residents by $114,975.00 annually.

[310] Mr. Chilton refers to the effect of minimum staffing requirements on increasing costs, particularly in a small rural setting. He notes that as of April 2006, PCH gave a $2.00 per hour supplement to nursing attendants in continuing care and to some support workers in its own facilities, and a $250.00 per month supplement to all of the staff in the Region to support recruiting and retention initiatives. Comparable funding increases have been allocated to the independent facility in PCH for similar remuneration.

[311] To demonstrate that PCH makes a number of accommodations to take into account local conditions and desires of local residents, Mr. Chilton cites the example of an individual in need of ventilatory support who required one-to-one nursing care in one of PCH's continuing care facilities. The individual had moved from British Columbia to stay in relatives' homes in the PCH Region, but the family members were unable to care for this person. Normally, PCH's continuing care facilities do not have the capacity to care for ventilated residents, but no other appropriate accommodations were available. Accordingly, PCH undertook to train its staff sufficiently and significantly increased staffing levels to care for the resident.

[312] Mr. Chilton states that studies undertaken by PCH indicate that, in 2003, seniors made up 9.1 percent of the population served by PCH.

[313] In September 2006, PCH had 411 PCH-owned and operated continuing care beds, with an additional 60 beds in the independently-owned and operated facility. In 2005-2006, the total funding for the PCH facilities, which did not include funds recovered by facilities for Accommodation Charges or costs for therapies, support services, or allocation of administration, was $19,664,000.00. During the same time period, the total funding provided by PCH to the independently-owned and operated facility was $1,944,301.00, which included $96,475.00 for high-cost drugs. In PCH-owned and operated facilities, the accumulative increase in direct nursing costs per resident day in the three-year period from 2003 to 2006 was 6.8 percent; in the independently-owned and operated facility, the increase has been 6.6 percent.

[314] Mr. Chilton asserts that residents who are discharged and have been assessed for placement in continuing care are charged the Accommodation Charge, notwithstanding that they remain in acute care while waiting for placement. Residents who are admitted to acute care from continuing care facilities are charged the Accommodation Charge by the PCH-owned and operated facilities while in acute care.

[315] During cross-examination on his affidavit, Mr. Chilton confirmed that PCH is responsible for ensuring that services are provided by continuing care facilities, regardless of whether the facility is public or private. PCH receives global funding from the Government and is required to report to the Government as to its use of the funds. According to Mr. Chilton, PCH is required to follow certain financial directives in the reporting process and these instructions are set by the Government. The reporting requirements are the same for all RHAs.

[316] Mr. Chilton advised that there was no difference in terms of the budgeting process for facilities owned and operated by PCH depending on whether the beds are nursing home beds or auxiliary hospital beds; both types are treated the same and funded according to the same criteria.

There is also no difference in treatment and care received by long-term care residents based on the type of bed. One of the facilities in the PCH region, Mackenzie Place, has both nursing home beds and auxiliary hospital beds. Mr. Chilton confirmed that in that facility, the residents in the auxiliary beds receive the same types of care and treatment, and have similar needs to those in the nursing home beds.

[317] Mr. Chilton indicated that in order to be admitted to a LTCF in the PCH Region, a potential resident is required to undergo a continuing care assessment and placement process, where an interdisciplinary team, in consultation with the attending physician, will assess the individual to determine eligibility for placement. The admission procedure is exactly the same for both nursing homes and auxiliary hospitals. In order to warrant their admission into a LTCFs, an individual must require a level of nursing care that cannot be provided in a home setting. They may also require assistance with various activities of daily living, such as toiletting, bathing, dressing and transferring.

[318] Mr. Chilton confirmed that apart from seniors who receive either ASB, AISH or SFI, residents in nursing homes and auxiliary hospitals are charged the maximum Accommodation Charges. PCH has adjusted the Accommodation Charges for two residents, based on hardship in one case and on the availability of beds in the other. The Peace River and Manning facilities only have private rooms, and the residents in those facilities were charged the semi-private rate.

[319] Mr. Chilton admitted that PCH did not conduct any analysis, financial review or study to determine whether the residents should be charged something less than the maximum Accommodation Charge, or to determine the actual cost of accommodation and meals in the Region. He stated that he is not aware of any cases where the Accommodation Charge was adjusted or modified to reflect the actual cost of accommodation and meals for a particular resident. PCH does not have a classification system or other kind of analysis to measure the cost of accommodation and meals for residents in LTCFs on either an individual basis or on a region-wide basis. PCH does not review or analyze the records and statements of the facilities to determine whether the Accommodation Charges are used exclusively to pay for accommodation and meals.

(i) Denise McBain - David Thompson Regional Health Authority

[320] Denise McBain is the Senior Vice-President and Chief Operating Officer, Health Services, at the David Thompson Regional Health Authority ("DTHR") and has held this position since April 2003. She has also held other positions with DTHR, including Senior Vice-President, Client Care Operations from 1998 to March 2003, and Vice-President of Community Health Services from January 1995 to 1998.

[321] Ms. McBain asserts that the increased Accommodation Charges were lobbied for by a number of stakeholders who advocated for an increase in rates because the existing rates fell well short of accommodation costs and had not been adjusted since 1994. One notable stakeholder is ALTCA. Ms. McBain notes that the DTHR is not a member of ALTCA.

[322] According to Ms. McBain, the CMI for the twenty-five facilities in the DTHR varied from a low of 84.4 to a high of 135.5. Not only do the facilities and caregivers deal with different funding levels for different levels of care requirements as shown by the CMI, there are a number of different factors involved in how the Accommodation Charges are paid by each individual. Ms. McBain asserts that there was a Ministerial Directive that no matter what the source of funding, each long-term care resident is to have $265.00 of discretionary income monthly. Further, residents who medically require a private room pay the lower Accommodation Charge for a semi-private room and the shortfall is made up by the RHAs or the operators. Given the wide range of residents in the continuing care facilities, from the very wealthy to those who are completely subsidized, and given that $265.00 of discretionary income must be made available to each resident, Ms. McBain claims that not all of the Accommodation Charges are paid. For the DTHR, the unpaid Accommodation Charges amounted to $134,326.41 for 2004, $141,866.38 for 2005, and $154,307.42 for 2006. These unpaid fees arose due to hardship or where there was a delay in the receipt of subsidies. Although the subsidies are paid retroactively, the DTHR could not claw back the Accommodation Charges.

[323] Ms. McBain asserts that the Accommodation Charges which were paid up until August 1, 2003 did not adequately recover the accommodation costs for any residents and that despite the increase in Accommodation Charges, the current rates still do not cover the accommodation costs. According to Ms. McBain, those most affected by the increased Accommodation Charges were those best able to pay. Residents pay a wide array of different levels of Accommodation Charges from their own resources and receive substantially different levels of care depending on the nature of their independence and their need for more expensive forms of therapy such as medication therapy.

[324] Ms. McBain further asserts that continuing care facilities are subsidized by the health care system through accessing any number of health-care related funding sources for various capital and equipment expenses. Such expenses include purchasing and replacing mattresses, lifts, and tubs. Expenditures for equipment for on-going elder care were made from a number of funds, including the following sources: fundraisers held by or benefiting the DTHR; federal grants; provincial funding; the DTHR's equipment reserve; the DTHR's special purpose funds; a charitable foundation operated by the Region; and private donations. Ms. McBain claims that the vast majority of this equipment will be used by the seniors' population of the DTHR, most of it by those in LTCFs. She also claims that these expenditures were made from various sources quite independent of the Accommodation Charges. While Ms. McBain admits that some of this equipment may benefit individuals who are not residents of LTCFs, she asserts that these residents continue to benefit from the general resources of the DTHR and from a disproportionate amount of the expenditure which is made towards the care of elders.

[325] Ms. McBain provides a "weighted cases and direct nursing care expenditures" during the three year period ending March 31, 2005. The analysis shows that those over the age of 75 years make up between 5.4 and 5.5 percent of the population receiving services, and constitute 35.5 to 37 percent of all weighted cases in in-patient beds. The average per capita spending for those over age 75 varied from $1,943.00 in 2003-2004 to $2,057.00 in 2004-2005. In comparison, the average per capita spending for those under the age of 75 varied from $191.00 in 2003-2004 to

$204.00 in 2004-2005. In addition, home care expenses, which are primarily spent on the elder population, exceeded $20,000,000.00 annually. Expenditures relating to infrastructure maintenance for continuing care were 42.98 percent of the Region's budget in 2003-2004, 47.62 percent in 2004-2005, and 32.09 percent in 2005-2006, all of which absorbed a bigger percentage of the infrastructure maintenance budget than any other sector in the DTHR.

[326] Ms. McBain notes that each facility is funded differently, according to the functional care needs of the long-term care residents. The facilities are subsidized in capital terms from sources available to the RHAs, some of which are quite outside the block funding provided by the Government. She notes that residents in these facilities, unlike other citizens, have their pharmaceutical costs paid for by the DTHR.

[327] Ms. McBain refers to the example of Northcott Care Centre, one of the DTHRs private operators, to demonstrate the complexity of the calculation for providing care. According to these calculations, the personal care funding for each of the 73 beds at Northcott would be $3,080.30 per month. In a 30-day month, the personal care component paid by DTHR to Northcott is $102.78 per resident per day.

[328] According to Ms. McBain, improving continuing care is an on-going task towards which the DTHR has made substantial progress. As of September 2004, improvements made to continuing care facilities included: renovations for environmental improvements and safety concerns, painting and general upgrades, more flexibility in menu choices, and improved food quality and temperature. Other planned initiatives include: replacement of nurse call system, tub room renovations, replacement of carpets and flooring, installation of wheelchair accessible doors, improvements to residential dining areas, and improvements to security.

[329] Ms. McBain asserts that continuing care expenses to the DTHR have increased each year since 2000 and that the most dramatic increase occurred in the years 2003 and 2004. After the increase in Accommodation Charges in August 2003, the DTHR did not attempt to reduce its funding of continuing care facilities. Ms. McBain deposes that, in fact, such funding has actually increased.

[330] During cross-examination on her affidavit, Ms. McBain indicated that the DTHR's responsibility for administering its contracts with facility operators to ensure that the care component of the funding is provided does not depend on whether the facility is public, private or voluntary. All the facilities are funded in accordance with the same formula.

[331] Ms. McBain stated that there is no longer any clear differentiation between nursing homes and auxiliary hospitals, as all the facilities are regarded as being nursing homes generally.

[332] Admission into a LTCF in the DTHR requires a physician's signature on the application form. If there is a question, concern or appeal with respect to a placement into a nursing home, an assessment committee is convened to consider the request.

[333] Ms. McBain admitted that the Accommodation Charges in the DTHR have not been adjusted to reflect the individual circumstances that are peculiar to the various long-term care residents in the Region. The DTHR has not conducted any financial analysis or review to determine whether residents in the Region should be charged less than the maximum Accommodation Charge. The DTHR does not specifically track how the money paid by the residents is used. The facility operators roll the Accommodation Charges into general revenue and do not specifically track expenses. Seniors who do not receive cash benefits through ASB, AISH or SFI are all charged the maximum Accommodation Charge.

[334] Ms. McBain advised that when the fee schedule changed in June of 2003, the Government sent a letter to long-term care residents, dated June 25, 2003, with the following explanation of the changes:

> I am writing to inform you of changes to long-term care accommodation charges in Alberta as announced by the Minister of Health and Wellness and the Minister of Alberta Seniors on Tuesday, June 17, 2003.
>
> There has been only one increase in accommodation charges in the last ten years. In order to catch up with the effects of inflation, effective August 1, 2003 long-term care facility accommodation charges will increase by between $11.40 and $15.70 per day
>
> Your charges will increase from $29.93 to $42.00 per day.
>
> For residents who receive cash benefits under the Alberta Seniors Benefit program, AISH or Support for Independence, the monthly cash benefit will be increased to help reduce the impact of the accommodation rate increase...
>
> A fact sheet and backgrounder from the Government of Alberta are attached and provide further information on the increases. The fact sheet has a chart, which illustrates the change in accommodation rates for each type of accommodation (private, semi-private & standard 4-bed ward)...

IV. Issues

[335] Pursuant to s. 5(1) of the *CPA*, this certification application raises the following issues:

(A) Do the pleadings disclose a cause of action?

(B) Is there an identifiable class of 2 or more persons?

(C) Do the claims of the prospective class members raise a common issue?

(D) Is a class proceeding the preferable procedure for the fair and efficient resolution of the common issues?

(E) Are either Mr. Darwish or the EAAS appropriate Representative Plaintiffs?

V. Analysis

[336] The Plaintiffs contend that the "heart of this case is that the class members have paid for Health Care costs which are the legal responsibility of the Defendants. These include housekeeping, laundry, administration costs, building maintenance costs, etc. What the Crown posits as a liability issue is in fact a 'damages' issue."

[337] The Plaintiffs say that the proper interpretation of the terms "basic care," "standard ward hospitalization," and "accommodation and meals" will serve to distinguish what services properly fall within the ambit of the Defendants' financial obligations as opposed to the financial obligations of members of the Proposed Class. The Plaintiffs allege that members of the Proposed Class are legally obliged to pay only for "accommodation and meals," as properly construed, and not for basic care, standard ward hospitalization or health care, and the constellation of services that fall within those concepts.

[338] The Plaintiffs claim the case will involve a determination of the statutory spheres of responsibility as between the long-term care residents and the Defendants. The case will involve statutory analysis and consideration of the evidence in the context of the various causes of action to determine liability and remedies. The Plaintiffs contend that the remedies sought are to recoup the monetary losses suffered by members of the Proposed Class; assure accountability; and encourage the Defendants to observe both statutory mandates and strictures in the future.

A. Do the Pleadings Disclose a Cause of Action?

[339] The Plaintiffs plead seven causes of action: (i) breach of fiduciary duty; (ii) breach of duty of care; (iii) breach of contract; (iv) unjust enrichment with the remedy of restitution; (v) *ultra vires* action; (vi) *ultra vires* tax; and (vii) s. 15(1) of the *Charter*.

[340] Pursuant to s. 5(1)(a) of the *CPA*, the Plaintiffs' pleadings must disclose at least one cause of action in order to satisfy the class proceedings certification test.

[341] While it is not a requirement that all class members be able to advance all causes of action pled, it is a requirement that all class members be able to advance at least one cause of action: ***Cuff LTCFCanadian National Railway Company***, 2007 ABQB 761 at para. 38, 51 C.P.C. (6th) 383.

[342] In his text, *Class Actions in Canada*, looseleaf (Vancouver: Western Legal Publications, 1996) at 4-1 to 4-8, W.K. Branch states the following in terms of the certification requirement that the pleadings must disclose a cause of action:

> 4.40 The certification test first seeks to weed out those actions which are clearly frivolous or manifestly unfounded.
>
> 4.50 The Acts in the common law provinces and in Federal Court require that the pleadings disclose a cause of action.
>
> 4.60 The wording of this requirement is very similar to those provisions in the rules of court in Ontario and B.C. permitting the dismissal of a proceeding that does not disclose a cause of action. A similar test is applied.
>
> 4.70 The court will presume the facts alleged in the pleadings are true, and will determine whether it is plain and obvious that no claim exists. This is not a preliminary merits test. As Mr. Justice Winkler stated in ***Edwards v. Law Society of Upper Canada*.**
>
> > There is a very low threshold to prove the existence of a cause of action ... the court should err on the side of protecting people who have a right of access to the courts.
>
> 4.80 Courts in B.C. have also adopted a low threshold for this requirement. The Statement of Claim is read as generously as possible, and as it might reasonably be amended, to accommodate inadequacies due solely to drafting deficiencies. Similarly, in ***Bellows v. Quick Cash Ltd.***, Goulding J. of the Newfoundland Supreme Court – Trial Division articulated a liberal standard for proof of a cause of action: "... the test to be applied is whether there is any chance, even the slightest or faintest chance, that the plaintiff could succeed against the individual defendants on the facts pleaded."

[343] Unlike the other certification criteria under s.5(1), which require some basis in fact, evidence is not required to determine whether the pleadings disclose a cause of action as this requirement is governed by the "plain and obvious" test similar to a Rule 129(1)(a) application: ***Windsor***, 2006 ABQB 348 at para. 54; see also ***Hollick*** at para. 25. The Alberta Court of Appeal in ***Windsor***, 2007 ABCA 417 at para. 35 stated that:

> The [*CPA*] specifically states in s. 6(2) that certification is not a determination on the merits, and only requires that the pleadings disclose a cause of action, which is a very low standard. It does not require a *prima facie* case or anything else. Nevertheless, the courts have required some threshold level of evidence [as to the other certification requirements] before certification will be granted. There are some actions that are purely speculative, have no air of reality, or are doomed to fail, and they will not be certified even if the pleadings disclose a cause of action. On the other hand, if the plaintiff can show an arguable case, then there is sufficient merit for certification.

[344] The test for striking pleadings under Rule 129(1)(a) is stringent. The flaw must be obvious and must be beyond doubt. The claim must be hopeless and the court should be extremely cautious in striking the pleadings on this basis. If a claim is novel, or dubious, it cannot be struck out and where the pleadings concern different interpretations of the statute, if there is any doubt, striking out is not appropriate: ***Rewega v. Rewega***, 2005 ABCA 365 at para. 9, 380 A.R. 224.

[345] In order for s. 5(1)(a) of the *CPA* not to be satisfied in this case, the Court must find that it is "plain and obvious" that the pleadings do not disclose a cause of action with any hope of success. The flaw must be obvious and beyond doubt.

1. Breach of Fiduciary Duty

[346] The Plaintiffs state in their Amended Amended Fresh Statement of Claim that on or about June 17, 2003, agents or employees of the Government, acting within the scope of their employment, sent letters and documents (Letters) to the RHAs and operators of LTCFs directing the operators to charge residents of LTCFs the maximum Accommodation Charge.

[347] They claim that the RHAs are responsible for monitoring the delivery of health care services and accommodation and meals at LTCFs.

[348] They plead that members of the Proposed Class are frail, have chronic disabilities, are incapable of living on their own, are vulnerable and are at the Defendants' mercy with regard to the determination and administration of the Accommodation Charge to be paid by them for accommodation and meals.

[349] The Plaintiffs plead that the Defendants are in a position to unilaterally exercise their power or discretion so as to affect the practical interests of the members of the Proposed Class as well as their legal right and entitlement to publically funded health care services and benefits.

[350] They claim that each member of the Proposed Class stands in a relationship of trust and confidence with the Defendants and had a reasonable expectation that the Defendants would act in their best interests. They plead that the Defendants owed a fiduciary duty to members of the Proposed Class, including a duty of loyalty and good faith, a duty to avoid conflicts of interest and a duty to act in their best interests. They say that the Government and RHAs owed a fiduciary duty to ensure that the Accommodation Charge was fair, reasonable and justifiable and to ensure that it reflected the cost of accommodation and meals.

[351] The Plaintiffs allege that the Government’s discretion in setting the Accommodation Charge was constrained by and subject to its fiduciary duty to members of the Proposed Class. They contend that the Government breached its fiduciary duty by setting an Accommodation Charge that was not justified and which did not reflect the cost of accommodation and meals. They allege that the Government was in a position of conflict of interest as it controlled the Accommodation Charge and the level of health care funding paid by it or by the RHAs as its agents. They plead that the Government acted in bad faith when it instructed operators of LTCFs to charge the maximum Accommodation Charge no matter what the actual cost of

accommodation and meals might be and that it improperly directed RHAs to use the Accommodation Charge monies received from members of the Proposed Class to pay for health care services. Further, they allege that the Government improperly advised the RHAs on August 1, 2003 that the Minister of Seniors and Community Supports was vested with responsibility for setting the Accommodation Charge when that responsibility was not transferred to the Minister until April 1, 2005.

[352] The Plaintiffs plead that the RHAs breached their fiduciary duty and acted recklessly and in bad faith by failing to conduct any analysis to determine the true cost of accommodation and meals in their regions and by levying the maximum Accommodation Charge.

[353] The Plaintiffs also allege that the Defendants owed members of the Proposed Class a fiduciary duty to exercise reasonable care, skill and diligence in auditing, supervising, monitoring and administering the health care benefits paid by the Government to the RHAs, the health care benefits provided by the RHAs to LTCFs and the money paid by the members of the Proposed Class in respect of the Accommodation Charge to ensure the cost of health care services were paid by the Defendants, and the Accommodation Charge monies paid by members of the Proposed Class would be used for accommodation and meals only. The Plaintiffs plead that the Defendants breached their fiduciary duty in that regard.

[354] The Plaintiffs' claim for breach of fiduciary duty is based on their interpretation of the legislative regime and is in part dependant on whether any of the monies paid for the Accommodation Charge in fact were used by the Defendants to underwrite services for which they, and not the members of the Proposed Class, were responsible.

[355] While the Plaintiffs acknowledge that the Government generally is not viewed as a fiduciary towards its subjects, they argue that it may have fiduciary obligations to particular persons or groups of persons for whom it has assumed a caretaker role, which the Plaintiffs allege is the case here.

[356] The Plaintiffs submit that the three general characteristics for identifying fiduciary relationships and imposing fiduciary obligations set out in ***Frame v. Smith***, [1987] 2 S.C.R. 99 at paras. 56-76 are met in this case: first, the fiduciary has scope for the exercise of some discretion or power; second, the fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests; and third, the beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretionary power.

[357] In the alternative, the Plaintiffs contend that fact-based fiduciary obligations on the Defendants'part arose in the circumstances with regard to the determination and administration of the Accommodation Charge.

[358] The Defendants rely on the fundamental principle that the Crown generally is not viewed as being a fiduciary in the exercise of its legislative function: ***Guerin v. Canada***, [1984] 2 S.C.R. 335. They argue that this is not a situation where the Government pledged to act only in the best interests of the Proposed Class, as contemplated in ***Norberg v. Wynrib***, [1992] 2 S.C.R. 226 at

para. 65, or where the facts bring the case outside the established categories because there is evidence that one party has relinquished its own self-interest and agreed to act solely on behalf of the other party, as contemplated in ***Hodgkinson v. Simms***, [1994] 3 S.C.R. 377 at para. 33. They claim that the legislation does not place any duty on the Government to act solely in the best interests of long-term care residents. Rather, the Government must balance the competing interests of the residents, the operators, and the taxpayers. When the Government does so, no one person or group of people has a vested right to the law as it stood in the past: ***Ontario Black Bear/Ontario Sportsmen and Resource Users Association v. Ontario*** (2000), 19 Admin. L.R. (3d) 29 at paras. 77- 78 (Ont. S.C.J.).

[359] The Defendants further argue that the Plaintiffs' allegation that the Government breached its fiduciary duty by putting itself in a position where its financial interests conflicted with those of members of the Proposed Class tells against there being such a fiduciary duty. In ***Laroza Estate v. Ontario*** (2005), 257 D.L.R. (4th) 761 at para. 178 (Ont. S.C.J.), the court commented that: "... [a] fiduciary relationship is unlikely to exist where that would place the Crown in conflict between its responsibility to act in the public interest and the fiduciary's duty of loyalty to its beneficiary."

[360] The Defendants, relying on ***Hislop v. Canada (Attorney General)***, [2002] O.T.C. 506 at paras. 12-13 (S.C.J.), maintain that the claim for breach of fiduciary duty is hopeless as the Government had to take into account the interests of others besides the members of the Proposed Class when legislating the maximum Accommodation Charge.

[361] The Defendants also cite ***Perron v. Canada*** (2003), 32 C.P.C. (5th) 165 at paras. 57-73 (Ont. S.C.J.), which highlights the distinction between the exercise of statutory discretion by the Crown and enactment of legislation, which is a role given to Parliament and the provincial legislatures. The Defendants contend that the exercise of discretion is an essential ingredient to a claim that a fiduciary duty exists.

[362] The Defendants argue that no claim for breach of fiduciary duty can arise with respect to application of statutory provisions enacted by the legislature. They contend that the claimed duty is not analogous to duties found in recognized fiduciary relationships such as that of the Crown and First Nations people, the Crown and pension beneficiaries, and the parent-child relationship.

[363] In order to disclose a cause of action for breach of fiduciary duty, the Plaintiffs' pleadings must address (1) the existence of a fiduciary relationship arising out of the general type of relationship or specific circumstances of the particular relationship involved; (2) a fiduciary duty owed by the Defendants to the Plaintiffs; and (3) a breach of the fiduciary duty by the Defendants.

[364] According to Michael Ng in *Fiduciary Duties: Obligations of Loyalty and Faithfulness* looseleaf (Aurora, Ont.: Canada Law Book, 2003) at 5-21, para. 2:20.10), fiduciary liability historically was assessed by determining whether one person occupied a fiduciary role with respect to another, which turned on the type of relationship in which the two parties were engaged, "... for example, trustee-beneficiary, director-company, agent-principal, solicitor-client,

or parent-child, ... predominantly or essentially a relationship of trust whereby one party could be reasonably expected to act in the interest of the other." Fiduciary duties arose only in relationships clearly and predominantly fiduciary in nature.

[365] In the 1994 decision of ***Hodgkinson*** at paras. 29-32, LaForest J., for the majority of the court, summarized the development of the law relating to fiduciary obligations to that point:

> ... over the past ten years or so this Court has had occasion to consider and enforce fiduciary obligations in a wide variety of contexts, and this has led to the development of a "fiduciary principle" which can be defined and applied with some measure of precision. One may begin with the following words of Dickson J. (as he then was) in ***Guerin v. The Queen***, [1984] 2 S.C.R. 335, at p. 384:
>
> > ... where by statute, agreement, or perhaps by unilateral undertaking, one party has an obligation to act for the benefit of another, and that obligation carries with it a discretionary power, the party thus empowered becomes a fiduciary...
> >
> > It is sometimes said that the nature of fiduciary relationships is both established and exhausted by the standard categories of agent, trustee, partner, director and the like. I do not agree. It is the nature of the relationship, not the specific category of actor involved that gives rise to the fiduciary duty. The categories of fiduciary, like those of negligence, should not be considered closed.
>
> This conceptual approach to fiduciary duties was given analytical structure in the dissenting reasons of Wilson J. in ***Frame v. Smith***, [1987] 2 S.C.R. 99, at p. 136, who there proposed a three-step analysis to guide the courts in identifying new fiduciary relationships. She stated that relationships in which a fiduciary obligation has been imposed are marked by the following three characteristics: (1) scope for the exercise of some discretion or power; (2) that power or discretion can be exercised unilaterally so as to effect the beneficiary's legal or practical interests; and, (3) a peculiar vulnerability to the exercise of that discretion or power. Although the majority held on the facts that there was no fiduciary obligation, Wilson J.'s mode of analysis has been followed as a "rough and ready guide" in identifying new categories of fiduciary relationships; see ***Lac Minerals***, *supra*, per Sopinka J., at p. 599, and per La Forest J., at p. 646; ***Canson***, *supra*, at p. 543; and ***M. (K.) v. M. (H.)***, *supra*, at pp. 63-64. Wilson J.'s guidelines constitute *indicia* that help recognize a fiduciary relationship rather than ingredients that define it.
>
> In ***Lac Minerals*** I elaborated further on the approach proposed by Wilson J. in ***Frame v. Smith***. I there identified three uses of the term fiduciary, only two of which I thought were truly fiduciary. The first is in describing certain relationships that have as their essence discretion, influence over interests, and an inherent vulnerability. In these types of relationships, there is a rebuttable presumption,

> arising out of the inherent purpose of the relationship, that one party has a duty to act in the best interests of the other party. Two obvious examples of this type of fiduciary relationship are trustee-beneficiary and agent-principal. In seeking to determine whether new classes of relationships are *per se* fiduciary, Wilson J.'s three-step analysis is a useful guide.
>
> As I noted in ***Lac Minerals***, however, the three-step analysis proposed by Wilson J. encounters difficulties in identifying relationships described by a slightly different use of the term "fiduciary", viz., situations in which fiduciary obligations, though not innate to a given relationship, arise as a matter of fact out of the specific circumstances of that particular relationship; see at p. 648. In these cases, the question to ask is whether, given all the surrounding circumstances, one party could reasonably have expected that the other party would act in the former's best interests with respect to the subject matter at issue. Discretion, influence, vulnerability and trust were mentioned as non-exhaustive examples of evidential factors to be considered in making this determination. [Emphasis added.]

[366] La Forest J. went on to note at para. 34 that relationships characterized by a unilateral discretion, such as the relationship of trustee-beneficiary, "... are properly understood as simply a species of a broader family of relationships that may be termed ‘power-dependancy' relationships." He indicated that the concept describes any situation where one party, by statute, agreement, a particular course of conduct, or by unilateral undertaking, gains a position of overriding power or influence over another party. He indicated at para. 35 that, “[t]he existence of a fiduciary duty in a given case will depend upon the reasonable expectations of the parties, and these in turn depend on factors such as trust, confidence, complexity of subject matter, and community or industry standards . . .”

[367] Exercise of the Crown’s discretionary power can give rise to a fiduciary relationship, such that the Crown will be viewed as a fiduciary in relation to its citizens or to particular groups of citizens based on the factual context in a particular case.

[368] In ***Guerin*** at p. 385, Dickson J., writing for the majority, clarified that fiduciary obligations generally arise only in relation to the Crown’s exercise of discretionary power in the context of its private law duties:

> Public law duties, the performance of which requires the exercise of discretion, do not typically give rise to a fiduciary relationship. As the "political trust" cases indicate, the Crown is not normally viewed as a fiduciary in the exercise of its legislative or administrative function.

[369] Dickson J. concluded in ***Guerin*** that the Crown had become a fiduciary of the appellant members of an Indian band with respect to lands which had been surrendered by the band. The Indians’ interest in land was an independent legal interest rather than a creation of either the legislative or executive branches of government. Accordingly, the Crown's obligation to the Indians in terms of that interest was not a public law duty. Of note is that the *Indian Act* dictated

that reserves were to be held by the Crown for the use and benefit of the respective bands for which they had been set apart. In addition, the document by which the band surrendered the land in question provided that it was surrendered "TO HAVE AND TO HOLD the same unto Her said Majesty the Queen, her Heirs and Successors forever in trust to lease the same to such person or persons, and upon such terms as the Government of Canada may deem most conducive to our Welfare and that of our people."

[370] In ***Authorson (Litigation guardian of) v. Canada (Attorney General)*** (2001), 53 O.R. (3d) 221 (S.C.J.), Brockenshire J. decided opposing summary judgment applications concerning the Crown's liability to veterans whose pensions it administered as they were unable to do so. He held that the veteran class members had a property interest in their pensions, the Crown was a fiduciary to them while their funds were being administered by the Department of Veterans Affairs and the Crown had breached its fiduciary duty by failing to invest or pay interest on those funds. On appeal ((2002), 58 O.R. (3d) 417), the Court of Appeal agreed with this finding. It concluded that the veterans had a property interest in the funds being administered and, accordingly, this was not a "political trust" case which involves public funds or property held by the Crown. It also noted that the legislation in issue made no distinction between the Crown as administrator and a private citizen as administrator. Both were required to administer the veteran's pension for his benefit. The Crown was successful in its appeal to the Supreme Court of Canada on a different issue (2003 SCC 39, [2003] 2 S.C.R. 40). By then, it was no longer denying that it had a fiduciary duty to the veterans.

[371] In ***Wewaykum Indian Band v. Canada***, 2002 SCC 79, [2002] 4 S.C.R. 245, two First Nation bands claimed each other's reserve land, each arguing that it would possess both reserves if it was not for a breach of fiduciary duty by the Crown. Binnie J., who delivered the decision of the court, referred to ***Guerin*** and commented at para. 74 that:

> The enduring contribution of ***Guerin*** was to recognize that the concept of political trust did not exhaust the potential legal character of the multitude of relationships between the Crown and aboriginal people. A quasi-proprietary interest (e.g., reserve land) could not be put on the same footing as a government benefits program. The latter will generally give rise to public law remedies only.

[372] Binnie J. also cited ***R. v. Sparrow***, [1990] 1 S.C.R. 1075 at 1108, in which the Supreme Court of Canada recognized a broader fiduciary relationship on the part of the Crown to aboriginal peoples based on "[t]he *sui generis* nature of Indian title, and the historic powers and responsibility assumed by the Crown." Mr. Justice Binnie commented at para. 81 and 85 that "the fiduciary duty imposed on the Crown does not exist at large but in relation to specific Indian interests" and depends on "the Crown's undertaking of discretionary control in relation thereto in a way that invokes responsibility 'in the nature of a private law duty.'"

[373] In ***Harris v. Canada***, 2001 FCT 1408 at para. 178, 214 F.T.R. 1, Dawson J. of the Federal Court Trail Division summarized the emerging principles that must be considered in determining whether the Crown is a fiduciary in relation to its citizens or groups of citizens:

1. The Crown may in some circumstances owe a fiduciary duty, or a duty akin to a fiduciary duty.

2. In any particular case, the surrounding circumstances must be closely examined in order to determine whether the duty imposed on, or undertaken by, the Crown is in the nature of a private law duty...

3. Where the Crown owes duties to a number of interests it is more likely that the Crown is not in a fiduciary relationship, but rather is exercising a public authority governed by the proper construction of the relevant statute.

4. A fiduciary relationship is unlikely to exist where that would place the Crown in a conflict between its responsibility to act in the public interest and the fiduciary's duty of loyalty to its beneficiary.

[374] Dawson J. in ***Harris*** at para. 171 referred to the following passage from ***Swain v. Law Society***, [1982] 2 All E.R. 827 at 837 and 838, in which the House of Lords held that the Law Society was not a fiduciary to its members in terms of the commission earned in performance of its statutory authority as it was performing a public duty designed to benefit not only its members but also their clients.

> So, as I have said, in exercising the power conferred on it, the Law Society was performing a public duty, and not a private duty to premium-paying solicitors. This approach, which in my opinion is fundamental, has important consequences, because the nature of a public duty and the remedies of those who seek to challenge the manner in which it is performed differ markedly from the nature of a private duty and the remedies of those who say that the private duty has been breached. If a public duty is breached, there are the remedies of judicial review, declaration, injunction and recovery of money if wrongly demanded and paid. There is no remedy in breach of trust or equitable account. The latter remedies are available, and available only, where a private trust has been created: see the decision of your Lordships' House in ***Skinners' Co v Irish Society*** (1845) 12 Cl & Fin 425, 8 ER 1474. The duty imposed on the possessor of a statutory power for public purposes is not accurately described as fiduciary because there is no beneficiary in the equitable sense.

[375] Section 24(g) of the *Nursing Homes Act* provides that the Minister may make regulations "respecting the determination of accommodation charges." Clearly, the Government has some discretion in this regard and certainly it is arguable that members of the Proposed Class are in a vulnerable position. However, as stated by Simpson J. in ***Squamish Indian Band v. Canada*** (2001), 207 F.T.R. 1 at para. 521 (T.D.): "... in matters of public law, discretion and vulnerability can exist without triggering a fiduciary standard. There would have to be special circumstances, other than those created by the legislation, to justify the imposition of a fiduciary duty on the Crown."

[376] To the extent that there is any duty involved here, it is a public law duty as the Minister must consider the interests of LTCF operators, residents of LTCFs and the public at large in making any such regulation. The only regulation made by the Minister in relation to the Accommodation Charge was the *Nursing Homes Operation Regulation*, which specifies in s. 3(1) that an operator may charge an accommodation charge, which is not to exceed a certain maximum amount. In setting the maximum Accommodation Charge and instructing RHAs and operators that the maximum amount was to be charged (assuming for the purposes of this application the facts as pled by the Plaintiffs), the Government was exercising a public authority governed by the proper construction of the relevant statutes.

[377] In the present case, there are no facts pled by the Plaintiffs which would give rise to a private law duty on the part of the Government to members of the Proposed Class. Similarly, no facts are pled in relation to the RHAs which would give rise to a private law fiduciary duty on their part. This is not a situation as in ***Guerin*** or ***Authorson*** where the fiduciary has assumed control over an independent legal interest of the beneficiary. The members of the Proposed Class do not retain an interest in the Accommodation Charge once paid. Accordingly, I am of the view that this cause of action is bound to fail.

2. Breach of Duty of Care

[378] The Plaintiffs claim that the Government had a duty of care to ensure that the Accommodation Charge was fair, reasonable and justifiable and to ensure that it reflected the cost of accommodation and meals. They claim that in breach of that duty of care, the Accommodation Charge increase was implemented by the Government without any basis for determining what accommodation costs should consist of or how the Accommodation Charge should be calculated, without a basis for raising the Accommodation Charge and without a basis for separating health care costs and the Accommodation Charge. They claim that the Government breached its duty of care by intending, expecting and instructing LTCF operators to charge the maximum Accommodation Charge and by directing the RHAs and their agents to use money received from the Accommodation Charge to pay for health care services which were the Government's responsibility.

[379] The Plaintiffs claim that the RHAs owed the members of the Proposed Class a duty of care to exercise reasonable care, skill and diligence to ensure the Accommodation Charge was fair, just, reasonable and reflective of the cost of accommodation and meals. They contend that in breach of their duty of care, the RHAs failed to conduct any analysis to determine the cost of accommodation and meals in their regions but nevertheless levied, either directly or through their agents, the maximum Accommodation Charge throughout the province in circumstances where they were of the view that there was substantial regional disparity with respect to those costs.

[380] The Plaintiffs further claim that the Defendants owed the members of the Proposed Class a duty of care in auditing, supervising, monitoring and administering the health care benefits paid by the Government to the RHAs, the health care benefits paid by the RHAs to LTCFs and the money paid for the Accommodation Charge to ensure the cost of health care services would be paid by the Defendants and not members of the Proposed Class, money paid for the

Accommodation Charge would be used solely for accommodation and meals and the right of members of the Proposed Class to publicly funded health care services was protected. They claim that the Defendants breached their duty of care in this regard.

[381] Negligence is proved where it is established that: (a) the defendant owed a duty of care to the plaintiff; (b) that duty of care was breached; and (c) the plaintiff suffered loss or injury as a result.

[382] Whether a duty of care will be found to exist depends on whether: (1) the circumstances disclose reasonably foreseeable harm and proximity sufficient to establish a *prima facie* duty of care; and (2) there are no residual policy considerations which justify denying liability: ***Anns v. Merton London Borough Council***, [1978] A.C. 728 (H.L.), as revisited in ***Cooper v. Hobart***, 2001 SCC 79, [2001] 3 S.C.R. 537; ***Edwards v. Law Society of Upper Canada***, 2001 SCC 80, [2001] 3 S.C.R. 562.

[383] Where a duty of care previously has been found to exist in terms of the same category of relationship, the complete ***Anns*** analysis need not be undertaken as a *prima facie* duty of care will be found to arise. If the situation involves a new category of claim, it is necessary to consider whether proximity has been established: ***Childs v. Desormeaux***, 2006 SCC 18 at para. 15, [2006] 1 S.C.R. 643.

[384] A special feature of the proximity analysis in a regulatory setting is the strong emphasis that has been placed by the courts on the statutory scheme that governs the regulatory activities and the alleged duty of care. In particular, the Supreme Court of Canada has indicated that the court must examine the relevant legislation for provisions that reveal or imply a special private law duty to the injured party. Where a public authority exercises statutory powers and negligence is alleged, duties and proximity must be grounded in the relevant statutes: ***Cooper*** at para. 43.

[385] According to the court in ***Cooper*** at para. 30, policy considerations are a part of both the first and second steps in the analysis:

> At the first stage of the ***Anns*** test, two questions arise: (1) was the harm that occurred the reasonably foreseeable consequence of the defendant's act? and (2) are there reasons, notwithstanding the proximity between the parties established in the first part of this test, that tort liability should not be recognized here? The proximity analysis involved at the first stage of the ***Anns*** test focuses on factors arising from the relationship between the plaintiff and the defendant. These factors include questions of policy, in the broad sense of that word. If foreseeability and proximity are established at the first stage, a *prima facie* duty of care arises. At the second stage of the ***Anns*** test, the question still remains whether there are residual policy considerations outside the relationship of the parties that may negative the imposition of a duty of care. It may be, as the Privy Council suggests in ***Yuen Kun Yeu***, that such considerations will not often prevail. However, we think it useful expressly to ask, before imposing a new duty of care, whether despite

foreseeability and proximity of relationship, there are other policy reasons why the duty should not be imposed.

[386] A diverse and non-exhaustive range of factors has been identified as relevant to the first stage policy consideration:

(a) Expectation or reliance: generally, where a fair expectation or reliance exists, or representations of such have been made, proximity is favoured: ***Cooper*** at para. 34; ***Hill v. Hamilton-Wentworth Regional Police Services Board***, 2007 SCC 41 at para. 24, [2007] 3 S.C.R. 129.

(b) Economic loss as opposed to personal or property damage: prevention of economic loss does not lead to a strong presumption of proximity, while the opposite is true for injury to persons or damage to property: ***Cooper*** at para. 34; ***Hill*** at para. 34.

(c) Specific persons or known individuals: where legislation discloses a purpose to protect specific persons, or where the alleged duty-holder is aware of individual and particular persons who may be vulnerable and affected, proximity is more probable: ***Hill*** at para. 33. Correspondingly, where a duty is to the public as a whole, a finding of proximity and duty of care to a private person is likely negated: ***Cooper*** at paras. 44-50; ***Edwards*** at para. 6; ***Hill*** at paras. 144-145.

(d) Control over the risk: the proximity of the alleged duty-holder is proportional to the degree to which that duty-holder may influence and control the risk or threat: ***Just v. British Columbia***, [1989] 2 S.C.R. 1228. Similarly, where injury may not be a direct consequence of the actions of an alleged duty-holder but instead some other agent, proximity is proportional to the degree of control exerted by the alleged duty-holder over those agents: ***Odhavji Estate v. Woodhouse***, 2003 SCC 69, [2003] 3 S.C.R. 263.

(e) Public interest: proximity is favoured where the operation of the duty to a specific person is in the public's interest: ***Hill*** at para. 36.

(f) *Charter of Rights and Freedoms*: where an alleged duty is consistent with the values and spirit underlying the *Charter*, proximity is favoured: ***Hill*** at para. 38.

[387] Certain considerations which apply to the second stage of the ***Anns*** analysis also have been identified by the courts and include:

(a) the prospect of unlimited liability to an unlimited class: ***Hercules Managements Ltd. v. Ernst & Young***, [1997] 2 S.C.R. 165, 146 D.L.R.

(4th) 577; ***Martel Building Ltd. v. Canada***, 2000 SCC 60, [2000] 2 S.C.R. 860;

(b) judicial deference to the policy as opposed to the operational functions of non-judicial branches of government: ***Just***;

(c) immunity for legislative and quasi-judicial decisions: ***Welbridge Holdings v. Greater Winnipeg***, [1971] S.C.R. 957, 22 D.L.R. (3d) 470; ***Cooper***; ***Edwards***;

(d) the existence of an effective alternative remedy, other than a civil action for damages: ***A.L. v. Ontario (Minister of Community and Social Services)*** (2006), 83 O.R. (3d) 512, 274 D.L.R. (4th) 431 (C.A.), leave to appeal to S.C.C. ref'd [2007] S.C.C.A. No. 36; ***Comeau's Sea Foods Ltd. v. Canada (M.F.O.)***, [1997] 1 S.C.R. 12; and

(s) the existence of statutory provisions immunizing the good faith actions of public officials: ***Just***.

[388] The evidentiary burden of showing countervailing policy considerations falls on the defendant at this stage (***Childs*** at para. 130).

[389] The first question in the analysis for present purposes is whether it is plain and obvious that the circumstances do not disclose reasonably foreseeable harm and proximity sufficient to establish a *prima facie* duty of care.

[390] The Plaintiffs suggest that there is an analogy here to cases where a public authority exercises administrative or ministerial business powers and owes a duty of care in ascertaining the scope of their discretionary authority, and must base their decisions on relevant considerations, avoid arbitrariness, and act in good faith: ***Welbridge Holdings Ltd.*** They concede, however, that civil liability will only follow where that power is exercised in bad faith, whether recklessly, arbitrarily, or irrationally: ***Comeau's Sea Foods Ltd.*** at paras. 36, 53-54; ***Enterprises Sibeca Inc. v. Frelighsburg (Municipality of)***, 2004 SCC 61 at paras. 21-26, [2004] 3 S.C.R. 304.

[391] The Plaintiffs also submit that this situation is analogous to the proximate relationships found in ***Authorson*** and ***Wewaykum Indian Band***.

[392] The Plaintiffs argue that, alternatively, this is a case where a new duty of care should be recognized. They say the relationship is sufficiently close and direct that it is just and fair to impose a *prima facie* duty of care on the Defendants, after examining the proximity factors set out in ***Cooper*** at paras. 31-35. They contend that it was reasonably foreseeable by the Defendants that by arbitrarily increasing the Accommodation Charge and charging members of the Proposed Class the maximum amount without having first established the true cost of accommodation and meals and by failing to properly administer the moneys paid by members of the Proposed Class,

members of the Proposed Class might end up paying for health care services, products and programs for which they were not legally obliged to pay.

[393] They submit that this case is unlike ***Cooper***; ***Holtslag v. Alberta***, 2006 ABCA 51, 380 A.R. 133; and ***Edwards***, where no duty of care was found because the duties arising from the legislation were owed to the public as a whole rather than to the plaintiff class.

[394] The Plaintiffs acknowledge that the Court must consider whether the alleged harm is the result of government policy that should not be second guessed or the consequence of government policy implementation: ***Cooper*** at para. 38.

[395] They agree that determination of the maximum Accommodation Charges was a Ministerial decision made pursuant to regulation. However, they submit that the Government indicated in the *Backgrounder* that the RHAs were to charge the maximum amount and that this decision affected the private interests of the members of the Proposed Class. They maintain that the directive to pay the maximum amount was an administrative decision as were the Defendants' decisions not to monitor the relationship between the Accommodation Charge and the accommodation and meals provided to residents.

[396] They note that "... once a decision to act has been made, the government may be liable in negligence for the manner in which it implements that decision:" ***Holland v. Saskatchewan (Minister of Agriculture, Food and Rural Revitalization)***, 2008 SCC 42 at para. 14.

[397] The Plaintiffs here point to other class actions where the breach of a duty of care by a public authority was considered a cause of action with sufficient merit to proceed to trial: ***Cooper v. Hobart*** (1999), 68 B.C.L.R. (3d) 274 (S.C.); ***Edwards***; ***Holtslag v. Alberta***, 2000 ABQB 351, 263 A.R. 394; ***Renova Holdings Ltd. v. Canada***, 2005 FC 386, 270 F.T.R. 300; and ***Williams v. Canada (A.G.)*** (2005), 76 O.R. (3d) 763 at paras. 84-97 (S.C.J.).

[398] The Defendants respond by saying that the Plaintiffs' claim is based on a complaint about the Accommodation Charge established under the *Nursing Homes Operations Regulation*. They rely on ***Welbridge Holdings Ltd.*** for the principle that the Government cannot be sued for the consequences of invalid legislation. The basis for that immunity is that the risk of loss from the exercise of legislative authority is a general public risk, and not one for which compensation can be supported on the basis of a private law duty of care. The government will not be held liable in negligence because legislation is invalid due to a procedural defect or because it is *ultra vires*: ***Guimond v. Quebec (Attorney General)***, [1996] 3 S.C.R. 347, citing Dussault, René, and Louis Borgeat, *Administrative Law: A Treatise*, vol. 5, 2nd ed. (Toronto: Carswell, 1990); ***Wells v. Newfoundland***, [1999] 3 S.C.R. 199.

[399] The Defendants cite ***Ontario Black Bear/Ontario Sportsman and Resource Users Association***, in which the court refused to certify a class action because the pleadings disclosed no cause of action, stating that the law was clear that no one has a vested right in the continuance of a law or a cause of action against the government based on the passage of a valid statute or regulation which deprives the plaintiff of a benefit he or she once had.

[400] The Defendants rely in part on the following *obiter dicta* from ***A.O. Farms Inc. v. Canada*** (2000), 28 Admin. L.R. (3d) 315 at para. 12 (F.C.T.D.):

> A public authority must be free to make its choices with an eye only to their political consequences, not to the possibility of being sued for damages. That is the primary policy consideration underlying the ***Welbridge*** and ***Guimond*** decisions with which I started these Reasons and they are equally applicable here. Government, when it legislates, even wrongly, incompetently, stupidly, or misguidedly is not liable in damages. That, in essence, is what the plaintiff has alleged and it discloses, in my view, no cause of action for trial.

[401] Further, they argue that decisions at the planning level that are made in breach of procedural requirements, in bad faith or for an improper purpose may be held invalid by a court, but it does not follow that damages should be available to a person injured by the decision, as that would involve the court in deciding what the correct decision should have been.

[402] The Defendants also refer to ***Momi v. Canada (Minister of Citizenship and Immigration)***, 2005 FC 1484, 283 F.T.R. 143, where the Minister of Citizenship and Immigration was successful in having the plaintiff's negligence claim for levying excessive immigration fees struck in a class action.

[403] The Plaintiffs contend that the Government had a duty of care to ensure that the Accommodation Charge was fair, reasonable and justifiable and to ensure that it reflected the cost of accommodation and meals. They complain that the Minister recklessly and in bad faith increased the Accommodation Charge without ensuring that there was a correlation between that increase and the actual cost of accommodation and meals. They claim that the Government acted in bad faith in directing operators of LTCFs to charge the maximum Accommodation Charge.

[404] Pursuant to s. 24(g) of the *Nursing Homes Act*, the Minister was authorized to make regulations respecting the determination of Accommodation Charges. The Minister set a maximum Accommodation Charge by regulation and, again by regulation, increased that charge.

[405] As noted by the Defendants, s. 22 of the *Nursing Homes Act* specifically provides that operators who violate s. 8(2) of the Act by charging in excess of the amount prescribed in the regulations for the Accommodation Charge are guilty of an offence and subject to prosecution. The same situation prevails under s. 46 of the *Hospitals Act* for contravention of the *Hospitalization Benefits Regulation*. In my view, it is plain and obvious that the legislative scheme does not support a private law duty of care on the part of the Minister in setting a maximum Accommodation Charge.

[406] As stated by Laskin J. in ***Welbridge*** at pp. 968-969:

> A municipality at what may be called the operating level is different in kind from the same municipality at the legislative or quasi-judicial level where it is

> exercising discretionary statutory authority. In exercising such authority, a municipality (no less than a provincial Legislature or the Parliament of Canada) may act beyond its powers in the ultimate view of a court, *albeit* it acted on the advice of counsel. It would be incredible to say in such circumstances that it owed a duty of care giving rise to liability in damages for its breach. "Invalidity is not the test of fault and it should not be the test of liability": see Davis, 3 *Administrative Law Treatise*, 1958, at p. 487.

[407] The Plaintiffs submit that the Minister directed that operators charge the maximum Accommodation Charge and that certain health care services be paid using the monies collected. They contend that this was an administrative decision for which tort liability may lie. In ***Just*** at para. 19, Cory J. for the majority cited the following passage from ***Sutherland Shire Council v. Heyman*** (1985), 60 A.L.R. 1 (H.C.) as setting out a helpful guideline for distinguishing between policy and operational decisions:

> The distinction between policy and operational factors is not easy to formulate, but the dividing line between them will be observed if we recognize that a public authority is under no duty of care in relation to decisions which involve or are dictated by financial, economic, social or political factors or constraints. Thus budgetary allocations and the constraints which they entail in terms of allocation of resources cannot be made the subject of a duty of care. But it may be otherwise when the courts are called upon to apply a standard of care to action or inaction that is merely the product of administrative direction, expert or professional opinion, technical standards or general standards of reasonableness.

[408] Even if the Plaintiff's interpretation of the Letters is found to be correct, the Minister's directive to operators involved financial or economic factors or constraints and therefore must be construed as policy rather than an operational decision. The only available ground of attack would be that it was an arbitrary exercise of discretion, one that was undertaken recklessly or in bad faith. This would not be the basis for a claim of damages but rather for an administrative law remedy.

[409] The Plaintiffs have pled that the Defendants owed the members of the Proposed Class a duty of care in auditing, supervising, monitoring and administering the health care benefits paid by the Government to the RHAs, the health care benefits paid by the RHAs to LTCFs and the money paid for the Accommodation Charge to ensure the cost of health care services would be paid by the Defendants and not members of the Proposed Class, money paid for the Accommodation Charge would be used solely for accommodation and meals and the right of members of the Proposed Class to publicly funded health care services was protected.

[410] In my view, it is not plain and obvious that such activities cannot be classified as operational. An analogy may well be drawn to the operational decisions which gave rise to liability in ***Kamloops (City of) v. Nielsen***, [1984] 2 S.C.R. 2, ***Anns*** and ***Just***. Accordingly, it is not plain and obvious that a *prima facie* duty of care could not be established in terms of operational decisions or actions by the Defendants. Certainly, it is arguable that it was foreseeable

on the part of the Defendants that negligence in carrying out their duties in regard to those activities might cause loss or damage to members of the Proposed Class. It is also arguable that the Defendants and members of the Plaintiff Class were in sufficient proximity such that a duty of care with respect to operational decisions or activities would arise, given the vulnerability of the members of the Proposed Class and their reliance on the Government and RHAs to ensure they were honouring not only their service but also their payment obligations.

[411] Even if the decisions relating to auditing, supervising, monitoring and administering the health care benefits are properly classified as policy decisions, the Plaintiffs could proceed with their claim that such decisions were undertaken in bad faith.

[412] The Defendants argue that the spectre arises of a multiplicity of law suits and an intolerable financial burden on the public purse if tort liability is imposed in the present circumstances.

[413] The Plaintiffs argue that imposition of a duty of care on the public Defendants in this case would not cause conflict with other interests, including an overarching duty to the public; would not create the spectre of indeterminate liability to an unlimited class; and would not make taxpayers insurers. Rather, they argue that the Proposed Class is a well defined group under a legislative scheme created and administered by the Defendants and the duty concerns the determination and administration of the Accommodation Charge the members of the Proposed Class are obliged to pay. The Plaintiffs suggest that there are no other remedies which the members of the Proposed Class may pursue for recovery of their loss (***Cooper*** at para. 37), other than the claim for breach of contract based on implied terms.

[414] In my view, the prospect of unlimited liability to an unlimited class does not arise in the circumstances of this case. A complete review of the second stage policy considerations is best left to trial.

[415] In summary, I conclude that it is not plain and obvious that the Defendants did not owe the members of the Proposed Class a duty of care in auditing, supervising, monitoring and administering the health care benefits. Even if such activities are not found to be operational, the Plaintiffs could proceed with their claim that such decisions related to such activities were undertaken in bad faith. However, the Minister's directive to the operators must be construed as policy rather than an operational decision, which does not give rise to a private law duty of care. Further, it is plain and obvious that the legislative scheme does not support a private law duty of care on the part of the Minister in setting a maximum Accommodation Charge. As such, while the pleadings do disclose a cause of action based on a breach of a duty of care, any such duty is restricted to the operational decisions relating to auditing, supervising, monitoring and administration of the health care benefits.

3. Breach of Contract

[416] The Plaintiffs have pled that each member of the Proposed Class entered into an agreement with a RHA or their agent with respect to the provision of accommodation and meals and that each

such agreement contained the express or implied term that money paid by a member of the Proposed Class in respect of the Accommodation Charge would be used for accommodation and meals only and not for health care services, in accordance with the legislative scheme.

[417] They allege that the RHAs breached their agreements with members of the Proposed Class by using or permitting the money paid by members of the Proposed Class for accommodation and meals to be used for health care costs and, as a result, members of the Proposed Class have suffered loss or damage.

[418] As noted by the Plaintiffs, s. 6(1) of the *Regional Health Authorities Act* provides that a RHA "has the rights, powers and privileges of a natural person." Accordingly, RHAs can enter into contracts.

[419] The RHAs acknowledge that residents entered into agreements with operators of LTCFs (including the RHAs) whereby they agreed to pay the Accommodation Charges.

[420] The RHAs argue that the Accommodation Charges are not defined in the agreements and the agreements do not contain any term that the Accommodation Charges will not be used to pay for anything other than accommodation and meals.

[421] As noted by the Plaintiffs, terms in a contract may be implied from the facts and legislative framework governing the relationship between the parties. In the present case, it is arguable that if the legislative scheme is such that LTCF operators may charge an Accommodation Charge for accommodation and meals only and not health care services, a term could be implied in the contracts to that effect.

[422] On an application for certification, the facts in the plaintiff's pleadings are presumed to be true. On that basis, the facts pled here in the Amended Amended Fresh Statement of Claim support a finding that the agreements between the RHAs and the members of the Proposed Class have been breached. In my view, it is not plain and obvious that the claim for breach of contract as against the RHAs cannot succeed.

4. Unjust Enrichment with Remedy of Restitution

[423] The Plaintiffs plead that payment of the Accommodation Charges resulted in the members of the Proposed Class experiencing a deprivation equal to the amounts of the charge and "constitutes a corresponding benefit to the Defendants in that the payments relieved the Defendants from inevitable expenses they were required to incur pursuant to the *Hospitals Act*, the *Nursing Homes Act*, and *Ministerial Directive D-317*."

[424] The Plaintiffs cite the tripartite test for unjust enrichment set out in ***Garland v. Consumers' Gas Co.***, 2004 SCC 25, [2004] 1 S.C.R. 6 at para. 30, and other authorities: that the claimant must show enrichment, a corresponding deprivation, and an absence of any juristic reason for the enrichment.

[425] The Plaintiffs argue that the effect of the legislation and regulations, together with *Ministerial Directive D-317*, is that the Defendants are not entitled to charge residents of LTCFs for health care services falling within the definition of "basic care" in s. 2 of the *Nursing Homes General Regulation*, except for accommodation and meals. Thus, the Defendants must provide and pay for facilities services, nursing services, personal services, therapeutic and special diets, drugs and medicine, dressings, and life enrichment services. The Plaintiffs say that, to the extent the members of the Proposed Class have conferred a benefit on the Defendants by having paid such costs, "[t]here exists no jurisdic reason for the Class members' deprivation and the Defendants' corresponding benefit."

[426] The Government, relying on ***Garland*** and Karen Horsman and J. Gareth Morley, *Government Liability: Law and Practice* (Aurora, Ont. : Canada Law Book, 2007) at 3 - 10, argues that if a plaintiff has suffered and a defendant has benefited because of a statute or regulation, there can be no possible claim for unjust enrichment.

[427] The Defendants submit that the "...word 'enrichment' connotes a tangible benefit. It follows that without a benefit which has 'enriched' the defendant and which can be restored to the donor in *specie* or by money, no recovery lies for unjust enrichment:" ***Peel (Regional Municipality) v. Canada***, [1992] 3 S.C.R. 762 at para. 45. They contend that the beneficiaries of any over-payment by the members of the Proposed Class are the populations who live within the health care regions and whose health care needs are serviced by the regions, including all members of the Proposed Class. They argue that such a generalized benefit does not fall within the law of unjust enrichment. They rely on the decision of McLachlin J. in ***Peel*** at para.62:

> The fact that the appellant's payments necessarily furthered the province's general interest in the welfare of its citizens or its more specific interest in the protection and supervision of children residing within its boundaries is, for the reasons already outlined, not a sufficient basis upon which to found recovery even if the Court were to apply the 'incontrovertible benefit' doctrine.

(a) The Enrichment of the Defendants

[428] The Court in ***Garland*** at paras. 31-37 discussed the proper approach to take to the question of enrichment. At issue in that case was the payment of money to the utilities company by late payers at an interest rate prohibited by criminal law. At para. 31, reference is made to ***Peel*** at p. 790, where McLachlin J. noted that the benefit can be a positive benefit, such as the payment of money, or a negative benefit, such as sparing the defendant money he or she would have otherwise incurred. Moral or policy considerations would not be considered under this element of the test. Rather, the Supreme Court of Canada has "...consistently taken a straightforward economic approach to the first two elements of the test for unjust enrichment." Other considerations belong under the third element.

[429] The trial judge in ***Garland*** (2000), 185 D.L.R. (4th) 536 (Ont. Ct. (Gen. Div.)) adopted that straightforward approach: "Simply stated," he wrote at para.95, "as a result of each LPP

received by Consumers' Gas, the company had more money than it had previously and accordingly is enriched."

[430] On appeal ((2001), 208 D.L.R. (4th) 494), McMurtry C.J.O., for the majority of the Ontario Court of Appeal, disagreed, instead accepting the contrary argument that because of the rate structure at Consumers', it had not actually been enriched since the LPPs were part of an overall scheme and any increase in LPPs was offset by a corresponding decrease in regular rates: the real beneficiaries were the customers. Borins J.A., in dissent, held that where there is payment of money, there is little controversy over whether or not a benefit was received and since a payment of money was received in this case, a benefit was conferred.

[431] The Supreme Court of Canada, on further appeal, agreed with the latter approach (at paras. 36-37):

> The law on this question is relatively clear. Where money is transferred from the plaintiff to the defendant, there is an enrichment. Transfer of money so clearly confers a benefit that it is the main example used in the case law and by commentators of a transaction that meets the threshold for a benefit ... . There is simply no doubt that Consumers' Gas received the monies represented by the LPPs and had that money available for use in the carrying on of its business. The availability of those funds constitutes a benefit to Consumer's Gas. We are not, at this stage, concerned with what happened to this benefit in the ongoing operation of the regulatory scheme.
>
> Whether recovery should be barred because the benefit was passed on to the respondent's other customers ought to be considered under the change of position defence.

[432] The RHAs position based on ***Peel*** initially was attractive, that any payment was not held by the Defendants, but rather applied to the general benefit of citizens of the region. However, ***Peel*** pre-dates ***Garland***.

[433] Using the straightforward economic analysis endorsed in ***Garland*** rather than the "received and retained" analysis, it is certainly arguable that the members of the Proposed Class have shown the element of enrichment by the payment of the Accommodation Charge for accommodation and meals.

[434] As the Plaintiffs acknowledge, the present case does not involve a direct payment by members of the Proposed Class to the Crown. Instead, the Accommodation Charge was paid to the operators or RHAs. However, in ***Carleton (County) v. Ottawa (City)***, [1965] S.C.R. 663, the Supreme Court of Canada found that the defendant municipality had benefited from a payment made by the plaintiff municipality to a third party which had discharged the defendant's obligations to the third party. In the present case, it is arguable that the Government has benefited in like fashion from payment of the whole or a portion of the Accommodation Charge by the members of the Proposed Class.

[435] Also, if the Plaintiffs are correct, the Crown directed that members of the Proposed Class pay the Accommodation Charge to the RHAs or the operators. In ***Pacific National Investments Ltd. v. Victoria (City)***, [2004] 3 S.C.R. 575 at para. 17, Binnie J. for a unanimous Supreme Court of Canada noted the useful comment made by the American Law Institute in its *Restatement of the Law of Restitution: Quasi Contracts and Constructive Trusts* (St. Paul: 1937) at p. 12 that: "[a] person confers a benefit upon another if he... performs services beneficial to or at the request of the other" (emphasis added by Binnie J.).

(b) Corresponding Deprivation of the Plaintiffs

[436] Certainly, it is arguable that the Plaintiffs were correspondingly deprived of the monies given in payment of the Accommodation Charge itself, if that charge is found to infringe s. 15 of the *Charter*, or at least by that portion of the Accommodation Charge which exceeds the actual costs of accommodation and meals for members of the Proposed Class. The debate centres on the purpose to which these monies were applied and whether or not they were applied in whole or in part to the legislatively authorized services.

(c) Absence of Juristic Reason for Enrichment

[437] In ***Garland*** at para. 39, the court affirmed the general principle articulated by McLachlin J. in ***Peter v. Beblow***, [1993] 1 S.C.R. 980 at 990 that it "... is at this stage that the court must consider whether the enrichment and detriment, morally neutral in themselves, are 'unjust.'" The court then contemplated the dilemma posed by the authorities and the academics: whether the 'absence of juristic reason' should be interpreted literally to require a plaintiff to show the absence of a reason for the defendant to keep the enrichment, the almost impossible task of proving a negative, or whether, as in the English model, the Plaintiff must show a reason for reversing the transfer of wealth.

[438] The court formulated a two-step approach (at paras. 44-46). First, the plaintiff must show that no juristic reason from an established category exists to deny recovery. The established categories include the disposition of law, a donative intent, and other valid common law, equitable or statutory obligations. If there is no juristic reason from an established category, the plaintiff has made out a *prima facie* case under the juristic reason element.

[439] In ***Garland***, the court commented that an unjust enrichment will not be established in any case where enrichment of the defendant at the plaintiff's expense is required by law. Valid legislation can provide a juristic reason which bars recovery in restitution. In ***Mack v. Canada (Attorney General)*** (2002), 60 O.R. (3rd) 737, the Ontario Court of Appeal held that the legislation that created the Chinese head tax provided a juristic reason which prevented the plaintiffs' recovery of the head tax in unjust enrichment.

[440] At the second step, the *prima facie* case is rebuttable where the defendant can show there is another reason to deny recovery. There is a *de facto* burden of proof on the defendant to show the reason why the enrichment should be retained. This is a defence in which the courts can look

to all of the circumstances of the transaction in order to determine whether there is another reason to deny recovery. In considering the defendant's attempt to rebut, the court should look at two factors: the reasonable expectations of the parties and public policy considerations. A new category of juristic reason may arise, or consideration of these factors may show that there is no juristic reason for the enrichment and recovery will be allowed. This is an evolving area.

[441] At the first step in this case, the members of the Proposed Class must show that there is no juristic reason from an established category to deny recovery. It is arguable that the legislative scheme in this case, properly interpreted, does not countenance use of the Accommodation Charge monies obtained from long-term care residents for any purpose other than for accommodation and meals. As I indicate below, it also is arguable that the impugned legislation is contrary to s. 15 of the *Charter* if it does allow for other uses of the Accommodation Charge monies. Whether such other uses can be proved is another matter. The contracts entered into between the Defendants and the Members of the Proposed Class are in furtherance of the legislative scheme and arguably must comport with its strictures. In my view, it is arguable that there is no juristic reason from an established category for the Defendants to retain whatever portion of the Accommodation Charge is not used for meals and accommodation and, therefore, arguable that the Plaintiffs will be able to show a *prima facie* case in terms of this cause of action.

[442] As noted, at the second step, the *prima facie* case is rebuttable where the defendant can show there is another reason to deny recovery. This is the *de facto* burden of proof on the defendant to show the reason why the enrichment should be retained. It is unnecessary to turn to the second step in this case given the low threshold for the members of the Proposed Class to meet for certification with respect to this cause of action. However, the Defendants have entered voluminous evidence to show that the monies received were used for the benefit of the members of the Proposed Class and not for the provision of healthcare, although they had no system in place to draw a rational connection between the increase in the Accommodation Charges and the need to defray the increased costs of meals and accommodation. The members of the Proposed Class will have the opportunity to assess whether this evidence might provide the basis at trial for the court to find a reason to deny recovery. The reasonable expectations and public policy considerations at the second stage will require weighing of evidence and are issues for trial.

[443] I am satisfied that the cause of action based on unjust enrichment with the remedy of restitution is not hopeless, but rather analytically defensible, *albeit* novel, even dubious. I cannot say that it is "plain and obvious" that no claim exists; nor that the pleadings do not disclose a cause of action based on unjust enrichment with any hope of success.

5. *Ultra Vires* Action

[444] The Plaintiffs have pled that s. 3(1) of the *Nursing Homes Operation Regulation*, ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulation* and the Letters are contrary to the *Nursing Homes Act* and the *Hospitals Act* and therefore are *ultra vires* as they purport to authorize the imposition of charges, fees or taxes against members of the Proposed Class for services other than the cost of accommodation and meals. Further, they have pled that the Letters

are *ultra vires* as there was no statutory obligation on the part of LTCF operators to impose the Accommodation Charge and no obligation on members of the Proposed Class to pay the Charge.

[445] The Plaintiffs assert that the Government increased the Accommodation Charges by a factor of 40 to 48 percent. At the same time, the Defendants decreased health care funding to LTCFs by 5.35 percent at a time when health care costs were increasing. The Plaintiffs contend that from the fiscal year ended March 31, 2002 to the fiscal year ended March 31, 2005, health care funding from the Crown to the RHAs increased by 27 percent (from $4,169,939,000 to $5,299,508,000). During the same period of time, health care funding to LTCFs remained essentially flat.

[446] This *ultra vires* claim is reliant on the Plaintiffs' contended legislative interpretation. They point out that the *Canada Health Act* provides that Alberta may receive a "cash contribution" from the federal Crown upon the province achieving certain standards of health care. They argue that the provincial legislation is a part of an integrated legislative scheme dealing with the medicare system in the province that reflects Alberta's intention to meet the *Canada Health Act* requirements, as was the case in ***Yu v. British Columbia (Attorney General)***, 2003 BCSC 1869, 22 B.C.L.R. (4th) 284 at paras. 5 and 90.

[447] The Plaintiffs maintain that the relevant portions of the *Canada Health Act* indicate that Alberta must insure and pay for "hospital services" in the province. These hospital services include "accommodation and meals" and, as a separate category, "services provided by persons who receive remuneration therefor from the hospital." In addition to the general requirements reflected above, a province wishing to receive a full cash contribution from the federal government is prohibited from charging user charges for any products or services other than for accommodation and meals provided to in-patients who are more or less permanently resident in the hospital or other institution. Section 19 of the *Canada Health Act* reads:

> 19(1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.
>
> (2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

[448] The Plaintiffs argue that Alberta's Accommodation Charges are prescribed with a view to s. 19 of the *Canada Health Act*. That is, Alberta clearly intended to authorize the enactment of regulations imposing user charges for "accommodation and meals" within the meaning of s. 19(2) of the *Canada Health Act*, and not to authorize any user charges which would render Alberta's health care system contrary to s. 19(1).

[449] In summary, the Plaintiffs assert that the *Canada Health Act* provides that in order to obtain the "cash contribution," Alberta "must insure all insured health services provided by

hospitals" (s. 9), it "must provide for payment for insured health services" (s. 12(b)), and it "must provide for the payment of amounts to hospitals... in respect of the cost of insured health services" (s. 12(d)). These "insured health services" include "services provided by persons who receive remuneration therefor from the hospital" (s. 2(i) definition of "hospital services"). The only user fees which the Province may charge to patients are those for "hospital services" which constitute "accommodation and meals" (ss. 19(1) and (2)).

[450] The Plaintiffs' position is that in enacting the *Hospitals Act*, Alberta intended to create and confirm the legal obligations required by the *Canada Health Act*.

[451] They say that the *Hospitals Act* imposes a general legal obligation on Alberta to provide "insured services" to residents of Alberta. Consistent with the *Canada Health Act*, these "insured services" include separate components for "accommodation and meals at the standard or public ward level" and "services rendered by persons who receive remuneration for those services from the hospital" (ss. 36(j)(i) and (j)(ix)). Also consistent with the *Canada Health Act*, user charges are only permitted and prescribed with respect to the former component of "insured services, i.e. "accommodation and meals."

[452] The Plaintiffs also argue that s. 10 of the *Nursing Homes Act* confirms Alberta's legal obligation to pay "benefits" to a nursing home operator in respect of an eligible resident. "Benefits" for the purposes of this obligation is defined as including the cost of "nursing home care," which is defined as including "basic care." "Basic care" is defined as including all those categories of services defined by the regulations which are to be provided to residents.

[453] In summary, the Plaintiffs claim that the *Nursing Homes Act* imposes a legal obligation on Alberta to provide residents with "benefits," "nursing home care," and "basic care." It also prohibits any charges to residents of nursing homes other than those in respect of "accommodation and meals."

[454] The Plaintiffs say that through the *Regional Health Authorities Act*, Alberta has created a statutory mechanism for the fulfilment of the Province's statutory duties under the *Hospitals Act* and the *Nursing Homes Act* . Section 5(a) of the *Regional Health Authorities Act* provides that RHAs are to:

> (i) promote and protect the health of the population in the health region and work toward the prevention of disease and injury,
>
> (ii) assess on an ongoing basis the health needs of the health region,
>
> (iii) determine priorities in the provision of health services in the health region and allocate resources accordingly,
>
> (iv) ensure that reasonable access to quality health services is provided in and through the health region, and

(v) promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

[455] Section 5(b) indicates that a RHA "has final authority in the health region in respect of the matters referred to in clause (a)."

[456] The Plaintiffs argue that pursuant to s. 5 of the *Regional Health Authorities Act*, the RHAs share the legal obligations for the provision of heath care services to residents as created by the *Hospitals Act* and the *Nursing Homes Act* .

[457] The Plaintiffs contend that *Directive D-317* further confirms the Defendants' legal obligations and that compliance with the Directive is mandatory by operation of s. 9 of the *Regional Health Authorities Regulation*.

[458] The Plaintiffs argue that the evidence marshalled to date indicates that the amounts prescribed by A.R. 260/2003 for the Accommodation Charges are intended to indemnify or compensate the RHAs or their agents for products and services which are the legal responsibility of the Defendants.

[459] The Plaintiffs say that the products and services which members of the Proposed Class have funded through their payment of the Accommodation Charges were described by Alberta in the Letters as including food; nutritional supplements; meal preparation and meal service; extra baths when required; incontinence supplies, including disposable diapers when required; wander guard bracelet with batteries; bed linens and towels, including laundering; cable television connection to room and access to shared leisure equipment such as TV, radio/music, telephone; minor equipment for resident care such as commode/shower chairs and lifts; housekeeping services (for resident rooms and common areas); utilities; routine maintenance; improvements to facility decor (paint, carpet, furnishings); and facility management/administration.

[460] The Plaintiffs argue that the Letters indicate the Accommodation Charge includes fees for matters which fall outside the meaning of "accommodation and meals" for the purposes of the governing legislation. These matters in large part constitute either user fees for "services rendered by persons who receive remuneration for those services from the hospital" under the *Hospitals Act* or "basic care" under the *Nursing Homes Act*, which the Government and the RHAs are required by law to provide to the residents of Alberta.

[461] Mr. Darwish stated in his affidavit of June 1, 2006 that he had been advised by the Capital Care Group that the monthly accommodation charge of $1,260 paid by his mother in 2005 included a "care component" of $834 which consisted of meal preparation, delivery, supervision and services, housekeeping services, laundry services, transportation, activities - social programmer, and security. The Plaintiffs argue that these services are the responsibility of the Defendants under the *Nursing Homes Act*, the *Hospitals Act*, the *Regional Health Authorities Act* and related regulations and directives.

[462] The Plaintiffs argue that the ***Welbridge*** principle does not immunize the Government and RHAs against claims for the recovery of money paid pursuant to invalid legislation. They rely on the observations of Richards J.A. in ***Holland* v. *Saskatchewan (Minister of Agriculture, Food and Rural Revitalization)***, 2007 SKCA 18 at paras. 31 and 32, 281 D.L.R. (4th) 349; var'd on a different issue 2008 SCC 42 that "a finding of public law wrongdoing in the form of *ultra vires* activity on the part of a public authority does not, in and of itself, give rise to private law liability, including private law liability for damages," and that "a public authority acting beyond its jurisdiction will be subject to tortious liability only if the necessary elements of tortious responsibility can be established." As noted by Richards J.A. at para. 33:

> ... there is no general principle to the effect that *ultra vires* action on the part of a public authority somehow invokes an immunity which shields the authority from private law liability in relation to the action in question. The fact that, as recognized in ***Welbridge Holdings***, *supra*, legislative and quasi-judicial decisions are not susceptible to claims in negligence does not create a broad-based immunity from private suit which operates when a public authority is found to have acted beyond the scope of its legislative mandate.

[463] The Plaintiffs submit that the ***Welbridge*** principle does not apply to conduct by a government official that is neither legislative nor judicial, such as the issuance of the Letters. They contend that the ***Welbridge*** principle does not assist the Crown in relation to restitutionary claims for recovery of money paid pursuant to invalid legislation.

[464] The *ultra vires* argument then dovetails with the unjust enrichment remedy that is sought. The Plaintiffs argue that it is well established that an invalid law cannot constitute a "juristic reason" for purposes of the unjust enrichment analysis: ***Kingstreet*** at para. 20; ***Garland*** at para. 51.

[465] The Defendants argue that even if the regulations were *ultra vires,* the only result of invalidity would be that under the governing statute there would be no limit on what can be charged by the LTCFs, relying on ***Rex v. Carling Export Brewing and Malting Co. Ltd.***, [1931] A.C. 435 at para. 9 (P.C.). However, the Plaintiffs have sought declaratory relief.

[466] The Plaintiffs' argument, as I understand it, harkens back to their fundamental premise that the "heart of this case is that the class members have paid for Health Care costs which are the legal responsibility of the Defendants. These include housekeeping, laundry, administration costs, building maintenance costs, etc. . . ."

[467] As noted above, the Plaintiffs say that the proper interpretation of the terms "basic care," "standard ward hospitalization," and "accommodation and meals" will serve to distinguish what services properly fall within the ambit of the Defendants' financial obligations as opposed to the financial obligations of members of the Proposed Class. The Plaintiffs allege that members of the Proposed Class are legally obliged to pay only for "accommodation and meals," as properly

construed, and not for basic care, standard ward hospitalization or health care, and the constellation of services that fall within those concepts.

[468] The Plaintiffs claim the case will involve a determination of the statutory spheres of responsibility as between the long-term care residents and the Defendants. The case will involve statutory analysis and consideration of the evidence in the context of the various causes of action to determine liability and remedies. The Plaintiffs contend that the remedies sought are to recoup the monetary losses suffered by members of the Proposed Class; assure accountability; and encourage the Defendants to observe both statutory mandates and strictures in the future.

[469] I am satisfied that the cause of action based on *ultra vires* legislation and action with the remedy of declaration and restitution is not hopeless, but rather analytically defensible. I cannot say that it is "plain and obvious" that no such claim exists, nor that the pleadings do not disclose such a cause of action with any hope of success.

6. *Ultra Vires* Tax

[470] The Plaintiffs have pled that the Accommodation Charge constitutes an *ultra vires* tax in that it is compulsory and enforceable by law, is imposed under the authority of the Alberta legislature, is levied by a public body, is intended for a public purpose, and has no reasonable nexus with the cost of accommodation and meals and no reasonable attempts were made by the Defendants to match the actual cost of accommodation and meals with the Accommodation Charges. The Plaintiffs cite ***Kingstreet Investments v. New Brunswick (Finance)***, [2007] 1 S.C.R. 3 in support of their claim.

[471] The Government argues that the Accommodation Charge is not a tax as the amount paid is not imposed or collected by a public authority but rather by the LTCFs; the amount paid is not imposed by statute but rather by agreement between the LTCFs and the residents; payment cannot be enforced by statute; only the maximum Accommodation Charge is set by regulation; and payment is not for a public purpose but for services provided by the LTCFs.

[472] The Government contends that the Letters cannot create a tax as a tax must be grounded in legislation: ***Professional Institute of the Public Service of Canada c. Canada (Attorney General)*** (2007), 66 C.C.P.B. 54 at paras. 160-167.

[473] The Government suggests that, in any event, the Accommodation Charge is imposed on those receiving the services. It argues that a tax levied on the ultimate consumer is a direct tax and *intra vires* the legislature: ***Allard Contractors Ltd. v. District of Coquitlam***, [1993] 4 S.C.R. 371 at para. 148.

[474] It maintains that, to the extent that it is a tax, it is authorized by statute and not by regulation. Further, the Government submits that if the regulation and the Letters are *ultra vires*, the only result would be that there is no limit on the Accommodation Charge that may be charged by LTCFs.

[475] In ***Westbank First Nation v. British Columbia Hydro***, [1999] 3 S.C.R. 134 at para. 21, the Supreme Court of Canada outlined the basic indicia of a tax: (1) it must be compulsory and enforceable by law; (2) it must be imposed under the authority of the legislature; (3) it must be imposed by a public body; and (4) it must be intended for a public purpose.

[476] Section s. 3(1) of the *Nursing Homes Operation Regulation* provides that a LTCF operator "may charge a resident an accommodation charge," which is not to exceed a specified maximum amount. While this provision implies that the Accommodation Charge is discretionary, the Plaintiffs have pled that the Government directed that LTCF operators charge the maximum Accommodation Charge. Even if that allegation and the claim that a portion of the Accommodation Charge was spent on items for which the Government was responsible are presumed to be true for purposes of this application, the Accommodation Charge would still not possess all indicia of a tax. The Plaintiffs have not pled that the Accommodation Charge is enforceable by law or that the legislature authorized that it be levied as a compulsory charge.

[477] As a result, it is plain and obvious that this claim would fail.

7. Section 15(1) of the *Charter*

[478] There appear to be two aspects of the Plaintiffs' s. 15 claim. First, in para. 43(a) of the Amended Amended Fresh Statement of Claim, the Plaintiffs assert that the differential treatment was the imposition of the Accommodation Charge as a whole on members of the Proposed Class which was not imposed on other patients. They claim the provisions in question and the Minister's directive are not saved by s. 1 of the *Charter*.

[479] Second, the Plaintiffs allege in para. 49 of their pleading that s. 19(2) of the *Canada Health Act*, R.S.C. 1985, c. C-6; s. 8(2) of the *Nursing Homes Act*; s. 3(1) of the *Nursing Homes Operation Regulation*; ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulation* and the Letters issued by the Government to various RHAs and LTCF operators, by their operation, imposed on the members of the Proposed Class an obligation to pay for publicly funded health care costs. They assert that such differential entitlement to statutory health care benefits was discriminatory and contrary to s. 15(1) of the *Charter* in that the Government, acting in bad faith, imposed on the members of the Proposed Class, due to their age or mental and/or physical disabilities, financial burdens for health care costs that were not imposed on others.

[480] Section 15(1) of the *Charter* provides as follows:

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

(a) Discrimination

[481] The discrimination complained of must be based on an "enumerated or analogous ground" to those listed in s. 15(1).

[482] In this case, the Plaintiffs have pled that the basis of the discriminatory treatment was the "age or mental and/or physical disabilities" of members of the Proposed Class, a prohibited ground of discrimination in s. 15(1). Their arguments do not develop the “age” aspect of the claim. However, the pleadings satisfy this stage of the s. 15 analysis.

[483] The Plaintiffs allege discrimination because the degree of disability of the members of the Proposed Class (based on medical assessment) triggers long-term care providers to levy charges for accommodation and meals that other recipients of the same services are not charged because they are not similarly disabled. This distinction in treatment is *prima facie* discriminatory on the ground of disability.

(b) Human Dignity

[484] A party alleging discrimination must establish that the differential treatment complained of impaired his or her human dignity: ***Law v. Canada (Minister of Employment and Immigration)***, [1999] 1 S.C.R. 497.

[485] The Court in ***Law*** did not define "human dignity," but did make reference to four (non-exclusive) "contextual factors" that aid in this inquiry:

(1) pre-existing disadvantage, stereotyping, prejudice or vulnerability;

(2) relationship between the grounds and the claimant's characteristics or circumstances;

(3) the existence of ameliorative purposes or effects on other groups;

(4) the nature of the interest affected.

[486] In ***Law*** at para. 70, Iacobucci J. advised that “it will be easier to establish discrimination to the extent that impugned legislation fails to take into account a claimant's actual situation, and more difficult to establish discrimination to the extent that legislation properly accommodates the claimant's needs, capacities, and circumstances.” In my view, it is at least arguable at this stage of the proceedings that the members of the Proposed Class are a group defined by "pre-existing disadvantage" and that the legislation fails to take into account the "correspondence" between the chronically disabled person's fixed income and his or her need for greater social support. There is no "flaw" in this part of the claim that is "obvious and beyond doubt."

(c) Disadvantage

[487] In order for "disadvantage" or "unequal treatment" to be established, there must be a comparison between the position of the plaintiffs and that of other people who may form a legitimate "comparator group."

[488] In rare cases, as in ***Thibaudeau v. Canada***, [1995] 2 S.C.R. 627, the proposed class may actually be better off, as a whole, than the comparator group. This is not an issue in the present case: the Proposed Class definition quite clearly includes those who are charged the extra Accommodation Charges, and excludes those who are receiving additional financial aid. It is arguable, therefore, that the members of the Proposed Class are disadvantaged by at least some of the impugned legislation.

[489] The selection of the appropriate comparator group "involves finding the group that shares with the claimant all the characteristics that qualify for the benefit (or burden), except for a personal characteristic that is listed in… s. 15" : Peter W. Hogg, *Constitutional Law of Canada*, 5th ed. Supp., vol, 2 (Toronto: Thomson Carswell, 2007) at 55-32.

[490] In ***Auton v. British Columbia***, [2004] 3 S.C.R. 657, the issue was government funding for "applied behavioural therapy" for autistic children. Like the case at bar, "mental or physical disability" was the alleged ground of discrimination. The province's statutory health care plan provided full funding for all medically necessary services provided by physicians. Some medically necessary services provided by non-physicians were also funded, but applied behavioural therapy was not. Both the trial judge and the Court of Appeal held that there was a breach of s. 15 because the province funded some medically necessary therapies, but not autism therapy (which was equally necessary).

[491] The Supreme Court of Canada, reversing the decisions of the lower courts, held that an incorrect comparator group had been used. The claimants in that case had used groups receiving "medically necessary therapies" as a comparator. Chief Justice McLachlin, however, found that the applied behavioural therapy was a "novel medically necessary therapy" because the therapy had only recently become recognized as medically necessary. Since the claimants had not brought evidence that the province was funding "other comparable, novel therapies," disadvantage/unequal treatment could not be shown and the claimant's s. 15 claim failed.

[492] In ***Nova Scotia v. Martin***, [2003] 2 S.C.R. 504, the impugned law denied long-term workers' compensation benefits to sufferers of work-related "chronic pain." The Supreme Court of Canada found that the comparator group of "workers subject to the Act who do not have chronic pain and are eligible for compensation for their employment-related injuries" was appropriate. However, the Court acknowledged the problem that "chronic pain" was unlike other work-related injuries in that it had no accepted method of diagnosis or treatment.

[493] Hogg in *Constitutional Law of Canada* suggests that ***Auton*** and ***Martin*** can be reconciled by reference to the differing purposes of the statutory schemes. He states at para. 55-34:

> In ***Auton***, the health care plan did not purport to be comprehensive in its funding of even medically necessary services if they were not provided by physicians. In ***Martin***, the workers' compensation scheme did purport to provide comprehensive coverage for all work-related injuries (for which the tort action was barred). In a scheme that is supposed to be comprehensive, it is natural to make the comparison between those who are denied benefits and those who are granted benefits. The comparison is less persuasive (and the consequences more costly) where the scheme is not comprehensive and the claimant group is only one of a number of groups from whom benefits are withheld.

[494] In the present case, it will be necessary to examine the legislative scheme in greater detail in order to assess on which side of the ***Auton/Martin*** dichotomy the case at bar falls.

(d) Proposed Comparator Groups

[495] It is worth noting that the pleadings filed by the Plaintiffs have changed over time. The Plaintiffs initially proposed a comparator group that would include "all other individuals, within the province of Alberta, who receive 'standard ward hospitalization' as defined by s. 36(j) of the *Hospitals Act*," but who are not charged for those services.

[496] The Plaintiffs then suggested the following alternative comparator group:

> All individuals within the Province of Alberta who are entitled to receive the following health care benefits at no cost and who do not pay for such benefits: meal preparation and meal service, extra bathing when required, housekeeping services, facility laundry services, building maintenance, improvements to facility decor and administration.

[497] The Plaintiffs now propose a different comparator group of "other patients who are long-term Residents in Alberta health care facilities such as hospitals, and whose accommodation and meals are provided at public expense through those health care facilities" but who "are not persons who require chronic care and who are ‘more or less permanently resident in a hospital or other institution'" and as a result do not incur the accommodation and meal charges complained of. This proposed comparator group does not deal with the equality complaint concerning the Residents bearing some of the costs of health care.

[498] A possible comparator group that reflects the Residents’ arguments would be:

> All disabled individuals within Alberta who are entitled to receive the following health care benefits at no cost and who do not pay for such benefits: health care, meal preparation and meal service, extra bathing when required, housekeeping services, facility laundry services, building maintenance, improvements to facility decor and administration.

[499] This comparator group passes the certification threshold. It is logically related to both arms of the claimants' Charter argument as I understand it: that it is contrary to the Charter to discriminate amongst disabled Albertans by requiring those disabled patients in LTCFs to bear the costs of meals and accommodation and other benefits, as well as some costs of health care, while those disabled patients in acute care hospitals bear neither of these costs. The quality or characteristic that distinguishes the two groups of disabled people is the degree of disability: those institutionalized with chronic, long-term health care needs as compared to those institutionalized with acute, short-term health care needs. Discrimination amongst categories of the disabled in the provision of benefits has been held to amount to prohibited discrimination in the human rights context: ***Gibbs* v. *Battlefords and District Co-Operative Ltd.***, [1996] 3 S.C.R. 566.

(e) Conclusion on *Charter* claim

[500] The test for class certification has a low threshold. The pleadings, on their face, disclose a cause of action based on s. 15 of the *Charter*.

B. Is there an Identifiable Class of Two or More Persons?

[501] In order for the action to be certified as a class proceeding, s. 5(1)(b) of the *CPA* requires that the Plaintiffs establish that there is an identifiable class of two or more persons. However, the court cannot refuse to certify an action as a class proceeding merely because the number of prospective class members or the identity of each prospective class member has not been ascertained or may not be ascertainable: *CPA*, s. 8(d).

[502] In ***Bywater v. Toronto Transit Commission*** (1998), 27 C.P.C. (4th) 172 at paras. 10-11 (Ont. Ct. (Gen. Div.)), Winkler J. discussed the importance of the proper formulation of a class definition:

> The purpose of the class definition is threefold: a) it identifies those persons who have a potential claim for relief against the defendant; b) it defines the parameters of the lawsuit so as to identify those persons who are bound by its result; and lastly, c) it describes who is entitled to notice pursuant to the Act. Thus for the mutual benefit of the plaintiff and the defendant the class definition ought not to be unduly narrow nor unduly broad.
>
> In the instant proceeding the identities of many of the passengers who would come within the class definition are not presently known. This does not constitute a defect in the class definition. In ***Anderson v. Wilson*** (1998), 37 O.R. (3d) 235 (Div. Ct.), Campbell J. adopted the words of the Ontario Law Reform Commission and stated at 248:
>
> > ... a class definition that would enable the court to determine whether any person coming forward was or was not a class member would seem to be sufficient.

On this point, *Newberg on Class Actions* (3d ed. Looseleaf) (West Publishing) states at 6-61:

> Care should be taken to define the class in objective terms capable of membership ascertainment when appropriate, without regard to the merits of the claim or the seeking of particular relief. Such a definition in terms of objective characteristics of class members avoids problems of circular definitions which depend on the outcome of the litigation on the merits before class members may be ascertained ...

The Manual for Complex Litigation, Third (1995, West Publishing) states at 217:

> Class definition is of critical importance because it identifies the persons (1) entitled to relief, (2) bound by a final judgment, and (3) entitled to notice in a [class] action. It is therefore necessary to arrive at a definition that is precise, objective, and presently ascertainable ... Definitions ... should avoid criteria that are subjective (e.g. a plaintiff s state of mind) or that depend upon the merits (e.g., persons who were discriminated against). Such definitions frustrate efforts to identify class members, contravene the policy against considering the merits of a claim in deciding whether to certify a class, and create potential problems of manageability.
>
> The defendant urges, in the alternative, that the class definition should include a reference to damages resulting from smoke inhalation. This requirement, if adopted, would run contrary to the tenets set out above. It would unduly narrow the class and it anticipates entitlement. Moreover, it would eliminate persons with strictly property damage claims. The reference to damages impinges on the merits of the claim and, thus, goes beyond the purpose of class definition. The definition proposed by the plaintiff is approved with the deletion of words "and toxic gases".

[503] The representative plaintiffs are entitled to define the class in such a way that the litigation is manageable. A class definition should not be overly broad and should not include persons who have no claim against the defendants. The plaintiff must establish that the class could not be defined more narrowly without arbitrarily excluding persons with claims similar to those asserted on behalf of the proposed class: ***Windsor***, 2007 ABCA 294 at paras. 19 and 26.

[504] As stated by the Court of Appeal in ***Windsor*** at para. 18:

> A plaintiff must establish that the class is capable of being defined by objective criteria that will permit the identification of potential class members without reference to the merits of the claim, and that there is a rational connection between the proposed class definition, the proposed causes of action and the proposed common issues.

[505] The identifiable class requirement is an inquiry into whether the members of the class can be identified by objective criteria. While the criteria should bear a rational relationship to the common issues asserted by all class members, they should not depend on the outcome of the litigation. However, the class should not be made unnecessarily broad simply to ensure ease of identification through objective criteria. If the class could be defined more narrowly, the court should disallow certification or allow it on condition that the definition of the class is amended: ***Ayrton v. PRL Financial (Alta.) Ltd.***, 2005 ABQB 311 at para. 52, aff'd 2006 ABCA 88.

[506] The requirement is not an onerous one. The representative plaintiff need not show that everyone in the class shares the same interest in the resolution of the asserted common issue. However, there must be some showing that the class could not be defined more narrowly without arbitrarily excluding some people who share the same interest in the resolution of the common issue: ***Hollick*** at para. 21.

[507] Over-inclusion, under-inclusion, or both, are not fatal as long as they are not illogical or arbitrary. The low threshold is met if there is good reason for defining the class restrictively so as to cover off what is known about the circumstances of the case, as opposed to producing a speculative class: ***Windsor***, 2006 ABQB 348 at para. 91.

[508] Clear class definition at the outset of class litigation is critical because it identifies those: (1) entitled to notice; (2) entitled to relief (if relief is awarded); and (3) bound by a final judgment. Consequently, the definition must be precise, objective, and presently ascertainable: ***Paron v. Alberta (Environmental Protection)***, 2006 ABQB 375 at para. 41, 402 A.R. 85; see also ***Condominium Plan No. 0020701*** at para. 55; ***Western Canadian Shopping Centres Inc.*** at para. 38.

[509] Class definition must avoid criteria that are subjective or that depend on the merits because: (1) they frustrate efforts to identify class members; (2) contravene the policy against considering the merits of a claim in deciding whether to certify a class; and (3) create potential problems of manageability. The criteria must bear a rational relationship to the common issues asserted by all the class members: ***Paron*** at para. 42.

[510] In the present case, the Proposed Class includes all residents of LTCFs and patients in general hospitals in Alberta who have been assessed as requiring auxiliary hospital or nursing home level care, and the estates of such persons who, since August 1, 2003, have been charged the Accommodation Charge, except certain categories of such persons who have received specified subsidies or an exemption.

[511] This is an identifiable class of two or more persons, the identity of whom is ascertainable. The class could not be defined more narrowly without exclusion of persons with claims similar to those asserted by the Proposed Class.

[512] The objective criteria that permit identification of potential class members are:

(a) residents of LTCFs, or their estates;

(b) patients in general hospitals who have been assessed as requiring auxiliary hospital or nursing home level care, or their estates;

(c) having been charged the Accommodation Charge after August 1, 2003;

(d) not having received any of the specified subsidies or exemptions since August 1, 2003.

[513] The specific category exclusions are delineated by the nature of the subsidy obtained, and its basis.

[514] Payment of the Accommodation Charge by a member of the Proposed Class is the action which propels the person into the class. There is no rational basis to define the class more narrowly.

[515] The levy of the Accommodation Charge by the LTCF operators as agents of RHAs, which provide long-term or auxiliary nursing care to residents of Alberta for the Government, is the impugned action which gives rise to the causes of action found to have merit. There is a rational connection between the Proposed Class definition (Accommodation Charge payors), proposed causes of action for negligence in operational decisions or actions, breach of contract, *ultra vires* action, unjust enrichment, breach of equality rights and administrative law claims of the members of the Proposed Class, and proposed common issues.

C. Do the Claims of the Prospective Class Members Raise a Common Issue?

[516] Section 1 of the *CPA* defines "common issue" as follows:

"common issue" means

(i) common but not necessarily identical issues of fact, or

(ii) common but not necessarily identical issues of law that arise from common but not necessarily identical facts.

[517] In order to certify an action as a class proceeding, the court must be satisfied that the claims of the prospective class members raise a common issue, whether or not the common issue predominates over issues affecting individual prospective class members only: *CPA*, s. 5(1)(c) . A class proceeding will always consist of some common issues that are decided once, followed by a number of individual issues that are decided by some suitable procedure: ***Metera v. Financial Planning Group***, 2003 ABQB 326 at para. 69, 12 Alta. L.R. (4th) 120. The question of whether the common issues predominate over the individual issues does not enter into the analysis at the common issues stage, but is a factor to consider in determining whether the class action is the preferable procedure: see *CPA*, s. 5(2)(a).

[518] There must be a rational connection between the class definition and the asserted common issues: see ***Hollick*** at para. 20.

[519] A common issue is an issue central to the class members' claims, which, when determined, will advance the class members' claims in a meaningful way: ***Ayrton***, 2005 ABQB 311 at paras. 84-85. A common issue need not answer the claim completely, as long as its resolution materially advances the litigation: ***Condominium Plan No. 0020701*** at para. 70.

[520] An issue is common if its resolution is necessary to the resolution of each class member's claim: ***Western Canadian Shopping Centres Inc.*** at para. 39. As such, it must be a substantial ingredient of each of the class members' claims, and resolution of the issue must materially advance the litigation. Something may be a substantial ingredient of the claim even if it makes up a limited aspect of the liability question and even though many individual issues remain to be decided after its resolution. The latter does not undermine the commonality conclusion, but is a factor in the assessment of whether a class action is the "preferable procedure:" ***Paron*** at para. 65; see also ***Metera*** at para. 54.

[521] Success for one class member must mean success for all. All members of the class must benefit from the successful prosecution of the action, although not necessarily to the same extent. A class action should not be allowed if class members have conflicting interests: ***Western Canadian Shopping Centres Inc.*** at para. 40. If one class member is successful on a common issue, either all class members are successful or some class members are indifferent to that issue. There is no common issue if success for one member of the class means loss for another: ***Paron*** at para. 66 (citing ***Western Canadian Shopping Centres*** at para. 40).

[522] Class members need not be identically situated and wide differences between class members can be tolerated: ***Condominium Plan No. 0020701*** at para. 77; see also ***Western Canadian Shopping Centres Inc.*** at para. 54. The real focus of this analysis is whether there is a conflict of interest within the class, as such conflicts tend to destroy the commonality of interest and put counsel in an impossible situation. In some cases, a conflict of interest can be dealt with by naming formal subclasses and, if necessary, providing separate representation for each of the subclasses. Alternatively, the problem can be resolved by redefining the class to exclude those with conflicting interests. In other instances, however, the conflict may be so fundamental that it prevents the action from proceeding as a class action; for example, where all the issues are only "sub-class common" and there are no "universally common issues:" ***Paron*** at para. 67; ***Metera*** at paras. 56-57.

[523] A purposive approach ought to be taken to the commonality question in class actions. Such an approach may involve interpreting legislation liberally in order to facilitate, rather than stifle, the development and use of class actions as a procedural tool: ***Ayrton***, 2006 ABCA 88 at para. 24.

[524] The assessment of the common issues is also contextual, in light of all the issues raised by the case, and caution must be exercised to ensure that the issues are truly common, not just made to appear common by the manner in which they are posed: ***Paron*** at para. 68. It would not serve

the ends of either fairness or efficiency to certify an action on the basis of issues that are common only when stated in the most general terms. Inevitably, such an action would ultimately break down into individual proceedings: ***L.R. v. British Columbia***, 2001 SCC 69 at para. 29, [2001] 3 S.C.R. 184.

[525] It is necessary to explore the merits to identify the common issues: ***T.L.*** at para. 36. If, on the pleading and evidentiary record, the conclusion is that an issue would have to be decided separately in light of the particular circumstances of each class member, certification on the basis of such an issue is not justified. This is so whether the defect is to be understood as detracting from the commonality of the issue, or as affecting the question of the preferable procedure to be determined under s. 5(1)(d) of the *CPA*: ***Paron*** at para. 69.

[526] When common issues are stated in terms of "defendants," it can be easy to lose sight of how the complexity of proceedings may increase when multiple defendants are involved, as certain of the common issues may not apply to each defendant, either at all or in the same way. However, this is not necessarily a bar to certification. The purpose of class action proceedings is to provide a clear procedural mechanism to enable the courts to deal efficiently with a large number of claims being made by many aggrieved persons who have all suffered injuries from the same event: see ***Condominium Plan No. 0020701*** at para. 83.

[527] The Plaintiffs have proposed the following common issues that relate to the causes of action that I have determined may proceed:

1. The Legislative Framework

1.0 Did the Government voluntarily undertake to establish a legislative framework embodied by the *Alberta Health Care Insurance Act* and the regulations made thereunder, the *Nursing Homes Act* and the regulations made thereunder, and the *Hospitals Act* and the regulations made thereunder, to deliver health related services and benefits to residents of Alberta, and to pay for such services and benefits out of public funds?

1.1 Pursuant to the legislative framework for long-term care in Alberta, are the RHAs responsible for the delivery of health care services and accommodation and meals in LTCFs?

1.2 Pursuant to the legislative framework for long-term care in Alberta, do the RHAs deliver health care services and accommodation and meals in LTCFs either directly or indirectly through agents acting on their behalf?

1.3 Pursuant to the legislative framework for long-term care in Alberta, do the RHAs or the Government, or both, exercise exclusive powers over auditing, monitoring and financial reporting with respect to health care benefits paid to LTCFs and the money paid by the class members for accommodation and meals?

1.4 Pursuant to the legislative framework for long-term care in Alberta, do the RHAs discharge their responsibilities as agents of the Government?

2. LTCFs

2.0 Are nursing homes and auxiliary hospitals funded by the Government on the same basis?

2.1 Are nursing homes and auxiliary hospitals treated by the Government in the same way for the purpose of gathering statistics?

2.2 Has the Government used funding methodologies and policy directives to create one integrated system for the delivery of long-term care in Alberta?

3. The Meaning and Calculation of the "Accommodation Charge"

3.0 What is the meaning of “accommodation and meals” in the definition of “accommodation charge” in s. 1(a) of the *Nursing Homes Act*?

3.1 What is the meaning of "accommodation charge" in s. 3(1) of the *Nursing Homes Operation Regulation*?

3.2 Does s. 3(1) of the *Nursing Homes Operation Regulation*, when read with s. 8(2) of the *Nursing Homes Act*, prescribe an accommodation charge that is permissive and discretionary?

3.3 Should the words "in respect of nursing home care" contained in the definition of "benefits" in s. 1(d) of the *Nursing Homes Act* be given a broad interpretation of the widest possible scope?

3.4 Referring to the definition of "basic care" in s. 2 of *the Nursing Homes General Regulation*, AR 232/85, what services, costs or expenses are properly included within the meaning of:

(a) accommodation and meals;

(b) facilities services;

(c) necessary nursing services

(d) personal services

(e) therapeutic and special diets as required;

(f) drugs and medicine specified by the Minister for use on a routine or emergency basis as prescribed by a physician;

(g) routine dressings as required;

(h) life enrichment services?

3.5 Does s. 3(1) of the *Nursing Homes Operation Regulation*, when read with s. 8(2) of the *Nursing Homes Act*, mean that the Defendants are solely responsible for paying for the cost of items (b) through (h) of basic care?

3.6 What is the legal effect, if any, of *Ministerial Directive D-317*?

3.7 Are auxiliary hospitals and general hospitals "approved hospitals" within the meaning of s. 37(1) of the *Hospitals Act*?

3.8 Is "standard ward hospitalization" an "insured service" within the meaning of ss. 36(h) and 37(1) of the *Hospitals Act*?

3.9 What services, costs or expenses are included within the meaning of "services rendered by persons who receive remuneration for those services from the hospital" in s. 36(j)(ix) of the *Hospitals Act*?

3.10 Does the *Hospitals Act* require auxiliary hospitals and general hospitals to provide “standard ward hospitalization” at no cost to patients in such hospitals?

3.11 Do ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulations*, when read with s. 3(1) of the *Nursing Homes Operation Regulation* and s. 8(2) of the *Nursing Homes Act*, prescribe accommodation charges that are permissive and discretionary?

3.12 Does “accommodation and meals” in s. 2(a) of the *Nursing Homes General Regulation* have the same meaning as “accommodation and meals” in s. 36(j)(i) of the *Hospitals Act*?

4. Determining the Accommodation Charge

4.0 Did the Government owe a duty of care with respect to operational decisions/actions to the Class members?

4.1 If so, what was the nature and extent of the Government’s duty of care with respect to operational decisions/actions?

4.2 When the Government set the maximum Accommodation Charge in 2003, did it have a proper basis for determining what the Accommodation Charge should consist of?

4.3 When the Government set the maximum Accommodation Charge in 2003, did it have a proper basis for determining how to calculate the Accommodation Charge?

4.4 Did the Government act recklessly when it increased the maximum Accommodation Charge in 2003 pursuant to AR 260/2003 or the Letters?

4.5 Did the Government act in bad faith when it increased the maximum Accommodation Charge in 2003 pursuant to AR 260/2003 or the Letters?

4.5(a) Did the Government expect that effective August 1, 2003, the maximum Accommodation Charge would be charged across the Province?

4.5(b) In 2003, did the Government make reasonable attempts to match revenue received from the Accommodation Charge on a province-wide basis to the cost of accommodation and meals on a province-wide basis?

4.5(c) Does a nexus exist between the maximum Accommodation Charge that took effect August 1, 2003 and the cost of accommodation and meals in a province-wide basis?

4.5(d) Has the cost of accommodation and meals changed on a province-wide basis since August 1, 2003? If so, how?

4.6 Did the RHAs take adequate and proper steps to determine the cost of accommodation and meals in their regions?

4.6(a) Did the RHAs act recklessly or in bad faith by charging, either directly or indirectly through their agents, the maximum Accommodation Charge throughout the Province (apart from the limited number of hardship exceptions)?

4.7 Was the Minister of Seniors and Community Supports vested with lawful authority as of August 1, 2003 to make determinations with respect to the Accommodation Charge?

4.7(a) In or about August of 2003, did the Minister of Seniors and Community Supports purport to make determinations with respect to the Accommodation Charge?

4.8 Did the Government's agents or employees who were responsible for publishing the Letters have lawful authority to nullify or abridge the permissive and discretionary language of s. 3(1) and s. 3(5) of the *Nursing Homes Operation Regulation* and s. 8(2) of the *Nursing Homes Act* with respect to the Accommodation Charge?

4.9 In the Letters, did the Government's agents or employees publish accommodation rates that were fixed and mandatory?

4.10 If so, did the Government's agents and employees act in bad faith?

4.11 In the Letters, did the Government's agents or employees instruct the RHAs and operators of LTCFs to charge the maximum Accommodation Charge?

4.12 If so, did the Government's agents and employees act in bad faith?

4.13 In the Letters, did the Government's agents or employees instruct the RHAs and operators of LTCFs to charge the Class members for the following services as part of the Accommodation Charge: meal preparation and meal service, extra bathing when required, housekeeping services, utilities, bed linens and towels, facility laundry services, facility maintenance, facility upgrades, facility management and facility administration?

4.14 If so, did the Government's servants and employees act in bad faith?

5. Administration of the Money

5.0 Did the Defendants owe the Class members a duty of care to exercise all reasonable care, skill and diligence with respect to the administration, monitoring and auditing of

(a) the health care benefits paid by the Government to the RHAs;

(b) the health care benefit provided by the RHAs to LTCFs;

(c) the money paid by the Class members in respect of the Accommodation Charge?

5.1 If so, what was the nature and extent of the Defendants' duties of care?

5.2 Did the Government or the RHAs take reasonable and prudent steps to ensure that money paid by the Class members for the Accommodation

Charge was used to pay for accommodation and meals only and not for health care costs?

6. Breaches of Duty

6.0 Did the Defendants breach any duties of care owed to the Class members?

7. Restitution

7.0 Have the Defendants been unjustly enriched as a result of their actions?

7.1 If so, is there a juristic reason for the Defendants to retain such enrichment?

7.2 Are s. 3(1) of the *Nursing Homes Operation Regulation*, ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulation* and the Letters *ultra vires* and inoperative?

7.3 Do s. 3(1) of the *Nursing Homes Operation Regulation*, ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulation* and the Letters purport to authorize the imposition of charges or fees against the Class members for services other than the cost of accommodation and meals?

7.4 Has payment of the Accommodation Charge relieved the Defendants from inevitable expenses they were required to incur pursuant to the *Nursing Homes Act* and the *Hospitals Act*?

8. Contractual Relations between the Class Members and the RHAs

8.0 Is there an agreement, express or implied, between the Class members and the RHAs with respect to the provision of accommodation and meals to the class members?

8.1 If so, what terms, if any, should be implied from the legislation?

8.2 Did the agreement between the Class members and the RHAs contain a term, express or implied, that the Class members would pay for accommodation and meals only and not for the cost of health care services?

8.3 Has there been a breach of the RHAs' agreements with the Class members?

9. *Charter of Rights and Freedoms*

9.0 Do s. 19(2) of the *Canada Health Act*, s. 3(1) of the *Nursing Homes Operation Regulation*, s. 8(2) of the *Nursing Homes Act*, ss. 5(1)(d) and

5(8) of the *Hospitalization Benefits Regulation* and the Letters violate the rights of the Class members protected under s. 15(1) of the *Charter*?

9.1 Did the Government act in bad faith by establishing a differential entitlement to statutory health care benefits, whereby financial burdens for health care costs have been imposed on the class members but not others?

9.2 If s. 19(2) of the *Canada Health Act*, s. 3(1) of the *Nursing Homes Operation Regulation*, s. 8(2) of the *Nursing Homes Act*, ss. 5(1)(d) and 5(8) of the *Hospitalization Benefits Regulation* and the Letters violate the rights of the Class members protected under 15(1) of the *Charter*, and if the violations are not saved by s. 1 of the *Charter*, are the Class members entitled to damages pursuant to s. 24 of the *Charter* and, if so, how are such damages to be measured?

10. Damages

10.0 Are the Class members entitled to damages and, if so, how are such damages to be measured?

10.1 Are the Class members entitled to a money judgment or other relief as against the Defendants? If so, what relief should be provided?

10.2 Should the Court issue an order for an accounting and restitution? If so, why and what are the particulars?

10.2(a) If the Class members are entitled to damages or restitution, should the cost of accommodation and meals be determined on a province-wide basis, on a regional basis, or individually, and with what frequency?

10.2(b) What was the cost of accommodation and meals on a province-wide basis (or alternatively on a regional basis) as of August 1, 2003 and annually thereafter?

10.3 Can the Court assess damages globally for the Class members? If so, what is the damages assessment?

10.4 Should the Defendants pay exemplary or punitive damages to the class members? If so, in what amount?

10.5 Should the Defendants pay the costs of administering and distributing the recovered damages? If so, what amount should the Defendants pay?

10.6 Are the Defendants obligated to pay pre-judgment interest? If so, at what annual or compound rate, on what amount and what is the amount of prejudgment interest?

[528] I am satisfied that the issues as identified by the Plaintiffs above meet the criteria to be certified as common issues. There is a rational connection between the Proposed Class and the asserted common issues. Most of the common issues involve questions of legislative interpretation, which are central to the class members' claims. As such, it is my view that the resolution of the common issues as defined above will materially advance this litigation.

D. Is a Class Proceeding the Preferable Procedure for the Fair and Efficient Resolution of the Common Issues?

[529] Section 5(1)(d) of the *CPA* requires that in order for a proceeding to be certified as a class proceeding, the court must be satisfied that a class proceeding would be the preferable procedure for the fair and efficient resolution of the common issues. Furthermore, s. 5(2) sets out five mandatory factors that the court must consider in determining whether a class proceeding is the preferable procedure, although other factors may also be taken into account:

(a) whether questions of fact or law common to the prospective class members predominate over any questions affecting only individual prospective class members;

(b) whether a significant number of the prospective class members have a valid interest in individually controlling the prosecution of separate actions;

(c) whether the class proceeding would involve claims that are or have been the subject of other proceedings;

(d) whether other means of resolving the claims are practical or less efficient; and

(e) whether the administration of the class proceeding would create greater difficulties that those likely to be experienced if relief were sought by other means.

[530] The court is required to take a purposive approach to the interpretation and application of these factors, meaning that they are to be read with and tested against the objectives of the legislation: ***Condominium Plan No. 0020701*** at para. 86. Class proceedings statutes shall be construed generously to give full effect to the objectives of judicial economy, access to justice and behaviour modification: ***Ayrton***, 2006 ABCA 88 at para. 36. As such, purposive approach requires the court to be mindful of these objectives of class litigation:

(1) enhancing judicial economy by avoiding unnecessary duplication of fact-finding and legal analysis (thereby freeing up judicial resources and reducing the costs of litigation);

(2) improving access to justice by dividing litigation costs over a large number of plaintiffs;

(3) effecting behaviour modification by ensuring that actual and potential wrongdoers do not ignore their obligations to the public;

(4) avoiding inconsistent results; and

(5) with the assistance of case management and alternative dispute resolution, reducing adversity and increasing the likelihood of reaching a fair and equitable result.

(***T.L. v. Alberta (Child, Youth and Family Enhancement Act (Director)***, 2008 ABQB 114, at para 96 (***T.L. #2***), ***Paron*** at paras. 36-37; see also ***Condominium Plan No. 0020701*** at para. 30; ***Ayrton***, 2005 ABQB 311 at para. 33).

[531] Achieving judicial economy requires a simple and efficient means of dealing with a large number of claims involving common issues of fact or law within a single proceeding with a view to preventing a drain on court resources: ***Paron*** at para. 113.

[532] Class actions provide plaintiffs with access to justice by providing a means for them to sue defendants who might otherwise, practically speaking, be immune from suit. Such actions allow claimants to share the costs of litigation and financially justify the pursuit of smaller value claims that otherwise would be prohibitively expensive: ***Paron*** at para. 102.

[533] The objective of behaviour modification is to ensure that actual and potential wrongdoers do not ignore their obligations to the public. Modification of behaviour does not look only at the particular defendant, but looks more broadly at similarly situated defendants: ***Paron*** at paras. 99-100.

[534] Whether a class proceeding is the "preferable" procedure is a question of law to be determined by the certification justice based on his or her knowledge of the court's processes: ***T.L.#2*** at para 96. A pragmatic approach must be used in determining if the class action is the preferable procedure, or if the action will turn out to be a "monster of complexity and cost": ***T.L.*** at para. 129.

[535] The merits of the action are relevant to determining whether a class proceeding is the preferable procedure for the fair and efficient resolution of the common issues: ***T.L.*** at para. 36.

[536] As noted by Thomas J. at para. 101 of ***T.L. #2***:

> The question of preferability must take into account the importance of the common issues in relation to the claims as a whole: ***Hollick**, supra* at para. 30. It is clear that some individual issues must be determined after the common issues in many, if not most, class actions, and that fact alone is not a bar to certification; in determining preferability, all of the individual and common issues arising from the claims must be considered in the context of the factual matrix: ***Paron**, supra* at para. 114. Even where individual issues might predominate in the sense that much work will remain after resolution of the common issues, there might still be practical utility in deciding the common issues once, even if the overall benefits are slight: see ***T.L. #1**,* at para. 133.

[537] The law in this area was neatly summarized by Topolniski J. at para. 90 of ***Paron***:

> A class proceeding is the preferable procedure if it presents a fair, efficient and manageable method of determining common issues, and if such determinations will advance the proceeding in accordance with the goals of judicial economy, access to justice, and behaviour modification. The essence of the inquiry is to assess the common and individual issues contextually, and consider the impact of the individual issues on the trial process, including fairness to plaintiffs, defendants and the court. It focuses on two questions: (1) would the class action be a fair, efficient and manageable method of advancing the claim; (2) would the class action be preferable to all other reasonably available means of resolving the claims of class members.

[538] As such, preferability involves a balancing of all the interests of the parties and of the court and may involve an assessment of the economics of the litigation, the number of individual issues to be dealt with, the complexities if there are third party claims and the alternative means available for adjudicating the dispute: ***T.L. #2*** at para 99, ***Condominium Plan No. 0020701*** at para. 89.

[539] Where the common issues are overwhelmed by the individual issues, certification is not appropriate as the litigation will inevitably break down into individual proceedings: ***Condominium Plan No. 0020701*** at para. 91. However, even if the individual issues predominate over the common issues, an action may still be certified if there is some practical utility in deciding the common issues once: see ***T.L.*** at paras. 131-133. The question of preferability must take into account the importance of the common issues in relation to the claims as a whole: ***Hollick*** at para. 30. As such, the Supreme Court has advocated a contextual approach.

[540] The preferability analysis also requires the court to look at all reasonably available means of resolving the class members' claims, such as joinder, test cases, consolidation, and not just at the possibility of individual actions: ***Hollick*** at para. 31.

[541] The court is not restricted to the five factors articulated in s. 5(2) of the *CPA*; these are the minimum factors to consider, and the court may look at additional factors if necessary. For example, in ***T.L.***, where a question arose as to whether certain third parties ought to be added to the action as "necessary parties" for the purposes of determining liability, Slatter J. (as he then

was) introduced a new factor: whether all the parties necessary to the action had been named as defendants.

[542] Section 8 of the *CPA* provides that a court should not refuse certification by reasons only that the relief claimed includes a claim for damages that would require individual assessment after determination of the common issues; the relief claimed relates to separate contracts involving different prospective class members; different remedies are sought for different prospective class members; the number of prospective class members or the identity of each prospective class member has not been ascertained or may not be ascertainable; and the class includes a subclass where the prospective subclass members have claims that raise common issues not shared by all the prospective class members.

[543] In determining whether an action should be certified as a class proceeding, the court must strike a balance between efficiency and fairness: ***Western Canadian Shopping Centres*** at para. 44. Indeed, the Supreme Court of Canada has recognized the growing importance of the class action as a procedural tool in modern litigation, especially given the benefits that such actions can offer the parties, the court system and society: see ***Western Canadian Shopping Centres*** at para. 46; also ***Hollick*** at para. 15. As such, it is essential that the court not take an overly restrictive approach to class proceedings legislation, but rather interpret the legislation in a way that gives effect to the benefits foreseen by the drafters: *ibid.* The Alberta class proceedings legislation supports a purposive approach and provides for extensive flexibility in terms of procedures available to certification judges to deal with class actions as they unfold: ***Ayrton*** at para. 14.

[544] I conclude that a class proceeding is the preferable procedure for the fair and efficient resolution of the common issues identified. Questions of fact or law common to the members of the Proposed Class predominate over any questions affecting only individual prospective members of the Proposed Class. The only issue that will remain after the resolution of the common issues is a damages calculation based on comparing the cost of accommodation and meals (however determined) to what was paid. Given the mental and/or physical disability and age of members of the Proposed Class, it is unlikely that a significant number of them would have a valid interest in individually controlling the prosecution of separate actions. I am unaware of any claims that would be involved in the class proceeding that are or have been the subject of other proceedings. In my view, other means of resolving the claims would not be practical or more efficient. While difficulties may arise in the administration of the class proceeding, I do not anticipate that these would be greater that those likely to be experienced if relief were sought by other means.

E. Are Either Mr. Darwish or the EAAS Appropriate Representative Plaintiffs?

[545] Section 2(1) of the *CPA* provides that one member of a class of persons may commence a proceeding on behalf of the members of the class. Neither Mr. Darwish nor EAAS are members of the class. Section 2(4) provides that the Court may certify a person who is not a member of the class as the representative plaintiff for the class proceeding but may do so only if, in the opinion of the Court, to do so will avoid a substantial injustice to the class. Section 2(6) provides that the

Court may, where it considers it appropriate, appoint as a representative plaintiff a non-profit organization that is incorporated.

[546] I have concluded that certain of the causes of action pass the minimal threshold test for certification. The Proposed Class is comprised of people who are, in the main, aged and disabled by chronic health problems to the point that they are institutionalized. Mr. Darwish is skilled and experienced in the machinations of government and the mysteries of government finance. He is public-minded and has become involved through his concern for the residents of LTCFs, one of whom was his mother, and his concern with the problem that, as the auditor general has noted, Alberta does not have a policy on the portion of accommodation costs that are the responsibility of the Residents, what accommodation charges should consist of, or how to calculate the accommodation rate. Mr. Darwish has a legitimate interest in pursing accountability by Alberta on behalf of this vulnerable group.

[547] This class is entitled to pursue accountability for how the Accommodation Charge which its members pay is set and is spent. Without a civic-minded person to attempt to ensure that the Government is accountable to this class of seniors, it is unlikely that the questions raised and causes pursued will see the light of day. This would amount to a substantial injustice to the class. I am satisfied that Mr. Darwish, although not a member of the class, is an appropriate Representative Plaintiff for the class proceeding since, in my opinion, certifying him as such will avoid a substantial injustice to the class. However, he is not entitled to act as Representative Plaintiff in terms of the *Charter* claim given that his mother is now deceased.

[548] EAAS is a non-profit seniors collective and advocacy group incorporated under the *Societies Act*. The concern of EAAS is that there be a properly monitored, cohesive regime of care and medical treatment for the elderly. Further concerns of EAAS are reflected in the Auditor General's *Report*. Sometimes in a democratic system, it falls to community organizations to perform the role of watch dog in relation to government actions and services. At the heart of this case is an effort to assure accountability by Alberta and its agencies in the provision of one narrow band of services to the residents of LTCFs, a class comprised largely of senior and disabled people. I consider it appropriate to appoint as a Representative Plaintiff, EAAS, a seniors' advocacy group that is a non-profit, incorporated organization.

VI. Summary of Findings

[549] Pursuant to s. 5(1) of the *CPA*, this certification application raised the following issues and the following are the findings:

1. Do the pleadings disclose a cause of action?

   Yes. The action may proceed on the causes of breach of duty in terms of operational decisions/actions, breach of contract; *ultra vires* action; unjust enrichment; the administrative law claim (bad faith in the exercise of discretion); and on the *Charter* claims.

2. Is there an identifiable class of two or more persons?

   Yes. The following Class is approved:

   All residents of long-term care facilities, and patients in general hospitals in Alberta who have been assessed as requiring auxiliary hospital or nursing home level care, and the estates of such persons, who since August 1, 2003 have been charged the Accommodation Charge, save and except for all such persons who at any time since August 1, 2003 have received:

   (a) AISH benefits;

   (b) Supports for Independence (SFI);

   (c) the full Supplementary Accommodation Benefit;

   (d) benefits to pay the Accommodation Charge from WCB, the Department of Veteran Affairs (Canada), the Department of National Defence (Canada), the First Nations and Inuit Branch of Health Canada, and the RCMP; or

   (e) a waiver, in its entirety, of the Accommodation Charge increase which took effect August 1, 2003 pursuant to AR 260/2003, for reasons of financial hardship.

3. Do the claims of the members of the Class raise a common issue?

   Yes. The common issues include those outlined above.

4. Is a class proceeding the preferable procedure for the fair and efficient resolution of the common issues?

   Yes. The class proceeding is the preferable procedure for the fair and efficient resolution of the common issues.

5. Are either Mr. Darwish or the EAAS appropriate Representative Plaintiffs?

   Yes. While Mr. Darwish is not a member of the Class, he is an appropriate Representative Plaintiff except in terms of the *Charter* cause of action. The *Charter* cause of action may be brought by EAAS. It is also appropriate to appoint as a Representative Plaintiff, EAAS, a senior's advocacy group that is a non-profit, incorporated organization.

VII. Disposition

[550] The Plaintiff's application for certification succeeds. I reserve jurisdiction to deal with any issues that arise as a result of this judgement.

[551] The length of this Certification decision, while unfortunate, was necessary in order to properly assemble the facts and arguments for the litigants, interested members of the public, as well as any other Courts that may have occasion to deal with this case. Though I have certified this class action, I make no comment on its prospects for success.

Heard on the 28th, 29th, and 30th days of January, 2008.
Dated at the City of Edmonton, Alberta this 13th day of August, 2008.

S.J. Greckol
J.C.Q.B.A.

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