The Effects of Health Care Restructuring on Hospital Foundations in Ontario

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Introduction

Since the advent of universal medical care, Canadians have taken their right to medical care for granted and have assumed that there will always be doctors, nurses and other health care professionals and facilities available to them at no private cost whenever such services are needed. But somewhere along the line, the system has failed to work; Canadians now face lineups, delays, and shortages in health care. At least six provincial governments have recently, or are now, in the process of trying to correct the problems, so that once again Canadians can enjoy the best of medical care freely available to all lawful residents. Establishing a new system, in whatever form it may take, is not easy and Canadians have suffered and are, in many places, continuing to suffer the dislocation and uncertainty that accompanies change of any kind.

This article does not deal with the health care system directly, but instead with the charitable foundations that support the health care services provided by hospitals. As hospitals themselves come under attack for their failure to change with the times, what will be the impact on the foundations associated with the hospitals? In this context, the word "associated" is used, not in any legal sense, but simply to refer to the link which members of the public would expect to exist between, for example, Central Hospital and Central Hospital Foundation.

Hospital Foundations:

Functions

Throughout the 1980s, the increase in the costs of, and demand for, health services in Ontario continued to be a cause for concern to governments, health providers and the public. In the 1990s the costs of, and demand for, health services in Ontario have not abated, and indeed, may have increased, but the level of increases in funding for such services in the 1990s has not, and likely will not, be at the levels experienced in the 1980s. It is anticipated that the aging population will add to the demands for services. New developments in

technology and research will continue to make available to the health care system innovative procedures, new drugs and equipment, all of which will have an impact on the use of resources and need for services. As economic pressures on governments continue to increase, it becomes more difficult for them to respond to the needs of the communities. Fiscal restraints imposed by government require hospitals to respond to the cuts to funding by finding new sources of funding in order to maintain their services. Added to this is the fact that donors increasingly are being solicited by a greater number of charities, and on a more frequent basis, spreading ever more thinly this limited source of funding. These recent political and socio-economic realities have significantly affected hospitals. The challenge will be to find solutions to these difficult problems.

While not a solution in itself, donations realized through fundraising by hospitals' charitable organizations do somewhat lessen the impact of the current fiscal restraints. In many cases, a separate hospital foundation is established so that some or all fundraising can be carried on by the foundation.

A charitable foundation provides funds to charitable organizations or other qualified donees so that those organizations may carry out their objects. A foundation also can carry on charitable activities directly if its objects expressly permit the foundation to do so. The foundation is a legal entity separate from the hospital, and managed separately. It is either a charitable trust or a corporation without share capital. Since the latter is by far the most common form, this article will treat hospital foundations as such corporations.

As the need for funds increases, the resulting pressure on a hospital board to focus its attention on fundraising may detract from the board's primary focus which is the overall supervision of the management of the hospital and the delivery of health services. Nevertheless the establishment of a foundation and the consequent movement of fundraising to that entity can achieve several objectives. For example, the board and the management of the hospital are relieved of duties associated with fundraising, thereby permitting them to focus on their mandate which is the delivery of health services while board members of the hospital foundation can be selected for their interest and expertise in foundations and fundraising. Their commitment to the objects of the foundation and the dedication of their time and energy solely to these activities is more likely to achieve the desired goals. Further, the establishment of a foundation signals to the community a high degree of commitment by the hospital to fundraising and a desire for public support and voluntary giving towards the purchase of new equipment, special services, updated facilities and innovative programs, above and beyond the day-to-day hospital operations.

Each hospital must evaluate individually its fundraising requirements and its need for a foundation because a foundation may not be appropriate in all circumstances.

Control

a) *Preservation of Capital from Dissipation by Future Boards*

Where a particular hospital board has received capital through donations, the board may wish to ensure that these funds are not dissipated by future board members, but are protected for use by the hospital for many years to come. Future boards may not share an existing board's focus in planning for the hospital's future specifically in respect of funds realized through capital donations.

Recognizing that some future boards may be willing to permit capital funds to be used by the hospital for short-term purposes such as operating funds, the existing board may consider the possibility of transferring such capital funds to a foundation to protect them for long-term purposes.

b) *Preservation of Capital From the Ministry of Health*

The majority of funding for hospitals in Ontario comes from the provincial government through the Ministry of Health in the form of annual transfer payments. The transfer payment is made to the hospital to fund the programs and services contemplated for the fiscal year, may vary from year to year, and while funding formulae are employed to determine the level of funding for a particular hospital, generally, the amount of any payment is at the discretion of the Minister.

Hospitals are required to submit financial statements to the Ministry of Health annually. A hospital may have built up a capital base by way of large cash gifts, bequests or other planned gifts which are not specified for particular purposes. As disclosure to the government of these funds in financial statements is mandatory, the concern is that such funds may be viewed as available for operating expenses and, as a consequence, the government may reduce funding.

Thus, many hospital foundations were established so that hospitals could transfer funds to the foundation in an attempt to avoid the possibility of a government cutback. There can also be a concern that an accumulated surplus of donated funds may be treated as if it is simply undisbursed government grants, subject to possible demands for reimbursement. The transfer of such capital into a separate foundation with the appropriate control mechanisms can offer protection.

Changes Effected by Bill 26

Creation of the Health Services Restructuring Commission

Bill 26, the *Savings and Restructuring Act, 1996*, S.O. 1996 c1, addresses the restructuring of health services in Ontario and was proclaimed in force on March 1, 1996. Part I of Schedule F of the *Act* amends the *Ministry of Health Act* and creates the Health Services Restructuring Commission. Established on April 1, 1996, the Commission will be in existence for a period of up to four years. Any duties and powers to be assigned to the Commission are to be with respect to the development, establishment and maintenance of an effective and adequate health care system and the restructuring of health care services provided in Ontario communities having regard to district health council reports for those communities. Part II of Schedule F of the *Act* amends the *Public Hospitals Act* and expands the powers of the Ministry of Health to control hospitals directly in matters related to funding, operations, the provision of services and amalgamations of hospitals.

Changes to the Public Hospitals Act *and Expanded Powers of the Ministry to Control Hospitals Directly*

The amendments to the *Public Hospitals Act* give the Minister of Health broad powers to issue directions in respect of a hospital where the Minister considers it in the public interest to do so. Specifically, section 6 of the *Act* authorizes the Minister to do any of the following: to direct the board of a hospital to cease operating as a public hospital; to direct the board of a hospital to provide specified services to a specified extent or of a specified volume; to cease to provide specified services, or to increase or decrease the extent or volume of specified services; to direct the boards of two or more hospitals to take all necessary steps required for their amalgamation under section 113 of the *Corporations Act;* or to make any other direction related to a hospital that the Minister considers in the public interest. The *Act* sets out a test with respect to what the Minister may consider in making a decision in the public interest. Subsection 9.1 (1) provides that in making a decision in the public interest the Minister may consider any matter he or she regards as relevant, including: (a) the quality of the management and administration of the hospital; (b) the proper management of the health care system in general; (c) the availability of financial resources for the management of the health care system and for the delivery of health care services; (d) the accessibility to health services in the community where the hospital is located; and (e) the quality of the care and treatment of patients.

Where the Minister issues a direction under section 6, the Minister must have regard to district health council reports for the communities to which the

direction relates. The Minister may amend or revoke any direction where the Minister considers it in the public interest to do so.

Ontario Regulation 87/96 made under the *Public Hospitals Act* came into force on April 1, 1996 and authorizes the Health Services Restructuring Commission to issue directions under section 6 of the *Act* in place of the Minister. In this regard the Commission may issue directions under section 6 where it considers it in the public interest to do so. In issuing a direction, the public interest test applies and the Commission may consider any matter it regards as relevant including any or all of the matters set out in subsection 9.1 (1) of the *Act.*

The board of a hospital is required to ensure that any direction is carried out in accordance with its terms, the *Act* and the regulations. The board has the unrestricted power to carry out the direction despite the *Corporations Act,* any special *Acts* governing hospitals, the letters patent, supplementary letters patent or bylaws of a hospital. Such powers must not contravene the provisions of any other *Act.*

The authority to make directions in respect of a hospital under section 6 of the *Act* is repealed as of March 1, 2000.

a) *Payments to Hospitals*

The amendments to the *Public Hospitals Act* give the Minster of Health the discretion to determine all funding matters related to a hospital. The Minister may pay any grant, make any loan and provide any financial assistance to a hospital if the Minister considers it in the public interest to do so. In making a grant or loan, or in providing financial assistance to a hospital, the Minister of Health may impose, amend or revoke terms and conditions, or require the hospital to secure repayment in the manner determined by the Minister. If the Minister considers it in the public interest to do so, he or she may reduce the amount of a grant, loan or financial assistance to a hospital and suspend, terminate or withhold payment in whole or in part. In making any funding decision, the public interest test would apply and in this regard the Minister may consider any matter he or she believes to be relevant, including the matters set out in subsection 9.1 (1) of the *Act.*

b) *Other Powers*

The pre-existing provisions of the *Public Hospitals Act* were related to matters concerned with the supervision or regulation of the quality of the management and administration of hospitals and the care and treatment of patients in the hospital. There was no authority to require a hospital to cease operations or to amalgamate, nor were there any provisions requiring a hospital to alter the services it provided. The amendments to the *Public Hospitals Act* have sig-

nificantly broadened the scope of matters for which the Minister, Lieutenant Governor in Council or Commission may have regard when making decisions under the *Act*. These now include matters related to the proper management of the health care system in general and the availability of financial resources for the management of the health care system and for the delivery of health care services. It could be argued that it is reasonable that the power to issue a direction to a hospital to cease operations should be supported by evidence that either the hospital itself is not being managed or administered properly or that the hospital should cease operations having regard to the proper management of the health care system overall, including the availability of financial resources for the management of the system. The decision-making powers that have been given to the Minister, Lieutenant Governor in Council and the Commission are virtually all-encompassing with respect to hospitals, and the criteria that may be considered by the decision makers are beyond the scope of the supervision and regulation of the administration and management of individual hospitals.

The Minister is also given extensive powers to appoint inspectors and supervisors, and the supervisors may exercise all the powers of the board and the corporation, its officers and members. The Lieutenant Governor in Council may specify the duties and powers of a supervisor and the terms and conditions governing those duties and powers. In addition, the Minister may, under subsection 9(10) of the *Act*, issue directions to a hospital supervisor about any matter within the jurisdiction of the supervisor. Ontario Regulation 87/96 under the *Public Hospitals Act* authorizes the Health Services Restructuring Commission to issue directions in the place of the Minister.

"Public Interest" Powers

General

Subsection 9.1(1) of the *Act* provides that the Minister of Health, or the Lieutenant Governor in Council, as the case may be, in making a decision under the *Act* in the public interest may consider any matter he or she regards as relevant, including:

a) the quality of the management and administration of the hospital;

b) the proper management of the health care system in general;

c) the availability of financial resources for the management of the health care system and for the delivery of health care services;

d) the accessibility of health services in the community where the hospital is located; and

e) the quality of the care and treatment of patients.

Decisions about hospitals that may be made "in the public interest" by the Minister of Health under the *Act* include: funding; directions to cease operations under section 6; directions to provide or alter or cease to provide services or to amalgamate; or to take any other action that the Minister considers in the public interest; and directions to a hospital supervisor with regard to any matter within the jurisdiction of such a supervisor. The decisions that may be made by the Lieutenant Governor in Council "in the public interest" include the appointment of an investigator or supervisor for a hospital.

Clause 32(1) (z. 1) of the *Public Hospitals Act* provides that regulations may be made authorizing any person, group of persons or other body to issue directions related to a hospital under section 6 and subsection 9 (10) in the place of the Minister and respecting any conditions to which that authority may be subject. Pursuant to subsection 32 (2) of the *Act,* where a person or body is authorized to issue directions under a regulation, then subsection 9.1 (1) of the *Act* applies with respect to the person or body as if the person or body were the Minister. O. Reg. 87/96 made under the *Public Hospitals Act* authorizes the Health Services Restructuring Commission to issue directions under section 6 and subsection 9 (10) of the *Act* in place of the Minister.

Restructuring

Subsection 6(5) of the *Public Hospital Act* requires that, at least 30 days before issuing a direction to the board of a hospital to cease operating as a public hospital or to two or more boards to amalgamate, the Minister or the Commission, as the case may be, is required to serve notice of intention to issue the direction. Guidelines are to be set by the Commission respecting representations that may be made to the Commission by a hospital that has received notice under subsection 6(5) of the *Public Hospitals Act* that the Commission intends to issue a direction that the hospital cease to operate or that it amalgamate with another hospital. The guidelines are to set out the manner in which representations may be made and the procedure for making the representations.

Powers

Ontario Regulation 88/96 further provides that the Commission may exercise such powers as are necessary to carry out the duties of the Commission. The powers of the Commission are to consult with providers of health care services and such other persons as the Commission considers necessary in order to determine: (i) which local hospital restructuring plans provided by the Ministry shall be implemented; (ii) whether and in what manner to vary or add to a local hospital restructuring plan, (iii) the timing of the implementation of a local hospital restructuring plan, and (iv) the manner in which a local

hospital restructuring plan is to be implemented. Also, the Commission may exercise any power under section 6 or subsection 9(10) of the *Public Hospitals Act* assigned to the Commission by regulation under that *Act,* and may advise the Minister as to the revocation of a licence under section 15.1 of the *Private Hospitals Act.* The Commission may advise the Minister on all matters relating to the development, establishment and maintenance of an effective and adequate health care system and the restructuring of health care services provided in Ontario communities.

Protection from Liability

The *Public Hospitals Act* prohibits any proceeding against the Crown or the Minister with respect to a decision or direction under section 5 or 6, the appointment of an investigator or a hospital supervisor under section 8 or 9 or an action or omission of an investigator or hospital supervisor done in good faith in the performance of a power or an authority under either section 8 or 9. The exception to this is that the Crown is not relieved of liability in respect of a tort committed by an investigator, hospital supervisor or person(s) or body to whom the Minister's powers have been assigned to which the Crown would otherwise be subject and the Crown is liable for such tort.

The *Public Hospitals Act* also prohibits any action or other proceeding for damages or otherwise to be instituted against an investigator or a hospital supervisor appointed under section 8 or 9 or against the Health Services Restructuring Commission for any act done in good faith in the execution or intended execution of any duty or authority under the *Public Hospitals Act* or regulations or for any alleged neglect or default in execution in good faith of such duty or authority.

Subsection 8 (8) of the *Ministry of Health Act* prohibits any proceedings for damages or otherwise to be commenced against the Commission or against any member, officer, employee or agent of the Commission for any act done in good faith in the execution or intended execution of any of its or their powers or duties or for any alleged neglect or default in the execution in good faith of any of its or their powers or duties.

Impact on Hospital Foundations

Historically, the *Public Hospitals Act* was intended to provide an exclusive statutory scheme for the supervision and regulation of public hospitals. The provisions of the *Act* and its regulations are concerned with the management and administration of hospitals. The areas in which decision-making powers have now been granted to the Minister, the Lieutenant Governor in Council

and the Commission under the *Public Hospitals Act,* coupled with the power to make these decisions in the public interest, raise questions as to the extent of control that the Minister of Health or the Commission can exercise not only over hospitals but, potentially, hospital foundations. The "public interest" powers may have far-reaching implications because the matters that the Minister may consider in making decisions under the *Act* relate not only to the management and administration of the hospital itself, but also to the proper management of the health care system in general, the availability of financial resources for the management of the health care system, and the delivery of health care services. It is arguable that these powers could be exercised to effect the regulation or control of hospital foundations. The potential for such control arises from the power under the *Public Hospitals Act* to make regulations respecting the disposition of assets acquired or used for the purposes of a hospital.

To date no regulation has been made in respect of this provision, but it does raise the question as to how far-reaching such a regulation could be and to what extent, if at all, it could be made to apply to funds held by a foundation and designated for a hospital.

Clause 32 (1) (t) of the *Act* provides that regulations may be made respecting matters that relate to, or arise as a result of, a direction under section 6 including matters related to: the powers and duties of a board that is subject to a direction; present and future property, rights, privileges and franchises; present and future liabilities; contracts, disabilities and debts; and medical records, including their ownership, custody, use, disclosure, retention and disposal. Again, no such regulation has been made. However, where a board is directed to close a hospital, or two boards are directed to amalgamate their hospitals, or a hospital is directed to alter its services, could a regulation be made with respect to the hospital's present and future property, specifically in respect of its hospital foundation which provides funds to the hospital so that it may carry out its objects?

The Bill 26 amendments provide for the enactment of regulations to define hospitals and hospital subsidiaries and to require those entities to provide financial reports and returns to the Minister. The recent enactment of regulations defining a hospital foundation and hospital subsidiary and requiring such entities to provide financial reports to the Minister is evidence of control being exercised by the Minister over such foundations.

Subsection 32(4) of the *Act* provides that the Minister of Health may, by regulation, require hospital subsidiaries and hospital foundations to provide reports and returns to the Minister and may prescribe the accounting principles and rules to be followed in making those financial reports and returns

and the manner in which they are to be provided. Ontario Regulation 552/96 made under the *Public Hospitals Act* amends Regulation 965 adding new section 35 which came into force on December 20, 1996. Subsection 35(1) of Regulation 965 now defines "hospital foundation" and "hospital subsidiary" for the purpose of section 32(4) of the *Public Hospitals Act.* "Hospital foundation" is defined to mean a trust, corporation or other organization, other than a hospital, that is a registered charity under the *Income Tax Act (Canada)* and that, during its most recently completed taxation year, was designated under the *Income Tax Act (Canada)* as a registered charity associated with another registered charity that was a hospital, or received one or more gifts having an aggregate value of more than $100,000 from one or more hospitals or hospital foundations. "Hospital foundation" is also defined to mean a trust, corporation or other organization, other than a hospital, that is a registered charity under the *Income Tax Act (Canada),* but is not a private foundation as defined in Subsection 149.1 (1) of the *Income Tax Act (Canada),* and that during the most recently completed taxation year, made expenditures and gifts for the benefit of one or more hospitals or hospital foundations in an amount that was greater than 50 per cent of the value of its total expenditures and gifts for the taxation year, or had, as its principal object, the object of benefiting one or more hospitals or hospital foundations, whether the object was express or implied.

Ontario Regulation 553/96 made under the *Public Hospitals Act* came into force on December 20, 1996 and requires hospital foundations to provide a copy of their most recent audited annual financial statements to the Minister of Health. A hospital foundation must include with its financial statements a list indicating the name of every person, group of persons, organization or other body who, during the taxation year to which the financial statements relate, received $50,000 or more, or assets with a value of $50,000 or more, from the foundation for no consideration or for consideration that is substantially less than the amount of money or the value of the assets at the time of the transfer. A hospital foundation is required to include in the list the amount of money and the value of the assets received by each person, group of persons, organization or other body whose name appears on the list.

The new provisions also affect hospital subsidiaries. Hospital subsidiaries must now provide a copy of their most recent audited annual financial statements to the Minister of Health. "Hospital subsidiary" is defined as a corporation that is controlled directly or indirectly in any manner by one or more hospitals.

The amendments to Regulation 965 of the *Public Hospitals Act* also provide that a corporation that owns or operates a hospital or that has previously owned or operated a hospital shall not take any action that may result in the dissolution of the corporation unless the Minister approves the action.

In recent court cases involving challenges to the Commission's decisions, one of the grounds for upholding the powers of the Commission to deal with the assets of hospitals was the fact that in many cases the bulk of the hospital's assets had come from public funds. This fact could be relied on to give the Commission extra rights or to lessen the onus on the Commission to prove that it was acting within its powers. This ground is far less likely to be applicable in the case of hospital foundations.

Experience In Other Provinces

Several Canadian provinces have undertaken health care restructuring in the past 10 years.

In New Brunswick, effective March 1, 1992, the *Hospital Act*, Chapter H-6.1 of the *Acts of New Brunswick*, 1992, repealed the existing *Public Hospitals Act*. The new *Act* brought about a massive restructuring and consolidation of health care services. In 1988, by Regulation 88–200 under the *Health Act*, the province had been divided into seven health districts. The new *Act* established a new body corporate, called a "hospital corporation", in each of the seven districts (now referred to as "regions") (one district was split into two parts) and transferred "(a)ll rights, powers, privileges, franchises, entitlements, debts, obligations, liabilities, duties and responsibilities" of the hospitals in each region to the new corporation. The corporations were to establish, operate and maintain hospitals and provide health services. The Minister of Health and Community Services appointed the boards of the hospital corporations for the first two years.

The new *Act* contained no provisions with respect to hospital foundations. Accordingly, each of the regions has dealt with previously existing foundations in its own way. The results vary from a region in which each health care facility kept its own foundation to a region in which all of the hospital foundations have consolidated to form one regional foundation for the general support of health care in the region.

Alberta is well-known for the recent changes in its health care system, including a significant number of hospital closings. Such changes are perhaps too recent to have had any impact on previously existing hospital foundations. Anecdotal comments suggest that problems involving hospital foundations have not yet worked their way into the system. Note should be taken of the

position of the government with respect to hospital foundations as set out in the *Hospital Act*, R.S.A. 1980, c.H-11, as amended by S.A. 1985, c.32, s.11. Ss. 72(2) which reads:

> No person shall operate a hospital foundation established to benefit a general or auxiliary hospital, including any corporation established before the commencement of this section, to receive, hold, administer and apply any property or the income from it for purposes or objects in connection with a hospital unless exempted by the Minister subject to any terms and conditions he prescribes.

In British Columbia, the *Health Authorities Amendment Act*, 1997 (the "new *Act*") had its first reading on May 21, 1997. It was intended to amend the *Health Authorities Act*, R.S.B.C. 1996, chapter 180, replacing the "New Directions" approach to regionalization with the "Better Teamwork, Better Care" approach to regionalization. The *Health Authorities Act* established regional health boards and community health councils across British Columbia (s. 2 of the *Act*). Under the new *Act*, the previous structure of regional health boards *and* community health councils in each region was replaced by a structure consisting of a regional health board *or* community health councils in each region. Effective April 1, 1997, the province was to be divided into 11 regions. In each region, a health board has been appointed by the government to operate the health care facilities, including hospitals, treatment centres and extended-care institutions. Effective October 1, 1997, community health councils were to come into existence to operate the health care facilities in smaller centres throughout the province. In order to implement the changes, the new *Act* provides for the amalgamation of some boards and councils.

Neither the *Health Authorities Act* nor the *Health Authorities Amendment Act, 1997* specifically refers to independent hospital foundations.

The British Experience

Large scale restructuring of health services by government action is not a process unique to this decade or to Canada. In Great Britain, the Labour Government radically transformed the hospital system by nationalizing virtually all hospitals on July 5, 1948 (the "appointed day") pursuant to the *National Health Services Act, 1946*. The goal of the restructuring was to ensure that health services were universally available and financed by the central government. Nationalization also included the transfer to the Minister of Health of endowments held by the hospital governing bodies and endowments held by third parties solely for the use of such hospitals.

Prior to nationalization, Britain's hospitals fell into two nonintegrated categories. One group consisted of local authority hospitals that were financed

by the local rates and occasional exchequer grants.[1] The second consisted of the voluntary hospitals financed by gifts, donations and endowments and by contributions from fee-paying patients and from quasi-insurance contributory schemes.[2] There was no significant co-ordination of hospitals and services were not universally accessible throughout Britain. Although the *Local Government Act, 1929* empowered local authorities to provide hospital services, it was permissive and not mandatory so the provision of local authority hospitals was uneven in terms of availability and quality. The distribution of voluntary hospitals was not based on the ascertained needs of particular populations. Provision largely depended on the donations of the living and the legacies of the dead.[3] In addition, voluntary hospitals did not pay their doctors. Their positions were honorary and doctors depended on fee-paying private patients for their living. Consequently, voluntary hospitals tended to be concentrated near the wealthier parts of major centres. Poorer and less populated areas were often badly serviced.[4]

Upon nationalization, the equipment, buildings and other property used to provide treatment were transferred to the Minister (s. 6 of the *National Health Services Act, 1946*). Income-generating endowments of nonteaching voluntary hospitals were also transferred (s. 7 of the *National Health Services Act, 1946*). The boards of governors of designated teaching hospitals were allowed to keep their endowments for hospital purposes or research (s. 7(1) of the *National Health Services Act, 1946*).[5]

The endowments of nonteaching hospitals were transferred to the Hospital Endowments Fund which was established by, and vested in, the Minister. The government used these funds to meet the liabilities of the voluntary hospital system and the remaining capital was apportioned according to the proportion of beds administered by the hospital authorities as of December 31, 1948. Income from the Fund was paid out *pro rata* to the hospital authorities according to their apportioned share of the capital. Endowments were transferred free of any existing trusts. However the hospital authorities were required to ensure that, as far as was reasonably practicable, the original objects of the gift were preserved, particularly any conditions intended to preserve the memory of any person or class of persons.[6]

The term "endowment" was defined in s. 7(10) of the *Act* as meaning "property held by the governing body of the hospital or by trustees solely for the purposes of that hospital". Endowment property included interests in land not included in s.6 of the *Act*, investments, money, and rights under a bill of exchange, promissory notes or gratuitous covenants for the payment of money.

Minister of Health v. *Fox and Another*, [1950] 1 All E.R. 1050 interpreted the phrase "property held by trustees solely for the purposes of that hospital". The issue was the disposal of trust monies on the transfer of a maternity hospital to the Minister. The trustees had been authorized to apply the money "either for the general purposes of the maternity home aforesaid or for such other public charitable purposes and in such manner as the trustees see fit". It was held that since the trustees were holding the property for the purposes of the maternity home *immediately before the appointed day* under the *Act*, it passed to the Minister notwithstanding that the trust deed empowered the trustees to divert the property or endowments to other purposes. The decision was based on the conclusion that the phrase was to be construed exclusively by reference to the uses to which the land was, in fact, being put on July 4, 1948 without reference to any purpose or trust which might become operative in the future.

This narrow approach was rejected in *Majoribanks and Others Trust Deed; Frankland* v. *Minister of Health*, [1952] Ch. 181, 1 All E.R. 191. This case dealt with the transfer of nonendowment property under section 6 which uses similar wording. The trustees held certain premises for use as a home for the incurably ill. There was a remote remainder in favour of other charitable purposes if the voluntary hospital ceased to exist. There was also a provision enabling the income of the invested proceeds of sale of the premises to be applied to pay pensions to "incurables" who were not hospital patients. The Court of Appeal held that, on the particular facts, the premises were held solely for the purposes of the hospital. The key question was, on July 4, 1948, for what purposes did the trustees hold the land? The Court held that consideration had to be given to the entire trust instrument and its surrounding circumstances. In this instance, the remote remainder and the pension stipulation, although distinct from the activities of the home as a physical entity, were so closely connected with, and so much a part of, the purposes of the home that they would have ceased if the home itself had ceased to exist. A court cannot apply an analysis that would exclude all property that has any sort of distant contingent interest, especially if that interest deals with the disposition of property should the primary objects fail, since this would cause a large number of endowments to be excluded. However, there may be some instances where a hospital receives the benefit of a piece of property on the appointed day but the property is not being held by the trustees *solely* for the benefit of the hospital as contemplated by the *Act*.. An example would be premises held on trust for the limited purpose of providing hospital services to men wounded in the Second World War and, upon the exhaustion of that purpose (as would necessarily happen in a relatively short time), on trust for some educational purpose, and where the premises were in fact being used for the former purpose on July 4, 1948. The Court opined that referring to the

former purpose and neglecting to make reference to the latter would fail to satisfy the ordinary requirements of common sense or accuracy.

Re Galloway (deceased); Hollins and Others v. *Attorney-General of the Duchy of Lancaster and Others*, [1952] 1 All E.R. 1379 (C.C.P. Lancaster) adopted the approach in *Majoribanks*. The testator left an estate worth about £150,000. The trustees were granted complete discretion to use the funds to provide for the maintenance of the poor residing in or near Preston. After the testator's death, the trustees obtained a court order allowing them to invest £20,000 and to pay (or not pay) some or all of the income to the Preston and County of Lancaster Queen Victoria Royal Infirmary at their discretion. The Court held that although the trustees of a trust fund had been paying the whole income of the fund to the hospital governing body for the purposes of the hospital, they had the discretion *not* to pay under the terms of the trust. They exercised that discretion on July 2, 1948 and ceased paying income from the fund to the hospital, therefore the trust property was not held *solely* for the purposes of the hospital on the appointed day and did not pass to the Minister.

There were also a number of charities that existed independently of hospitals at the time of nationalization whose aims were to provide funds in support of groups of voluntary hospitals. The King Edward's Hospital Fund for London was founded in 1897. Before the appointed day it provided funds to the voluntary hospitals of London and to projects designed to encourage the efficient co-ordination of hospital resources in the capital.[7] The Nuffield Provincial Hospitals Trust was established to pursue similar objectives outside of London.[8] Prior to nationalization, the Minister of Health indicated that the government was not interested in confiscating the endowments of organizations such as the King's Fund and that these organizations would be allowed to continue their charitable purposes after nationalization without adverse effects.[9] In fact, provisions were made to allow nationalized hospital authorities to accept charitable gifts after July 5, 1948 (s. 59 of the *National Health Services Act, 1946*). Presumably, funds like these fell outside the definition of endowments set out in the *Act* since they were not held by hospitals and their objects were not *solely* for the benefit of patients in any particular hospital and were subject to the broad discretion of the trustees. Indeed, the King's Fund and the Nuffield Trust have survived to the present day. Their original objects were broad enough to permit them to continue their activities although nationalization accomplished the primary goals of providing operating funds and regional co-ordination. The King's Fund provides money to compensate for government shortfalls in funding[10] and the Nuffield Trust concentrates on investigating and analyzing the workings of the Health Service by research and experimentation and suggesting ideas for improvement.[11]

The British experience is informative since it shows the extent to which a government has gone to control health services, including appropriating endowments held by third party trustees solely for the purposes of a particular nationalized hospital. However, the case law indicates that the English courts of the time were inclined to interpret these statutes in accordance with common sense and were disinclined to interpret provisions in a way that would deprive potential beneficiaries of interests that were not directly connected to, or necessarily incidental to, the purposes of the hospital.

Impact On Hospital Foundations

Introduction

In many cases, the impact of health care restructuring on hospital foundations will be directly related to the impact of health care restructuring on the hospital with which a foundation is associated.

The Health Services Restructuring Commission has issued directions to each of the Ontario hospitals on which it has reported to date. The most common directions are as follows:

1. Transfer all services to another hospital and cease to operate as a public hospital.
2. Accept some services transferred from another hospital and continue to operate as a public hospital.
3. Transfer some services out to another hospital and then continue to operate as a public hospital.
4. Amalgamate with one or more other hospitals.
5. Make no changes in the operations of the hospital.
   (Recommendation 5 will obviously not create any new problems for the hospital or its associated foundation and accordingly will not be discussed further.)

The response of each hospital foundation will depend on which of the recommendations set out above has been made for the hospital with which the foundation is associated. In addition, the response of each foundation will depend on whether the foundation's assets were received by it as unrestricted gifts, or as gifts subject to restrictions or trusts. The restrictions or trusts may be imposed by the foundation's objects as set out in its letters patent, or as terms attaching to particular gifts. Each of these two broad categories of gifts will be dealt with separately below in relation to each type of recommendation made for the foundation's associated hospital although, in practice, a founda-

tion may hold both unrestricted and restricted assets and may have to deal with each asset on a different basis.

A further factor, the wishes of the directors of each foundation, is more difficult to analyze and will be dealt with by implication in each section below. Directors are, of course, required to act in the best interest of the corporation, i.e., the foundation, a difficult interest to determine in some cases of hospital restructuring.

Unrestricted Gifts

a) *Meaning*

Most donations made to hospital foundations are made without any restrictions being imposed by the donor on the use of the funds. The foundation gives a charitable donation receipt for the amount of the gift and adds the funds to its assets. But can the directors of the foundation use the funds for any purpose they see fit? The answer would appear to be no, for two reasons. First, the foundation is bound by Revenue Canada's requirements regarding the use of its assets and income. Second, the foundation is bound by the terms of its incorporating statute, its bylaws, and, most importantly, its letters patent.

The objects of a hospital foundation as set out in its letters patent can take a wide variety of forms. In the simplest case, the objects of a hospital foundation would be to support health care generally as well as permitting the directors to make donations to the hospital with which the foundation is associated. At the opposite end of the spectrum, hospital foundations may have objects which restrict them to making gifts only to the hospital with which the foundation is associated.

If there are no restrictions on the types of health care organizations which may be benefited by a particular hospital foundation, would the hospital foundation be permitted to make gifts to any charitable organization involved in health care, or are the potential donees limited because of the public perception of the foundation's work? In other words, is there an assumption in making a gift to, for example, Big Hospital Foundation, that the foundation's work will benefit Big Hospital even if Big Hospital Foundation's letters patent do not limit it so narrowly? In the view of the authors it is the wording of the objects in the letters patent which governs the authority of the directors and unless the directors had accepted funds subject to a particular restriction or had assured a donor that the funds would be used for a certain purpose, there would be no such restrictions on them. The directors would therefore be free to use the income and assets of the foundation to support health care without specifically benefiting Big Hospital.

b) *Position of a hospital foundation whose associated hospital is told to transfer all services to another hospital and then cease to operate as a public hospital*

If the hospital foundation had objects as broad as those set out above, it would appear that the directors of the foundation would be free to choose to carry on operating and to continue to fund health care services chosen by the directors, including the hospital to which the associated hospital's services had been transferred. The directors could also choose to give substantial capital gifts, even to the extent of exhausting the capital of the foundation if the letters patent permitted it, to charities involved in health care. The foundation could then be dissolved with no assets left to be concerned about.

Alternatively, if the directors choose not to continue to operate the foundation, the directors may wish to dissolve it while it still holds its assets. If the letters patent of the foundation provide that, on dissolution, all of the assets are to pass to the hospital with which the foundation was associated, it will be important to ensure that the foundation is dissolved and the assets transferred before the associated hospital ceases to operate as a public hospital. If this is not done, or in preference to doing this, it may be possible to bring a *cy-près* application (see below) to determine what the directors may do with the foundation's assets.

If the foundation's assets are not given away to other health care charities while the associated hospital continues to exist, would it be possible to amend the letters patent of the foundation to provide that other charities would be benefited on the dissolution of the foundation? This depends on whether or not the assets of the foundation are seen as being held on a "charitable trust" for the ultimate benefit of the associated hospital. Certainly if the charitable foundation were not an incorporated entity but instead were a trust, and the agreement creating the trust provided that on the dissolution of the trust all of the property of the trust was to be transferred to the hospital with which the foundation was associated, unless the settlor of the trust had reserved a power to himself or to the trustees to amend the terms of the trust on the winding-up of the trust, all of the assets would have to be transferred to the hospital. The Public Guardian and Trustee of Ontario would take the position that regardless of the form of the charitable foundation, the same obligation would exist to transfer assets to the named charity on the dissolution of the foundation. It is not clear why this should be the case with a charitable foundation which is an incorporated entity. The *Corporations Act (Ontario)* permits the directors of a nonshare corporation incorporated under that statute to amend the corporation's letters patent from time to time. Paragraph 131(1)(c) specifically states that a corporation may apply for supplementary letters patent "varying any provision in its letters patent or prior supplementary letters patent".

We would take the position that it is the corporate statute which governs what the directors of an incorporated charitable foundation may or may not do. Unless the directors hold funds subject to a specific trust imposed by the donor of the funds, the directors should have the power to amend the letters patent of the foundation to provide that a different charity or a group of different charities would receive the property of the foundation on its dissolution.

Reference should also be made to the Ontario court decision in *Re Centenary Hospital Association* (1989), 69 O. R. (2d) 1. There the Court decided that the hospital held the land which it owned and wanted to develop into a medical arts centre as its own property and that the land was not subject to a charitable trust. Counsel for the hospital conceded that the Public Trustee would have jurisdiction under the *Charities Accounting Act* in respect of property of which the hospital was a trustee. The Court gave the example of "funds contributed for a specific purpose such as the endowment of a number of beds" which "may not be misapplied by the corporation or its board of directors for purposes other than those for which the endowment was made" (at page 8). Using this same distinction, if funds had been donated to a foundation for the express purpose of benefiting the associated hospital, the directors would be bound by that obligation, but if there has been no restrictions on the gifts to the foundation, the directors should be able to amend the foundation's letters patent to choose new recipients of funds on the winding-up of the foundation.

It is possible that there may be an argument by the hospital which had received the services of the associated hospital that the directors of the foundation had acted in bad faith by refusing to transfer the assets to the associated hospital (and thus possibly to the new hospital) before the associated hospital ceased to operate. Unless the new hospital was clearly entitled to all of the assets of the associated hospital, it is difficult to see how the new hospital would have been unfairly deprived of a benefit.

If the letters patent of a foundation are not amended and the associated hospital is dissolved, it would be necessary for the foundation to bring a *cy-près* application to the court to determine what other charities should receive the funds. Because the funds were clearly dedicated to charity, there would be no need for the foundation to prove a general charitable intent on the part of the original donor of the funds. No one other than charities would have an interest in the funds.

c) *Position of a hospital foundation whose associated hospital will accept some additional services from other hospitals and go on operating as a public hospital*

In this situation, there should be very little change in the operations of the foundation. The fact that the associated hospital will now offer additional services may give new opportunities to the foundation for additional fundraising opportunities. The wording of the foundation's letters patent may have to be amended to add references to the new services if they will be different from the health care services for which the existing letters patent authorized support.

d) *Position of a hospital foundation whose associated hospital is to transfer out some services and then go on operating as a public hospital*

In this situation, as long as the funds which the foundation holds are unrestricted gifts, there should be no effect on the operations of the foundation. This situation is the reverse of c) above. The foundation may lose some opportunities for fundraising as the services of its associated hospital will be narrower than had previously been the case. The wording of the foundation's letters patent could probably be amended to delete references to the services being transferred out or, alternatively, the directors could simply direct future funds to be used for the services still being carried on by the associated hospital.

e) *Position of a hospital foundation whose associated hospital has been told to amalgamate with one (or more) other hospitals*

The major question for the foundation will be whether or not it should copy the amalgamation which its associated hospital will be effecting and amalgamate with the foundation associated with the second hospital. This will depend on several factors. First, an amalgamation will be impossible if the two foundations were not incorporated under the same statute. It is not possible to amalgamate a federally incorporated nonprofit foundation with a provincially incorporated nonprofit foundation. Second, the possibility and desirability of amalgamation will depend on the similarity in the objects of the two foundations. Subsection 113(1) of the *Corporations Act (Ontario)* provides that:

> Any two or more companies, including a holding and subsidiary company, having the same or similar objects may amalgamate and continue as one company.

Supplementary letters patent may be required to change the objects of either or both of the foundations before an amalgamation can take place. The approval of the Public Guardian and Trustee would also be required as part of

this process. (The *Canada Corporations Act* does not contain any provisions dealing with the amalgamation of nonshare corporations.)

If each foundation has been permitted to make donations to health care organizations generally and the amalgamated hospital corporation will continue to offer health care services as a public hospital, there should be no legal impediment to the amalgamation. If the objects of each foundation permitted it only to support the work of its associated hospital, there should be no legal impediment to an amalgamation. The objects in the letters patent of the amalgamated foundation will refer to supporting the work of the now amalgamated hospital. As the amalgamated hospital will possess "all the property, rights, privileges and franchises" of each of the amalgamating companies (subsection 113(4)), the objects of each foundation could still be carried out by making donations to the amalgamated foundation.

What would the situation be if each foundation had been permitted to make donations to health care organizations generally, but the two hospitals which were amalgamating offered very different services? For example, if hospital A were a cancer hospital and its associated foundation had total assets of $2 million, and the hospital with which it was amalgamating had been a general hospital with no cancer services and its associated foundation had assets of $4 million, following the amalgamation of the two foundations would it be necessary to ensure that at least $2 million of the new foundation's assets were kept separate to support cancer services in the associated amalgamated hospital? As a matter of corporate law, this would appear not to be necessary. For example, if a shareholder purchases shares in a corporation which does mining exploration and the corporation later amalgamates with a much larger corporation which manufactures widgets, there would be no obligation on the amalgamated corporation to continue to use the funds initially subscribed to the mining exploration corporation for that purpose. Is the situation different for charitable foundations? Is some tracing of funds into the amalgamated foundation necessary?

The answer would depend on whether or not the foundation's assets were seen as being impressed with a trust to use the donations received by it in a particular manner. Earlier, we stated the proposition that it was the objects of the foundation as set out in letters patent which governed what the directors of the foundation could do with the foundation's funds. The public perception of the use to which the funds would be put was not legally binding on the foundation, barring some restrictions on the gift or some commitment to the donors. Is the situation different where an amalgamation has or will take place and the directors of the amalgamated foundation may not use the funds for the same purposes as would have been chosen by the directors of the original

foundation? In our opinion, the situation is not different. The directors of the amalgamated foundation would be free to use the funds which had come from each of the original foundations in accordance with the amalgamated foundation's own letters patent. If, instead of an amalgamation, the directors of the Cancer Hospital Foundation were to transfer all of the foundation's assets to the General Hospital Foundation, the directors could impose some restricted terms on the gift so that the funds could be used only for specific purposes, such as cancer treatment. Can the directors of the Cancer Hospital Foundation impose a restriction on the funds which will flow to the amalgamated foundation in order to bind the directors of the amalgamated foundation to use the funds for a cancer-related purpose? It would appear that in order to do this, the directors of the Cancer Hospital Foundation would have to impose a trust on some or all of the Foundation's assets prior to the amalgamation. The directors would be able to meet the three "certainty" requirements of a trust (certainty of intention to create a trust, certainty of objects, and certainty of subject matter) and bind certain funds subject to the terms of the trust. On the amalgamation, the assets would flow through to the amalgamated foundation still impressed with these trust terms.

Two sections of the *Charities Accounting Act*, R.S.O. 1990, Chapter C.10, provide for possible court applications to determine these issues.

Subsection 6(1) provides:

> Any person may complain as to the manner in which a person or organization has solicited or procured funds by way of contribution or gift from the public for any purpose, or as to the manner in which any such funds have been dealt with or disposed of.

Subsection 10(1) provides:

> Where any two or more persons allege a breach of a trust created for a charitable purpose or seek the direction of the court for the administration of a trust for a charitable purpose, they may apply to the Ontario Court (General Division) and the court may hear the application and make such order as it considers just for the carrying out of the trust under the law.

What would the situation be if the directors of the Cancer Hospital Foundation determined that they had no interest whatsoever in supporting the amalgamated hospital and instead preferred to support some other health care services, as permitted by the Foundation's letters patent? If the Foundation were controlled by the hospital with which it was associated, the directors of the Foundation might not be permitted to make this choice. On the other hand, if there is no control exercised by the associated hospital, and the directors of

the Foundation are completely free to choose the future role of the Foundation, it would be difficult to see what pressures could be brought on the directors of the Foundation to force it to amalgamate. It may be in the best interests of the cancer patients being treated by the associated hospital to have the two foundations remain separate so that the directors of the Cancer Hospital Foundation could ensure that any amounts they paid to the amalgamated hospital would be used solely for the benefit of cancer patients. This would require the willingness of the directors of the Cancer Hospital Foundation to go on operating it as a separate entity.

Endowed/Restricted/In Trust Gifts

a) *Meaning*

Foundations often solicit funds for particular purposes such as new equipment or the construction of a new hospital wing. Donors often wish to give restricted gifts, because they have found a particular need at a hospital and wish the foundation associated with the hospital to hold the funds on a long-term or permanent basis and use only the income to provide for that need. The letters patent of a foundation may limit it to making gifts only to the associated hospital or for particular purposes. In any of these cases, the foundation will be holding funds which are subject to limitations on their use. What will happen to these funds if the foundation's associated hospital undergoes the types of changes recommended by the Health Services Restructuring Commission?

b) *Position of a hospital foundation whose associated hospital has been told to transfer all of its services to another hospital and to cease to operate as a public hospital*

The wording of the letters patent of the foundation will determine whether the directors of the foundation can hand its assets over to the foundation associated with the hospital which is receiving the services. If the letters patent of the foundation are very broad and permit the foundation to support the work of any hospital, the foundation could simply make future gifts to the new hospital. Alternatively, the directors of the foundation may prefer to amalgamate with the foundation of the new hospital. Regardless of which method it adopts, the funds should remain subject to the same restrictions or the donors or the Public Guardian and Trustee would have legitimate cause for complaint if an attempt were made to change the intended use of the funds. For example, if funds were given to Big Hospital Foundation to improve the level of services provided by its physiotherapy department and the foundation accepted the donation on that basis but physiotherapy services are now to be transferred from Big Hospital to Bigger Hospital, the directors could continue

to make annual gifts to Bigger Hospital but would have to ensure that the funds were being used for physiotherapy services.

What would happen if the use of the funds were limited, not only to a particular purpose, but to the implementation of that purpose at the hospital which is now going to cease to operate? It would not seem possible for the directors of the foundation to ensure that this purpose could be carried out. It is likely that a *cy-près* application would have to be brought to obtain the instructions of the court.

c) *Position of a hospital foundation whose associated hospital is to accept some additional services and then to go on operating as a public hospital*

As is the case with unrestricted gifts, the foundation in these circumstances should not have any difficulty in continuing to hold the restricted funds and using them for their original purpose.

d) *Position of a hospital foundation whose associated hospital is to transfer out some services and then go on operating as a public hospital*

The directors of the foundation would have to determine whether the restricted gift related to services which its associated hospital was now to transfer out or to services which its associated hospital would continue to provide. If it were the latter, as is the case with unrestricted gifts, the foundation in these circumstances should not have any difficulty in continuing to hold the restricted funds and using them for their original purpose.

If the restricted gift related to services which were being transferred out to a new hospital, the directors would have to determine whether they were permitted under the terms of the foundation's letters patent to make a gift of the restricted funds to the new hospital (or its associated foundation) in order to allow the gift to be used for the particular services. For example, if a hospital foundation had received funds for an eye clinic and the associated hospital had been instructed to transfer all eye care services to another hospital, the directors of the foundation may be able to transfer the funds subject to that particular purpose to the hospital (or its foundation) which will now be offering eye clinic services. On the other hand, the directors of the foundation may prefer to retain the restricted funds and make annual gifts from the restricted funds to the hospital which will now be offering eye clinic services.

e) *Position of a hospital foundation whose associated hospital is to amalgamate with another hospital*

Where the foundations choose to parallel the amalgamation of the hospitals, the restricted assets of the foundation would remain subject to the same restrictions in the amalgamated foundation. Assuming the purpose was still a useful one and the corporate criteria set out above can be met, the directors of

the amalgamated foundation should have no difficulty in continuing to carry out the restricted purposes.

Where the directors of the foundation choose not to amalgamate, there should still be no difficulty in continuing to carry out the restricted purposes. Even though the associated hospital has now become an amalgamated hospital, references in gifts to the foundation "for the purpose of" the associated hospital would be considered references to the amalgamated hospital and accordingly the foundation should be able to accept these gifts.

Effects on Pending Gifts

a) *Introduction*

Assuming foundations are able to deal with all of their assets in existence at the time of any change to the foundations or their associated hospitals, what is the impact on a gift which would have been paid to the foundation after the date of any changes? For example, what would become of a gift in a will to a foundation whose corporate existence or purpose had changed? The validity of a gift to a foundation will depend on the existence and objects of the foundation. Difficulties may arise in each of the scenarios outlined above.

b) *Position of a hospital foundation where the foundation's associated hospital has been told to transfer all of its services to another hospital and to cease to operate as a public hospital*

If the foundation continues its corporate existence under its original name or a new name, it should be entitled to receive any donation made to it even if its activities have changed as long as the gift is not subject to conditions which the foundation cannot fulfil (for example, to support the work of the now-dissolved associated hospital). If the foundation has been dissolved, the gift will fail.

If a will leaves a legacy to a foundation to be used for the purposes of a hospital which is not in existence at the time of the death of the testator, either of two results will occur. First, it can be argued that the gift is a valid gift to the foundation. The foundation then holds the gift on trust for a particular hospital but because the particular hospital has been dissolved, the trust cannot be carried out. Accordingly, the gift to the foundation will not fail but a court would propound a scheme to determine how the gift should be used. Alternatively, the gift in the will may fail because it is intended that the gift be used for a specific purpose which cannot be carried out. In the former case, the legacy would go for the ultimate benefit of charities while in the second case, the gift would probably lapse and the benefit would pass to the testator's other beneficiaries or next of kin. The analysis would depend on whether the reference to the particular hospital was seen as descriptive only or limiting the

gift to a specific purpose. It is obvious that the exact wording of the bequest would be of great importance. In many cases, a court may find that the testator intended to benefit the hospital through his gift to the foundation and therefore the correct result would be for the gift to fail unless the court can find that the testator had a more general charitable intent.

c) *Position of a hospital foundation whose associated hospital is to accept some additional services and then to go on operating as a public hospital*

As long as the foundation is still in existence, it should be able to accept any donation made to it. Even if the gift were subject to restrictions, the changes to the associated hospital as a result of the restructuring should not have an impact on the ability of the foundation to accept the gift.

d) *Position of a hospital foundation whose associated hospital is to transfer out some services and then go on operating as a public hospital*

The foundation should have no difficulty in accepting gifts made to it as long as the gifts were not to be used for a particular purpose related to the services which the associated hospital is no longer carrying out. For example, if a gift is made to the hospital foundation to support the physiotherapy services at the associated hospital and these services are no longer carried out at the associated hospital, the foundation could not accept the gift. If the gift were from a living donor, an attempt can be made to change the intended use of the gift. If the gift were pursuant to a will, it is likely that the executors of the estate would have to bring a *cy-près* application to determine whether the gift was to the *foundation* or to the *purpose*. If the gift were for the purpose, the court would have to decide whether there was a general charitable intent behind the gift and, if so, what charity should receive the benefit of the gift.

e) *Position of a hospital foundation whose associated hospital is to amalgamate with another hospital*

If a foundation has amalgamated, pursuant to corporate law, it will be viewed as a continuation of the original foundation, even if the name of the foundation has changed. For example, a gift to the B Hospital Foundation would now validly be paid to the AB Hospital Foundation, where the A Hospital Foundation and the B Hospital had amalgamated to form the AB Hospital Foundation. Accordingly, as long as the foundation referred to can be traced to the existing foundation, there should be no difficulty with any gifts made to it as a result of the restructuring of its associated hospital. Although there should be no problem with corporate amalgamations, other corporate arrangements may produce a less than clear result and it may be impossible to trace a foundation from one entity into another.

Again, the situation would be less clear if a gift had been made to a foundation for use at an associated hospital which had formerly provided a narrow range

of services but which now, as part of an amalgamated hospital, provides a much broader range of services. For example, a particular will may be interpreted to conclude that a gift to a hospital foundation for a particular hospital was not intended to represent a gift through an amalgamated foundation to an amalgamated hospital.

When Toronto General Hospital and Toronto Western Hospital were amalgamated by statute (see S. O. 1986, c. 36), the statute provided that gifts, etc. previously or subsequently made by deed, will or other document to either of the hospitals were to be construed as though they had been made to the amalgamated hospital. Although the statute did not bring about the amalgamation of the foundations associated with each hospital, subsection 4(2) of the statute contains a similar provision with respect to gifts, etc. previously or subsequently made to the foundation of either hospital. Such gifts were to be construed as having been made to the amalgamated foundation. Legislation should not be necessary where both (or all) foundations being amalgamated were incorporated under the *Corporations Act.*

Possible Foundation Responses to Health Care Restructuring

Revising Letters Patent

It may be necessary for the directors of a hospital foundation to amend the letters patent of the foundation in order to broaden, narrow, or completely change the objects of the foundation. The ability of the directors to do this would depend on the terms of the existing letters patent and on any restrictions which may apply to assets held by the foundation. It would be necessary for the directors to continue to make it possible for the foundation to carry out the terms of any restricted gifts held by it and to continue the qualification of the foundation as a charitable entity. In order to allow for an amalgamation of a foundation with another hospital foundation, it may be necessary to broaden the objects of the foundation as set out in its letters patent in order to permit the two foundations to have similar objects so that the amalgamation may be carried out more easily. The letters patent of hospital foundations may have to be changed simply to amend the name of the hospital referred to in the letters patent if the associated hospital were to amalgamate with another hospital.

Directors would be running the risk of complaints under the *Charities Accounting Act* if they were to change the objects of their foundation completely so that gifts would not be used for the original purpose, even if there were no restrictions on the gifts. Unfortunately, there is no case law which sets out the obligations of the directors in this regard. Certainly, any changes which were made by the directors in bad faith could be set aside by the court. Apart from that extreme example, however, it is arguable that the directors would have a

free hand in amending the letters patent of the foundation so long as the directors continued to preserve its status as a charity. If a donor wished funds to a charitable foundation to be used for a specific purpose, the onus would be on the donor to ensure that the directors accepted the gift to be used only for that purpose. This would appear to be the appropriate result, as it is unreasonable to expect a foundation to use gifts solely for the purposes of the foundation as set out in its objects at the time the gift was made. With health care restructuring taking on substantial proportions, it would be difficult for directors of a hospital foundation to ensure that it would be appropriate, or even possible, for the funds of the foundation to be used for particular purposes five or 10 years into the future.

Removing the foundation from the ambit of the Public Hospitals Act *and related regulations*

As set out above, the Ministry of Health is beginning to look more closely into foundations which are associated with hospitals. In particular, directions issued by the Health Services Restructuring Commission specifically forbid hospitals to transfer any assets to their associated foundations. It is quite possible that the Ministry will begin to regard the assets held by a hospital foundation as somehow available to the associated hospital. A foundation must provide reports and returns to the Minister of Health if the foundation comes within the definition of a "hospital foundation" or a "hospital subsidiary" as set out in Ontario Regulation 552/96. The definition would catch all foundations designated by Revenue Canada as "associated" with a hospital. It would also catch foundations which had received gifts with an aggregate value of more than $100,000 from one or more hospitals or hospital foundations, although this would probably be an unusual event. A foundation would not be a "hospital foundation" if it were a private foundation (as designated by Revenue Canada). A foundation could become a private foundation if more than 50 per cent of its assets had been received from one source (a very substantial new donation would be required in most cases) or if more than 50 per cent of its directors did not deal with each other and with each of the other directors at arm's length. Changes to the board and an application to Revenue Canada to redesignate the foundation as a private foundation may take the foundation outside the ambit of the reporting regulation. (Becoming a private foundation does, of course, have other repercussions which must be considered.) A foundation would also not be subject to the reporting requirements if it gave less than 50 per cent of its total expenditures and gifts in the year to hospitals and to hospital foundations. Other worthy recipients of funds could perhaps be found — such as universities carrying out medical research. Lastly, the reporting requirement would not apply to a foundation which did not have as its principal object, whether express or implied, the object of benefiting one

or more hospitals or hospital foundations. Again, the directors could change the letters patent of the foundation to create new objects which were less specifically directed to hospitals.

Changing the directors of the foundation in the event of government intervention with the associated hospital

At the time of establishing a hospital foundation, a choice was likely made by the incorporators as to the extent of the link between the foundation and its associated hospital. In extreme cases, the associated hospital would have been made a member of the foundation with enough votes to control the foundation. (The hospital could not have been the sole member of the foundation as section 286 of the *Corporations Act* provides that the directors of a non-share corporation must be members of the corporation, or become members within 10 days of becoming directors.) At the opposite end of the spectrum, the incorporators may have chosen to keep the foundation entirely independent of the hospital so as to allow the directors a free hand in running the foundation. Because most hospital foundations preferred not to have broad membership bases (if only because of the additional cost of notifying members of meetings), the requirement that directors be members has frequently resulted in a board structure which directly parallels the membership structure.

It may be more important to sever the link between a foundation and its associated entity if future regulations or legislation attempt to exercise more direct control on foundations through their associated hospitals. It may even be necessary to sever any link on an emergency basis. Blake Bromley, in his article "Parallel Foundations and Crown Foundations" (1993), XI Philanthrop., No. 4, p. 37, speaks (at page 42) of building "in a mechanism to transfer control of a hospital foundation to independent community directors in the event that the government attempts to seize control of the foundation endowments for normal operational expenses". This sounds like the provisions in offshore trust agreements that allow a protector to change the trustees of the trust in the event of threatened insurrection or, even worse, income tax changes, in the jurisdiction where the trust was considered resident. Considering the lack of consultation around issues involving Ontario hospitals and foundations, this response may not be too extreme. The letters patent of the foundation could be amended to provide for a change in the directors if certain events occurred.

Balancing issues of protecting the foundation with the original goals of the foundation

This issue brings up the question of the motives of the directors of the foundation. As set out above, hospital foundations were generally established in order to provide a means of collecting and holding funds for the ultimate benefit of the hospital with which the foundation was associated. How will this purpose be carried out if the associated hospital is no longer in existence as a distinct entity? Like many of the previous issues, the answer to this question will be very dependent on the facts surrounding the particular foundation. Where the associated hospital is to accept some services from a second hospital and then go on operating as a public hospital, it is unlikely that the directors of the foundation would wish to do anything other than possibly broaden the objects in their letters patent in order to allow funds to be raised for the new services to be offered by the associated hospital.

On the other hand, where the associated hospital is to amalgamate with a second hospital, the directors of the foundation may experience any among of a range of desires from wishing to immediately amalgamate with the second hospital's associated foundation to completely opposing the amalgamation and accordingly taking all possible steps to retain control over the foundation's assets so as not to benefit the new amalgamated hospital.

Where, in an amalgamation, the two foundations are of substantially different sizes, the directors of the foundation whose associated hospital is essentially being taken over by the other amalgamating hospital may prefer simply to transfer all of their assets to the foundation associated with the takeover hospital and have no further involvement with the foundation. This may sound like a "sour grapes" approach but may also make the most sense in practical terms. The difficulty with such an approach is that the foundation which transfers away all of its assets and then dissolves has no continued legal existence and any donations which are made to that foundation in future would not pass to the continuing foundation.

Concerns about Directors' Liability

Directors of charitable foundations face a very substantial number of statutory liabilities dealing with everything from sales taxes and employment deductions to environmental concerns. In addition, directors of charitable foundations have fiduciary obligations which are not set out in statutes. These obligations require directors to act honestly and in good faith with a view to the best interests of the foundation. Breach of these fiduciary obligations can lead to personal liability for the directors.

Dealing in good faith requires that there be no conflicts of interest between a director and the corporation. Directors must consider whether decisions to have the foundation amalgamate or not amalgamate, change its letters patent or not change its letters patent, donate substantial assets or not donate substantial assets create a potential conflict of interest for the director. If they do, the director must declare his or her interest and refrain from voting as provided by the governing corporate statute. In a more serious case, the director may have to consider resigning.

Is the protection of the foundation from government intervention consistent with the directors' fiduciary duties? One of the concerns with health care restructuring, as referred to above, is that there will be increased government intervention in the operations of hospitals and even in the operations of hospital foundations. The English experience referred to above suggests that these concerns may be well founded. The directors' duty is to the foundation, and as long as the directors are acting in good faith to protect the foundation, and are not otherwise in breach of, for example, reporting obligations, it would seem that the directors would be acting properly.

Drafting Responses that are consistent with the wishes and intentions of donors — avoiding court applications

Gifts made pursuant to a will may fail because of the lack of certainty in the identity of the beneficiary. For example, a gift made in a will to "my five best friends" would not ordinarily be sufficiently certain because one could not determine with certainty whom the testator considered to be "best friends". Where, however, the gift is made to a charity, courts are reluctant to allow the gift to fail for uncertainty. The court's response has been to invoke a power called *cy-près*. Alternatively, if it is clear that the donor had a charitable intent but the recipients of the gift were not identified, the court may use its power to make a scheme for the proper use of the gift. In each case, the court will attempt to discover and carry out the intent of the donor.

Any court application to determine the recipient or the use of funds will be expensive and will probably reduce the amount of the gift ultimately available for charitable purposes. The message for drafters of wills would be to ensure that a hospital foundation which has or may undergo restructuring is willing and able to carry out a charitable gift at least at the time the will is made. It would also be preferable to draft the terms of the gift either as broadly as the testator will approve or in terms of a wish only in order to lessen the possibility that the foundation will later find the gift impossible to accept.

For foundations, the caution should be to keep their objects broad and to continue their corporate existence wherever possible in order to avoid having

to turn down gifts. It is interesting to note the lengths it may be necessary to go in order to achieve this. In 1975, a private member's bill was passed in the Alberta Legislature as S. A. 1975, c. 89, *An Act Respecting Alberta Children's Hospital Foundation*. Its intention was to preserve gifts which had been made to the foundation under any of its previous names. The *Act* states in section 3:

> Any donation which, by its terms, is to be given, conveyed, transferred, demised or otherwise disposed of to any of the following:
>
> a) Alberta Red Cross Crippled Children's Hospital;
> b) Junior Red Cross Hospital;
> c) Crippled Children's Hospital, Calgary;
> d) Alberta Red Cross Hospital;
> e) Alberta Crippled Children's Hospital;
> f) Alberta Children's Hospital;
> g) A hospital with a name resembling the foregoing and duly confirmed under section 4 hereof;
>
> is hereby declared to be altered and amended in so far as may be necessary, so that such donation shall be used for the objects of Alberta Children's Hospital Foundation as fully and effectively as though the name "Alberta Children's Hospital Foundation" was included in the terms of the donation in the place and stead of such other name.

However, it is worth noting that under its previous names, the foundation owned and operated a hospital. By the time the *Act* was passed, the Foundation no longer owned or operated a hospital but instead had objects which enabled it to "assist" the hospital and provide related services.

The rationale for the *Act* was to save the time and expense of court applications to determine the identity of the charity referred to in testamentary gifts. The *Act* goes beyond reciting the name changes by determining that the Foundation is the successor to the hospital (which as a matter of corporate law it would appear to be) not only despite the name changes but also despite the fact that the Foundation does not carry out the charitable work that the hospital carried out. If there are significant changes in the identities of hospital foundations as a result of the current hospital restructuring, perhaps similar legislation should be passed in Ontario. This would deal with name changes and with changes in charitable purposes, as long as the corporate history could be tracked.[12]

Conclusion

Naturally it is impossible to anticipate the situation of every hospital foundation in Ontario, and this article does not aspire to advise any foundation

definitively. Foundations must however take note of the statute and the regulations (by which much may be done), and consider the consequences to themselves if "their" hospitals are to disappear or be radically changed. Only time will tell whether Ontario's hospital foundations will continue to play the vital and supportive role that they have maintained to date.

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FOOTNOTES

1. Sharon Schildein Grimes, *The British National Health Service: State Intervention in the Medical Marketplace, 1911–1948* (London: Garland Publishing, Inc., 1991), p. 140.
2. Brian Abel-Smith, *The Hospitals 1800–1948* (Cambridge, Massachusetts: Harvard, 1964), p. 385.
3. *Ibid.*, p. 405.
4. *Ibid.*, pp. 405–406.
5. C.R. Seaton, *Aspects of the National Health Service Acts* (London: Pergamon Press), p. 19.
6. Geoffrey A. Robinson, *Hospital Administration* (2nd ed.) (London: Butterworths, 1966), p. 388.
7. *Ibid.*, p. 400.
8. Gordon McLachlan, *A History of the Nuffield Provincial Hospitals Trust, 1940–1990* (London: Nuffield Provincial Hospitals Trust, 1992), p. 51.
9. F.K. Prochaska, *Philanthropy and the Hospitals of London: The King's Fund, 1897–1990* (Oxford: Clarendon Press; New York: Oxford University Press, 1992), p. 159.
10. *Ibid.*, pp. 175–176.
11. *Supra*, footnote 6, p. 403.
12. For general information regarding hospital foundations see also Blake Bromley, "Parallel Foundations and Crown Foundations" (1993), XI *Philanthrop.* No. 4, p. 37 and Jane Burke-Robertson, "Establishing a Parallel Foundation: Why? Why Not? How? (1996), 13 *Philanthrop.* No. 2, p. 3.