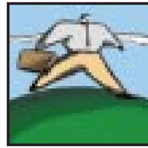


Case Law

Disposition of Hospital Assets:

The Legal Issues

By Mark Bain and Heidi Visser

The transfer or sale of hospital assets raises legal issues which have not yet been well analyzed. Hospitals have historically not disposed of their assets in any significant measure; however, with the current wave of hospital restructuring and refinancing, such transactions will become more common, making it timely to review the legal issues surrounding asset sales or dispositions by a hospital.

In the halcyon days of Canadian healthcare, federal and provincial governments funded a large proportion of a hospital's asset acquisitions. Assets were routinely acquired, but seldom financed and rarely disposed of. Now we are experiencing declining levels of public funding and significant restructuring of hospitals, accompanied by mergers, asset dispositions and the introduction of private financing structures such as sale-leaseback transactions. The existing hospital infrastructure was put in place in the belief that hospitals would be permanent, stable and growing institutions, and so the rules for transferring or disposing of hospitals' assets are not yet well established. In the current Ontario restructuring climate, there have been a few well-publicized closures and mergers to date, and more have been directed by the Health Services Restructuring Commission (HSRC).

This discussion of the transfer of assets is based on the term "disposition" as used within Ontario's *Public Hospitals Act*, i.e., a sale, lease, mortgage or other disposition of assets. The outright sale of assets is the most obvious , but not the only possible, type of disposition. Asset dispositions by hospitals raise at least the following four legal issues:

1. Who owns the assets?
2. Who may authorize their disposition?;
3. What is the liability of board members who approve these transactions?
4. How are the disposition proceeds distributed?

These legal issues are examined here in turn, followed by an examination of how these issues have been addressed in the few actual examples to date, which generally arise in the course of a hospital restructuring.This discussion emphasizes the impact of Ontario legislation; however, many of the concepts discussed here have analogies in the laws of the other Canadian provinces.

1. Who owns the assets?

In Ontario, the assets of a public hospital are generally owned by an independent non-profit corporation known as a hospital corporation, which is a non-share capital corporation, either incorporated under the *Corporations Act*, or through a private act of the provincial legislature. A smaller number of hospitals remain owned by religious orders. In Ontario, Alberta and British Columbia, the assets of some hospitals have been transferred to umbrella organizations such as District Health Councils, Regional Health Authorities or Capital Health Authorities. Nonetheless, the owner of the hospital assets is almost invariably a non-profit entity with a volunteer board of directors, which is responsible for the ownership and care of the hospital's assets as well as for the hospital's operation and patient care.

Looking through the hospital's corporate structure, one wonders who really owns the assets? For business corporations incorporated under the Business Corporations Act (Ontario), the shareholders are generally entitled to receive the corporation's remaining assets upon its dissolution, after paying the creditors. Hospital corporations have no shareholders, and in many cases their articles of incorporation or letters patent, incorporating acts or religious rules do not contemplate either the disposition of assets or the dissolution of the entity. For those hospitals established as charitable trusts, there may be specific rules for the disposition of assets which provide that they be used for purposes similar to the original charitable purposes. Provincial governments have assumed a significant degree of control over a hospital's fixed assets, although they have stopped short of claiming ownership of those assets. Such control consists of exercising the rights of ownership without actually taking possession of the assets. Therefore, the issue of who should receive the proceeds of any sale of hospital assets (whether in cash or in property) becomes germane only in the

With the myriad of origins, structures and stakeholders, and the many creative forms of reorganization and refinancing plans proposed, there are as many possible scenarios as there are hospitals.

context of asset transfers which occur as part of a hospital's closure or other discontinuance of the entire hospital corporation. The potential conflicts and uncertainty inherent in such a procedure are compelling some Ontario hospital corporations to reorganize by way of merger, rather than closure, in part to avoid or delay addressing the ownership issues. Possible resolutions of this issue are addressed in point 4 below.

2. Who may authorize the transfer or sale of hospital assets?

The board of directors of a hospital corporation must authorize an asset disposition. The powers of the board may be delegated to the president or another executive officer of the corporation, either for all transactions or for those of minor significance only. In Ontario, the Minister of Health (under section 4(5) of the Public Hospitals Act) must also consent to the sale, lease or mortgage of those assets of a hospital corporation comprising its land, buildings, premises or any part thereof,

With the introduction of the Savings and Restructuring Act, 1996, the Ontario Ministry of Health gained expanded powers, under section 6 the Public Hospitals Act, to direct hospital boards to engage in certain restructuring transactions, including asset dispositions, which the Minister considers to be in the public interest. Ontario Regulation 87/96, under the Public Hospitals Act, authorizes the HSRC to issue such "section 6 directions" to hospitals. As a result, the HSRC may effectively require a disposition of assets, whether or not the board concurs. This has led to confusion and confrontation in certain cases, for example, the HRSC direction that Wellesley Hospital transfer its Central Hospital site to St. Michael's Hospital in Toronto. In Alberta, hospital assets were arguably nationalized in substance by being rolled into Regional Health Authorities without the consent of the directors of the prior hospital corporations being required. Clearly it is not beyond the province to usurp the power of a hospital board.

A disposition of assets coincident with the closure of a hospital raises different issues. A corporation that owns or operates a hospital, or that has previously owned or operated a hospital, may not take any action that may result in the dissolution of the hospital corporation without the consent of the Minister of Health. In practice, several hospitals that in substance will be "closed" have tailored their reorganizations (or have had them tailored by the HSRC) as amalgamations, in which all assets and liabilities of the amalgamating (predecessor) corporations become those of the amalgamated (successor) corporation. This approach is immediately convenient, but may become cumbersome if excess assets of the amalgamated hospital must be disposed of at a later date, when it may be difficult to "unscramble the omelette" and properly allocate the sale proceeds. For a business corporation, these issues would be clearly addressed in an amalgamation agreement. Since a hospital corporation has no shareholders, defining the respective rights of the stakeholders of the successor company becomes difficult. However, directions by the Minister or the HSRC, or statutes to implement the amalgamation, attempt to conclusively resolve any such ambiguity as to the ownership of assets or the proper authorization to dispose of those assets.

3. What is the liability of the board members who authorize these transfers?

The board of directors of a hospital has duties mandated under the Public Hospitals Act, extending to both the hospital corporation and to the greater public who fund the hospital and use its resources. In certain circumstances, the interests of the corporation and the public may conflict. In that case, there may be the desire to put the public's needs first. Some board members view their duty to the public as being more akin to the standard required of a trustee than to that applicable to a business corporation's director. While this is not necessarily true, in the case of conflict some hospital directors will favour the public interest - the most conservative course and the path most likely to avoid liability. Section 13(1) of the Public Hospitals Act provides protection from liability for directors who acted in "good faith."

Business-corporation legislation generally holds board members to the objective standard of the "reasonably prudent person." The standard for directors of a non-profit corporation, such as a hospital corporation, is a subjective one according to the principles of common law. Different people will be held to different standards, depending on the nature and extent of their skills and knowledge. There is no statutory standard of care in either the Ontario Corporations Act or the Canada Corporations Act, but this is not true across the country. For example, the British Columbia's Society Act does have a statutory standard of care required of directors of non-profit corporations.

In a closure or merger situation, decisions are generally made not at the initiative of the board but as a result of external demands. The HSRC has recommended that hospitals continue to be managed by volunteer boards. During amalga-

mation, some hospitals will cease to exist in their current form, while others will be wound up, their licences revoked, and their assets transferred to the successor entity. It is likely that the members of boards which transfer assets as a result of a direction of the Minister or the HSRC will be exculpated and saved harmless from any directors' liability, as they would have exercised no discretion in approving such transfers and the question will thus not arise whether or not they acted in good faith in authorizing the transaction.

4. How are the sale proceeds distributed?

The proceeds of sale should be distributed to the vendor, the hospital corporation. The conclusion is less clear if the hospital corporation simultaneously dissolves, is amalgamated with another hospital corporation, or is nationalized.

In a dissolution scenario, assets or their sale proceeds are likely to be allocated between those who funded the acquisition and maintenance of the corporation's assets and operations. Those funding sources would include

(a) the federal government in part through transfer payments under the Canada Health Act;
(b) the provincial governments through capital contributions and annual operating allocations to the hospitals;
(c) hospital foundations, through their capital campaigns and other fundraising efforts;
(d) the local community, through donations of funds and property; and
(e) religious or charitable organizations which may have contributed the original capital or property to found the hospital, and which may be governed by a charitable trust limiting the free transferability of those assets.

The ratios of such contributions vary between hospitals. In particular, the relative importance of the provincial contribution varies widely between teaching hospitals and other hospitals, and also according to funding ratios applicable during the period when capital funding was contributed by the province. In Ontario, the recent allocations of capital funding to carry out the directions of the HSRC are again applied unequally between hospitals. As a result, no two hospitals have been identically created and funded, and so determining the proportionate ownership of assets must be considered on a case-by-case basis.

In an amalgamation context, the process is not treated as a disposition, and so there are no sale proceeds. The successor amalgamated company assumes the ownership of the assets, along with any other liabilities of the predecessor corporations.

In a nationalization context, the process might likely mirror the rationale adopted in the wide-scale reorganization of British hospitals, most of which were nationalized on July 5, 1948, under the National Health Services Act, 1946. The equipment, buildings and other property were transferred to the Minister, along with the endowments for non-teaching hospitals. Those endowments were pooled and distributed among hospitals based on their proportion of beds administered on the appointed day. A review of relevant cases indicates that the English courts were sensitive to preserving the object of charitable trusts with designated purposes, such that some assets could not be pooled.

It is generally acknowledged that a hospital is a charitable organization; however, it is not entirely clear whether, in this capacity, it holds its assets in its own right, or as trustee for a charitable purpose. In the 1989 Ontario case Re Centenary Hospital Association, the court held that the Centenary Hospital held the land which it wanted to develop into a medical arts centre as its own property, and not subject to a charitable trust. If the hospital had held its land as a trustee, the Public Trustee would have had jurisdiction under the Public Charities Accounting Act.

How Does This All Work In The Real World?

Although there are but few examples to date, those that do exist demonstrate that a flexible approach will be adopted to suit the circumstances.

(a) **Disposition and closure outside of a restructuring**: Outside of a restructuring, there are few examples of a hospital which has been deemed to be excess and closed. Indeed, Doctors' Hospital in Toronto in a 1976 Ontario court decision which held that the Public Hospitals Act could not be used to close hospitals for financial reasons successfully resisted the Lieutenant-Governor's attempts to close it. If the assets were sold, proceeds could be allocated between the provincial government (its capital contribution less the accumulated depreciation) and the local community (the excess). Such a process was implemented in the 1948 hospital restructuring in the United Kingdom; however, it is not clear whether this rationale would apply in any specific Ontario closure, as it is not evident that the physical assets of specific hospitals are impressed with a charitable trust and could not be redistributed.
(b) **Disposition and closure within a restructuring**: The operations of Doctors' Hospital in Toronto are currently being transferred to The Toronto Hospital. Certain of its assets, in particular its land and buildings, will remain with the hospital corporation. Doctors' Hospital is scheduled to close in December 1998, when all its programs will have been transferred to TTH. It is possible that Doctors' will then have its licence revoked under the Public Hospitals Act. The hospital faces the challenge of deciding whether to dissolve or to resurface as an amended and possibly vertically integrated operation, and if so how to deal with its assets. Several other hospitals, such as Salvation Army Toronto Grace Hospital and the Paris Street Site in Sudbury

of the Sisters of St. Joseph of Sault Ste. Marie, have taken the initiative in light of their closure to seek approval from the Ministry of Health to provide alternative healthcare services such as long-term care facilities.

(c) **Disposition without closure**: A restructuring of this sort generally involves the broad use of the term "disposition": i.e., a lease or mortgage. For example, with the Minister's consent, certain assets of a hospital may be leased to an entity in which a non-hospital healthcare corporation held an interest.

(d) **Merger of hospital corporations**: In New Brunswick, a 1992 province-wide restructuring under the Hospital Act created a hospital corporation in each of seven regions and transferred all assets and liabilities of the hospitals in each region to the new regional hospital corporation. Many such mergers are contemplated in Ontario to carry out the HSRC directions. For example, in Ottawa, Ottawa General, Riverside and the Ottawa Civic hospitals will merge into one hospital, with each site dedicated to a different focus of health. In Peel Region, Peel Memorial, Georgetown and Etobicoke hospitals will amalgamate into a new entity, which will assume all the assets and liabilities of the amalgamating hospitals. If dispositions occur following amalgamation, arguably the proceeds will flow to the amalgamated corporation. Toronto General and Toronto Western Hospitals (incorporated under different acts) were amalgamated by a statute (S.O. 1986, c. 36) which provided that gifts to either hospital would become the property of the successor. The assets of Sudbury General, Sudbury Memorial and Laurentian hospitals were transferred to the new Sudbury Regional Hospital Corporation, which assumed responsibility for the finances, human resources, buildings and equipment of its predecessors. As a general principle of corporate law, upon an amalgamation, all assets and liabilities will flow through to the amalgamated entity. The consent of the Minister will be required for the transfer of land and buildings, but presumably will be readily available as the Minister, directly or by power delegated to the HSRC, will have authorized the transaction.

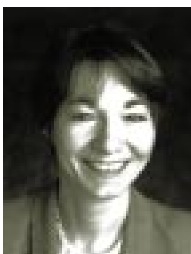
(e) **Merger of management alone**: In Chatham-Kent, the HSRC has directed St, Joseph's Hospital and the Public General Hospital to consolidate their operations on one site. The boards of the two hospitals have established a Joint Executive Committee (JEC) to oversee the process. It appears that they contemplate continuing to operate two hospital corporations under one management umbrella. In Prescott, Cornwall General and Hotel Dieu will maintain their corporate status and form a JEC. In Huron-Perth, eight hospitals have endorsed the concept of a "Partnership Agreement," which would delegate certain management duties to a JEC, but would leave each hospital corporation with ownership of its assets, its foundation arrangements and its operating funding allocation from the Ministry of Health. These types of restructuring amount to changes in governance without a disposition of assets, and so the legal issues addressed here will not be of great significance.

Conclusion

Hospitals will be disposing of assets with increasing regularity, whether in response to financial pressures, to implement innovative financing structures or to carry out restructuring initiatives. The rules for such transfers are not yet well explored, but the basic concepts are well understood. The board must authorize asset dispositions or delegate this responsibility to its executive officers. Both the board and the Ministry will be involved for transactions involving a hospital's land or buildings. Board members who authorize such voluntary transactions will be required to act in good faith, and to exercise a degree of prudence appropriate to their skills and expertise. If a transaction is mandated by the HSRC, or another governmental entity, a lesser standard will be required of the director. The proceeds of sale will generally flow to the vendor hospital corporation or to its successor. Difficult issues of charitable trusts may arise if a hospital corporation is dissolved coincident with a disposition of assets, though that is expected to be an infrequent event. These issues may be merely deferred, and not eliminated, by the amalgamation scheme. With the myriad of origins, structures and stakeholders, and the many creative forms of reorganization and refinancing plans proposed, there are as many possible scenarios as there are hospitals. Any hospital which is contemplating a significant asset disposition, whether inside or outside a reorganization context, is encouraged to obtain professional legal advice on these matters. HQ

Mark Bain

Mark Bain and Heidi Visser are corporate commercial lawyers in the Toronto office of Bennett Jones Verchere. Mark's practice focuses on financial services and commercial real-estate transactions.



Heidi Visser

Heidi's practice includes acting for providers in the healthcare field. Both are members of the firm's Healthcare Practice Group.

The authors gratefully acknowledge the research assistance of Elizabeth Rumble, student-at-law.