Ontario Human Rights Commission

The **Ontario Human Rights Commission** (OHRC) was established in the Canadian province of Ontario on March 29, 1961 to administer the Ontario Human Rights Code. The OHRC is an arm's length agency of government accountable to the legislature through the Ministry of the Attorney General of Ontario.

The OHRC's mandate under the Code includes: preventing discrimination through public education and public policy; and looking into situations where discriminatory behaviour exists.

Since June 30, 2008, all new complaints of discrimination are filed as applications with the Human Rights Tribunal of Ontario. However, OHRC has the right to be informed of applications before the HRTO, and receives copies of all applications and responses. The OHRC can intervene in any application with the consent of the applicant; the Commission can also ask to intervene without the applicant's consent, subject to any directions or terms that the HRTO sets after hearing from the parties. The Commission also has the right to bring its own application to the HRTO if the Commission is of the opinion that the application is in the public interest.[1][2]

There is a full-time chief commissioner and a varying number of part-time commissioners, appointed by Order in Council. Staff of the OHRC is appointed under the Public Service of Ontario Act, 2006.

On February 19, 2015, the Lieutenant Governor in Council appointed Ruth Goba as Chief Commissioner of the Ontario Human Rights Commission on an interim basis for a period of three months, effective from February 28, 2015, and ending May 27, 2015, or when a new Chief Commissioner is appointed, whichever occurs first.

Function and Vision Statement

The Ontario Human Rights Commission is committed to the elimination of discrimination in society by providing the people of Ontario with strong leadership and quality service:

> in the effective enforcement of the Ontario Human Rights Code; and
> in the promotion and advancement of human rights.

Proposal for a National Press Council

In February 2009, in a report to the Canadian Human Rights Commission, the OHRC commented on the proposal to create a National Press Council that would serve as a national media watchdog. Unlike current press councils in Canada, membership to this proposed new council would have been required by all publishers, webmasters and radio and television producers. No other steps were taken to implement the proposal.

Hall argued that a National Press Council would facilitate the protection of human rights without imposing censorship of the media, explaining that while the council duties would be limited to accepting complaints of discrimimation (in particular, from what Hall described as "vulnerable groups") and requiring media outlets to publish counterarguments. However, the council would have no authority to censor media outlets.

Mary Agnes Welch, president of the Canadian Association of Journalists, stated that the current provincial press councils are "the only real place that readers can go to complain about stories short of the courts" but that they "are largely toothless and ineffective." However, she argued against a mandatory national press council, stating that:

"The provincial ones don't even work, so how could we have a national one? And I know a lot of journalists who would take umbrage at essentially being in a federally regulated profession.... If on the crazy off-chance that there is some momentum behind this idea of a national press council, it won't be coming from journalists."[9]

In an editorial, *National Post* strongly opposed the OHRC's proposal, arguing that a mandatory national press council "is merely the first step toward letting the Barbara Halls of the world decide what you get to hear, see and read." The *Post* further argued that nobody "has the ability to judge which speech should be free and which not."[10] Barbara Kay also strongly opposed Hall's suggestion, stating that her experience with the Quebec Press Council (QPC) was evidence that press councils are abused by those wishing to suppress the discussion of sensitive or controversial issues.[11]

General Principles for Human Rights

1 When is differential treatment discriminatory?

The purpose of anti-discrimination laws is to prevent the violation of human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice. In many cases, differential treatment because of age will clearly be discriminatory. However, in other cases, it may be necessary to consider whether the treatment can be said to constitute "discrimination" in the sense of being something that is protected by human rights law.

Some age-based criteria or qualifications are not based on stereotypes, are not offensive to human dignity and do not target a historically disadvantaged age group. For example, discounts on services for persons under 25 or over 55, retirement schemes that are based on a minimum age combined with years of service and measures aimed at facilitating the transition from full-time employment to retirement[8]would not likely be considered discrimination within the meaning of human rights law and policy.
In the context of equality claims under s. 15 of the Canadian *Charter of Rights and Freedoms* (the "*Charter*"), the Supreme Court of Canada has offered the following three broad inquiries as a tool for determining whether discrimination has occurred:
(1) Differential treatment
Was there substantively differential treatment, either because of a distinction, exclusion or preference, or because of a failure to take into account the individual's already disadvantaged position within Canadian society?
(2) An Enumerated ground
Was the differential treatment based on an enumerated ground, in this case age?
(3) Discrimination in a substantive sense
Finally, does the differential treatment discriminate by imposing a burden upon, or withholding a benefit from, an individual? The discrimination might be based on stereotypes of a presumed group or personal characteristics, or might perpetuate or promote the view that an individual is less capable or worthy of recognition or value as a human being or as a member of Canadian society who is equally deserving of concern, respect and consideration. Does the differential treatment amount to discrimination because it makes distinctions that are offensive to human dignity?
In *Law v. Canada (Minister of Employment and Immigration)*[9] the Supreme Court of Canada applied these three inquiries to conclude that even though the claimant was not entitled to a survivor's pension when her spouse died simply because of her age (she was 30), it was not discrimination under s. 15 of the Charter. Under the pension scheme, full benefits were paid to surviving spouses over the age of 45, partial benefits were paid to those between 35 and 45 and no benefits were available to surviving spouses under age 35. The Court found that persons under age 45 have not historically been subjected to discrimination and that younger persons do not face the same barriers to long-term labour force participation that the benefit was designed to address. The law did not stereotype, exclude, devalue or demean adults of the claimant's age.

2 Age 65 benefits, special programs and special interest organizations

In certain circumstances, the *Code* permits programs and benefits aimed at a specific age group.
The *Code* expressly provides for the preference of persons over 65 years of age:
15. A right under Part I to non-discrimination because of age is not infringed where an age of sixty-five years or over is a requirement, qualification or consideration for preferential treatment.

This permits seniors' discounts, seniors-only housing and other benefits aimed only at persons over 65.

As well, section 14 of the *Code* permits the use of special programs in all social areas. This allows preferential treatment or programs aimed only at older persons, even if they have not yet reached the age of 65, if the purpose of the program is to relieve hardship or economic disadvantage or to assist disadvantaged persons or groups to achieve equal opportunity.
It is important that special programs be designed so that restrictions within the program, for example with regard to the age of those eligible to participate, are rationally connected to the objective of the program. A failure to do so, can lead to successful challenge of the program and a finding that it is discriminatory.[10]
The OHRC's *Guidelines on Special Programs* provide detailed information on how a special program can be planned, implemented and monitored.[11]
Section 18 of the *Code* allows certain types of organizations to limit participation or membership based on *Code* grounds including age:
18. The rights under Part I to equal treatment with respect to services and facilities, with or without accommodation, are not infringed where membership or participation in a religious, philanthropic, educational, fraternal or social institution or organization that is primarily engaged in serving the interests of persons identified by a prohibited ground of discrimination is restricted to persons who are similarly identified.

Example: A charitable organization that is primarily engaged in serving the interests of women over the age of 55 through researching issues of interest to this group and lobbying government to make changes to law and policy limits its membership to persons similarly identified.
An organization that wishes to rely on this defence must show it meets all of the requirements of this section.

3 When are standards, factors, requirements or rules that discriminate on the basis of age justifiable?

A person who wishes to assert a human rights claim (a "claimant" or "applicant") has the burden of making out a *prima facie* case of discrimination. After that, the legal burden shifts to the party complained about (often known as the "respondent") to justify that its action is reasonable and *bona fide* in the circumstances (rules that can be justified as *bona fide* are often referred to as *bona fide* requirements or BFRs.).
Section 11 of the *Code* allows a respondent to justify a standard, factor, requirement or rule that has an adverse effect because of age by showing that it is a BFR. For example, a requirement that job applicants be "recent graduates" of a program may have the effect of excluding older candidates who are less likely to have completed their studies recently. However, the employer has the opportunity to show a justifiable reason for this requirement.
Section 24 allows direct discrimination in employment for reasons of age if the age of the applicant is a BFR because of the nature of the employment. For example, if an employer has a policy of hiring persons under a certain age only, it can attempt to show that this is reasonable in the circumstances.

Whether the discrimination is direct or by adverse effect, the Supreme Court of Canada has set out the same **three-step test** for determining whether discriminatory standard, factor, requirement or rule can be justified as a BFR. The respondent must establish on a balance of probabilities that the standard, factor, requirement or rule

1. was adopted for a purpose or goal that is rationally connected to the function being performed
2. was adopted in good faith, in the belief that it is necessary for the fulfilment of the purpose or goal
3. is reasonably necessary to accomplish its purpose or goal, in the sense that it is impossible to accommodate the claimant without undue hardship.
   The ultimate issue is whether the person who seeks to justify the discriminatory standard, factor, requirement or rule has shown that accommodation has been incorporated into the standard up to the point of undue hardship.

   In this analysis, the procedure used to assess and achieve accommodation is as important as the substantive content of accommodation. The following non-exhaustive factors should be considered in the course of the analysis:

- whether the person responsible for accommodation investigated alternative approaches that do not have a discriminatory effect
- reasons why viable alternatives were not implemented
- ability to have differing standards that reflect group or individual differences and capabilities
- whether persons responsible for accommodation can meet their legitimate objectives in a less discriminatory manner
- whether the standard is properly designed to ensure the desired qualification is met without placing undue burden on those to whom it applies
- whether other parties who are obliged to assist in the search for accommodation have fulfilled their roles.

4 Combating "ageism" through inclusive design

The OHRC has defined "ageism" to mean, in part, "a tendency to structure society based on an assumption that everyone is young, thereby failing to respond appropriately to the real needs of older persons."[12] Ageism occurs when planning and design choices do not reflect the circumstances of all age groups to the greatest extent possible.
The Supreme Court of Canada has recently made it clear that society must be designed to be inclusive of all persons. It is no longer acceptable to structure systems in a way that assumes that everyone is young and then to try to accommodate those who do not fit this assumption. Rather, the age diversity that exists in society should be reflected in the design stages so that physical, attitudinal and systemic barriers are not created.[13]
As a corollary to the notion that barriers should be prevented at the design stage through inclusive design, where systems and structures already exist, organizations should be aware of the possibility of systemic barriers and actively seek to identify and remove them.

4.5 Individualization vs. assumption

Another emerging human rights principle that has particular significance for age discrimination is the notion of individualized assessment and accommodation.

In the past, many standards, factors, requirements and qualifications that discriminate on the basis of age have been justified on the basis of **presumed characteristics** associated with aging.

Health care, institutions & services

"Basic health care is a foundation in our society and differences are never justifiable. Seniors' needs are real and they surely deserve easy access to basic health care in the same manner afforded to other groups in Ontario."
(Chatham-Kent CCAC)

The submissions received by the Commission consistently mentioned the barriers faced by older persons in the areas of health care, institutions and services. The Commission heard about concerns with the current health care system, including: insufficient funding and the resulting inadequacy of community-based care, the shortage of care professionals; and a number of concerns regarding long-term care facilities. Submissions mentioned physical barriers such as building accessibility and social barriers such as restrictive attitudes within the health care system as major obstacles facing older persons. Similarly, the Commission heard that physical and social barriers exist in the area of general services, and a number of consultees noted barriers specific to transportation. The message offered by participants throughout the consultation process was clear: barriers to health care, institutions and services serve to adversely affect the dignity, self-worth, independence and full-participation of older persons in the province of Ontario.

Community-based care: limited funding and services

Insufficient funding of community-based care was identified as a critical barrier for older persons seeking access to the health care system. The Ministry of Health and Long-term Care (MOHLTC) told the Commission that "significant investments have been directed to the expansion of long-term care community services designed to help people remain in their own homes for as long as possible." The Commission was pleased to learn that MOHLTC committed to an investment of $1.6 billion in long-term care community services for the fiscal year 2000-01, of which, $1.1 billion is for Community Care Access Centres (CCACs). Another $448 million of that investment is for other long-term care community services such as adult day programs and attendant care services.

"The Ministry recognizes the long-term care service system as an essential component of an integrated health service system and is committed to ensuring a quality system of community and facility long-term care services."
(Ministry of Health and Long-Term Care)

Despite such investments, the Commission heard about concerns regarding the insufficient funding of community-based services resulting in diminished capacity to appropriately address the health care needs of older persons. The Chatham-Kent CCAC indicated that over 50% of the population that they serve are older persons. However, the chronic under-funding of CCACs serves to severely limit their capacity to address the unique care needs of older persons. They noted that due to an emphasis on cost containment, they have been forced to reduce their caseload from 3,000 to 2,600 persons daily, translating into approximately 200 fewer older persons receiving care daily. Without appropriate funding, CCACs told the Commission that it is difficult to respond to the current demand for services.

“Many seniors cannot access physicians because there is such a shortage of physicians and because seniors with health problems require an above average amount of time and attention... available physicians do not welcome seniors as patients.”
(CCAC Timiskaming)

Health care for older persons is unique and requires an approach that takes into account evolving needs throughout the process of aging. A number of groups told the Commission that the care needs of older persons often demand more time of care professionals. However, the health care system in Ontario is not funded to allow care providers to spend the appropriate amount of time tending to their unique health care needs. The Advocacy Centre for the Elderly emphasized this very point in stating, “ there are maximum limits with respect to services...strict limitations on the amount of hours [of care] you can get...in no way [do they] meet the needs of many seniors in the community... that’s what we are finding with many of the services...It is the system itself, the structure that has the negative impact on the older person because the hours aren’t there, the time isn’t there to deal with the senior.”

Addressing this very issue, the Chatham-Kent CCAC noted that due to inadequate funding, they have been forced to reduce the hours of home support from 12 to 16 hours per week down to currently less than eight hours per week. The Ottawa-Carleton CCAC added that the *Long-Term Care Act, 1994*,[30] sets limits on the quantity of services that CCACs can provide to older person within the community. They noted that as a result, the level of community care can, at times, be insufficient to address the health care needs of older persons. In the context of early discharge and a shortage of convalescent care beds, they stated that older persons are often discharged into the community without a comprehensive care plan. For those older persons in need of longer periods of convalescent care, this can translate into lives at risk.

“If we want to keep people in the community and out of hospitals, you need to find the money to do so. When we have a shortage of beds and therefore discharge people after a very short period of time, they go home very frail and are still very much in need of help at home...they suffer like everybody else from a lack of medical care services, but more so because they are so vulnerable.”
(Ontario Association of Social Workers)

A number of submissions also emphasized that the inadequate funding of community-based services negates that capacity for older persons to “age in place”. As the Ottawa- Carleton CCAC noted, in order for older persons to be able to remain within their own communities, there is a need for an expansion of the care currently provided by CCACs and government-sponsored residential care facilities. In the context of inadequate funding, several groups noted that this is difficult to achieve.

The Older Women's Network and the Ontario Association of Social Workers emphasized that the Commission should not forget those older persons who are most marginalized within the context of the current system of community-based care. Older women who have disabilities, are poor, are from diverse racial and/or ethno-cultural backgrounds, or are lesbian or transgendered suffer "double jeopardy" in the context of community-based care. Age discrimination, in addition to exclusion based on other personal characteristics, means that vital community-based services are even more difficult to access.

In response to these concerns, a number of the consultees recommended that funding must be made available so that CCACs and others providing care to older persons have the capability, both in terms of resources and time, to provide the highest level of care. Multidisciplinary services, including community-based care, rehabilitation, chronic and complex continuing care and supports such as nursing care, home support services, therapies and case management services, should receive the appropriate focus in funding. The Ontario Association of Social Workers recommended that Commission policy initiatives related to age, "must encourage and promote equal access to a comprehensive range of community-based services and supports regardless of age or other attributes".

"We know that elderly people and their families want assurance that care in a long-term care facility will be available when care in the home and community is no longer possible. The expansion and redevelopment facilities (nursing homes and charitable homes for the aged) are specific goals of this Ministry."
(MOHLTC)

Long-Term Care Facilities: Barriers and Concerns

MOHLTC told the Commission that it recognizes the importance of long-term care as a key element of Ontario's health system, and has committed to investment in long-term community-based and facility services. It told the Commission that, "in 1998, to meet the needs of a growing elderly population, Government announced support for the construction of 20,000 new long-term care facility beds and the redevelopment of approximately 16,000 existing beds. This investment in long-term care beds is $602.4 million". Recognizing that residents of long-term facilities have increasingly complex needs, MOHLTC also introduced new design standards and guidelines for long-term care facility design in 1998. These standards and guidelines will apply to the 20,000 new beds and 16,000 renovated beds expected to be completed in 2004.

Furthermore, MMAH told the Commission that through the protections provided under the *TPA*, it maintains its role in the regulation of care homes. MMAH said that protections include the ability of care home tenants to terminate their tenancies with

30 days notice; the requirement that care providers give tenants written tenancy agreements outlining care and meal services to be provided; and the requirement that care providers provide tenants with information packages regarding the cost and availability of meal and care services and emergency services.

Nevertheless, a number of the submissions identified concerns with long-term care facilities in Ontario. The Canadian Mental Health Association highlighted the shortage of long-term care beds. They told the Commission that, at times, this has resulted in the inappropriate placement of older adults who experience mental health issues, a particularly vulnerable group of older persons.

Senior Link and a number of other groups highlighted the concern regarding the lack of regulation of rest and retirement homes. The Commission was told that the lack of regulation in such facilities allows for substandard care to exist and the abuse of older persons to occur (Ontario Coalition of Senior Citizens' Organization and Canadian Pensioners Concerned). ARCH (A Legal Resource Centre for Persons with Disabilities) expressed concern about "the indiscriminate use of physical restraints in institutions on elderly patients and the psychologically disabled". Another group noted, "low income seniors are at a disadvantage because they have to take what they can afford in a retirement home which may be sub-standard (Alliance of Seniors to Protection Canada's Social Programs)". A number of groups told the Commission of the need for monitoring, standards and legislation that will ensure appropriate care and safety for older persons living in retirement residences. The need for a Residents' Bill of Rights was highlighted. CARP specifically recommended that the provincial government take responsibility for developing the necessary legislation and standards.

Alternatively, the Chatham-Kent CCAC suggested that MOHLTC should enhance the capacity of the Ontario Residential Care Association (ORCA) to enable it to self-regulate the industry. The MOHLTC submission provided insight into government action on this issue. It noted that "with funding assistance from the government, the Ontario Residential Care Association (ORCA) is expanding its self-regulatory program for retirement homes [to include] a consumer complaint investigation system and the development of a checklist for consumers on what to look for in a resident's contract with a retirement home." Details as to the progress of this expansion were not provided.

Several groups expressed concern regarding the cultural, linguistic and religious needs of older persons living in long-term care facilities. One group noted that not all ethnic groups have their needs addressed equally within such facilities. Dieticians of Canada noted that the cultural, linguistic and religious needs of older persons must be given equal consideration. They suggested that the provincial government support the development of educational packages to be used in long-term care facilities that would

assist staff in providing appropriate and respectful care (for example in the provision of food, religious observation and culturally specific social activities).

The Canadian Association of the Deaf and the Canadian Hearing Society expressed great concern regarding the treatment of Deaf older persons in long-term care facilities and senior residences. The lack of TTY systems, visual alarms in bedrooms, hallways and bathrooms, and shake awake alarms means that Deaf persons are placed at risk and excluded within their own living spaces. There is a critical need for more residences specifically designed for Deaf seniors given that there currently exists only one (The Bob Rumball Centre for the Deaf) in the entire province. Several groups noted that this issue is further compounded for those living in rural areas where programs for Deaf persons may not be available at all. It was recommended that all levels of government, in partnership with the Deaf community, must work to ensure that nursing homes and retirement homes are accessible to Deaf older persons (Canadian Association of the Deaf).

"Current practices tend to generalize and treat all people over the age of 65 as identical...this can unfairly limit access to required services for people with Alzheimer Disease, ultimately threatening the independence and dignity of this growing segment of the population."
(The Alzheimer Society of Ontario)

The Alzheimer Society of Ontario raised specific concerns regarding the treatment of persons living with Alzheimer Disease while residing in long-term care facilities. MOHLTC told the Commission that, "half of the residents in facilities have Alzheimer Disease or related dementia." The Alzheimer Society of Ontario emphasized that this group has unique needs, however, "current practices tend to generalize and treat all people over the age of 65 as identical...this can unfairly limit access to required services for people with Alzheimer Disease, ultimately threatening the independence and dignity of this growing segment of the population." As well, the way in which funding levels for long-term care facilities are determined, does not take into account the cognitive and behavioural care needs of persons with Alzheimer Disease. This impacts on the ability of care facilities to appropriately address the needs of this growing group of older persons.

Others expressed concern regarding the independence of certain groups of older persons in care facilities. The Canadian Mental Health Association noted that sometimes, a conflict of rights occurs, wherein the right of an older person to live at risk comes into conflict with the rights of caregivers to intervene. The Ottawa-Carleton CCAC stated that staff in institutions must be knowledgeable of the older person's right to refuse treatment or care, a right that must be respected, even if it leaves the older person at risk. The Ontario Association of Social Workers

emphasized that health decision-makers within long-term care facilities must take seriously and support the wishes and decisions of the older person in care. With respect to end of life decisions, the Alzheimer Society of Ontario added that, "it is the right of all individuals to be able to make choices regarding end of life and to have those choices respected. In Ontario, legislation exists to protect this right, however, the legislation is not always followed, for example, when family members are vigorously opposed to an Advance Directive or the decision of the Substitute Decision Maker."

Finally, a number of organizations commented on the barriers faced by older couples once they reside in a care facility. Dieticians of Canada noted that older couples face difficulty in obtaining accommodation in the same room, the result of which can be "forced separation" of the couple. Anxiety and loneliness can occur as a result. This, in turn, can have a negative impact on the older couple's health and well-being. Separation may also occur due to differing levels of care required by the couple. They suggested that multi-level care facilities that can address varying levels of care would assist in ensuring older couples are not forced to live separately. As noted earlier, ACT and CLGRO added that gay and lesbian couples face considerable barriers in care facilities, given that at the outset, their relationships are often not even recognized or validated.

The focus on acute care

"Health care for seniors takes second place to other aspects of the health care system. Comparative spending on community health care and long-term care, whose target population is primarily seniors, is a fraction of the health care spending for acute care."
(Chatham-Kent CCAC)

A number of the submissions noted an emphasis on acute care, which diverts attention from the long-term care needs of older persons. Senior Link told the Commission that, "in the process of hospital restructuring, what we have found is that community-based care has become acute care...long-term care has been put on the shelf..." The Alzheimer Society of Ontario emphasized that the focus on acute care means that, "elderly people, particularly those with chronic diseases like Alzheimer Disease or related dementia are not able to get adequate services, or in some cases any services at all."

A shortage of knowledgeable health care professionals

Consultees also noted that access to health care professionals who are knowledgeable about the aging process is a key concern, particularly in the context of the growing

population of older persons in Ontario. The Alzheimer Society told the Commission that its own research has revealed that minimal amounts of teaching time are currently allocated to the issues of aging and dementia in Ontario medical schools. As they and others noted, "[the] lack of training in these areas will lead to barriers for older adults who need to utilize the health care system and will compromise the quality of care and/or access to appropriate care" (Alzheimer Society of Ontario).

The Commission also heard that it is very difficult for older persons without a physician to obtain one (KFL&A CCAC). The CCAC of Timiskaming told the panel that accessibility to health care is limited by the shortage of physicians throughout Ontario. To address this issue, they suggested "incentives for physicians to specialize in geriatrics". It was emphasized that because many physicians no longer make home visits, accessibility is limited for some older persons. The Commission heard that this issue is compounded in rural communities where the access to doctors, and in particular specialists, is "virtually non-existent". As the number of older persons increases, these problems will intensify. The Canadian Mental Health Association – Windsor-Essex, branch added that as a result of shortages in physicians, nursing staff and personal support staff, inadequate and inappropriate care can result.

To address the shortage of physicians within the province, MOHLTC told the Commission that it has implemented the "Underserviced Area Program" to attract and retain health care providers within the northern, rural and remote areas of the province. The program includes "financial incentives for physicians willing to relocate to under serviced areas, recruitment initiatives, practice supports and enhancements to access to medical services for affected communities".

Barriers to health care information

The Commission heard that a number of groups of older persons are not receiving information about health care services, thereby limiting access. They emphasized that while CCACs have services to offer, many older persons are either unaware of the existence of CCACs and the availability of their services or are reluctant to ask about them. Additionally, the Commission was told that internet-based communication is not very effective in reaching older persons. Consultees noted the need for outreach so that older persons throughout Ontario are aware of the services that are available. CCACs indicated that with additional funding, they would acquire greater capacity to do so.

The Commission learned about barriers to health information that extend beyond the issue of public education. Issues such as language and citizenship status pose particular barriers for certain groups of older persons:

"We have often found that a family will be reunited in Canada and [the older person] will not have citizenship status and that leaves them very vulnerable because they cannot access the health care system."
(Senior Link)

The Ontario Association of Social Workers noted health care and other service providers must ensure that linguistically appropriate services are available: "services in the language of the elderly person is of course crucial...[service providers should] make it a policy to employ people who speak the language of the people [they] are serving". In addition, they noted that CCACs should ensure that their materials are published in various languages.

"Health care, long-term care, elder care, mental health service providers, employed by the public and private sectors must be provided with in-service training to give them a better understanding of ...the use of various communication strategies for Deaf, deafened and hard of hearing people."
(The Canadian Hearing Society)

The Canadian Hearing Society noted that Deaf, deafened and hard of hearing older persons experience communication barriers in the context of health care services. It told the Commission that staff within the health care system are unable to communicate with older persons who experience hearing loss. The Supreme Court of Canada's decision in *Eldridge v. British Columbia (Attorney General)*,[31] has confirmed that sign language interpretation, where necessary to ensure equal access to health care, must be provided. Nevertheless, consultees indicated that while the decision was a significant milestone, its implementation has been slow.

It is the Commission's view that health care providers in Ontario should abide by the *Eldridge* decision by providing sign language interpretation to respond to the needs of Deaf persons. As consultees noted, it would appear that health care and other service providers should be trained in appropriate communication techniques that respond to the needs of Deaf, deafened and hard of hearing people.

Cost as a barrier to access

The consultation revealed that a critical barrier for older persons is the limited access to health care benefits often experienced in later life. Many employer drug benefit programs cease on retirement or termination. Those who are too young to be eligible for the Ontario Drug Benefit plan, or those who find themselves "in-between" private coverage are often required to pay for health related products and services. Some older persons may not be able to afford to do so.

Canadian Pensioners Concerned emphasized the reality of cost as a barrier to health care services for older persons. They told the Commission that the costs of prescriptions can sometimes place older persons in a position of choosing between buying medicine or other necessities of life. This can, in turn, lead to a life at risk. The Alzheimer Society of Ontario added that drugs to treat Alzheimer Disease cost approximately $5 per day, creating a significant barrier for older persons who are not covered by a health plan or the Ontario Drug Benefit (ODB). As they noted, "without coverage, many adults do not have access to timely interventions that can maximize quality of life and minimize their stress, anxiety and caregiver burden." Dieticians of Canada added that, "coverage of nutrition supplements [under the ODB] is not adequate. Many of Ontario's elderly, whether living at home, in retirement homes or in long-term care facilities are experiencing complications of malnutrition." The Commission was told that to address this issue, MOHLTC should work to expand the types of prescription drugs and alternative therapies that will be covered for older persons by the Ontario Health Insurance Plan (OHIP).

"More and more seniors are having to resort to the use of food banks because they can't afford to buy food and the very expensive drugs which are often prescribed but not included on the list covered by the provincial health plan (The Ontario Drug Benefit)...the alternative is to go without drugs."
(Canadian Pensioners Concerned)

Older persons who have or may develop a disability also experience barriers because of the cost and availability of assistive devices. The cost related to assistive devices presents a significant barrier, particularly since those who may need them most may be the least likely to be able to afford them.

Even where government funded assistive devices programs exist, they may only offset some of the costs or pay for basic technology instead of better devices that would improve an individual's quality of life. In addition, age limits in the provision of such programs pose another barrier and have been challenged as a form of age discrimination. For example, in *Ontario (Human Rights Commission) v. Ontario (Ministry of Health)*[32] the Court of Appeal found that the Ontario Ministry of Health's Assistive Devices Program could not restrict the provision of closed circuit television magnifiers only to persons under the age of 25. A 71-year-old man had been refused this visual aid. Additionally, the Commission has recently initiated a complaint against the MOHLTC and its contractor, the West Park Healthcare Centre, for using age-based criteria in the provision of assistive devices. Under the program, access to incontinence devices is restricted to persons born after July 1, 1963, thereby excluding older persons.

Consultees also mentioned the cost associated with dental benefits as a significant barrier for older persons. The CCAC of Halton noted that "Ontario does not have a universal dental program for seniors [and]...the majority of older adults are without dental insurance". It told the Commission that without a dental plan and with limited income, older persons do not access regular dental care. This can result in poor oral health leading to "physical, psychological and social problems". Dieticians of Canada and the CCAC of Halton noted the importance of good oral care to the ability of an older persons to maintain weight and avoid "systemic health problems". The need for affordable and accessible dental coverage for older persons was emphasized as a critical aspect of any efforts to address the health-related needs of older persons in Ontario (Halton Health Department).

Social barriers to access

Throughout the consultation, the Commission heard about the social barriers to accessing health care and institutions experienced by older persons. The Ontario Association of Social Workers told the Commission that, "older adults are frequently characterized as non-contributing members of our communities and their need for services [are] portrayed as being a drain on scarce public resources". The Ontario Coalition of Senior Citizens' Organizations and others told the Commission that older persons are often labelled as "bed-blockers". The Ontario Association of Social Workers added that this labelling of older persons, "infers that patients who are legitimately in need of long-term care beds are partially responsible for the shortage of emergency room beds...[and] shifts attention away from the vitally needed public debate about government priorities and funding for our health care system".

"The health care system tends to place priority on those who are younger and those who are working...If you are older, the younger person gets to the top...that is age discrimination."
(Canadian Pensioners Concerned)

A number of organizations told the Commission about the impact of ageist assumptions upon the care of older persons. Canadian Pensioners Concerned told the Commission that older persons in Ontario are the last to be considered when it comes to health care services. The Canadian Mental Health Association provided the Commission with an example of how this is experienced by older persons. It told the Commission that older persons, particularly those facing mental health issues, are often faced with the comment "what do you expect for your age" when they meet with health care professionals. A number of groups added that some physicians "normalize" concerns of older persons, often relating them to the aging process and, in turn, providing inadequate assessment and follow-up.

The Ontario Coalition of Senior Citizens' Organizations emphasized that older persons are often identified as a lower priority for surgical procedures and are often over-prescribed medication. Additionally, a couple of organizations expressed concern that powers under the *Canada Health Act*could allow for health care providers to limit access to health care procedures on the basis of age. A number of the consultees, including the Chatham-Kent CCAC noted that they had heard anecdotal evidence of doctors limiting the access of older persons to procedures and to their practice. As ESAC told the Commission, the health care system in Ontario must provide older persons with the same level of care and consideration as would be provided to a younger person.

The Canadian Mental Health Association, Windsor-Essex branch, told the Commission that for older persons experiencing mental health issues, ageist assumptions continue to compound their marginalization within the health care system. Such attitudes lead to insufficient levels of attention paid to the mental health needs of older persons. They told the Commission that this frequently results in the use of chemical or physical restraints that have been documented in research as leading to further deterioration. The Ontario Coalition of Senior Citizens' Organizations noted that older persons also experience infantalization at the hands of health care providers and that when an older person requires admittance to a hospital, they are often faced with resistance, particularly if the person is also experiencing mental health issues. Karen Henderson emphasized that in response to such treatment, "there is a critical need for training to be instituted for health care providers so that they may be equipped to address the health care needs of older persons in a manner that is effective and respectful of human dignity".

"There is a critical need for training to be instituted for health care providers so that they may be equipped to address the health care needs of older persons in a manner that is effective and respectful of human dignity."
(Karen Henderson)

General Services

"The Canadian Hearing Society would recommend that you, the Human Rights Commission, urge the Secretary of Cabinet and the Deputy Minister of Management Board Secretariat to ensure that all Ontario Ministries are aware that the Ontario *Human Rights Code* requires their services, including contracted services, be accessible to all older people with disabilities."
(The Canadian Hearing Society)

A number of consultees said that ageism and age discrimination extend beyond health care services into other areas of service delivery. The Canadian Centre for Activity

and Aging told the Commission that older persons are “politely discriminated against” by virtue of the fact that many public buildings and facilities are not accessible. As the Golden Years Club of Lakefield pointed out, access to buildings for older persons, particularly those who experience a disability, remains an issue of access to services. They told the Commission that municipalities should ensure that municipally owned buildings are accessible. Canadian Pensioners Concerned and others noted that there is a strong need for a disability act and a [revised] building code in Ontario that would require service providers to ensure that their buildings and services are fully accessible. The Advocacy Centre for the Elderly noted that, “ the impact of this type of legislation, if made mandatory compliance and if applied to all sectors (not just government), could result in a great improvement in services and systems for seniors”.

Several organizations told the Commission that older persons who are Deaf, deafened and hard of hearing face additional barriers to services because of the systemic exclusion that they experience throughout their lives. The Canadian Association of the Deaf told the Commission that the major barriers tend to be systemic and economic discrimination. The Canadian Hearing Society told the Commission that the shortage of persons trained and available for interpretation presents a substantial barrier for older Deaf persons. The Canadian Association of the Deaf added that barriers are created when a hearing person refuses to pay for interpretation services or when funding is unavailable to cover the costs related to interpretation and other forms of accommodation. As well, they noted that older persons may face communication issues when younger interpreters do not recognize or understand the signs used by older persons. This can lead to frustration and a loss of confidence as to whether others are receiving their information correctly. The Commission heard that when appropriate supports, such as interpreters, are available and accessible for Deaf seniors’ a greater balance of power is had and self-determination encouraged because they are able to express their needs and concerns in their first language.

Others reported that older persons also face attitudinal barriers in the area of services. The Advocacy Centre for the Elderly told the Commission that they receive complaints regarding the paternalism experienced by older persons at the hands of service providers. It noted that older persons are often labelled as “hard-to-serve” clients. At other times, they are treated as if they are incapable and when important decisions are required, service providers often defer to family rather than to the older person him or herself. It explained to the Commission that, “in the end it has a discriminatory effect upon the older person because they are not involved in the service delivery themselves... it exacerbates the situation and lessens the contact they have with the service provider”. Clearly such practices negate the principles of dignity, independence and full–participation for older persons in such circumstances.

"The paternalism we see in service delivery...we receive complaints from seniors who identify that they are not the people being dealt with in terms of services...its their family...[seniors] are not treated as the decision maker or they are treated as if they are incapable."
(Advocacy Centre for the Elderly)

Transportation Services

Many of the submissions identified the same concerns that the Commission noted in its recent *Discussion Paper on Accessible Transportation Services in Ontario*. Senior Link told that Commission that, "the transit system and wheel trans are not accessible for many seniors who need assistance getting to a doctor or into a hospital...they need to be supported so that seniors can access programs...in rural Ontario, this issue is amplified because of the isolation and the lack of transit". Canadian Pensioners Concerned echoed this concern and told the Commission that for older persons, particularly those with mobility impairments, transportation is extremely limited and this can lead to isolation from family, community and from the general activities of daily living. One group told the Commission that, " travel to the doctor, dentist, or store for rural seniors is very difficult...if they cannot drive or there is no public transportation, they must rely on family or home support" (Council on Aging for Renfrew County). Given what the Commission heard about limitations in community-based supports and the availability of physicians, transit inaccessibility compounds the barriers to health care and other services for older adults.

"The populations of many small communities have a large proportion of seniors. These communities do not now have, nor have [they] ever had, public transportation. This restricts seniors from accessing health, social and commercial services in larger centres. Recognize that any policy initiatives will have a different effect in the rural north than in, for example, Toronto, Ottawa or Sudbury."
(CCAC Timiskaming)

A number of organizations strongly emphasized the need for more accessible transportation. Ramps, elevators, escalators and low floor and lift-equipped buses are critical for ensuring equal participation of older persons with disabilities. Bright lighting, contrasting floor materials and audio announcements make it easier for persons with low vision to use public transit. TTY phones and written announcements improve accessibility for persons who are Deaf, deafened or hard of hearing. As the Canadian Hearing Society (London) noted, public transportation buildings often are not equipped with sufficient and proper TTY equipment or public address systems. Others noted that in addition to physical barriers, older persons often face "poor treatment" by public transportation employees signalling the need for sensitivity and

awareness training to address such social barriers (The Ontario Coalition of Senior Citizens' Organizations).

For those who cannot access even a well-integrated conventional system, there is a need for parallel para-transit services. The Commission heard, however, that the eligibility criteria for many para-transit services may disentitle older persons with certain types of disabilities, *e.g.*, disabilities that arise from respiratory problems, heart conditions, and cognitive impairments resulting from stroke, dementia or brain tumours, and sensory disabilities. Consultees also noted that even those who are eligible find that para-transit services are not adequate to allow them equal access to public transit.

The Commission heard that while there have been some improvements over the last few years, transportation in Ontario remains inadequately funded. The Ontario Coalition of Senior Citizens' Organizations noted that evidence of under-funding can be found in the area of volunteer escort services provided by MOHLTC. It told the Commission that such services are only available for medical appointments. Transportation that would allow older persons to attend social and recreational activities is either unavailable or limited. ESAC recommended the implementation of creative solutions to the transportation issues facing older persons in urban and rural areas. They suggested a subsidized taxi program while Senior Link recommended community-based volunteer networks based in local organizations that could provide older persons with transportation to their various appointments. Dieticians of Canada suggested that, "Municipalities, District Health Councils and the Ministry of Health and Long-Term Care need to support the development of funded transit systems and review eligibility so that transit is available to all who need it". The Older Women's Network simply suggested that to address the transportation issues facing older persons, all levels of government should provide subsidies and invest appropriate amounts of money to ensure that an adequate system of transportation is available.

Recommendations For Government & Community Action

21. THAT medical schools and training centres for health care professionals and others who work with older persons enhance education on the needs of older persons.

22. THAT health care institutions, facilities and services be made accessible to all older persons, particularly those with disabilities.

23. THAT the government should exercise caution in the use of age-based criteria in health care programs such as assistive devices, prescription drug and dental programs.

24. Consistent with the *Eldridge* decision, that service providers provide sign language interpretation services where necessary to ensure equal access for persons who are Deaf, deafened and hard of hearing.

25. THAT the provincial government take further steps to regulate rest and retirement homes. Issues to address might include a Resident's Bill of Rights and standards for the use of restraints and end-of-life decisions.

Commission Commitments

5. The Commission will communicate with the Ontario College of Physicians and Surgeons, the Ontario Medical Association and the Canadian Medical Association and other appropriate organizations to advise that unequal access to medical treatment and other health care services on the basis of age or disability may constitute discrimination.

6. The Commission will contact and meet with professional faculties such as medicine, nursing, dentistry, nutritional sciences and social work to discuss the urgent need to include comprehensive education on age discrimination within their curricula and to ascertain their plans for including such education in their programs.

7. The Commission will continue to take steps to promote accessibility amongst service providers throughout Ontario.

Elder abuse & neglect

"Elder abuse and neglect should be identified as abuses of human rights."
(Canada's Association for the Fifty-Plus (CARP))

Many individuals and organizations provided comment on the issue of elder abuse. The submissions emphasized that elder abuse is a human rights issue requiring an effective response by government and by communities throughout Ontario. The Commission heard that any action concerning elder abuse, whether by government, community organizations or by individual caregivers, must be grounded in a respect for the dignity, independence, full participation and the security of older persons. The following pages provide an overview of the comments offered to the Commission throughout the consultation process.

Although a universal definition of the term *elder abuse* does not exist, Health Canada has defined it as "the physical, psychosocial or financial mistreatment of a senior". [33] *Physical abuse* of an older person can include assault, rough physical treatment,

sexual exploitation, or the failure to provide an older person with food, or with appropriate personal, hygienic or medical care. *Psychosocial* abuse includes verbal abuse, the social isolation, the failure to provide affection, and the denial of the opportunity to make or take part in decisions concerning one's own life. *Financial abuse* includes the mishandling of an older persons money or property, and also includes fraud. [34] However, a 1999 report by the Ontario Legislative Assembly adds to this list a number of additional forms of elder abuse including: medication abuse (*e.g.*, the misuse or withholding of medications), the denial of fundamental rights and freedoms, abandonment, and self-neglect.[35]

Financial abuse tends to be most common (62.5%), with verbal and physical abuse second most common (35% and 12.5% respectively) followed by neglect (10%).[36] Submissions received by the Commission highlighted that elder abuse and neglect occur in all contexts; in the home, in hospitals, in long-term care facilities, and in retirement homes.

The Under-Reported Nature of Elder Abuse

The Commission heard that approximately 4% or 60,000 of the 1.5 million older persons living in Ontario experience elder abuse.[37] However, many older persons are not willing to report elder abuse because of the social stigma attached to it or because of concern regarding the consequences of reporting a loved one or caregiver. As a result, this percentage may be under-estimated.[38]

A number of the submissions highlighted the complex nature of elder abuse. As one group told the Commission, the dependency of older persons upon their caregivers means that abuse inflicted by a caregiver is more difficult to address. The embarrassment experienced by older persons who are abused by their family members and caregivers makes elder abuse a "hidden form of familial abuse" (The Ontario Association of Social Workers). Older persons who are experiencing abuse are often faced with the decision of whether or not to report their abuser, the result of which could mean the loss of their caregiver, making their decision to report that much more difficult (Chatham-Kent CCAC). Others told the Commission panel about the serious dilemma facing older persons who are abused by those for whom they themselves are caring for, wherein the older person's desire to care for that person conflicts with their own need for safety.

CARP discussed the issue of elder abuse in the context of care facilities. It noted that for those who experience abuse within care facilities, fear can act as a real deterrent to reporting abuse. A number of consultess told the Commission that families may also be too afraid to complain about the abuse of their older relatives because they fear retribution against their loved ones in the form of poorer care or further abuse (ARCH

and Karen Henderson). As the Council on Aging noted, the problem of elder abuse is very much like domestic violence and requires a systemic approach to ensure that victims of elder abuse are not further victimized in the process of seeking recourse and in defending their rights.

Abuse of Deaf and "Deaf-Plus" Older Persons

Several consultees told the Commission of the particular experience of elder abuse faced by Deaf, deafened and hard of hearing older persons. While Deaf seniors experience the same forms of abuse as other seniors (*e.g.,* financial abuse, physical abuse, emotional abuse, *etc*.), they also experience communication abuse. The communication barriers faced by Deaf older persons makes this group particularly vulnerable to the other various forms of abuse (The Canadian Association of the Deaf). The Canadian Hearing Society provided the Commission with several anecdotal descriptions of situations of communication abuse:

"A client who went into hospital uses hearing aids and speechreads. The client needed information from the nurse regarding her medical situation. The nurse refused to turn on the light so the client could speechread, even though the client requested it and told [the nurse] why."

"[A] Client's medical condition [was] discussed over the person's head to a third party rather than being discussed with the client."

"A colleague of mine had a client who was misdiagnosed with dementia and was hospitalized. It took my colleague a year to get that person out of the psychiatric ward and back home...he had been tested without his hearing aids in."

The vulnerability that occurs in the context of elder abuse is heightened for "Deaf-Plus" older persons, that is, those who experience hearing impairment in addition to other disabilities such as blindness, Cerebral Palsy or intellectual disabilities. This group of older persons is often the easiest to abuse because they are vulnerable and unlikely to report the occurrence of abuse (The Canadian Association of the Deaf). The Canadian Association of the Deaf emphasized that, "people with this kind of special vulnerability often simply do not know where to go or how to seek assistance, so they endure the abuse as being almost a birthright of 'superior' hearing people".[39]

A report by the Canadian Association of the Deaf entitled, *Keeping the Hands in Motion*[40] highlighted the communication barriers faced by "Deaf-Plus" older persons. For those who have arthritis in their fingers or hands, the ability to communicate through sign language and writing is limited. Given the importance of vision for Deaf persons in communication, where a person experiences a visual

impairment, communication barriers are further compounded. These barriers further exacerbate an older person's vulnerability in the context of an abusive situation.

Throughout the consultations, organizations emphasized the need for broad public education and awareness building with respect to elder abuse and neglect. Others suggested the need for targeted education, particularly geared toward professionals who work with older persons on a regular basis (*i.e.*, doctors, nurses, social workers, *etc.*). In addition, a number of consultees called for more education and supports for caregivers.

With respect to Deaf and Deaf-Plus older persons, the Canadian Association of the Deaf suggested that a network of advocates should be set-up to assist Deaf seniors with abuse and neglect-related issues, to protect Deaf seniors from abuse and ensure that they are aware of their rights. Others suggested that more funding should be provided to develop educational programs that could alert Deaf and Deaf-Plus older persons to the issues of elder abuse, neglect issues, to their rights and to possible mechanisms of recourse.

Causes of and Contributors to Elder Abuse

"Until the elderly are fully recognized as individuals with the same human rights...as other citizens, abuse of the elderly will prevail – whether it takes place in the home, community or institutions."
(Ontario Association of Social Workers)

The Commission heard that the causes and contributors to elder abuse are varied and extensive. A number of submissions noted that ageism and a general negative attitude toward seniors is a key underlying contributor to elder abuse. ESAC told the Commission that elder abuse is tied to a lack of services in the community as well as the lack of available long-term care beds and available, affordable and accessible housing. Still others noted that the economic and social vulnerability of older persons contributes to elder abuse.

The Ontario Coalition of Senior Citizens' Organizations told the Commission that elder abuse frequently occurs when primary caregivers experience "burn-out or significant stress". This includes professional caregivers who are facing a growing caseload, as well as complex care responsibilities within the context of an under-funded system of services. This also refers to family caregivers who are expected to provide care for aging relatives in the context of dwindling government services and supports. Reports by Health Canada and the Government of Nova Scotia also support this notion. They both report that elder abuse can result when a caregiver's stress is exacerbated by a lack of available information and resources about caring for an aging

person. Furthermore, a caregiver's own issues such as unemployment, substance abuse, personal relationship problems and unresolved family conflict can contribute to the occurrence of elder abuse.[41]

Submissions noted that many well-intentioned adult children or other caregivers want to make decisions for older persons, especially when they perceive that an older adult cannot make decisions for themselves. However, a number of organizations noted that seniors often lose their rights to self-determination, independence and dignity in the process (Ontario Association of Social Workers and The Canadian Mental Health Association). As Health Canada's work on elder abuse notes, the denial of the opportunity for an older person to make or take part in decisions concerning his or her own life can be a form of psychosocial abuse. The Canadian Mental Health Association suggested that in order to ensure that an aging person's rights to independence and dignity remain in tact, widespread public education is needed.

The lack of regulation of privately-run care facilities was also noted as a contributor to the vulnerability of older persons to abuse. The need for regulation of privately-run care facilities and for standards for all such homes across the province was discussed in the section on **Health Care, Institutions & Services.**

The lack of emergency shelters available for older persons who have experienced abuse was also mentioned as a factor that contributed to elder abuse. The Ottawa-Carleton CCAC told the Commission that existing emergency shelters are often full and tend to address the needs of younger women and children. Such facilities are not appropriate for older persons and options for people suffering abuse by caregivers are limited. Other organizations told the Commission that barriers to accessing shelters include a general lack of knowledge on the part of older persons regarding how to access emergency shelters. Furthermore, language and cultural barriers exist that further limit the accessibility of these facilities. ESAC suggested that temporary shelters should be established to aid older persons and those with disabilities in their transition from an abusive situation to a safe environment. The Ottawa-Carleton CCAC suggested that shelters should exist for both men and women, should be walker and wheelchair accessible and staffed with people who are able to address the complex needs of older persons.

Programs to Combat Elder Abuse

A number of organizations told the Commission about programs to combat abuse of older persons. One such program is Phone Busters, a program implemented by the Ontario Provincial Police. Phone Busters accepts calls from across North America from older persons who have fallen victim to telemarketing fraud. Representatives from Phone Busters told the Commission that, "80 per cent of the people that call

Phone Busters are seniors [and] have lost money to telemarketing fraud". Others added that single older women are particularly vulnerable to financial "scams" such as telemarketing fraud. As with other forms of abuse, financial abuse of older persons is under-reported. Phone Busters estimates that, "only one per cent of the losses are actually being reported due to embarrassment and shame on the part of the victim".

"We are teaching them to [regain] their dignity because a lot of [older persons] are embarrassed and will not talk to their family members...If you lost [money], the last thing you would want to do is tell your children..."
(Ontario Provincial Police, Phone Busters)

The statistics for the Phone Busters program illustrate that it has been very successful in reducing the dollars lost by older persons who are vulnerable to financial abuse. As a result, the group sought new mechanisms through which further outreach to older persons could occur. The result was a partnership between the Near North CCAC and Phone Busters to implement an elder abuse hotline pilot study. The pilot is aimed at addressing systemic abuse, neglect, physical and psychological abuse of older persons. The Commission was told that the six-month pilot ended early this year and that the Ministry of Citizenship, Seniors' Secretariat will determine the next steps for the program.

Recommendations for Government & Community Action

26. THAT mechanisms currently in place to address other forms of familial abuse should be extended to apply to elder abuse.

27. THAT the provincial and municipal governments take steps to support specialized programs, including shelters, for victims of elder abuse.

Commission Commitments

8. The Commission will continue to monitor the outcomes of the provincial plan of the Round Table for Ontario's Elder Abuse Strategy that are within its mandate.

Elder care

The Commission heard that elder care is a growing need, and largely provided in the community by family members. As well, the gendered nature of elder care and the disproportionate burden that women face in caring for aging relatives was noted. Consultees described the stress caused by caring for older persons and the need for efforts to address caregiver stress. Finally, the Commission heard that issues relating

to elder care require creative responses by government in terms of legislation, programming and funding and by employers in terms of workplace flexibility to ensure that caregivers are supported in their provision of care. The message presented to the Commission was that caregivers are fulfilling an important societal role and should not have to bear the responsibility alone. Society should be supportive of their efforts.

"Informal caregivers are...silent victims in a silent system...they have inherited unfair burden and responsibility without enough support in the downloading of responsibility [as a result of] hospital closures."
(Canada's Association for the Fifty-Plus (CARP))

The Squeeze in Elder Care

A number of organizations told the Commission that that there is mounting pressure in the area of elder care: as the population continues to age, hospitals continue to discharge patients at a faster rate and inadequate provincial funding is provided to community based health care providers. These factors together make it difficult for home care providers to provide adequate care (The Council on Aging). This means that families will increasingly be required to provide care for their aging relatives. Submissions by the Council on Aging and others highlighted that in this context, older persons themselves will become the victims of an inadequate system, particularly those older persons who do not have family or the capacity to access private health care.

The Gendered Nature of Elder Care

A report submitted by CARP noted that in 1999, 46% of all working Canadians provided general eldercare.[42] The Older Women's Network told the Commission that the care of older persons is most often performed by women; 90% of paid caregivers are women and a significant proportion of informal caregivers are also women. This is supported by a recent report by the Ontario Community Support Association.[43] Canadian Pensioners Concerned told the Commission that the role of women as primary caregivers has existed as a "norm" within society, requiring women to place caregiving responsibilities above their own aspirations. They noted, "because of family responsibilities, lower salaries, and fewer opportunities for education and job promotions, [women] have been unable to amass sufficient retirement income through pensions and savings". The gendered nature of elder care therefore has repercussions for women in other areas, likely to last far into their later lives.

Caregiver Stress

Caregiver stress has been identified as a significant and increasingly important issue as the number of older persons requiring care in the community grows. One individual told the Commission that caregiving places a significant burden upon families, particularly when family members do not have the necessary training to provide appropriate care for their aging relative. The Chatham-Kent CCAC noted that particular expertise is required in the care of older persons given that elder care often requires knowledge of polypharmacy and diseases related to aging, and the know-how to deal with consent and capacity issues. Without such expertise, stress can be further compounded. A number of submissions emphasized that the burden experienced by the family can also cause stress for the older person because it can cause the older person to feel like a burden. The Ottawa-Carleton CCAC and others stated that for older people who are caring for another older person, this burden can be exacerbated by their own care needs.

Accommodating Caregiving

The Consultation Paper asked for comments on the extent of an employer's duty to accommodate employees who care for older persons. A number of organizations responded with creative suggestions that could apply in the workplace and beyond. ESAC told the Commission that support for caregiving in the form of job flexibility is necessary. They stated that the ten days of emergency leave to care for family members, as prescribed by Subsection 50(5) of the *Employment Standards Act, 2000*[44], is not enough in most cases. ESAC suggested that leave to care for family members should be flexible, similar to the current provisions for maternity leave. The Ottawa-Carleton CCAC suggested that temporary leaves and reassignments are possible options to help employees address caregiving obligations. The Alzheimer Society of Ontario added that, "there is a need for employers to offer provisions such as a leave of absence, benefits or other support for those who care for a family member with Alzheimer Disease that are at least comparable to benefits that exist to address childcare needs". While a number of the consultees recognized that employers do not have unlimited resources, consultees also suggested that employers should be willing to accommodate reasonable requests for care leave.

The fact that the significant costs associated with elder care have not been formally recognized by current policies is causing many caregivers some degree of financial hardship...There is a need [to] review related policy to ensure that equal value is placed on elder care as is placed on caring for adults and children with disabilities and to financially assist caregivers to provide the type of support that older care recipients need.
(The Alzheimer Society of Ontario)

A number of concrete recommendations were offered for the manner in which governments can respond to the needs of caregivers in Ontario. The Ottawa-Carleton CCAC emphasized that legislation is required to ensure that persons providing care are supported and not punished. CARP recommended that support for informal caregivers in the form of CPP benefits and retraining programs should be made available. The Alzheimer Society of Ontario emphasized that caregivers should be offered a "caregiver tax-credit" similar to credits available for caregivers of persons with disabilities. Furthermore, extended health benefits, such as those available for dependent children, should be available for dependent adults. Union Culturelle des Franco-Ontariennes told the Commission that guaranteed remuneration should be available to people who stay at home to care for sick family members.

Alternative Care Options

The Commission heard that to relieve caregiver stress, caregivers need a break from their duties. Day programs, respite programs and home care programs were discussed. The Chatham-Kent CCAC noted that day programs and short stay beds are options for caregiver relief but that they often have limited value. They are useful in the sense that they provide caregivers a break, however, such programs can be difficult to access due to issues regarding transportation to and from such programs. With respect to respite care, they told the Commission that many of the forms of respite care are not flexible enough to address the various needs of caregivers. They suggested that respite care in the home often presents a better option for families. The Ontario Association of Senior Citizens' Organizations told the Commission that universal services, such as long-term care facilities and home care programs, should be in place with adequate funding to ensure that real alternatives to family care are available.

Recommendations for Government & Community Action

28. THAT the Ministry of Labour extend the new leave provisions of the *Employment Standards Act, 2000,* to smaller workplaces (including those of less than fifty employees).

29. THAT all levels of government and employers consider providing various forms of support to caregivers. Options for consideration include program support (*e.g.* programs for caregiver relief), financial support (*e.g.* tax credits) and flexible work options.

Commission Commitments

9. The Commission will develop a policy statement on elder care that identifies the related human rights issues.

10. The Commission will consider complaints where employees, who care for aging or ailing parents, spouses or same-sex partners, face discrimination on the basis of "family status", "marital status" and "same-sex partnership status".

Ontario Human Rights Code

The **Ontario Human Rights Code** is a law in the Canadian province of Ontario that gives all people equal rights and opportunities without discrimination in specific areas such as housing and services. The Code's goal is to prevent discrimination and harassment because of race, colour, gender identity or expression, sex, sexual orientation, disability, creed, age and other grounds.

Human Rights Tribunal of Ontario

The **Human Rights Tribunal of Ontario** (French: *Tribunal des droits de la personne de l'Ontario*) is an administrative tribunal in Ontario, Canada that hears and determines applications brought under the Ontario Human Rights Code, the provincial statute that sets out human or civil rights in Ontario prohibiting discrimination on the basis of a number of grounds (such as race, sex or disability) in certain social areas (such as services, housing or employment).

Human rights in Canada

Human rights in Canada have come under increasing public attention and legal protection since World War II. Prior to that time, there were few legal protections for human rights. The protections which did exist focussed on specific issues, rather than taking a general approach to human rights. There were notable events in Canada's history which would today be considered violations of human rights.

Controversial human rights issues in Canada have included patient rights, freedom of speech, freedom of religion, parents' rights, children's rights, abortion rights vs rights of the unborn, minority rights, majority rights, rights of the disabled, aboriginal rights, tenant rights and economic, social and political rights.

Canadian Human Rights Commission

The **Canadian Human Rights Commission** (**CHRC**) was established in 1977 by the government of Canada. It is empowered under the *Canadian Human Rights Act* to investigate and try to settle complaints of discrimination in employment and in the provision of services within federal jurisdiction. The CHRC is also empowered under the *Employment Equity Act* to ensure that federally regulated employers provide equal opportunities for four designated groups: women, Aboriginal people, the disabled and visible minorities. The CHRC helps enforce these human rights and inform the general public and employers of these rights.

Canadian Human Rights Commission free speech controversy

The **Canadian Human Rights Commission free speech controversy** refers to the events leading to the repeal of section 13 of the Canadian Human Rights Act[1] which is the responsibility of the Canadian Human Rights Commission. Section 13(1) of the *Canadian Human Rights Act* was repealed in 2013 by the Harper government after unlikely coalitions of mainly reform conservatives, and mainstream media mounted a concerted attack on the provision.

However, in 2013, the Supreme Court of Canada unanimously affirmed the legitimacy of human rights legislation that restricts hate speech under similar legislation in Saskatchewan in *Saskatchewan (Human Rights*

Commission) v. Whatcott 2013 SCC 11: "Hate speech lays the groundwork for later, broad attacks on vulnerable groups that can range from discrimination, to ostracism, segregation, deportation, violence and, in the most extreme cases, to genocide.

Court of Appeal for Ontario

The **Court of Appeal for Ontario** (frequently referred to as the **Ontario Court of Appeal** or **ONCA**) is an appellate court in Ontario that is based at historic Osgoode Hall in downtown Toronto.

Supreme Court of Canada

The **Supreme Court of Canada** (French: *Cour supr âme du Canada*) is the highest court of Canada, the final court of appeals in the Canadian justice system.[1] The court grants permission to between 40 and 75 litigants each year to appeal decisions rendered by provincial, territorial and federal appellate courts. Its decisions are the ultimate expression and application of Canadian law and binding upon all lower courts of Canada, except to the extent that they are overridden or otherwise made ineffective by an Act of Parliament or the Act of a provincial legislative assembly pursuant to section 33 of the *Canadian Charter of Rights and Freedoms* (the "notwithstanding clause").

Library and Material:

Human Right Legal Support in Ontario

https://www.hrlsc.on.ca/en/how-guides-and-faqs/human-rights-ontario

Elder Abuse Ontario

http://www.elderabuseontario.com/what-is-elder-abuse/know-your-rights/

Ontario Human Rights Commission

http://www.ohrc.on.ca/en/annual-report-2011-2012-human-rights-next-generation/government-programs-seniors