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AGEISM AND THE LAW: EMERGING CONCEPTS AND PRACTICES IN HOUSING AND HEALTH

**Advancing Substantive Equality for Older Persons
through Law, Policy and Practice**

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Part I Introduction

*We climbe the slippery stairs of Infancy,
Of Childhood, Youth, middle age, and then
Decline, grow old, decrepit, bed rid lye,
Bending to infant weakness once agen,
And to our Cophines (as to our cradles) goe
That at the stair foot stand, and stint our woe.*

Thomas Bancroft¹

Ageism is a relatively new socially constructed concept, first coined in 1969 by Robert Butler.² It can be defined as the stereotyping and discrimination against older people because of age with a distinct valuing of younger age groups. Ageism is also the structural framework within a particular society that can facilitate the devaluation of older adults as full citizens, create or perpetuate their marginalization (individually or as a group) and their exclusion. Ageism can contribute to a social apathy, implicitly accepting the negative ways that older individuals, particular groups of older adults, or older adults as a whole are treated. Ageism allows people to covertly justify certain discriminatory behaviours, and tolerate activities towards older adults that would be considered unacceptable if experienced by other adults.³

“Ageism” as used in social sciences refers to the set of attitudes that stereotype older adults, while “age discrimination” refers to the negative behaviours within law or society generally towards groups of persons at various ages. Ageism is more than discrimination that centres on a particular chronological age. Ageism reflects power relations between groups.⁴ The behaviours are often premised on (or the consequences of) the ageist attitudes or beliefs, many of which are implicit in society and the way it is structured.

While ageism and age discrimination can occur at any age and different age groups experience different types of age discrimination (e.g. youth, later life), the focus within this paper is on ageism in later life. The paper draws on older adults’, service providers’ and advocates’ perspectives, in conjunction with the emerging literature. It considers ageism in the context of key issues such as subordination of older adults’ interests, older adults’ under-inclusion in law, as well as personal and systemic barriers that older adults face in access to justice. Within this paper, ageism will be discussed in several different but sometimes complementary forms, including (a) how aging adds another layer on other isms experienced in life such as racism, sexism, or ableism, and (b) ageism as an element that arises specifically at some point in later life and is experienced only by those who are old. Ageism will be described in the context of exclusion and loss, as well as social separation, as being treated as lesser persons, or having the spheres of people’s lives considered as less important, or less worthy of consideration.

Throughout Canada's history, the law has both corrected and created deficits for various populations, including older adults. This paper examines ageism and its cousin, age discrimination, in the context of two important areas of law that have significant effects on people's wellbeing in later life – housing law and health care in the community. More specifically it considers how discrimination in housing or health care is manifested in later life. The paper begins with an exploration of the concept of ageism, noting that not all distinctions are ageist, nor are all age-based criteria. Ageism is then considered in the context of several types of legal theory, ideology and structural issues. This is followed by specific examples of ageism in the context of health care and in rental housing outlining some of the areas in which ageism may be manifested in law, policy, or practice. The paper introduces some of the access to justice issues, looking at the capacity of and barriers in laws, including human rights, residential tenancy and others to adequately and fairly address the needs of older adults in this area.

The forms of ageism in areas such as housing or health are extremely diverse. Any one of them easily merits its own in-depth consideration. However this paper is only intended to introduce some of the forms, and areas of law in which there may be “special vulnerabilities”, and as such it is not intended as a comprehensive discussion. The paper does not address ageism in health care in the long term care (nursing home) settings, although this is an extremely important issue warranting its own special consideration.

The paper highlights the Ontario experience wherever possible, but also draws on examples and illustrations from health and housing in other jurisdictions. The paper considers ageism and the law issues from a “broad strokes” perspective and it is not intended to be an in-depth analysis of the specifics of residential tenancy law or aspects of health law in Ontario.

Throughout this paper, the term “older adult” and “seniors” are used interchangeably. There is a lack of consensus in society, including among older adults, about the most acceptable and preferred term for people in later life. For the past three decades in policy and practice, “seniors” has been considered as preferable to “the elderly”. Yet some now consider the term somewhat old fashioned, but still far better than newly coined marketing terms like “zoomers” that craftfully expand business markets.

A. Who is an older adult?

In any framework related to age, ageism and older adults, it is important to consider who we are talking about in the first place. The field of gerontology offers four ways of viewing aging. These are (a) chronological aging – the number of years the individual has lived; (b) biological aging – the physical changes that are taking place in the body; (c) psychological aging – changes that take place in relation to one's adaptability, one's intelligence, memory and learning; and (d) social aging – the nature of social interaction that the older person has with family, extended family, the work environment and the community and society more generally.

Gerontological frameworks in the 1970s and 1980s began to describe distinct ages of life: preparation (childhood and youth), achievement and fulfillment (young and middle age) and completion (retirees and those nearing death). Young and middle aged persons comprised the “Second Age” of life comprised of family and career. Although initially the “Third Age” of life was considered to include everything after that, today the term tends to refer to the span between retirement and the advent of age imposed limitations for people of post retirement years.⁵ This group is often described as retirees from the work force who are in relatively good health and are socially engaged.⁶ The “Fourth Age” is generally considered as represented by people of advanced age who are often experiencing an increased likelihood (but not certainty) of declining health, physical and mental impairment, and are facing end of life issues. Thus the Fourth Age is often typified as “an era of final dependence, decrepitude, and death, essentially all the negative stereotypes of old age.”⁷

Using chronological age, people aged 60 to 65 are often referred to in the gerontological literature as “near seniors”; those aged 64 to 75 years as “young seniors” and those aged 75 and over as “old(er) seniors”. Young seniors are often considered to more closely represent the near seniors than people over the age of 75 years.

Practically speaking, Canadian society tends to use a beginning of age 65 when referring to “seniors” or “older adults”. This may represent a work force model of aging that is based on traditional retirement at age 65. At the same time the labour market field often uses ages 45 or 50 to delineate older workers who are considered as experiencing special challenges in gaining or retaining employment.⁸ At a policy and program level, other age thresholds such as age 60 and age 55 have sometimes been used in special contexts such as housing to identify general ages of eligibility.

Internationally, the World Health Organization generally uses age 60 as a threshold for identifying any person as an “older adult”.⁹ This reflects, in part, the different stages of economic development among countries in many parts of the world. It also captures the reality that some groups of people within a country will reach their “later years” at an earlier chronological age than others because of the more difficult conditions under which they live. In Canada, for example Aboriginal seniors, adults with developmental or severe physical disabilities, and older adults who are homeless are among some other of the groups of adults who may fall into this category of “premature aging”.

B. Aging: the Canadian success story

Many parts of the world (and Canada in particular) have witnessed a noteworthy demographic shift and a remarkable success story. Within less than three generations, the average longevity increased in Canada from 50 years in early 1910s to over 80 years for women and 78 years for

men by the end of the century.¹⁰ Only about two percent of the population in the 1920s was over the age of sixty five. Since then, as a result of lower mortality among mothers giving birth, lower infant and child mortality, along with improvements in health, housing and the workplace, a much greater percentage of people today have a reasonable expectation of living to reach milestones of 65, 80, and even 100 years.

Canada is in the mid range percentage in terms of industrial countries that are experiencing population aging. Italy and Japan, for example, have much higher percentages of older persons.¹¹ In 2008, there were over 4,563,000 people aged 65 and over in Canada (2,007,800 men and 2,555,000 women).¹² The percentage of older adults in Canada is expected to increase from about 14.5% in 2009 to over 25.0% by 2036.¹³ The fastest growing segment among older adults is among people aged 85 and over.

The growth in the number of seniors in Ontario has been equally dramatic. In 1971 there were about 650,000 people aged 65 and over, representing 8.3% of the population. In 2008 there were 1,744, 000 seniors in Ontario, representing 13.5% of the population.¹⁴ In several communities in Ontario, over one quarter of the population is already aged 65 and over.¹⁵

C. Aging: the diversity story

Older adults in Canada have become a growing and increasingly diverse population. Pre-eminent geriatrician Robert Moulias recently noted that

*“in industrialized countries only a small minority (about ten percent) of people in later life are “the rich, young- like” (such as the recently retired). Disabled or dependent frail older persons are also a minority but larger in size. The large majority of the 60-100 year olds are neither young nor physically nor mentally dependent”.*¹⁶

There is economic variation among older adults, increasing ethnic diversity, as well as differences in sexual orientation, and disability or physical or mental limitations. There are also important gender and cultural differences among seniors that affect how they age, as well as how they view and experience aging and later life.

As people age they may experience changes in physical or mental health, albeit with a wide range in the extent and speed at which that happens. The vast majority of older adults in Canada are mentally capable of making decisions about their personal lives and wellbeing. Only two percent of people aged 65 and over have dementia. However the percentage increases among age groups; one third of people aged 85 and over has dementia.¹⁷

1. Gender is important

Layered upon Ontario's general aging trend is the gender distribution, which is fairly equal among people in their 60s, but changes rapidly after people reach their mid 70s. At this point, women outnumber the men, and as a result of widowhood, women are much more likely to live on their own. In 2005, for example, there were 184 women aged 80 years and over for every 100 men.¹⁸ Older women are very likely to experience changes in their social and economic conditions in later life as a result of widowhood.

As noted, the population aged 85 and over is increasing rapidly.¹⁹ In 2001 (the most recent figures available), almost two thirds (62.3%) of those aged 85 and over in Canada were widowed, compared to just over a quarter (28.6%) of seniors aged 65 and over.²⁰ At the same time, there are important differences and gaps in marital status for women and men in Canada. Over four in ten (42.2%) of women aged 65 and over were widowed, compared to only over one in ten (11.2%) of men in this age group. Over three quarters (77.2%) of women aged 85 and over are widowed, compared to one third (33.3%) for men aged 85 and over.²¹ That status change may be a very important factor to consider in the context of understanding aging, ageism, and the law, in part because widowhood often represents an economic, social and power diminution for many older women.

2. Diversity in people, income and education

Older adults are not a homogeneous group, and the profile of older adults in Canada has been changed significantly in the past thirty or forty years. Immigrants, for example, comprise a relatively large proportion (over 28 per cent) of seniors in Canada. Most immigrant seniors have initially arrived in Canada when they were young adults. They typically came from the United Kingdom and Western Europe. Only nine percent of immigrant seniors arrived in Canada since 1991.²² In 2001, about 7.2% of seniors were members of a visible minority.²³

The 2006 report, *A Portrait of Seniors in Canada*, notes that there have been large changes over the last 20 years in the countries from which immigrants have come. Between 1981 and 2001, the share of all immigrants from Western or Northern Europe declined from 45.5% to 24.6%, while the share from Asia increased from 13.9% to 36.5%. These changes are just beginning to be reflected in the characteristics of immigrants aged 65 and older. For example, the share of seniors from Asia increased from 5.6% to 19.1% between 1981 and 2001.²⁴

Ontario's seniors' population has the largest percentage of immigrants in Canada: about one half (53.1%) of them are long term immigrants.²⁵ Approximately 5,000 sponsored immigrants arrive in Canada each year, most living in Ontario or British Columbia. Most immigrant seniors speak either French or English. Only about six percent do not speak either French or English, although more than double that proportion (13-14 % of immigrant seniors) speak a language

other than French or English at home, and some immigrant seniors lose their English or French fluency if their mental capacity deteriorates.

In 2001, more than 976,000 Canadians reported that they were Aboriginal, including about 39,600 Aboriginal seniors (65 years of age or older). Although the average life expectancy in Aboriginal communities has increased in recent decades, Aboriginal people still tend to have a much shorter life expectancy on average compared to the general population, reflective of a wide variety of social and environmental factors. The age gap in life expectancy between Aboriginal and non-Aboriginal persons was 5.2 years for women and 7.4 years for men in 2000.²⁶ Aboriginal older adults are nearly twice as likely to be living with extended family members compared to non-Aboriginal seniors, reflecting both the community's cultural and economic realities.²⁷

Older adults also vary in their physical, mental or social circumstances. For example, today many persons with physical or mental disabilities in Canada have an increased likelihood of surviving to middle age and longer. Those with developmental disabilities or severe physical disabilities now live longer than previously but their average life expectancy is less than that of persons without these disabilities. Life expectancy also varies as a function of the severity of the person's physical disability.²⁸ Both disability groups can face an accumulation of disadvantage over the course of their lifetimes. Older persons who are homeless are also at an aging disadvantage. At age 55, many homeless people may have the equivalent health of 78 year olds who are not homeless.²⁹

Older people who are lesbian, gays, bisexual or transsexual (LGBT) are still largely invisible, and marginalized.³⁰ Older LGBT adults are less likely than LGBT youth or younger adults to self identify as gay or lesbian.³¹ While older LGBT adults may represent a small percentage of the population (an estimated five per cent), they are very likely to have different experiences or risk factors in the areas of housing and health, compared to other segments of the older adult population.³²

- **Level of economic security**

The National Council on Seniors notes that *overall* today's seniors, while not affluent, are financially secure.³³ The incidence of low income among seniors has been reduced significantly over the past thirty years. The Old Age Security (OAS) and Guaranteed Income Supplement (GIS) programs (both publicly funded programs which are age based) helped increase the overall living standards for many seniors and have played a critical role in ensuring that seniors have a modest base of income. In addition, the Canada Pension Plan which began in the mid 1960s has matured, adding another significant component to the income security for paid workers in later life.³⁴

This represents a remarkable success story in poverty reduction. Still, a significant core group of seniors remains vulnerable: recent immigrants, “unattached” older adults (those who have always been single, or those who are widowed, divorced or separated), as well as those with fewer than ten years in the labour force, and Aboriginal seniors.³⁵ In addition, those in precarious work throughout their working life (in temporary, part-time, irregular hours jobs with little, if any security, low paid, no benefits) often find they are economically precarious in later life – little if any opportunity to save, no private pension or RRSP, no retirement benefits, and often few if any assets such as a home.³⁶ Working poor in middle age typically see some economic improvement when they reach age 65, but often remain poor throughout later life.

About one in seven (15.5%) unattached seniors lived below the Low Income Cutoff in 2006.³⁷ Women represented about three-quarters of the 179,000 unattached low-income seniors in Canada that year.³⁸ Low-income seniors spend most of their money on housing, food, transportation and health-related costs.³⁹ These costs along with access to services and benefits remain the major challenges for low income seniors.⁴⁰

Couples, in general, fare better in terms of economic security. The median after-tax income of senior couples was \$41,400 in 2006, an increase of 18 percent since 1996, and compared to about \$54,100 median income for all other families. Between 1996 and 2006, the median incomes for unattached seniors increased by fourteen percent to \$20,800.⁴¹

Low income for many seniors often reflects an accumulation of disadvantages over the course of the lifetime, race and gender differences, as well as structural issues. The Special Senate Committee on Aging notes, for example, that some seniors do not receive all the benefits they are entitled to because they cannot understand the complex programs that exist. Others are penalized due to interactions between various federal and provincial government programs. Still others receive multiple benefits – and still don’t reach the poverty line.⁴² In addition to the percentage of older adults who are consistently in the lower income range, a larger proportion is only marginally better. Their circumstances are often strongly affected by changes in the economy (including investment environments) as well as changes in government policy and budgets, especially in areas affecting housing and health care.

Income and health are closely linked throughout life, but especially in later life. For example, the recently released Power Study (Project for an Ontario Women's Health Evidence-Based Report) found that among Ontario women, 70 percent of low-income women aged 65 and older have two or more chronic conditions compared to 57 percent of higher-income women and 50 per cent of higher-income men. Low-income women and men are more likely to die prematurely.⁴³ These differences may affect their need for supports in housing and their contact with health services.

- **Education**

People's level of education is associated with a very broad range of socio-economic outcomes. Many older adults have not had the same opportunities for formal education as the younger persons who are now becoming seniors. There have been considerable changes in the levels of educational attainment of older Canadians over the past 20 years. In 1990, two thirds (62.7%) of men aged 65 and older had less than high school. By 2004, this rate had declined to 46.6%, with similar rates and decreases for women.⁴⁴ The rates of lower education are higher among long term immigrant seniors, compared to non immigrant seniors. Many recent immigrant seniors have come to Canada under immigration's family class category, which does not require specific education qualifications.

In 2003, over 80% of seniors had a level of literacy skills below the level considered sufficient to cope well in a complex knowledge society.⁴⁵ While the education level in general is higher for many people who are becoming seniors, many seniors retain their lifelong educational disadvantage.

Education (and the closely related issue of functional literacy) has important implications for older adults in terms of their knowledge of their rights, in key areas such as health and housing. Education level can also affect their access to justice. Moreover, Canadian literacy research indicates that people with the lowest level of literacy often are unaware that they are having difficulty understanding what they read (they may not know what they don't know). This will become important in terms of understanding how rights information is being offered to older adults and the limits of plain language as a tool for justice.

Part II Ageism: Concepts and Theories

Old age is not a status we choose to become; it is a status that we inherit simply by the virtue of living, not dying.

Holstein, 2006, 317⁴⁶

A. What is meant by ageism?

“You’re not important in society.”⁴⁷

When Robert Butler coined the word “ageism”, he defined it as

“[a] process of systematic stereotyping or discrimination against people because they are old, just as racism and sexism accomplish with skin colour and gender. Ageism allows the younger generations to see older people as different than themselves; thus they subtly cease to identify with their elders as human beings.” (as cited in Butler, 1975)⁴⁸

Butler saw ageism manifested in “a wide range of phenomena on both individual and institutional levels- stereotypes and myths, outright disdain and dislike, simple avoidance of contact, and discriminatory practices in housing, employment, and services of all kinds.” The strongest stereotypes around aging are those which equate aging with the “3 Ds”- disease, disability (in terms of actual functional impairment, or as perceived potential to lose abilities), and death. The Ontario Human Rights Commission 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.”⁴⁹

Ageism can function as stereotypes (general statements about a group which may or may not be based on fact, or generalizing from the group to the individual). However ageism also functions as older persons’ invisibility, marginalization, and social exclusion. This is because the “other age” (persons who are not old) are treated as the norm and the more valued group. To the extent to which older people do not fit the perceived social norm, they are treated as “less”, which may include less valued and less visible. They become relegated to a second class status; their needs and their lives are treated as if they do not matter as much.

Ageist ideas are often ingrained and systemic. Ageism can inhibit people’s objectivity and subsequently influence decisions at the micro (individual/ family), meso (organization/ community) or macro (government/societal) levels of human interaction, law, and policy development without people even realizing this is happening. As a society, we seldom think to question the

basis for our attitudes and beliefs. People simply incorporate the societal “norms” and values into their own way of thinking about and behaving towards older adults.

Ageism can be manifested as many small behaviours and decisions that cumulatively have significant negative impact on the lives of older adults. If we look at “small decisions” individually and in isolation, any one may not appear to have much consequence or effect, but together they undermine rights and dignity of older persons. Phelan (2008) notes “Ageist assumptions become so integrated into common discourse in diverse social contexts that they become tacitly acceptable and legitimize a particular version of social reality which objectifies older people as a homogenous group in subject positions which emphasize these stereotypical negative attributes.”⁵⁰

Ageism is justly criticized as being exclusionary, anti-equality and anti-social justice. Among other things, ageism may be considered the lack of ability to have one’s interests represented or rights respected in society. Ageism is predicated on the belief that older adults do not and should not have equal rights and their interests “of course” should be subordinated to other persons and other interests.

B. What is the context of ageism?

At what points does ageism tend to occur? Do all persons experience ageism equally? Is there a conceptual difference between “ageism” and areas of law or policy that “simply” give greater attention to other exigencies?

While ageism is often characterized as only having to do with age or aging, a fuller understanding of the concept requires reflection on the multifaceted and diverse experiences of people before they reach (and in) later life. The concept of ageism must be able to reflect and integrate the fact there are differences in income, education, sexual orientation, gender, area of geographic residence, their family and marital status, immigration and citizenship status, race and ethnic origin, and mental, physical, or intellectual disabilities. It will be important to consider the cumulative effect of other “isms”, and the extent to which ageism may simply be later life sexism in disguise. There is likely not one ageism, but many diverse ageisms.

It has been suggested that ageism is somehow different (and implicitly not as bad) as other “isms”, because it is inherent to all persons (“we all grow old”). Because of this perceived “universal” nature, ageism is often taken for granted or not treated as seriously than sexism/heterosexism, able-bodiedism (ableism) or racism. The Ontario Human Rights Commission also points out that in law:

“Age cases tend to be treated differently than other discrimination cases, ... The most noticeable difference from a human rights perspective is the lack of a sense

of moral opprobrium linked to age discrimination which in comparable circumstances would generate outrage if the ground of discrimination were, say, race, sex or disability.”⁵¹

Jean Carette, retired professor at L’Université de Québec à Montréal, and president d’ESPACES 50 + has eloquently described the way in which many prejudices and negative images cultivated about older adults go beyond just a fear associated with aging and decline. Instead they are an unrestrained search for scapegoats for collective social difficulties, with increasingly virulent attacks against the current and emerging older generations. As baby boomers become “grandpa boomers” they are assumed to “have all the privileges and to have monopolized the advantages of their generation, leaving a country strangled by the debt, collapsing under the load of elder and condemned to the decline.” This caricature sets up a dangerous war between the ages, supplied with ignorance and prejudices, allowing for lapses of memory of the true historical and social causes.⁵²

C. Ageism and society

Ageism includes the wide range of stereotypes and a constellation of attitudes that prevent people from accurately assessing and responding to social problems and conditions of older adults. Like racism and sexism, it is a form of prejudice or prejudgment, and a form of oppression. It limits the lives of older people who are the object of this oppression; it also shapes perceptions of young and old. Both young and old can hold ageist attitudes. Ageism can contribute to apathy towards the ill treatment of older people and tolerance of activities which would be unacceptable for other age groups.⁵³ Ageism may be considered as a barrier to obtaining full social citizenship in Canada.

Ageism is based on primarily negative perceptions of older persons and what life can or should hold for people in the “third age” and “fourth age”. Ageism is also perpetuated by the ways in which our society communicates about older adults. Ageist language can homogenize through the use of terms like “the elderly” and “the aged” (both terms carrying connotations of mental and physical frailty). Language can paternalize through the use of terms like “our seniors”, or “your loved one”. Ageist language allows older people to be treated as property, possessions or objects, not as individuals.

There are two competing views of aging and as a result potential sources for ageism:

“The ancient Greeks had two views of aging- the “geronte”- the ridiculous old person with cognitive and other declines and the “presbyte”- the wise old person rich in experience and wisdom.”⁵⁴

In his original characterization of ageism, Robert Butler spoke of ageism in the context of positive and negative attitudes. The former refers to positive stereotypes about older adults (e.g. as

wise, always caring). However what happens when we view older people in this manner, and what happens to those who fall short of these perceived ideals?

In recent years the gerontological literature, the media, and social policy have been placing increasing emphasis on “successful aging”, exemplified by the 85 year old marathoner, and the ever busy (“Energizer Bunny”™) senior.⁵⁵ The focus of successful aging is on activity, volunteerism and engagement. In part, the perspective helps to counter the negative attitudes about aging and older persons, but it still relies on a youth norm. Charpentier notes

“...while these approaches are certainly dynamic and inspirational, we feel that they risk becoming solidified into a new “hyperactive and socially useful” conception of aging, which risks maintaining the marginalization and personal liability of sick and dependent old people who “haven’t succeeded in aging well.”⁵⁶

There is an unstated social expectation and responsibility to live up to that ideal, with those who do not (or cannot) being blamed for their failure.

Ageism is also the perpetuation of the belief that individuals *by themselves* can achieve this “successful aging”, or that by individual effort and sufficient willpower they can undo all the social inequities that have led up to their later years or the inequities that arise in later life. Calasanti (2008) notes

“It [ageism] includes “age-blindness”—the belief that ‘age doesn’t really matter, and we should ignore age.’ But age does matter: bodies do change, old age is a social location burdened with the stigma of marginal status, and accumulated experiences do make a difference. Why deny this?”⁵⁷

1. Ageism, power and contribution

One of the emerging gerontological debates for ageism is the extent to which ageism is experienced by persons. Do (or will) all older adults experience ageism, and do they experience it evenly? There is some suggestion that those with greater economic power or within communities where they have greater social capital may experience less absolute ageism.⁵⁸ Nonetheless, all adults will experience some ageism to some degree as they move into later life and some groups of older persons may be particularly vulnerable to its manifestations.

The extent to which the older adult feels the impact of that different treatment can be buffered by his or her level of education and economic status. Some view this different and devalued treatment of older persons as very much tied to the fact that in an industrial society, people’s perceived personal value is tied to their economic contribution. Significant past and current contributions which older adults have made to family, community, and society through relationships, work, volunteering and in paying taxes are overlooked or discounted. In an

exclusively economically focussed perspective, older adults become “disposable citizens”, having outlived their usefulness in adding to that economy.

2. Manifestations of ageism

Ageism can be manifested in many different forms. At a systemic level, laws and policies may be made without regard to the needs of older adults, or service cuts may have a disproportionate impact on older adults. Ageism may take the form of “granny bashing” in the popular press (blaming many of society’s current economic worries on older adults). It can be reflected in media where older adults are portrayed as uniformly poor (and consequently a perceived potential drain on society) or as a uniformly well off group who are unconcerned about the needs of others.⁵⁹

Ageism may be more commonplace in economic and political literature where demographic shifts in the population are characterized as portending a future health crisis or “age wars” with young and old fighting over their share of social and health services. Ageism and age discrimination are based on social fears, and social response expresses those fears.

It has been suggested that there can be both internalized and externalized ageism. Internalized ageism refers to the extent to which older adults take on the social norms that devalue or marginalize older persons. They may do this at an individual level by acting in ways that reinforces the youth norm – battling the obvious and visible markers of aging such as grey hair or wrinkles.⁶⁰ Internalized ageism may also be manifested by denial of any commonality with others in a cohort, such as the familiar objection of an eighty-five year old woman or man who vehemently does not want to be associated with “all those old people”.

D. Age, ageism and law

There are many ways in which age is used in law, policy and practice. It may be used as a prerequisite for eligibility for some service, entitlement or benefit. The fact that a specific age is tied to an entitlement may or may not be ageist. In some cases, the age of entitlement may reflect a “general statement” of need or perception at points at which the group can handle responsibilities.⁶¹

The Ontario *Human Rights Code* (OHRC) prohibits discrimination and harassment on the basis of age in all social areas covered by the Code.⁶² At the same time, age protection can be effected by a special program, such as in section 14 of the OHRC, which expressly provides for preference of persons over 65 years of age in certain circumstances.

In addition, section 15 of the OHRC on “preferential treatment” states

*“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.”*⁶³

This leaves government and other public and private bodies the ability to provide special housing for seniors, subsidies, rebates or other efforts intended to recognize the needs of many older adults.

Ageism within law, policy and practice by way of contrast, may be decisions or acts having a differential impact on seniors as a whole or a negative impact on specific populations of seniors. Ageism may reflect many different types of situations, including (a) distinctions between laws that benefit the young at the expense of the old; (b) laws that have a disproportionate impact on the old; (c) laws that remove certain entitlements from segments of the older adult population that are otherwise accorded to adults, as well as other emerging types. It may be useful to recognize and distinguish between ageism as acts or omissions directed at the old and ageism as actions that have a disproportionate negative impact on a group (who happen to be/the majority of whom are old). Ageism in this context may create an unfair burden on specific groups of older adults.

At a provincial, territorial or national level, ageist or discriminatory actions or decisions may largely go unrecognized, particularly when couched behind a façade of neutral explanations and justifications. Older adults and family members become very familiar with the refrain “it’s the policy”; “the government tells us to”; or “it was just part of the negotiations”. Policies, decisions and negotiations that fail to take into account the impact on older members of society may reflect systemic ageism.

Ageism and age discrimination are often harder to address than other forms of discrimination as older adults’ needs easily become subsumed to the needs of other age groups, or to the administrative needs for efficiency or cost cutting. Given pressure for scarce resources and given similar need, the fact that one is older often becomes the justification for not receiving a benefit or service or not be treated as a sufficiently high priority. In any cost-benefit analysis based on remaining years or future productivity, older adults are always at a disadvantage.

E. Ageism and the international stage

As a distinct group, older adults have not been well recognized at the international level until fairly recently. While the International Women’s Year was launched in 1975, and the International Year of Disabled Persons developed in 1981, it took another eighteen years until the International Year of Older Persons debuted in 1999. As a result, aging and ageism have largely remained peripheral to international discussions.

Over the past quarter century there have been some inroads. The Vienna International Plan of Action on Ageing (1982),⁶⁴ the Madrid International Plan of Action on Ageing, 2002,⁶⁵ and the United Nations Principles for Older Persons⁶⁶ have formed a nascent international framework on ageing. However, none of these provides any legally binding obligations. While the Plans incorporate norms and principles which governments agreed to be guided by, these documents do not require the member states to account for adherence.⁶⁷

More recently aging has begun to gain attention in international human rights arenas.⁶⁸ In late Spring 2009, the United Nations Report of the Expert Working Group Meeting “Rights of Older Persons” provided an overall analysis of the existing documents and international legal instruments. They found several key provisions outlined in basic international documents were of particular relevance to older persons, for example, the references to non-discrimination and equality; equal rights of men and women; women’s right to social security; protection of the family as the basic unit of society; and the right of physical and mental health. The convention on the elimination of discrimination makes references to older persons in the context of right to social security.

At the same time, the Report pointed to significant “normative gaps” in international law when it came to aging and the needs of older adults. While several texts proscribe discrimination on the basis of gender, race, religion and other categories, in most cases age discrimination was captured only by the catch all phrase “or other status”.⁶⁹ Equally pressing, there were important implementation gaps, in that states often failed to abide by the obligations they had undertaken.⁷⁰ Mindfulness of these gaps and the disadvantaged position of older adults in many parts of the world has led to a United Nations’ call for a Special Rapporteur for older persons.⁷¹ A Special Rapporteur bears a specific mandate from the UN Human Rights Council (or the former UN Commission on Human Rights, UNCHR), to investigate, monitor and recommend solutions to human rights problems.⁷²

The Expert Working Group of the United Nations agreed on twenty-six specific recommendations to national governments to advance the wellbeing of older adults, several of which should be of interest to law reform bodies. Among other things, governments were encouraged:

- to close the gap between law and implementation of the law;
- to promote positive discrimination (affirmative action) of older persons as a legitimate step in national laws;
- to put the burden of proof of age discrimination on violator not victim of age discrimination;
- to provide easily accessible and free identity documentation to older men and women to access their economic, social, political and civil entitlements;

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- to provide free paralegal support and free legal aid to older persons to defend their rights and help to resolve disputes within community structures and to gain them access to formal judicial systems;
 - to provide legal support regarding cases of strategic litigation to create legal precedent and change laws, e.g. on discrimination in social security provision or inheritance and property rights;
 - to incorporate a gender perspective in all policy actions on ageing and eliminate discrimination on the basis of age and gender;
 - to provide affordable and appropriate health care, support and social protection for older persons including preventive and rehabilitation;
 - to promote a set of measures aimed at the empowerment of older persons in various areas;
 - to initiate a set of measures geared at preventing discrimination against older persons in all fields and areas, changing negative stereotypes in media and other fields;
 - to promote evidence-based studies related to the empowerment of older persons, provision of health care and long-term care on a systematic basis;
 - to give visibility to older persons' rights among leading policy makers and educate them about the rights of older persons and the ageing process;
 - to request scholars to include older persons' concerns in their research;
 - to encourage national activity on older persons' rights in cooperation with the UN Regional Commissions;
 - to encourage alternative means of conflict resolution to promote mediation in the home, family and society as early as possible;
 - to support legal mechanisms in late life planning, health care, wills, and power of attorney, living wills, organ donations and property;
 - to assure legal capacity in late life with due process;
 - to ensure participation of older women and men in decision-making processes that affect them;
 - to acknowledge basic rights, such as legal assistance, access to paid family leave, and programs, such as tax incentives for formal care and relieve for care-givers;
 - to develop elder-specific professional-rules-of-ethics to ensure ethical and professional legal services for older clients;
 - to revise existing legislation in accordance with internationally accepted norms (for example on social security, health, property and inheritance) to avoid discrimination on the basis of age and gender.

Part III Theoretical approaches to understanding ageism

There are many different ways of looking at ageism. Ageism may be considered as an issue specifically tied to aging or older age, or it may be considered as having roots in earlier stages of life, to which the societal perceptions of aging and the actual changes associated with aging add more and more layers creating disadvantage or special burdens. In this latter view, ageism is an “add on” or may have a multiplicative effect for some groups such as the poor middle aged, who then become the poor old. Some frameworks for ageism will be more expansive than others, endeavouring to understand not only potential negative consequences of attitudes, behaviours, policies and practices for the lives and well being of older adult, but how systems respond to the people that informally and formally support older adults.

Most discussion of ageism has occurred within sociological, psychological and gerontological fields, as opposed to legal ones. There does not appear to be an explicit theory put forward to help understand ageism and the law. Indeed it has only been very recently (that is, 2009) that any theoretical framework has been put forward to understand aging and the law.⁷³

Still, there may be a number of other theoretical approaches in law that may help understand ageism in society and in the law in particular, why it arises and how it might be best remedied or approached. Perhaps some of the productive legal theories for ageism may be those looking at gender, disability and political economy. Few have actually made any attempt to articulate ageism, and what follows below is conjecture about approaches that may show merit. However, even in a best light, each is incomplete.

A. Feminist legal theory

Feminist theory represents a wide variety of analysis and jurisprudence, much of which is based on the belief that the law has been instrumental in women's historical subordination. Feminists work from within many disciplines, as well as a multitude of intellectual paradigms and political positions.⁷⁴ Feminist jurisprudence seeks to explain ways in which the law played a role in women's former subordinate status, as well as their present status, and is dedicated to changing women's status through a reworking of the law and its approach to gender. Feminism is also about power relations. It has been pointed out by feminist writers that age can be an organizing principle of power, just as gender, race, class, and sexual orientation are.⁷⁵

Discussion of aging by feminist scholars is in its formative stages and thusfar has tended to reach to middle age and in the context of middle class women.⁷⁶ Feminist legal theory and the common topics within it have given far less attention to older women, inadvertently leaving them marginalized and invisible to the discourse.⁷⁷ Where feminist discussion on aging has developed it has largely been in the context of daughters as “caregivers”, or in context of the

oppression of the women staff caring for the largely older woman population in long term care facilities. Critics pointed out that this discourse still places power relations “in the gaze of youth”.⁷⁸

Because feminist theory and jurisprudence is about many different types of power relations, the gender lens may also be useful in understanding power shifts within groups. For example, some gerontological research suggests that men feel the impact of ageism differently (stronger) than do women, and that it negatively affects men’s self esteem and health.⁷⁹

It has recently been suggested that feminist jurisprudence can be a useful framework for explaining and reforming elder law and policy.⁸⁰ Feminist gerontology and basic feminist principles such as awareness building (educating the group and the broader society about the issues), egalitarianism, empowerment, and inclusion can be used to improve older women’s experiences, especially in key areas such as in the health care system.⁸¹ Dayton (2009) for example, points out that laws and social policies affecting entitlement to public pensions, the delivery and financing of long term care and the allocation of public resources to prevent victimization and abuse of vulnerable adult, are infused with and reflect historic patterns of overt and covert discrimination against women in the workplace and the political arena, and perpetuate the systematic devaluation of “women’s work.”⁸²

Other authors have begun to consider age and gender lenses in the context of how systems support some arrangements but also may foster inequities in later life. For example as a group, married women and men tend to be better off in terms of their economic/material, health and social resources than those who are not married. At the same time, younger age cohorts of married women tend to be better off than older age cohorts of married women.⁸³ This invites consideration of how policies individually or cumulatively across the life course aid the relative advantage or disadvantage for various groups of older adults.

Feminist legal analysis in the future may be interested in exploring the various power differences evident in older age, to help explain for example why in healthcare, doctors often treat old persons differently – by withholding information, services, treatments; and often take older persons’ complaints or symptoms less seriously, often attributing them to old age.⁸⁴ In this power based schema, the requirements of health law such as consent remain at the margins, honoured neither in letter nor spirit, and old people’s authority and autonomy may become subordinated to the needs, interests, and wishes of all others.

It has been suggested that women’s subordination in the law is based on the assumption that male norm represents the full adult, and that women represent deviation.⁸⁵ Along a similar line, the roots of seniors’ subordination in the law may come from the assumption that the younger (NOT OLD) adult represents the full legally recognized adult, and that the aging older adult is a “deviation” of this norm. Within the gender framework women have often been treated as property. It may be useful to look at the extent to which older persons are treated as

commodities, with little if any inherent value as persons. As such, they can simply be discounted, ignored, or moved around like objects and removed when considered “too much work” in key areas such as housing and health care.

B. Critical race theory

Another potential useful framework of legal theory for understanding ageism is critical race theory, stemming from Critical Legal Studies. It is based on six or more premises: disenfranchised people’s stories illustrate the complex interplay of the events in people's lives and the barriers they face to accessing citizen's rights. Second, group or individual behaviour (such as racist behaviour, or in the present case, ageist behaviour) is not an aberration, but is normal practice. Third, elites act against discriminatory (sexist, racist or ageist) behaviour in society only when it serves them.⁸⁶

Fourth, race (or age) is a social construct, not biological. The expectations of who is a member of that race or “the elderly group”, changes, narrowing and expanding. Fifth, characteristics ascribed to a particular race (or age) will change. For example, older adults have been characterized in the past as “wise” and the “holders of history”, but are now more commonly called “economic burdens”, a “grey tsunami” or any other similar demographically apocalyptic terms. Older adults may be viewed as a valuable asset in times of economic expansion, but readily disposable and burdens during recessionary periods.

Critical legal studies also speak of “interest-convergence”, where the dominant group (e.g. whites) will promote opportunities for the non dominant groups (e.g. blacks. Aboriginal people) only when they converge with their own interests.⁸⁷ So similarly, the “Not Old” majority or the dominant group will promote opportunities for the older adults only when they converge with the interests of that dominant group. For example, changes to tax laws such as pension income splitting will be promoted by elites and will predominantly help those who are well off.⁸⁸

Sixth, people have intersecting identities, i.e. there is more than one way that they are affected by disenfranchisement or inequality in later life. For instance, an older man who is gay and HIV positive has at least three different lenses to look through.⁸⁹ So does an older Jamaican woman who is a paraplegic, and an older white Jewish immigrant, etc.

Others within critical legal studies assert that racism, sexism and classism are experienced amid other layers of subordination based on immigration status, sexuality, culture, language, phenotype, accent and surname. Similar themes are arising with the study of ageism, Calasanti (2007) has emphasized the utility of understanding age discrimination in terms of intersecting relations of inequality rather than as only reflecting people’s learned attitudes.⁹⁰

Another one of the areas in which critical race theory and feminist perspectives may aid our understanding is in the context of “privilege”. In 1990, in a well known essay on “white privi-

lege” Margaret McIntosh described the many accepted ways in which life is ordered around certain (white) values, beliefs, history, and experiences; how whites as a group were acknowledged and visible, and other groups were not.⁹¹ McIntosh argued there are a number of benefits that people gained from being a member of a privileged group, and this privilege reinforced power hierarchies.

There may be similar privileges for people who are not old (creating in effect, a socially enforced “age privilege”). Age privilege may be considered as the wide range of privileges and generally accepted entitlements accorded to young and middle aged persons (persons who are not old). Age privilege encompasses the many things that people can take for granted, can do or expect with some degree of ease because they are young or middle aged adults, as well as the “privilege” of not facing significant barriers and obstacles if they are not older persons.⁹² Examples of age privilege would include the fact that unlike the old, younger people will rarely have their mental capability questioned when they make decisions others consider unwise, will not be treated by a health care or legal professional in a patronizing or paternalistic manner and they will not be expected to live in certain types of segregated housing.

C. Disability theory and aging

People in the disability community and seniors organizations have actively resisted efforts by gerontologists or others to suggest there may be certain shared interests. Each group has traditionally underscored that their interests and perspectives are not the same and often tried to ensure that they are seen as “different than” that “other” (“I am disabled, not elderly”; or “I am growing old and yes my hearing is very poor, I am not disabled”).

In some cases, this is based on a belief that the interests, goals and perspectives of the two groups are fundamentally different in key areas such as euthanasia. It has also been argued from a disability perspective that older adults (in contrast to younger adults with disabilities) have lived lives characterized by having relatively greater power or at least once having been powerful, at least compared to persons with congenital disabilities.⁹³

Nonetheless, it has recently been suggested that the broad area of law and aging may benefit and drawing a number of lessons from the emergent trends within disability and disability law.⁹⁴ To a large extent, the modern understanding of disability has been shifting. It has moved from treating disability as a flaw in the person that requires “fixing”, to an emergent social model which recognized that disability is, at least in part, a social construct. Society can create a physical and social environment disabling to some people or it can open up opportunities that will include them. The general ways of doing things and ways of thinking which are considered normal in a society can create disability. From this work came the human (civil) rights approaches to accommodate persons with disabilities.

However, this approach still left persons with disability apart from society, because it was premised on distinguishing a minority group and a majority group. In the late 1990s a new model for conceptualizing abilities called *universalism* attempted to articulate a more inclusive approach. In contrast to the civil rights model, the universalism model defines society as a single group, made up of infinitely variable individuals with a continuum of ability levels. Efforts are made to shape the social and legal environment so that it is as inclusive as possible of this extremely wide variety of persons.

It has been suggested by one writer that universalism may serve older adults better in the long run than the civil rights model.⁹⁵ While its general value has yet to be seen, universalism might be particularly useful to expand our understanding of needs of some highly vulnerable groups such as older persons with dementia. In gerontology there is a nascent area which is highlighting the personhood among people who have dementia.⁹⁶ Universalism may offer the possibility of persons with dementia being better recognized as persons first, and whose cognitive and other abilities levels are part of that wide continuum among persons in a society.

D. Mental health law theory

Mental health law theory may offer insight into a number of key areas affecting the lives and well being of older adults, especially areas that touch on social control and mental capability issues. It has been noted in the area of laws and aging, there has been a dramatic historical shift of public policy about older persons from concerns about equity and social justice in the 1960s to current focus on efficiency and cost containment.⁹⁷ Schmidt (2009) points out that a sea change was achieved in the incidence of poverty and quality of life for older adults as result of changes to the social security and health care insurance systems. He notes however “the preoccupations with cost containment in the late twentieth century arguably changed the function and political economy of elder law and policy from social justice to social control.”⁹⁸ Mental health theory’s focus on social control will become increasingly relevant in the context of the emerging surveillance technologies increasingly being used to monitor the day to day lives and moment-to-moment experiences of people with dementia living at home or receiving home care services.⁹⁹

Schmidt also argues that a critical view of law and aging, drawing on mental health theory sees growing old as a form of social deviance:

*the elderly are punished by isolation and stigmatization for this ‘deviant’ act” [of growing older], the normative premises of law are free will and responsibility..., including the legal fiction of law treating people for policy reasons as if they are responsible, even if scientifically or medically they are not responsible.*¹⁰⁰

Mental health theory has coined the term “sanism” in jurisprudence to refer to the fear, stigmatizing and stereotyping of persons with mental illness, and consequently the use of the law as “protection for their own good”. Older adults are one of the two key groups of adults likely to have their mental capability called into question, especially if they have dementia and are part of the “old-old” age group.¹⁰¹ Schmidt argues that guardianship may be a sanist, ageist archetype, in that guardianship law strips people of their rights, and yet the evidence is equivocal on whether that guardianship actually leaves their lives safer or better.

The ways that that mental health issues are perceived and addressed in later life are important in the context of older adults. Only two percent of all adults aged sixty- five and over have dementia, but the rate increases with age.¹⁰² The disease is progressive but it also progresses at different rates, impairs people’s functioning to different degrees, and affects people quite differently. About one third of people aged eighty five and over has some degree of mental impairment as a result of Alzheimer’s disease or other dementia. One half of these individuals live independently or in a supportive housing environment in the community. Some reside alone, many with a spouse or partner, and some family members or others. Unfortunately for this group of individuals and for their family members and supporters, there is a lack of qualified dementia support across the care and housing continuum.¹⁰³

Mental capability arises in many other diverse and somewhat contradictory contexts for older adults. This includes for example, (a) when the mentally capable older person is ignored , not asked and not consulted (invisibility), (b) when the older person’s mental capability is questioned (personal risks, treatment, financial decision-making), (c) turning to substitute decisionmakers when the older person is still mentally capable, (circumventing the person) (d) when the older person’s mental *incapability* is ignored, i.e., the person is being held responsible for acts when their incapability should be at issue.

E. Ageism, economics and ideology

To date, ageism has been given greater consideration in the workplace and employment law than in other sectors. Roscigno in a 2007 analysis of ageism in the workplace considered (a) the interactional nature of age discrimination and its relation to status, (b) how explicit ageist stereotypes both invoked discrimination and helped gatekeepers justify such behavior, and (c) the ways in which supposedly age-neutral ideologies, centering specifically on corporate costs and well-being, may also spur ageist discriminatory treatment. Roscigno revealed precisely how stereotypes were used, and how people rationalized discrimination by invoking business costs.¹⁰⁴

It may also be beneficial to examine ageism in the context of ideological approaches including neo-liberalism. Aspects of neo-liberalism philosophy include: acceptance of an unregulated market economy; a minimal role for government; suspicion toward the welfare state; a view of

citizens as motivated only by self-interest; and a commitment to the central value of individualism.

Classical liberalism doctrines stress individual freedom, free markets, and limited government. The doctrine includes the importance of human rationality, individual property rights, natural rights, the protection of civil liberties, individual freedom from restraint, equality under the law, constitutional limitation of government, and a gold standard to place fiscal constraints on government. The neo-liberal focus on individual self-reliance often evident in government policy, is also subject to the continuing influence of moral and social conservatism with its emphasis on the traditional hierarchical, gendered family.¹⁰⁵

Neo-liberal policies prioritize economic growth and efficiency and, ideologically, emphasize individual responsibility for meeting basic needs as opposed to a collective responsibility to provide and aid. Neo-conservatism is distinguished by an emphasis on traditional, authoritarian structures and institutions and by a commitment to the traditional gendered family and to law and order campaigns.¹⁰⁶

Part IV The Search for Guiding Principles

One of the many challenges in this area is to find principles that will address an aging population and counter ageism, while being responsive to the diversity of older persons and their circumstances. Guiding principles in this area must be as relevant for (and as able to meet the needs of) the younger healthy person who is moving beyond her or his middle years, as to embrace and reflect the needs and interests of the very old, who may be dependent, who may have diminished cognitive ability, and may or may not be nearing the end of life.

It is essential that any legal framework in this area support the rights of seniors as adults. They are individuals with the same rights as adults of other ages.¹⁰⁷ This area must also be guided by substantive equality by recognizing the importance of context and disadvantage. Guiding principles must be able to look at age in the context of other statuses such as sex and gender identity, race, ethnicity and social class.

To date, principles of independence (autonomy), participation, security, dignity and respect for diversity have emerged in domestic and international legal and policy frameworks for aging.¹⁰⁸ For example, the Law Commission of Ontario has adopted the following principles as the basis for its approach to the law as it affects older adults:¹⁰⁹

- **Independence:** This applies in all spheres of life, including rights to meaningful opportunities to work, to age in place, to access education and training, and to make choices and do as much for oneself as possible. Given entrenched paternalism and stereotypes, the presumption of ability is essential to the independence of older persons. This principle also includes measures to enhance capacity for independence, including ensuring access to information, provision of programs and policies that support independence, and the provision of adequate supports for those who provide care for older persons.
- **Participation:** This includes the opportunity to be actively engaged in and integrated in one's community, and to have a meaningful role in affairs. Participation is enabled through inclusive design of laws, programs, policies and services. An important aspect of participation is the right of older adults to be meaningfully consulted on issues that affect them, whether at the individual or the group level.
- **Security:** Some frameworks refer to this principle as one of "care". This principle includes the right to physical, financial, and social security, such as the right to be free from abuse or exploitation. It also includes the right to basic supports in terms of health, legal and social services.

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- **Dignity:** This principle involves the right to be valued, respected and considered, to have both one's contributions and one's needs recognized, and to be treated as an individual. It includes a right to be treated equally and without discrimination, and a right to privacy. It includes the recognition that all members of the human family are full persons, unique and irreplaceable, that all have inherent and equal worth, and capacity for growth and expression.
 - **Respect for Diversity:** Older adults are not a homogenous group, and their needs and circumstances may be affected by a wide range of factors. The law as it affects older adults will respect the diversity of older adults, and take into account the impact of this diversity on their relationship with the law.

As the Law Commission of Ontario points out these principles must be read in the context of Canada's human rights framework, including both the *Charter of Rights and Freedoms* and the Ontario *Human Rights Code* and with a focus on substantive, rather than formal, equality.

All of these can be very important in promoting an anti-ageist approach in policy. At the same time, it is important to recognize that if principles of independence (autonomy) and participation are overstressed, there is the risk of representing another type of ageism. This ageism is largely focussed on "successful aging" and the functionally independent older person. If independence and participation are considered as the primary principles related to aging, they may leave a proportion of vulnerable dependent older adults that do not meet that definition of "success" further disadvantaged. This includes those who are frail, significantly physically, cognitively or socially impaired, and those at the end of life.

Perhaps for that reason, the Division of Aging and Seniors identified its principles for a "Comprehensive System of Support" as not only including dignity, independence and participation but also safety, security, and social support, along with justice, fairness and solidarity.¹¹⁰ Older adults, like all adults, live within personal, family and community relationships. Guiding principles for law and aging should recognize the older adult as both an independent and an interdependent person (i.e., where people rely on each other).

Security as a guiding principle should include ensuring good quality physical, mental and emotional care with an emphasis on meeting needs of the whole person; understanding and responding to special needs of people with dementia and other long term conditions. The Division noted "A society is fair and equitable when it ensures that all older persons have equal access to a continuum of quality health, social, financial, and legal services and resources regardless of age, gender, class, race, culture, income, residential setting, and health status, and when it distributes public sector resources throughout all stages of life on the basis of need."¹¹¹

Guiding principles for aging especially in the areas of health and housing should include a commitment to maximizing potential of older people and the potential of others to better

understand the ageing process. Security may also mean enabling through information – ensuring that older people understand range of options available to them and have access to suitable advocacy and support services. Valuing older people may include facilitating their contribution to decision-making processes.

A search for guiding principles in law must be guided by those principles in which the older adults are recognized, visible, valued; where older adults are recognized as contributing to society, and can have their identity reasserted. The principles must be enabling, as opposed to restricting, the lives of older adults.

Part V Examples of Ageism in Law, Policy, and Practice

A. Ageism and health law, policy and practice

The federal government is responsible for the *Canada Health Act*¹¹² but each of the provinces and territories is responsible for the administration of health care coverage and the overall distribution of health resources within health care and to different populations. Ageism in health care can be seen in many forms including the absence of services for older adults; age based decisionmaking in health and age rationing; making decisions about the quality of older people's lives; paternalism; forced decisions; and gender bias. Ageism can be evident in the allocation of health care resources, the respective burdens of the individual and spouse or partner, other family and the state.

It has been noted that as an institution of society, the health system perpetuates ageist assumptions. Thus, cultural conceptions of older people can legitimate differential treatment and this can be perpetuated in the delivery of health care.¹¹³ There is a growing international literature on the paternalistic and ageist ways that older adults are treated within health care systems. Renowned gerontologists Kane and Kane note

“Older people are always singled out as the most expensive demographically defined group of health care users. It is a cliché for journalists and many health policy authorities to remark to remark the X percent of people over the age of 65 account for XX percent of the health care dollar. Indeed older people do use disproportionately more care than do their younger counterparts as well they should. People accumulate chronic diseases as they age and some diseases have their onset in later life.... The unreflective repetition of this almost tautological claim about the high use of health care by older people (somewhat like the high use of health care by sick people) does verge on ageism.”¹¹⁴ [emphasis in the original]

In “Time for Action”, the Ontario Human Rights Commission highlighted health care as one of the important areas in which older adults can face significant discrimination with profound effects on health, quality of life and their longevity. Here we see the intersection of multiple “isms”, predominantly ageism, sexism and ableism, but also heterosexism, and racism. Older adults note they are often treated differently by some in the health care system:

“it’s like health care at 60. They don’t want to be bothered with you. You’re a drag on society and doctors don’t have time. They just don’t want to take the time with an older person. And it gets back to health care. Every time

*they have to cut healthcare back, the seniors seem to get it We're just living week to week to week.*¹¹⁵

There is a general concern expressed in many Canadian jurisdictions that the acute care system has failed to adapt to the changing needs of a changing population, in essence creating a "structural ageism". In other words, when health care is shaped as a traditional service designed around isolated episodes of care within well-defined specialties and agencies, it cannot fully meet the needs of increasing numbers of older patients, especially those with chronic, multiple and recurrent medical problems.¹¹⁶

At both an individual level and a structural level it has been recognized that in healthcare, old persons are often treated differently. At a practice level, that ageism may involve withholding information, services, or treatment, or it may involve taking older persons' complaints or symptoms less seriously and attributing them to old age.¹¹⁷ Research on health care professional attitudes in acute and rehabilitative care show a fair amount of agreement about subtle and not so subtle ageisms. Physicians, for example often provide inadequate treatment to the elderly.¹¹⁸ They give more respect and support, as well as more detailed medical information to younger patients.¹¹⁹ They also solicit more information from younger patients.¹²⁰

In a review of the health care literature and ageism, Diovios (2006) noted older people receive more medication prescriptions than younger people for equivalent symptoms.¹²¹ Anxiety medication use by Canadians more than doubles from 65 years of age on, and the hypnotic medication use more than triples. This has particular significance given that 40% percent of all emergency department visits by older adults are medication-related.¹²² Some physicians may rely on prescription medications as a substitute for taking time with an older patient, overlooking preventive care, good screening and diagnosis.

The Commission also points to the systemic effects of limited benefits coverage of health care system on older adults: Medicare does not cover all medically-related and dental health services. Instead, these must be paid by the individuals or from private insurance plans (which may have restrictions on coverage). This impact may be especially acute for older women. Similarly, there are inadequate facilities for chronic care, partly because the current health care system tends to focus on acute care facilities. Funding for long term care, complex continuing care, and rehabilitation (which are three key need areas for older many adults) is less a priority and funding adequacy is less developed in the current system.

The ways in which current health care funding is allocated disproportionately affects older women. Older women are much more likely than older men to have chronic conditions. Women are more likely to go into nursing homes, as they tend to live longer than men in general and older women tend to outlive their spouses. Many older women can expect to live twenty or thirty years as widows.

Prevention and rehabilitation tend to be viewed as less important with advancing age; and health care providers may feel that age limits for the access to medical services are acceptable and justifiable.¹²³ Kane and Kane draw a distinction between “disparity” (unfairness, inequality) and variation in health care practice. Legitimate reasons, unrelated to age, such as underlying conditions or ability to survive the treatment can make some distinctions between older persons and some younger persons with the same conditions justifiable.¹²⁴ Yet it is always important to be willing to test the underlying assumptions.

The effects of age related discrimination in areas such as health care are tangible, and discrimination is a life stressor. People who report experiencing discrimination also experience more mental health problems. Women who had experienced age discrimination have significantly lower positive well-being than men who had experienced age discrimination.¹²⁵

Ageism may be manifested at any stage and within any type of health care. Some types are directed directly at older adults. Others are structural, affecting older adults and those who care and support them. Ageism can arise in the context of health care consent, as well as in the context of the protection of those who care for older adults in the health care system. It can arise in the context of health care policy in key areas such as home care.

Noel Simard has commented that paternalism is an insidious expression of ageism, widely seen among health professionals. It is expressed by a condescending attitude and infantilizing approach that considers advanced age as a debilitating disease that places older persons at the same level as small children or the mentally incompetent, unable to make sensible decisions regarding their health or well-being.¹²⁶

There is a propensity in society to confuse the aging process with the disease process. That is, people tend to be more familiar with pathological aging (when things go wrong) than they are with healthy aging. The belief that continual decline is inevitable leads to disease or symptom management rather than health promotion or proactive intervention.¹²⁷ Symptoms are misdiagnosed in older adults because these are written off as part of the ‘normal aging process’.

Older adults are less likely to be referred for screening and treatment. For example, American data suggest that as many as nine of every ten adults over the age of 65 go without the appropriate screenings.¹²⁸ The Alliance for Aging Research notes: “Those numbers are startling considering that 80% of all fatal heart attacks and 60% of all cancer deaths afflict men and women age 65 and older, indicating that there is great need for aggressive screening measures within this age group”.¹²⁹ There is also a general tendency in health care to assume that older adults will not benefit from particular treatments, rather than find out from research and other clinical evidence whether that is actually the case.

Once an older patient encounters a health problem, studies show that physicians often use the person's age, not his or her functional status, as a factor in determining the appropriate treat-

ment. This means far fewer older patients receive interventions that can save their life or improve its quality. Their functional health, not their age, should remain the determining factor when deciding whether surgery is appropriate.¹³⁰

1. Structural ageism

(a) Omission from clinical trials

The systematic exclusion of older adults from clinical trials has been identified as one of the most flagrant examples of ageism.¹³¹ Although older adults are the heaviest users of many prescription drugs because bodies wear out, they have historically been excluded from clinical drug trials through overt age cut-offs or less explicit exclusions based on co-morbidity and frailty. The use of specific age limits appears to be chosen arbitrarily.¹³² Most trials (even those that specifically target therapies frequently used by older adults) try to actively exclude people with multiple diseases and conditions in the trial group. There are a number of practical and economic factors underlying this omission of older adults in clinical trials. Including them can complicate the data analysis and interpretation. However, very importantly from a marketing perspective, it dampens the effects sought (i.e. the drugs' efficacy may come off in a less positive light). The effect of the lack of older adults in the clinical trials means that they become *de facto* laboratory rats once the drugs are on the market. Health care consent to the medications becomes illusory because there is little if any information on how the drugs work on older adults.

While some of the explicit exclusion of older adults from clinical trials has diminished over the years, it is still there. A survey of Spanish research, for example, indicated that in the 1990s, 36% to 40% of the intervention studies submitted had an upper age limit. This number decreased to 19% in 2007. Non-intervention trials (where a group of people receive no care or medication), by way of contrast, rarely had upper age limits.

Today in the United States, the Food and Drug Administration now requires the population being targeted for a particular drug's use to be included in the drug trials. Nonetheless, the more complex cases and persons are still winnowed out.¹³³ International work shows some physicians are reluctant to enrol older patients in trials, citing concerns about coexisting conditions, the toxic effects of treatment, ineligibility, poor compliance, and lack of social support.¹³⁴ Thus it is often not chronological "age" *per se* that leads to the ageism in health care, but a number of interrelated factors that are associated with aging, as well as a lack of social effort to see if it is possible to address the underlying factors used to exclude older adults in the first place.

(b) Treatment and under treatment

Gender and age discrimination can intersect in areas such as health care treatment. Older adults often experience a fatalistic attitude among health care providers as expressed in the statement “Well, you are going to die of something ...”. This often leads to a lack of consideration of whether there are some treatments from which the older person will benefit. The issue is not that the person will die (as all people will), but what efforts are made to support a reasonable quality of life for the person until then.

Grant (1996) notes

*“Because ageism can be quite subtle, service providers need to continually examine their own attitudes toward aging and elderly people. Health care professionals need to move away from using the term “age” as an explanatory variable and the assumption that after enough time certain “things” will happen to people”.*¹³⁵

Medical research in several European countries and in the United States have found that the percentage of patients given cancer treatment varies with age, and this is independent of what stage of the disease a person has. For example, breast cancer treatment was significantly higher in the group younger than 70 than in the group of patients over 70 years.¹³⁶ Older women are less likely to be screened for breast cancer, and less likely to receive care (specifically, chemotherapy and radiotherapy) despite the fact that there were no differences in the disease stage between the two age groups at the time of diagnosis. This under-treatment explains why breast cancer-specific mortality rates have not declined among older women, to the degree to which they have among younger women. Older women are more likely than younger women to receive radical mastectomies, and less likely to be considered a candidate for and receive reconstructive surgery.

Research indicates that patterns of diagnosis, treatment and survival in cancer care differ considerably between younger and older age groups, even accounting for other underlying conditions in the older person. There is often a notion that many treatments are *not* tolerated well by older people.

Ageism and health care rationing often go hand in hand. In Ontario, research shows that whether or not a person is referred for dialysis will be affected by their age (less likely if they are older) and shorter life expectancy (less likely if they have other underlying conditions).¹³⁷

Ethnicity can also create important health disparities. The National Council on Aging (2005) notes that language and cultural barriers lead to the underutilization of health care by some ethnic groups. Communication difficulties (stemming from language and cultural differences) can also lead to inappropriate health care, such as inefficient treatment, unnecessary testing

and premature discharge for older adults.¹³⁸ In part, this reflects systemic problems such as a lack of interpretation services, e.g. in hospital. These trends are disturbing particularly because they continue to exist in spite of human rights case law underscoring the responsibility of health systems to reasonably accommodate the needs of individuals so that they can have and benefit from equal access to services.¹³⁹

2. Ageism in specific areas of health care

(a) Consent to health care

The legal right of the individual to control what happens to his or her body and life according to the person's values and beliefs is considered fundamental under both common law and statute. However, for reasons ranging from paternalism to convenience and expediency, that right is often not respected in health care for many older adults.

The law on consent is clear. Before providing treatment, health care providers must get an informed consent or refusal of consent to a treatment from the patient, if the person is mentally capable of making that decision. Under s. 11 of the *Health Care Consent Act*, consent must relate to the treatment; must be informed; must be given voluntarily; and must not have been obtained through misrepresentation or fraud. The patient must receive information on the nature of the treatment; expected benefits of the treatment; material risks of the treatment; material side effects; alternative course of action; likely consequences of not having the treatment.¹⁴⁰ Treatment is defined as: anything done for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose. It includes a course of treatment or plan of treatment.

Simard has commented

“Law is not well served if health care professionals perceive the achievement of consent as a legal password needed to do their job. They do not understand while adequate information for the patient is a necessity, paramount and a moral requirement of the integrity of the relationship. Consent is not only a kind of rite imposed by law. It should not be interpreted as acquiescence and agreement. This implies [there is] a freedom to act that is recognized [without] coercion and manipulation.”¹⁴¹ [translation, Noël Simard, 1996]

Basic legal principles of health care consent often go by the wayside when older adults encounter the health care system. In recent years, there has been a push in health care practice to use screening tools on older patients to “diagnose” potential domestic violence and abuse. Although the intention may be good, the practice occurs surreptitiously, without asking for consent, and often with the older adult having little control over what happens next.

The Advocacy Centre for the Elderly has noted the following practices and problems in Ontario. Some health providers, organizations or facility staff or administration do not seek informed consent before treatment. Other organizations may misuse advance care planning documents by using them as a replacement for informed consent and they do not obtain consent from capable older patients or the substitute decisionmakers when the older patient is not capable for treatment. Some organizations try to get “pre-consent” for health care.¹⁴²

It is also not uncommon in health care to presume a person is mentally incapable if she or he is of an advanced age or has a physical or mental disability. As the Advocacy Centre for the Elderly has noted, people of advanced age or persons with physical or mental disabilities may still be capable of making all or some decisions for themselves. The definition of capacity does not make exceptions for age, physical disability or mental disability. The definition of capacity in the *Health Care Consent Act* is not based on a diagnosis, although some health care practitioners treat it that way.¹⁴³

While it is clear that older adults have the same rights as other persons in terms of health care consent, age and aging are often taken for reasons to circumvent the requirement to seek and obtain true consent. It has been emphasized time and again that:

“The key is whether the person understands the information that is relevant to making a decision and is able to appreciate the reasonably foreseeable consequences of the decision or lack of the decision.

A person who is very old may, and most often does, have this capacity. A person with a physical disability, even if that physical disability makes communication difficult, is likely to have this mental capacity. Even a person who has been diagnosed as being mentally ill may still have capacity to make particular property, personal, treatment, admission and personal assistance service decisions.”¹⁴⁴

(b) Selection and retention of patients

An increasingly worrisome area of health care in which ageism can be manifest is the process by which physicians select and retain patients. Canada, like other countries, has been experiencing shortages of physicians in a number of key areas. In general, the vast majority of older adults in Ontario have a physician, and the rate is higher than for other age groups.¹⁴⁵

Physicians may have legitimate concerns about being able to competently manage their patient caseload and work within their clinical competence (their “scope of practice”). However in recent years there have been concerns raised in several Canadian jurisdictions about physicians who in the context of “caseload management”, screen and accept younger and relatively

healthier patients (“cherry picking”) while turning down or shedding the “non compliant” patient or the patient with chronic or complex medical issues, many of whom are older people. This practice violates the Canadian Medical Association Code of Ethics.¹⁴⁶

Some cases have come before on the Ontario Human Rights Commission on the issue.¹⁴⁷ The Ontario Human Rights Commission in 2004 strenuously reinforced the responsibility of all physicians to not discriminate in the provision of services. It further emphasized this point in 2008 in its submission to the College of Physicians and Surgeons of Ontario regarding the draft policies related to taking on new patients and ending physician-patient relationships.¹⁴⁸

(c) Ageism in physician services

Older adults can also experience systemic ageism in health care with certain health care practices. For example, physicians may reduce the time spent with an older patient by limiting the patient to “one problem per visit”. This practice is sometimes used to retain control over scheduling and timeliness in offering appointments to patients. However it works to the systemic disadvantage of people who have chronic conditions that need ongoing management such as diabetes, or chronic obstructive pulmonary disease. The vast majority of people with these conditions are older. Gender and race, and social economic status are all reflected in the incidence of chronic diseases.

The issue of “one problem per visit” has also been identified in Saskatchewan, New Brunswick and in Newfoundland and Labrador.¹⁴⁹ Speaking to this tendency emerging in their province, the College of Physicians and Surgeons of Saskatchewan noted its negative impact on health care, including the fact it can lead to inadequate information being exchanged between the patient and the physician about their problem, and incorrect diagnoses.¹⁵⁰ The College has stated

“Office visits should be used as an opportunity to assess illnesses/medical conditions, review care plans, pharmacological therapies, potential drug-to-drug interactions, or review any new medications added by additional caregivers. It is appropriate for a patient to be able to provide the list of problems for which they are seeking assistance, and for the physician and patient to go through the list and determine what requires urgent attention and what can be deferred to another appointment.”¹⁵¹

One problem, one visit is more likely to lead to inadequate care.

(d) Ageism and mental health practices

The ageism issues in mental health care are similar to those for physical care. Compared to younger adults presenting with the same symptoms, older patients are referred less frequently

for psychiatric assessments, and if they are assessed they are more likely than younger adults to be prescribed psychoactive drugs and less likely than younger adults to receive counselling and other therapies. The older the patient, the stronger this trend is.

The Ontario Human Rights Commission notes that negative attitudes in the health care context can result in significant difficulties for the older adults trying to access appropriate health care for their needs.¹⁵² The Commission gives as an example, far fewer older adults being treated for depression, or anxiety disorders and not receiving care for dementia by the health care system. The Commission points out that older adults only receive 15% of Ontario's mental health care, compared to more than 80% for those aged 20-to 64. The Commission states "the tendency to treat mental illness in older persons as less worthy of intervention is simply a direct form of systemic discrimination."

There is also a tendency of physicians to diagnose senile dementia among older patients, rather than depression. The diagnosis is made based largely on the patient's age, and often reflects the lack of training that physicians have with geriatric medicine.¹⁵³ The effect of not recognizing depression among older adults can be serious, even life threatening. Older males have the highest rate of successful suicides of any age group.¹⁵⁴ Seventy five percent of older adults that commit suicide do so within four weeks of seeing their primary care physician, and 39% do so within the same week. The Alliance for Aging Research report (2003) states that this clearly demonstrates "a discrepancy between the mental healthcare that is needed and what is actually initiated by primary care providers."¹⁵⁵

The issues for older adults extend beyond mental health practices, to the broader way in which mental health services are covered and delivered. The Canada Medical Association notes that while hospitals are covered under the *Canada Health Act* as insured services, the definition of hospital under the Act does not include "a hospital or institution primarily for the mentally disordered." CMA notes "Simply put, how are we to overcome stigma and discrimination if we validate these sentiments in our federal legislation?"¹⁵⁶

3. Ageism and home care

Much of the direct formal care and support provided to physically or mentally vulnerable older adults is delivered by home care services. In 2005/06, nearly 659,000 clients received home care in Ontario and almost 26 million visits/hours of home care were provided. On any given day, about 185,000 clients receive home nursing and supportive care, and many of them are long term clients, that is they require the services on an ongoing basis. In 2005/2006, the majority (58%) of clients were over 65 years of age. Older adults represent an even larger proportion of those needing to receive home care services on a long term basis.

In general terms, home care goals are four fold: (1) to help people with health and/or functional deficits in the home setting maintain their ability to live independently and, in many cases, prevent health and functional breakdowns and eventual institutionalization (“maintenance and prevention”); (2) to meet the needs of people who would otherwise require institutionalization (“long term care substitution”); (3) to meet the needs of people who would otherwise have to remain in, or enter, acute care facilities (“acute care substitution” such as when people are discharged from hospital early to recover at home); and (4) to meet the needs of clients who choose to die at home (palliative care).¹⁵⁸

The relative balance of clients needing acute care and long term support and maintenance has become a pressing issue. A 2005 Ontario review expressed concern that unless there was additional support made available for “maintenance clients”, the trend towards serving more acute clients may come at the expense of maintenance clients.¹⁵⁹ For example, a study in the *Journal of Aging and Society* reports “people in need of long term personal care and practical support are given lower priority and are gradually being rationed out of the system for all but the most minimal bodily maintenance. This medicalisation of home care generates particular jeopardies for the frail older people who dominate this category of need, most of whom are women.”¹⁶⁰

A number of other systemic issues can adversely affect the amount and quality of care that older adults receive within the home care system. Personal support workers provide much of the direct formal care and support to older adults with physical or mental limitations. In Ontario, unlike other health care professions such as nurses, there is no regulatory body for personal support workers. There is a lack of standards for the training and education that personal support workers receive, and many work in very precarious employment. As a result, there is an extremely high level of staff turnover, affecting both continuity of care and the quality of care for older adults and others needing ongoing support.

Other structural issues such as the competitive bidding process in Ontario for home care contracts has been seen as lowering workers’ wages and creating an unstable work force, again undermining quality and continuity of care for older adults and other home care clients. The Ontario Health Coalition reported on public hearings about home care in Ontario,

“The home care system described in the public hearings process revealed worried and even frightened clients, exasperated citizen and public interest groups, demoralized workers and a seriously destabilized provider community.”

In many cases, personal support workers are considered to be “casual employees” and therefore not subject to the *Employment Standards Act*.¹⁶² Instead they come under “elect to work” policies. As a result, they have none of the protections afforded other health workers in the province under this Act.¹⁶³ The Ontario Health Coalition notes:

*This status made them feel particularly insecure because “elect-to-work” meant they had to be available round the clock but never knew how many hours of work they would have in a given week.*¹⁶⁴

The Coalition goes on to note that elect-to-work also means no public holidays, notice of termination or severance pay for workers. At the same time “elect to work” policies meant that workers could cherry-pick the easiest clients and refuse to care for others.¹⁶⁵

Personal support workers are not the only health care providers who are employed on this basis. According to the Registered Nurses Association of Ontario, elect-to-work allows “nurses to skim the patients they prefer.” The RNAO goes on to suggest “this results in patients with complex psychosocial needs having many different caregivers - a factor that only increases the client's burden.” In reviewing home care in Ontario, the Procurement Review stated they were concerned that if this practice continues, the neediest clients will not receive necessary service.¹⁶⁶

If there is a problem, adults receiving home care services can only turn to the agency to remedy it. The ARCH Disability Law Centre reports that complainants are reluctant to formally report abuse or misconduct for fear of reprisal such as further abuse or loss of services. The fear of reprisal may be heightened by the client’s physical vulnerability, the absence of alternative providers, and instances of employer inaction regarding an abusive staff member.¹⁶⁷

Personal support workers are also not regulated. In 2005, the issue of whether they should be regulated under the *Regulated Health Professions Act, 1991*¹⁶⁸ came before the Health Professions Regulatory Advisory Council (HPRAC). Many personal support workers in Ontario have been advocating for this type of regulation to improve recognition of their work, standardize training and improve their working conditions. The HPRAC concluded that there was a risk of physical and psychological harm for patients when there was inadequate professional supervision, when clients did not have adequate recourse, or when employers were lax in ensuring that standards were met.¹⁶⁹ The HPRAC felt that enhanced supervision, adequate recourse for clients and patients, improved personal support workers’ training and the application of diligent employer standards were appropriate methods of addressing the issue of harm.

In the end, HPRAC recommended not regulating the personal support workers, but to have a registry system in place instead.¹⁷⁰ Parts of HPRAC’s analysis indicates a curious circular reasoning, in that they identified that personal support workers should not be regulated because they were not organized as a body and the workers were so poorly paid that they would not be able to support the costs of self regulation.¹⁷¹ Thus a mechanism that might improve their conditions and ability to advocate, plus safeguard clients, was rejected by the HPRAC because the personal support workers were so vulnerable. In response, PSW Canada started “The Stand for Change” initiative in January 2009, which included a petition to the On-

tario government to regulate the Personal Support Worker position within the province of Ontario.

4. Ageism and alternative level of care

The issue of where the care is provided has become increasingly important in Ontario in recent years. Seniors may be hospitalized for an acute care condition, but may need the support of a long term care facility which may not be available. Older adults in these circumstances have often disparagingly been referred to as “bed blockers”, with the implication that they are blocking hospital beds for those who “truly deserve it.”

The formal designation for these patients is “alternative level of care” (ALC). In order to ease pressure in acute care, some hospitals and other service providers have entered into agreements with retirement homes (described in greater detail in subsequent sections) to provide accommodation and services to those awaiting placement in ALC at a reduced rate. In some cases, the hospital or service provider may subsidize the fee itself in order to free up beds; in others, the retirement home may agree to provide the same services for a lower amount in order to fill beds.¹⁷²

According to the Canadian Institute for Health Information, the ALC patients represented 5% of hospitalizations and 14% of the hospital days in Canada. The rate of ALC is higher in Ontario and Newfoundland and Labrador compared to the rest of the country. Fifty eight percent of ALC patients are women and the median age is 80 years. Given that ALC seniors typically have dementia and many have had strokes, there are pressing questions about the ability of the retirement home staff to provide proper care and support to these older adults, and the residents’ lack of effective recourse if problems arise in the home.¹⁷³

5. Ageism, health care and marginalized groups

There are a number of groups of older adults who are marginalized within society and by the health care system. People with dementia, older gays and lesbians, and ethnocultural groups are among them.

(a) People with dementia and their families

There is growing evidence nationally and internationally that the daily concerns and day-to-day toll of care-giving on those looking after someone with dementia are hugely burdensome. This is compounded by the additional load of social isolation, prejudice, discrimination and poorly developed and fragmented services.¹⁷⁴ One key challenge for service providers and policy-makers is to understand to what extent the service difficulties are due to lack of planning in terms of the implications of a growing ageing population or due to either not valuing a particular group (people with dementia and their carers) or valuing the needs of other groups more.¹⁷⁵

(b) LGBT older adults

Older gays and lesbians can experience a number of risks and vulnerabilities throughout life that make them more likely to need physical care and/or home-maker services in later life. Their experiences with health care system historically have often not been very supportive. Some may have experienced psychiatric treatments, including shock therapy, in the 1970s in attempts to 'cure' them of their sexual orientation or gender identity

Homophobia in health care practice is a reality. A 1998 survey of nursing students showed that 8–12% "despised" lesbian, gay, and bisexual people, 5–12% found them "disgusting," and 40–43% thought they should keep their sexuality private. Internalized homophobia and/or heterosexism leads to a desire to remain invisible for self protection. There is often a distrust by LGBT people for authority and health care professionals, which causes communication barriers. For older gays and lesbians, disclosure of their sexual identity continues to be a risky business, and they regularly face the issue of whether they will be "in" or "out" and to whom.

Research with older LGBT adults has found that they are more likely than heterosexual respondents to believe that they do not have equal access to health care and social services, that LGBT residents of care facilities are victims of discrimination, that LGBT sensitivity training programs would benefit staff and residents of care facilities, and that LGBT retirement facilities would be a positive development for older LGBTs.¹⁷⁶

Older gays and lesbians are often made invisible throughout the health care system, starting with the intake process (questions asked on family status).¹⁷⁷ Health care employers also may fail to recognize their own and their staff's attitudes or beliefs and may lack policies that prohibit discrimination based on sexual identity.¹⁷⁸ Home care services for older adults are often delivered by faith or cultural based agencies and the particular faith of the staff can lead to discriminatory and hurtful behaviour. If an older gay or lesbian's health deteriorates, family members and health care providers may try to shut out their same sex partner's involvement in health care decisionmaking.

(c) Ethnocultural groups

Ethnic seniors are at greater risk of having poor access to health care and less positive experiences within the health care systems, leading to health inequities. Brotman (2003) notes "Over the past decade, policymakers and practitioners in the field of aging have been increasingly challenged to develop appropriate health and social services for elders from diverse ethnic communities. This has largely resulted from concerns regarding the significant barriers to care faced by disenfranchised elders."¹⁷⁹

As ethnic adults grow older, they can face problems owing to age-associated increased risks of common chronic diseases as well as racial discrimination.¹⁸⁰ These risks are further compounded by the fact there are cross-cultural differences in how and when people seek information, their communication styles, their perceptions of their health risk, and their ideas about prevention of disease, all of which have an impact on health. At the same time, institutional structures and power relations in health care may be marked by a lack of awareness of the needs of ethnocultural seniors and their families, and by racism. The lack of services in minority languages means that even basic necessities like conveying information and obtaining informed consent are lost.

There is evidence of discrimination in clinical-decision making and health outcomes, with a great number of studies showing differential clinical decision-making and even more studies showing differential health outcomes for minorities, particularly visible minorities.¹⁸¹ A number of studies have shown differences in the provision of basic care, as well as lower rates of surgeries for various racial groups as compared to people who are not members of an identifiable racial group. At the same time, many health care practitioners have misconceptions about ethnocultural seniors, and their families. Two common myths are that (a) in an Asian family, for example, families want and are able to care for the elderly parent, and that the care that can be provided is sufficient and (b) if there is no use of services by the person or group, that implies there no need within the family.¹⁸² In reality, there is often a shortfall between what older people in ethnocultural families need and the assistance they receive.¹⁸³

While this trend to health care inequity is not limited to older ethnocultural persons, they often feel a disproportionate impact of it. An Ontario Human Rights Commission sponsored research paper on racial inequality in access to health care notes that racial inequality in the health care context is most often indirect and systemic. It is affected by socio-economic factors, the underrepresentation of racial groups in the medical profession, the manner of health care communication, and the lack of culturally sensitive care. The paper points out that equal access is not ensured by uniformity (treating everyone the same).

Research shows there is a positive impact in health care access and utilization when there is an "ethnic match" between patient and clinician. For example, American research has found that the greater the proportion of minority staff in a mental health centre, the greater the utilisation rate by that minority. The report also notes "...culturally sensitive delivery of health care is a necessity if equality is to be a serious goal." The paper goes on to state that "In evaluating cultural sensitivity, we must first explore if the current delivery of services is equitable, and if not, how it could be made equitable."¹⁸⁴

6. Advance care planning

The term ‘advance care planning’ refers to a variety of documents and strategies to help adults plan for future incapacity. Although any person may experience future mental incapacity, e.g. as a result of motor vehicle, boating or skiing accident, advance care planning documents are far more likely to be promoted to older adults than to any other group of adults, including those with disabilities.

There is concern among legal practitioners that (a) some of the advance planning publications made available to the public misstate provincial law, (b) there is a serious ethical conflict when those who are responsible for providing care (health authorities) are also behind the promotion of advance care directives that may limit care and (c) emergency care, acute care and long-term care staff often misunderstand the purpose of advance care planning instruments. As a result there is a real risk of their misuse. Research indicates that many emergency personnel are likely to interpret the *existence* of a living will (which may deal with comfort and care) as a do not resuscitate order, and not treat the person.¹⁸⁵

Section 5 of the *Health Care Consent Act* states that a person may express “wishes” about future health care in a power of attorney for personal care, in any other written form, orally, or in any other manner.¹⁸⁶ The specific requirements for the Power of Attorney for Personal Care are set out in the *Substitute Decision Act*.¹⁸⁷ Personal care includes decisions about health care, nutrition, hygiene, shelter, safety and clothing. Under this *Act* the individual is selecting a person or persons to make decisions on her or his behalf if the individual becomes mentally incapable, and sets out specific duties of that substitute.

Advance directives and living wills are documents in which a person may express his or her wishes about future care. The terms “advance directive” and “living will” are not specifically defined in the *Health Care Consent Act*, *Substitute Decisions Act* or any other piece of Ontario legislation. The matter of requiring advance care planning by seniors, especially as a condition for receiving health care or other services, has been receiving increased attention in Canada at a policy level. This may be driven less out of respect for self determination and personal autonomy in making decisions, and more by the mistaken belief among policy makers that older adults “use” more than their fair share of the health care resources and that advance directives will help reduce health care costs.¹⁸⁸

As previously noted, advance care planning documents are often used inappropriately as a substitute for informed consent from a capable older adult or for their substitute decisionmaker. In addition, the Advocacy Centre for the Elderly notes that some organizations use “levels of care forms” inappropriately as health care consents to determine what health care the person will or will not receive. Some health practitioners, when they disagree with a substitute decisionmaker, use what they purport to be the patient’s “wishes”, instead of using the proper legal remedies, such as making an application to the Capacity and Consent Board.¹⁸⁹ In each of these

circumstances, the older adult becomes invisible, and it is easy for the older patient's wishes to be overlooked, discounted or ignored.

7. Ageism, quality of life and end of life

When looking for a framework for understanding aging in the context of health law and practice, it is important to consider the history of normativity ("what's 'normal'" and "who says"). Western philosophy carries certain conceptions of what a "good human life" is.¹⁹⁰ People who do not have a chronic illness or disability typically underestimate the quality of life of those with a chronic illness or disability to a significant degree and may assume that living with an impairment is a "bad life".¹⁹¹ Ageism must be considered in the context of the systemic devaluation of specific groups of people, including those who have disabilities and those who are old.

Ageism is also manifest at the extremes, particularly for dementia and end of life. In terms of people who have dementia, there is the unstated belief, "they are useless, they ought to die". In some cases, professionals are more frank. In 2008, Baroness Warnock, who is described as one of the most influential experts on medical ethics in the United Kingdom, is reported as stating that

*"If you are demented, you are wasting people's lives, your family's lives, and you are wasting the resources of the National Health Service."*¹⁹²

This blatantly ageist perspective needs to be considered against the emerging work in gerontology and geriatrics to better understand persons with dementia as persons and as valued persons (including as persons with a continuing capacity to enjoy life).¹⁹³

Some older adults express the wish to die. This may reflect a desire for control over their lives, but it may also be a response to an ageist society, people's concerns about being a "burden," and to the larger society's implications that it wishes to be "rid" of such "burdens". Ageism is an undercurrent in ethical discussions in health care about resource allocation, and qualitative and quantitative futility. To date, much of this discussion has been in the context of person with developmental disabilities, eugenics and children. Those whose lives are most likely to be affected – those who are old - remain invisible and marginalized.

Hospice palliative and end-of-life care is often said to not be about dying but about living well until the end. With appropriate end of life care, people at end of life and their families are supported through pain and symptom management, as well as physical, emotional, psychosocial, and spiritual care. It is an issue especially important to seniors and their families. More than 259,000 Canadians will die each year, and approximately 75% of these deaths will be people 65 years and over.¹⁹⁴

There are many disparities in the delivery of palliative care across Canada, and it is estimated that only 25% of Canadians requiring hospice palliative and end-of-life care services are able to access these services. Considerable evidence exists that older people suffer unnecessarily due to widespread under-assessment and undertreatment of their problems as well as lack of access to hospice palliative care.¹⁹⁵

8. Reasons for ageism in health care

(a) Lack of knowledge and expertise

It has been suggested that one of the reasons for ageism in health care is the general lack of qualified health care providers trained in the field of aging who can better understand and respond to the medical and other needs of older adults.¹⁹⁶ Health care providers working with older adults are often considered the overburdened “Cinderella” of health care, bearing heavy responsibilities with fewer and fewer resources.¹⁹⁷

The lack of specialized knowledge and the lack of specialists working with older adults has important negative consequences. Older patients may be much less likely than younger counterparts with similar injuries to receive appropriate treatment in accident or emergency care. Medical staff may not always recognise the life-threatening nature of apparently ‘moderate’ injuries in older patients.

In cardiac surgery waiting lists, the age of the patient (and other social factors such as social position) appeared to tacitly influence where they were placed in terms of priority on the waiting list.¹⁹⁸ Decisions were rationalised in terms of technical feasibility. Age tended to be only explicitly acknowledged as an important factor in decision-making in cases where patients were young.

(b) “Good law, but bad practice”

A number of areas of health care law can help advance the rights and interests of adults, including older adults. For example, the *Personal Health Information and Privacy Act, 2004*¹⁹⁹ (PHIPA), sets out a positive framework for collecting, using and disclosing personal health information. However, as the Advocacy Centre for the Elderly notes, PHIPA is not well understood by either health information custodians or the public and this leads to a misunderstanding of the law:

“People are often not advised of their legal rights and face numerous barriers when they attempt to do anything connected to their records of personal health information.”

PHIPA is repeatedly misapplied by health care providers. This is a trend the Advocacy Centre for the Elderly staff describe as “good law, but bad practice”. The lawyers stress that “education

about the statute is paramount to ensure that the rights of individuals are protected. Health information custodians must be reminded of the purposes of the legislation.”²⁰⁰ Accurate information is essential for any health care consumer, but it is particularly important to take any extra needed steps to help overcome the challenges that many older adults with low functional literacy can experience when interacting with health care systems.

Along a similar line, they also point out that provincial governments may inadvertently encourage people to misapply the law. For example health facilities are required to use provincially approved assessment tools, such as the MDS-RAI (Minimum Data Set – Resident Assessment Instruments), which unfortunately contains misstatements of the provincial law on health care consent, and as a consequence increases the risk of reducing and restricting patients’ rights.²⁰¹

(c) Misstatements and misunderstandings of the law

Ageism can be manifested when individuals and organizations do not take the time to understand and accurately represent the law to those to whom they are providing service. Older adults’ dignity, personal integrity, and health care rights are fundamentally affected by that inaction. It has been pointed out for example, that patients often receive misinformation from health care providers or sometimes from government forms on health care consent, advance care planning, etc. In some cases, as previously noted, tools such as advance care directives which are intended to be instruments to aid personal autonomy, become misused and in effect circumvent communication with the older person.

(B) Ageism in the context of housing law

Older persons should be able to live in environments that are safe and adaptable to personal preferences and changing capacities.

From United Nations Principles of Older Persons

Across much of the lifespan, the percentage of persons who are homeowners increases. Compared to other age groups, a larger proportion of older adults are homeowners (79% in 2006 compared to 63% among individuals aged 31 to 33, and 73% among those aged 37 to 39.). Older adults may own their property outright, or they may have other types of arrangements such as life leases. For this group, mechanisms such as age based property tax relief help them be able to retain that homeownership for a fairly long time. While older homeowners as a whole may not experience a significant amount of ageism related to their home, those living in strata units can encounter it, usually in the context of strata bylaws or the attitudes of neighbours.²⁰²

Older couples and seniors who are in good health and are physically active will be most likely to be in a home that they own.²⁰³ People are likely to move from home ownership to renting when their health deteriorates, and as their social support network changes (e.g., a spouse or partner become ill or dies, key friends become ill or move, or adult children live further away).

Older adults also represent an important group of renters. Some have been renters most or all of their lives; others make the change at widowhood or with changes in their health and ability, seeking housing environments that can help them live relatively independently with some support. Below, is a description of some of the ageism issues affecting older renters.

1. Understanding the general circumstances in rental housing in Ontario

*In 2006, 21 percent of people aged 65 to 74 were renters, as were 28 per cent of people aged 75 and over.*²⁰⁴

Most provinces during the 1960s and 1970s built a variety of forms of special, usually subsidized, housing for seniors. These were operated by non-profit organizations, municipalities or provincial governments with federal funding through the Canada Mortgage and Housing Corporation. However, by 1993, the federal government was no longer engaged in this area. Soon after, many provincial governments limited or ended their contributions to building affordable housing. This negatively affected many seniors.

The report “Where’s Home? 2008” prepared for the Ontario Non Profit Housing Association and the Cooperative Housing Federation of Canada notes the following significant trends in Ontario over the past decade: vacancy rates continued to decline; too few new rental housing units were being developed to meet demand, especially for people with low income; and rental increases exceeded the change in the Consumer Price Index; and increasing housing affordability problems for more renters.²⁰⁵ The effect on renters has been harsh.

(a) Profile of older renters

Some older adults have been renters most or all of their lives. Others make the change to renting at widowhood (especially if their financial circumstances deteriorate) or with changes in their health and ability. This latter group is often seeking housing environments that can help them live relatively independently, but with some support. For many older adults there is strong preference to be able to live in safe, affordable appropriate housing for as long as possible without being expected to having to “move on”.

Over one half (53.8%) of renters aged 65-74 and close to two thirds (61.8% percent) of renters aged 75 and over have housing affordability problems, and spend 30% or more of their income on rental housing. Almost one in five (18.8%) of tenants aged 75 and over spend 50 percent of more of their income on rent. In the new climate of vacancy decontrol, landlords may increase the rent as high as they like at the start of a new tenancy. Some landlords will actively seek ways to terminate tenancies to create new higher paying ones.²⁰⁶

Older renters are often financially less well off than other seniors. Those who rent are typically women, widowed, and living alone. Widowhood creates economic vulnerability for many older women. Unattached older women represent the second largest poverty group in Canada.²⁰⁷ Older women with low incomes who are living in large cities face significant problems in finding affordable housing, particularly in light of low vacancy rates.²⁰⁸

(b) Seniors in social (subsidized) housing

Seniors represent nearly one quarter of the applicants on a waiting list for social (subsidized) housing in Ontario.²⁰⁹ Single adults (of which older adults are a large group) face the longest wait times for subsidized housing - six years. In some parts of the province, the waiting list exceeds twenty years. An average of 72% of all households on the waiting lists had annual incomes below \$20,000.²¹⁰

Each of these trends in housing generally is important to understanding the significant economic vulnerability of many older renters, especially those living alone. The trends can reinforce vulnerability, undermine housing security and create or open up opportunities for exploitation. They mean fewer and often less appropriate housing choices with older renters needing to stay where they are, no matter what the conditions.

2. Ageism in the context of housing policy

Housing policy analyst David Hulchanski argues that Canadian housing policy has by and large favoured home ownership, and given far less policy consideration to the needs of those who live in rental housing. This policy emphasis leaves many persons, at all ages, marginalized, vulnerable and forced to live in unaffordable, inadequate, and inappropriate housing, and a growing number are at risk of homelessness.²¹¹ The result is not enough rental housing and not enough of the right types, leading to competition among groups for scarce resources. Older adults who rent are one of those groups who are particularly hard hit, because of their economic vulnerability and their special needs.

These economic conditions and the housing policies on which they are based create a “perfect storm” in which ageism can surface, and in which appropriate rental housing for many older

adults becomes a pipe dream. Hulchanski notes five types of programs that are needed to improve rental housing situation across the lifespan:

“First, capital subsidies are required to build new units. Second, rent supplements can make housing affordable for very low-income households by filling the gap between the renter’s ability to pay and the rent level. These two subsidy types ensure an income mix of very low-income to moderate-income households in social housing, create communities rather than “projects,” and allow for better integration into existing neighbourhoods. The other three types of programs address the needs of people requiring supportive housing, the rehabilitation of aging housing, and assistance for people who are homeless.”²¹²

The Ontario NonProfit Housing Association (ONPHA) in a June 2009 response to the Ontario Human Rights Commission report “Right at Home” (which was a consultation on human rights and rental housing in Ontario) stressed that “there are two fundamental conditions in the housing sector which provide a fertile ground for breaches of the Human Rights Code. The first is poverty –basically lack of income. The second is lack of affordable housing....”²¹³ ONPHA stressed that discrimination and disadvantage in housing is the result of the complex interplay of systemic factors including inequalities in income distribution, lack of appropriate supports and a wide range of competing needs.²¹⁴

There are also pressing structural issues that impede efforts in affordable housing to be more inclusive and non-ageist. Much of the available housing stock was built in the 1960s and 1970s, and has not been built with the needs of older adults or adults with disabilities in mind. The cost of retrofitting multiple units can be significant, especially given the thin budgets within which the non profit housing sectors are forced to function.

At the same time, human rights law recognizes the duty to accommodate the needs of people with disabilities to the point of undue hardship. The principle of undue hardship was raised by ONPHA and its members in the context of inclusive physical design and the need for physical modifications to units to accommodate the needs of elderly and disabled tenants. “Housing providers, including the Toronto Community Housing Corporation (TCHC) drew the Commission’s attention to situations in which the impact of combined requests for accommodation from multiple tenants might amount to Undue Hardship. An example is where a large proportion of tenants simultaneously require modifications to allow them to remain in their social housing units.” In its submission, TCHC provided a detailed statement of the condition of the housing stock in its portfolio, the lack of resources to fund repairs to the aging stock and the profile of its tenant population which leads to multiple requests for accommodation on an on-going basis.²¹⁵

During the Commission’s roundtables, housing providers focused on cost and funding. They stated that accommodation requirements cannot be implemented without straining resources

for other needs, such as building repair and maintenance. Generally, housing providers are not given the resources by the government to meet extensive needs for accommodation.²¹⁶

Toronto Community Housing Corporation apparently requested that the Commission consider “relocation as a form of reasonable accommodation” since they felt this “would infringe less on the rights of individuals and acknowledge the accountability of different levels of government to provide adequate funding for housing providers to meet their duty to accommodate”.²¹⁷ On its face, the Toronto Community Housing Corporation’s position may or may not be ageist, depending on whether by “relocation”, they meant encouraging and facilitating internal moves within a building to physically more suitable suite or simply “move out of here”.

ONPHA on the other hand stressed

“Social Housing providers are not trying to reduce or avoid the duty to accommodate; we only wish to have explicit recognition of the need for those who fund the housing to provide the resources that will enable them to meet that duty. ... , government departments go to extraordinary lengths to meet and even exceed Code requirements [in their services]. It seems reasonable that they should fund, or be required to fund, their transfer agencies to meet the same standard.”²¹⁸

3. Types of rental housing used by seniors

There are a number of different types of rental housing used by seniors, including

- (a) “independent housing “ (“ordinary apartments”) and
- (b) housing with some additional formal support services.

The latter may include not for profit rental housing with supports, a specific type of housing in Ontario called “supportive housing”, as well as for private “retirement residences”.²¹⁹ Further along the housing/ care continuum are long term care homes (currently referred to in Ontario law as nursing homes, homes for the aged, and charitable institutions).²²⁰ The focus of this section of the paper is only on independent rental housing and housing with some additional formal support services.

(a) What is “supportive housing”?

The term “supportive housing”, as it is used in Ontario, refers to units occupied by people receiving formal support services in order to maintain their tenancy and live independently in the community. In some cases, support service agencies receive funding from the Ministry of Community and Social Services or the Ministry of Health and Long- Term Care.²²¹

Supportive housing provides short or longer term housing for many different populations, including persons with developmental disabilities, and people with physical, mental health, or social needs requiring long term support. In some cases, special supportive housing has been established for people with mental health problems, people with substance use problems, or victims of domestic violence. A particular building may be completely comprised of supportive housing, or have some units in it that are considered supportive housing.

The term “retirement residences” refers to a private pay residence with some support services. They are a form of supportive housing. According to the Ontario Retirement Community Association:

“Retirement residences offer private pay accommodation and services for seniors. The accommodation is typically a private room with a 3 piece bathroom that is rented on a monthly basis. Services generally include 24 hour supervision, meal preparation, laundry/ housekeeping, medication distribution, assistance with activities of daily living, social events and recreation.”²²²

(b) Legal framework

Supportive housing, retirement homes and “ordinary apartments” are covered under the *Residential Tenancies Act* (RTA).²²³ Some of this rental housing is private, for profit (“market”) housing; others are not-for-profit, and some of it may be subsidized (social housing or rent geared to income). The general rules of tenancies apply to supportive housing, retirement homes and “ordinary apartments”, but there are some special exemptions for what the RTA terms “care homes”. These are defined by s. 2 (1) of the RTA in the following manner:

“care home” means a residential complex that is occupied or intended to be occupied by persons for the purpose of receiving care services, *whether or not receiving the services is the primary purpose of the occupancy*;

“care services” means, subject to the regulations, health care services, rehabilitative or therapeutic services or services that provide assistance with the activities of daily living;

In essence, this means most retirement homes and some supportive housing are considered “care homes” under the RTA.

Social housing refers to non-profit or co-operative housing communities where some or all the rents are subsidized. Subsidized households pay about 30% of gross income on shelter. If the older adult lives in “social housing” (profit or not for profit housing where the rent is subsidized

by public funds paid to the tenant or the landlord), the tenancy is also subject to a number of exemptions from the general protections of the law, most related to rent increases.

It should be pointed out that the language used by various provincial government ministries for the different types of housing is not used in any consistent manner.²²⁴ To further complicate conceptual matters, the Ontario Non Profit Housing Corporation points out there are three types of non-profit housing in Ontario, each distinctive in who owns and operates it. Private non-profits are buildings owned and managed by independent, community-based groups, such as faith groups, service clubs, ethnic organizations and community agencies. Municipal non-profits are owned and operated by over 100 different municipalities across Ontario. Local Housing Corporations are owned and managed by Service Managers - the local government body responsible for housing, social welfare and ambulance services. Until 2001, Local Housing Corporations were owned by the provincial government and were called "public housing".

4. Opportunities for ageism in housing

In housing, ageism needs to be understood in the context of several intersecting factors, including growing older, often needing more supports in order to maintain some relative degree of independence, changing marital status (especially for women), as well as temporary or more long term health changes. The Centre for Equality in Rental Accommodation (CERA) notes older people experience significant barriers to accessing and retaining housing:

“Landlords who have minimum income requirements can make it difficult for anyone living on a pension or other fixed income to rent an apartment. Many landlords are also hesitant to rent to older people for fear that they will become disabled – and a “burden” to the landlord – in the future. Where an elderly tenant does develop health conditions that require modifications to their unit or an apartment building, landlords will frequently avoid making the necessary changes, forcing the tenant to either live in uncomfortable, unhealthy – and often dangerous – circumstances, or try to find alternate housing. Sadly, “aging in place” is impossible for many elderly tenants.”²²⁵

The potential reasons behind the ageism in rental housing are multiple -- and may reflect economics, path of least resistance/ operational ease, or perceived efficiency. It may reflect in some cases a lack of knowledge, training or education on the needs of an older population among the operators, boards, and management companies, as well as “because they can” (power imbalances and legislative vacuums.)

In 2007/8 the Ontario Human Rights Commission looked at discrimination in housing and the ways it affected many groups. The Commission concluded that many of the problems in rental housing and access to housing were symptoms of systemic human rights violations. The Commission noted that the Human Right Code provides a range of tools to address violations of

housing rights and situations affecting access to housing because of Code grounds, even if section 2 does not explicitly create a freestanding right to housing.²²⁶

(a) Separating discrimination from relevant distinctions

Housing discrimination is conceptually challenging for several reasons. First, numerous distinctions are regularly made in housing law, policy, and practice that affect identifiable groups such as older adults. Landlords and sellers often make distinctions based on what they believe is prudent management and efforts to mitigate risk that requires them to exercise some selectivity in accepting new tenants or requiring existing tenants to leave.²²⁷

Housing programs are often framed in terms of meeting the needs of certain groups (such as low income seniors), and by necessity exclude other groups. Reaching a specific age is often one of the criteria for receiving benefits such as shelter allowances. Seniors' housing often operates as "special programs" under human rights laws. Separate housing for seniors is not usually considered as discriminatory. Much of this housing is geared to income and intended to ameliorate a historically disadvantaged group. Nonetheless some aspects of seniors' housing or the ways in which it is operated are discriminatory towards older adults. The issue of housing discrimination forces us to critically examine how we promote health and well-being in housing; the ways in which we assist groups with distinct housing needs (including seniors, persons with disabilities, people who are homeless); and how we are addressing consumer concerns.

Increasingly popular, supported housing models of housing for older adults often make within-group distinctions based on individuals' needs and functional abilities for their initial assessment of eligibility and in determining the point at which persons must leave. The fact that these supported living environments are functionally a combination of housing and health or related supports further complicates housing discrimination analysis. In the housing field, there are often competing responsibilities and expectations placed on providers-- to provide housing and services, to reasonably accommodate individuals, and to balance individual versus collective needs. Providers may struggle with balancing concepts such as providing some degree of "aging in place" and reasonable efforts to accommodate persons, along with other competing legal responsibilities to not provide support and services that could be characterized as institutional care.

(b) Potential for ageism in rental housing generally

People in a position of authority, such as building managers, owners or directors of non-profit society boards, are able to exercise considerable power over older adults who rent. This may be a broad reflection of societal attitudes, but it may also reflect the absence of business or regulatory norms that reinforce appropriate or inappropriate behaviours.

(i) Age related discrimination

Discrimination in housing may occur at any point in housing, from the screening process for potential tenants, to contractual requirements having a differential impact on older tenants, to the way some or all persons are treated in the housing, to the point at which the older adult is being required to leave.

Housing researchers have found age related discrimination in several countries, including the United Kingdom, the United States and Japan.²²⁸ Legally condoned ageism may be manifested in the fact that laws are often under-inclusive, by excluding the type of rental housing in which older adults are likely to live or by giving older adults fewer protections. In many Canadian jurisdictions, several types of rental housing in which predominantly seniors live, such as supportive housing and assisted living, are specifically excluded from regular tenancy legislation, and the laws they are covered by (if any) do not have equivalent protections in tenancy, and may not have safeguards in terms of service standards.²²⁹ The result is that tenants in these types of housing may have less security over rent and service cost increases, fewer rights of privacy, less control over the landlord's entry, and fewer legal remedies.

Supportive housing and assisted living are not heavily regulated across the country because there is an assumption that consumers can exercise choice between providers, thus placing upward pressure on service standards. The Special Senate Committee on Aging notes consumers can only "vote with their feet", however, if there are other suitable and affordable supportive housing options to which they can turn.²³⁰

This type of systemic discrimination against older adults in rental housing is not a phenomenon limited to Canada. In the United States, the federal *Fair Housing Act*²³¹ does not include age as a protected group, and their federal *Age Discrimination Act of 1975*²³² only covers publicly funded housing, not privately owned housing.²³³

Age related discrimination in housing can be manifested in a wide variety of ways, for example: by refusing the person's application; in the terms or conditions on which the accommodation is offered to the person; by deferring the other person's application for accommodation or according to them lower order of precedence in any waiting; by denying or limiting access to any benefit associated with the accommodation; or by evicting the person.

Older adults can be subject to direct discrimination. In some seniors' housing, managers have openly acknowledged that they will not rent to those who are 85 years and older ("the oldest of the old") because they are seen as "more trouble" than their younger senior neighbours who are likely to be less frail or disabled.²³⁴ Operators and managers may assume that older adults are *more likely to damage* an apartment because they have a walker or wheelchair (particularly a motorized one), *likely to be less capable* of keeping the apartment in a good condition, or that they *might* set a fire by accident, etc. Even ordinary business risks become exaggerated when

older adults are being considered. An older renter is seldom given any reason, let alone the real one, for being turned down or why the tenancy agreement was terminated. This creates evidentiary problems if the person tries to challenge the refusal.²³⁵

These types of discrimination reflect social perceptions both about people with disabilities and perceived likelihood of disabilities among older adults. They reflect failures to reasonably accommodate the needs of older adults. They also reflect adverse impact discrimination and systemic discrimination.²³⁶

(ii) Exploitation and legal onus

Both advocate experience with older tenants and the research literature indicate that exploitation of older tenants happens.²³⁷ In both the non-profit and private rental markets, some landlords purposefully exploit older tenants by holding on to security deposits which they are legally required to return. They may intentionally neglect suite or building repairs²³⁸ or may unlawfully evict the occupants. Older renters are forced to move so the suite can then be rented to younger tenants who will pay more.²³⁹ Less than reputable landlords purposefully have older tenants sign fixed term tenancy contracts. This permits them to easily rid themselves of anyone who is considered "difficult", and avoid having cases brought to rental arbitration over problems that may be occurring in the building. The abuse of process has proven to be a very effective means for them to keep the remaining older tenants fearful and 'in line'.²⁴⁰

Older tenants sometimes find they are being evicted because they are trying to enforce their rights. The Landlord and Tenant Board has the authority to refuse or delay an eviction in these circumstances. However the Interpretation Guidelines note that the tenant has a higher onus.²⁴¹ Tenants must prove that the reason for the application to evict was because they were trying enforce their legal rights or other accepted motivations. However, as the Guidelines and caselaw point out, it is often difficult to prove another person's state of mind.²⁴²

(iii) "House rules"

It is not unusual to see older adults in subsidized and seniors' housing in many parts of Canada facing arbitrary and unreasonable internally imposed requirements and practices ("house rules").²⁴³ Houses rules may be limited to a particular building or systematically applied by public (social) housing authorities in their tenant policies or tenancy agreement. House rules can have legitimate purposes, assuring safety and fairness to tenants. House rules can also be infantilizing and sometimes restrict older adults' tenancy or other rights.

It is not uncommon to find unreasonable house rules in rental housing where seniors live. For example this may include grandchildren being prohibited from visiting "because this is a seniors' building"; and rules that limit who can visit and how long guests can stay ("the two week

rule- a visitor may stay no more than 14 days total in a twelve month period”). Two rules specific to social housing are described in greater detail below. Provincial tenancy law in Canada is often silent on house rules generally, with Manitoba’s *Residential Tenancies Act* being a notable exception.²⁴⁴

House rules need to be considered in terms of their objectives, the method of achieving the objective, and in the context of the fairness to tenants generally and to specific groups. Perhaps one of the more troubling types of housing policies and one that creates the much controversy are those related to smoking. The issue significantly reduces the affordable housing stock for older persons who smoke.²⁴⁵

(iv) Suitability of the housing stock

Ontario Human Rights Commission in “Time for Action” noted a number of housing issues negatively affecting older adults in the province, including reduced housing affordability (leaves them vulnerable), the age and condition of the housing stock, the lack of barrier free design (affecting the older person’s ability to live there if physical or mental abilities decline), cost factors - adapting and renovating existing buildings can be costly, not designed for those with special needs, e.g. more insulation/sound proofing to accommodate older persons who are hard of hearing, and the housing location often did not encourage access to the community. Housing and care facilities for older persons should be close to amenities such as stores and transportation and near to other people.

The Commission notes that ageism occurs when planning and design choices do not reflect the circumstances of all age groups to the greatest extent possible.”²⁴⁶ Even though many provinces allow certain rental housing stock to be designated specifically for older adults as “seniors’ housing”, there may be few if any requirements as to which rental housing can legitimately be designated in this way. As a result, a growing number of these apartment buildings or complexes are often not suited to the basic physical needs of many older adults (particularly those older adults with some degree of physical impairment). The housing often lacks basic consideration of good environmental design (steps, ramps, railing, lighting, safety features etc.) Developers often ignore other important considerations such as the location of the housing relative to the kinds of services that seniors commonly need and use. Seniors’ housing built between the 1960s to 1990s (the period when the federal government was providing funds for affordable housing) is often unable to accommodate newer independence technologies such as motorized scooters and bulky electric wheelchairs that need to be plugged in.

(v) Failure to accommodate

Older adults’ needs and capabilities can change as they age. When this happens, they frequently find there is little or no effort by housing authorities or property owners to accommodate their

changing needs, in spite of the specific requirement under some human rights laws for reasonable accommodation in the area of facilities and services.

“Accommodation” in this age-related context could mean any range from minor to major adjustments (usually more the former). It may include training staff to understand age-related changes among tenants; changing a door handle or altering physical design of the suite, room and amenities of the housing to accommodate strollers, walkers or wheelchairs; or having some level of supportive services available to them such as home care so that the older adults can “age in place”.²⁴⁷

In an ageism-permissive environment, some housing providers will make little if any effort to adjust the living environment to meet the person’s changing needs. Instead the older person is expected to “put up with it” or move on to other “special” accommodation (e.g., housing with supports). The overall result is to deny older adults access to appropriate housing, support and care, or to force them into segregated special housing which may place significant restrictions on their independence in exchange for support or care.²⁴⁸

It has been pointed out that age-related discrimination in housing often intersects with age-related discrimination in health and community services.²⁴⁹ In many communities, health and community resources such as home support have remained underfunded relative to the growing need. In many Canadian communities, these services have been drastically cut back, providing fewer hours of support to those in need. The parallel discriminations can lead to older adults having important needs going unmet, with increased risk of morbidity and mortality or being “pushed” into long term care. Top down discrimination filters its way through successive layers to negatively affect the lives and independence of older adults.²⁵⁰

(c) Potential for ageism in social housing

Subsidized housing or rent geared to income housing as it is referred to in Ontario is directed to people who have low incomes. By its nature this may create a potential power imbalance between the owner or operators and the tenants. While many staff members are very supportive of the tenants, in many buildings, staff may receive minimal training for the job (especially on understanding aging, or tenant relations).

(i) The charity game

Ontario communities and charitable institutions have a long history of providing shelter and some supports for “the elderly, poor, and the dependant”, beginning in the early 1800s with “houses of industry” and “houses of refuge”, and later developing into the various types of homes for the aged. The individuals were highly dependent on the charity of local organizations and municipalities. Up to the 1960s, residents of these facilities were called “inmates” and the

operators were referred to as “keepers”. While the pejorative language has fortunately gone, a few vestiges of the “be thankful for what you have” attitude sometimes remain.

Seniors who rent identify having experienced several types of problems and forms of age-related discrimination from those who operate and manage the rental housing, springing from ageism and the marginalization of older people with low income. The difficulties they experience include: insulting behavior and insensitivity to their needs; having their legitimate concerns about the staff or the way that the building is run ignored or downplayed; threats and harassment (when they raise concerns, being told “you’re lucky to be subsidized” and “if you do not like it here you can go somewhere else”); infringement of their rights to privacy; and threats of eviction if they complain.²⁵¹ Societal ageism leaves some landlords or staff feeling entitled “to keep them in their place, because that’s all they deserve”. When low income older renters face a problem with discrimination or harassment in their building, they often cannot leave, as there is no affordable place to go.

These issues are very similar to those faced by other marginalized groups such as single mothers with children, and immigrants who are housed in similar accommodation, basically anyone who has few choices in terms of affordable housing and less power. However, age can also create important differences. Older adults frequently have less knowledge of their legal rights as tenants and a tendency to defer to authority. They often have fewer financial and physical resources to be able to use the available methods of redress such as tenancy mediation. They also have fewer social resources for self advocacy or advocacy by others.

(ii) “Over housed” / under utilization

Older adults more than any other age group are likely to face widowhood, which creates a special set of housing challenges, and arguably unfair burdens. In social housing under the law, when a spouse dies the tenant (typically an older woman) is expected she will leave her home and move to a smaller unit.²⁵² The assumption is that if she continues to live there she is “over housed” and the social housing is “underutilized.”

The Cooperative Housing Federation of Canada (CHFC) notes

*“Governments, as managers of taxpayers’ money, try to guard against the perception that a subsidized member may be receiving “too much housing space”. With growing waiting lists for affordable housing, governments are increasingly viewing the issue as one of “making good use of a scarce resource”.*²⁵³

On one hand, it is understandable to strive to meet the needs of the other tenants with larger families for appropriate housing. However, CHFC also notes the significant negative impact that forced relocation (as opposed to where people chose to downsize), and the fact that it affects

largely older women.²⁵⁴ At least one human rights case in British Columbia has heard this type of forced relocation matter, although the Tribunal found the rationale for the rule justifiable (*Bone v. Mission Co-op Housing Association*, 2008 BCHRT 122).²⁵⁵

Housing policy bases the argument for these moves within building or community on the need for housing stock “efficiency”, but in the process, the often frail older adults are treated as inanimate objects to be moved about. CHFC points to tangible costs (such as bearing the moving expenses at a time of diminished resources) and the very important intangibles such as the loss of sense of community and continuity when long time residents are forced to leave the housing cooperative because there are no one bedroom units in the co-operative.

Housing policy of this nature is also ageist in that it ignores the older woman or older man’s social and physical needs. Socially, it effectively restricts and undermines the family connections (there is no space for them to visit or care for her if she has an acute illness). The older adults’ physical world also shrinks to smaller environments, the person is forced to live with and is expected to accept less and less. Recognizing the overall impact of occupancy standards, the CHFC has put forward motions at their 2005 and 2006 Annual General Meetings for more flexible approaches by government and providers to the occupancy standards so that seniors would not be forced to move out of their housing co-operatives.²⁵⁶

(iii) Two week rule

In Ontario when the rent is geared to income, the person is limited to the length of time they can have guests. For example Waterloo Region Housing policy states the guests may stay two weeks without needing the property manager’s permission and the tenant must advise the property manager of the guest. To be able to stay longer requires asking for permission in writing, and the property manager may refuse in a variety of circumstances.²⁵⁷

A two week visitor rule in subsidized housing may be intended to avoid situations where other income earners are staying in the apartment and their income is not being considered in establishing the amount of the subsidy. Undeclared income may unfairly deprive others in need of rent geared to income.

However, advocates note that these guest policies have a disproportionate impact on lone mothers.²⁵⁸ The rule also works to the significant disadvantage of (and creates a much greater burden on) any older adult who becomes ill or frail and needs the assistance of a family member after a period of hospitalization. Without the family support, their health and safety becomes jeopardized. The policy also ignores that a family member is usually there at substantial personal cost and is not an income source. House rules like the two week rule impede older adults’ ability to “age in place”; they also mean the older adult is more likely to need public resources such as home care because family members are effectively shut out.

In the 2008 consultation on housing discrimination in Ontario, the Ontario Human Rights Commission was told that strict enforcement of these policies can have far reaching effects on the ability of tenants to maintain their privacy and lead normal lives while at the same time maintaining their housing. If the guest is deemed to be an illegal occupant, the tenant's subsidy can be revoked and the tenant may be evicted.²⁵⁹

(iv) The 120 days rule

In ordinary rentals, individuals come and go as they please. In Ontario when the rent is geared to income, if a person is absent from the apartment for more than 120 days, except for medical reasons, the tenant then becomes ineligible for rent geared to income.²⁶⁰ They are entitled to stay in their unit but will be paying market rent.

This rule works to the particular disadvantage of older immigrants or any older adult with a good relationship with an extended family, and where there is a cultural expectation of parents and grandparents being with them on extended visits (for example, seniors with South Asian or South East Asian backgrounds). Some Aboriginal seniors for example may live in an apartment in town or the city during the winter and spend summer months on reserve with extended family, living on the land, being with family and teaching grandchildren. The 120 day rule appears to be based on the idea that if a person is "truly low income", she or he should have little if any supports or family relationships.

(v) "Mixed housing" dilemma

In recent years, service providers working with seniors in several Canadian jurisdictions have expressed concern about an emerging housing policy strategy in their cities. "Hard to house" younger persons with severe mental illness (many of whom are homeless or at risk of homelessness) are priority for housing and are moved to what has traditionally been social housing for seniors.²⁶¹ Older adults in the now "mixed" housing environment often feel extremely vulnerable in this environment, and some can become increasingly isolated.²⁶²

This might be seen as competing "rights" or needs of two vulnerable groups to appropriate housing. An anti-ageism lens however highlights that (a) vulnerable groups should not be put in positions where they are competing for scarce resources, and that the scarcity is an artefact of broader housing policies; (b) at a housing level, changes are typically made without consultation with older adults as key stakeholders (older tenants are treated as irrelevant) and (iii) pragmatic concerns that the persons with chronic mental illness are being housed without adequate support, creating safety risks for them and for frail older tenants. In some cases, risks for the older adult may come from the new tenant, in other cases, or from the new tenant's entourage ("friends from the street").

Toronto Housing Commission began a pilot in November 2008 to establish an integrated support network to promote the community and mental health needs of all residents, while ensuring the seniors population is fully supported to age-in-place. The study allows for Toronto Housing Commission to “review the impacts on seniors who live in buildings that, due to a large number of small bachelor units, have had an influx of residents experiencing a multitude of complex issues related to mental and physical health, substance use, heavy reliance on social assistance, and street acculturation.”²⁶³ The pilot includes diverse committee of agency staff, Toronto Community Housing staff and tenant leaders.²⁶⁴ The pilot is expected to continue until the summer of 2009.

(d) Potential for ageism in retirement (care) homes

Retirement homes (or “care homes” as these they are referred to under the Residential Tenancies Act) have been recognized as having a special blend of rental housing and support services in Ontario. The term “retirement home” commonly used by the public and private industry and the legal term “care home “ will be used interchangeably below.

A “care home” is a rental unit where the tenant receives personal care services due to medical disability, commonly advanced age. Residents of this type of housing with supports are typically in their mid eighties, some entering at this age and others moving in their mid seventies and growing older there. Under Ontario law, all care homes are required to provide housekeeping, laundry services, assistance with transportation, and recreational or social activities.²⁶⁵ They *may provide* other services, such as meals and personal care.

(i) An area of confusion

Retirement homes are often confused by prospective tenants and the general public with other types of services such as boarding homes, or at the other end of the continuum --long term care (nursing) homes. Retirement home suites may comprise a few units within a building, a whole building, or part of a larger facility that also offers long term care. It is often not possible for individuals to know what types of accommodation and service a building offers simply by its name.

The care services of the care/retirement home will depend on the individual’s needs and can include personal care or activities of daily living - assistance with dressing, bathing, feeding, or help taking medications; incontinence care; assistance with personal hygiene; assistance moving around (ambulatory assistance); personal emergency response services; and nursing care.²⁶⁶ A person may have anything from mild impairment to fairly significant physical or mental impairments and live in a retirement home. There is no specific level of individual need or disability identified as appropriate or inappropriate for care homes.

To a large extent governments have taken a non- interventionist or *laissez-faire* approach to this kind of housing. Over the years, the primary legal approach to the special character of the retirement home housing has largely focused on providing contractual rights information (“so people know what they are signing”). For example, each tenant is to be provided with a Care Home Information Package (“CHIP”) *at the time of entering* into an agreement to help clarify exactly what they can expect to receive in terms of services and the costs associated with these.²⁶⁷

While required by law, the requirement is not always honoured by retirement home operators, even those who are deemed within the industry to be accredited. Clarity of legal information is important for any consumer and any renter. However, the only real effect of the CHIP requirement is that the landlord cannot legally increase rent or service charges until that information is provided.²⁶⁸

There are some important legal safeguards already in place for persons entering into contracts for this type of housing in Ontario. The care home agreement must be in writing (in an ordinary tenancy, terms can be written, oral or implied); and the person has a (limited) opportunity in the beginning to consult a third party and step away from the contract if the person changes his or her mind. To some extent these are seen as mechanisms to enhance clarity, build consumer awareness of what they are contracting for and help address part of the power imbalances that might otherwise occur for prospective older tenants, many of whom will have lower functional literacy. The difficulty, however, is that the approach equates “information” with “consumer power” or “choice”, when real choice may be much more elusive in this housing context.

Unlike many other Canadian jurisdictions, retirement home tenants in Ontario have some of the general protections available to other tenants, including timing and notice of rent increases. However, there are a number of ways in which the tenancy legislation is weaker for retirement homes than for either an “ordinary tenancy” or for long term care facilities (nursing homes). Compared to ordinary tenancy, less notice is required for service cost increases in care homes. Tenants are subject to forced mediation and eviction for change in health. In contrast to long term care, there are few standards for care and support services and less effective recourse. Each of these problems or differences is described below.

The retirement home industry relies heavily on “consumer choice”. However, for the market to operate effectively certain conditions must be met

- consumers must have an adequate supply of products or services to chose from
- they must have adequate information about the products
- they must be capable of exercising choice (that is they must have decisionmaking capacity and be free from coercion or undue influence) and
- they must have recourse when things go wrong.²⁶⁹

These criteria are noticeably absent in retirement homes and similar types of supportive housing in Canada.

(ii) Lack of standards

Retirement homes vary considerably in the scope of the services they provide. One of the growing concerns for Ontario retirement homes and similar types of housing for seniors in many other parts of Canada is the lack of standards, regulations and effective oversight. Outside of regulations that generally relate to tenancy, building safety and individual rights, the industry is largely unregulated. The Advocacy Centre for the Elderly notes that tenants have few if any remedies when it comes to the quality of care and supports provided in retirement homes.²⁷⁰

It has been argued that in effect, some retirement homes function as “bootleg “ or underground nursing homes in that they are providing care, support and services to older adults with the same level of needs as some persons in long term care homes, but without the same regulatory safeguards.²⁷¹ For example, some retirement homes have locked units and use restraints on tenants, without providing any of the rights protection or other safeguards provided to residents of long-term care homes.²⁷²

The Advocacy Centre for the Elderly also points out that the retirement home system lacks accountability or enforceability of legislation, regulation, policies, and enforcement mechanism that the Ministry of Health and Long-Term Care has within the long-term care system and this double standard fails to ensure the safety and protection of retirement home tenants.²⁷³ Drawing on their experience with problem care homes and the lack of effective industry oversight, the Advocacy Centre for the Elderly stresses:

“There is clearly a need for a comprehensive regulatory scheme for retirement homes so that all seniors can live in environments that that promote their independence to the extent possible, while also ensuring their safety and protecting their rights.”²⁷⁴

(iii) Patching the quality and safety gaps

In the past ten years, several Canadian jurisdictions have undertaken considerable efforts to establish standards and guidelines for housing similar to Ontario’s retirement homes. In British Columbia, a registry and administrative system of standards and guidelines for services was developed for “assisted living”, albeit still leaving a lacunae in terms of tenancy protections.

In 2007 the Ontario Seniors Secretariat undertook a consultation on possible regulatory approaches for retirement homes, including a third party regulatory model, (industry) self regulatory model, or municipal regulation. In its submission to the consultation on regulating retirement homes, the Advocacy Centre for the Elderly noted the special characteristics of the homes and the people who live there that made these models inappropriate. The Advocacy

Centre for the Elderly has proposed that a more suitable alternative is to have a provincially run tiered, licensed approach with agreed upon standards for the various tiers.²⁷⁵

One of the many forms of ageism within society is the systemic subordination of older adults' interests to those of others. Arguably, that is evident where the interests of private industry to minimize government oversight consistently take primacy over the interests of the older persons living in retirement homes or other supportive environments to a safe and secure environment with reasonable quality of care and support. The lack of enforceable regulatory standards and the lack of enforceability in retirement homes can create a systemic disadvantage and a significant burden that other adults do not experience.

Mahoney has argued that "In essence, care home tenants are reverse hostages held by care home operators. 'No one else will house them and take care of them,' operators tell the government, 'so stop criticizing us and leave us alone. Otherwise, we'll dump them right back in *your* lap.' Landlords are given benefit of law, lest they withdraw their services and throw responsibility for these vulnerable adults back on the state."²⁷⁶

(iv) Fewer legal safeguards

Like ordinary tenancies there are legal restrictions on retirement homes on how frequently they can have a *rent increase* (once in twelve months).²⁷⁷ On the other hand, retirement home *services* costs to the tenant can be increased more often as long as the landlord provides the tenant with at least ninety days written notice.²⁷⁸ Tenancy agreements that set costs for an identified period cannot be altered during that period.

The care home tenant may face significant housing (service) costs increases. As a result, many tenants, especially those whose support needs are fluctuating as a result of an acute or longer term condition are in a precarious position of not being able to anticipate whether they can continue to afford to live there. Some older adults may try to hide their changing needs so that they will not be seen as needing more and therefore more expensive services.

(v) The illusion of aging in place

Older persons should be able to reside at home for as long as possible.

from United Nations Principles of Older Persons

As previously noted, older adults who rent in Ontario often find that they are living in aging buildings environmentally unsuited to the physical needs of the tenants who are growing older. Similarly, there may be little effort for some housing providers to accommodate to their chang-

ing needs. The commonly held expectation is that the older tenants will “move on” to someplace else.

Under the current legal framework for care homes, security of tenure is tied to a person having a constant state of health. If his or her health needs changes for the better or worse, a care home landlord can apply to evict a tenant, alleging either the tenant no longer requires care or by claiming that the care required is beyond what the landlord can provide.²⁷⁹ Moreover, tenants who experience a health crisis and are taken to hospital may find upon their discharge from hospital that the retirement home refuses to take them back. In effect they are being evicted with no legal cause under the governing landlord-tenant legislation.²⁸⁰

Care home tenants have a right to dispute their landlord’s application for eviction but they must first go to mediation where parties may agree to contract out of their rights under the Act.²⁸¹ However as Elinor Mahoney, an Ontario community legal aid worker, has noted:

“Care home tenants are the only group facing mandatory mediation when their shelter is at stake, and the prospect is not a healthy one. What chance does a dependent, vulnerable (and probably unrepresented) tenant have in mediation against a well-dressed, soft-spoken care home operator who swears that the tenant’s care needs can no longer be met? No wonder the treatment of care home tenants in the [Act] has been labelled “anti-advocacy” by concerned groups.”²⁸²

Mahoney points out that sometimes care home residents are blamed for the effects of their disabilities. They are labelled “hard to house” by governments, bureaucrats, landlords, and social workers. Problematic behaviours are treated not as symptoms of illness but as character defects. She states “Sympathy is reserved for the poor care home landlord who must cope with this behaviour. It is the landlords who are given benefit of law, lest they withdraw their services and throw responsibility for these vulnerable adults back on the state.”²⁸³

(vi) Accessibility in retirement homes

Retirement homes are intended for older adults and that obviously includes older adults with disabilities. There is a responsibility of all private and public providers under Ontario’s human rights law to accommodate to the point of undue hardship the needs of persons with disabilities as it relates to the right to occupancy of accommodation and when providing services, good and facilities.²⁸⁴ However, the Advocacy Centre for the Elderly has noted several potentially discriminatory and ageist practices among some retirement homes in the general area of accessibility. These include:

-
- residents relying on mobility devices (such as wheelchairs or scooters) are not welcome in the communal dining areas (since these devices make other people feel “old” or “disabled”);²⁸⁵
 - residents who cannot enter the dining area on their own (or with a walker) must eat their meals in their room or they are required to pay an extra fee for “tray service” for these meals to be delivered.²⁸⁶

Some retirement homes have policies limiting access within the home (e.g. “no motorized vehicles are permitted in the common areas of a retirement home”) and the policies are applied even if the resident is able to demonstrate that he or she is able to safely operate a motorized vehicle.²⁸⁷ These internal policies significantly affect the older adults’ ability to live there, and use the basic retirement homes services for which they are paying.

(vii) Precarious tenancies

Older adults who reside in retirement homes often experience a precarious tenancy. Ordinary tenancy law provides for on-going “tenure” for almost all tenancies, i.e., tenancies “automatically renew” at the end of the term or period. The tenancy can be ended by the landlord only in specific circumstances. However, for care homes, if certain conditions are met, a care home landlord can require the tenant to give a Tenant’s Notice of Termination or to agree to an Agreement to Terminate as a condition of, entering into the tenancy agreement (i.e., the tenant’s notice is “pre-obtained”).²⁸⁸

This creates a true “term” tenancy which can be enforced by the landlord. The landlord can then decide to not renew the older adults’ term tenancy at the end of the term for any reason he or she sees fit. This mechanism (and ones like it in other Canadian jurisdictions for similar types of supportive housing) effectively undermine the basic security of tenure that is considered so fundamental to tenants of any age. The use of term tenancies also becomes a way that some landlords “keep tenants in line”, especially those brave enough to raise concerns about the services provided. The landlord simply refuses to renew the tenancy. It has a strong chilling effect on other older tenants.

Widows and widowers in care homes are also in a precarious position following death of a spouse. Under ordinary tenancy law in Ontario when a person named on the tenancy agreement dies, his or her spouse can continue to live there under the same terms of the tenancy. This is referred to as the spousal assumption.²⁸⁹ However, there is no spousal assumption for retirement homes or social housing.²⁹⁰ Instead the person is simply considered an “occupant”. The “new” widowed tenant “starts from scratch” and the application may be denied or the person may face higher rent and service costs.

The issue has been raised in at least one British Columbia human rights case (*Paulsen v. Terra Property Management Ltd* [2007] B.C.H.R.T.D. No. 471) where the tenancy contract required that “If any tenant leaves, the remaining persons whose names are shown cannot take over the tenancy or the premises without the written consent of the landlord.” In *Paulsen*, the plaintiff (a widow/surviving spouse) argued among other things that the provisions discriminated against her based on her marital status.²⁹¹ The discriminatory effect of the lack of tenancy protection for (usually female) spouses has been argued in legal cases affecting younger women in social housing, relying on a Charter analysis.²⁹² The issue of the lack of tenancy protection has also arisen in the context of a surviving family member living with and caring for an elderly parent who eventually dies.²⁹³

A similar issue can arise in cooperative housing, in the context of death of a member. Each household in cooperative housing has one membership (the “One Member Rule”). In *Ford v. Lavender Co-operative Housing Assn.* [2009] B.C.H.R.T.D. No. 38, the complainant (a widow) successfully argued that the application of the Cooperative’s One Member Rule was discriminatory in that it prevented her from obtaining security of tenure in her family home. The rule had required her to apply for co-operative membership after 23 years of residency, leaving her continued residency in her family home up to the discretion of the board of directors who would determine her “suitability” at that time.²⁹⁴

(viii) Care home evictions

In the Ontario Human Rights Commission consultation on housing discrimination, tenant advocates raised important concerns about accommodation and the criteria for eviction and eviction processes under the RTA for persons living in care homes. The tenant can be evicted if the care home operator feels they cannot meet the tenant's care needs.²⁹⁵

The special eviction process for care homes has several negative and disproportionate impacts on persons with illnesses and disabilities. For example, the criteria for eviction treat tenants who live in care homes because of age and/or disability, differently from other tenants. A care home tenant’s security of tenure is inappropriately made contingent on his or her state of health. It has been argued that the process set out in the RTA for care home evictions provides less protection to vulnerable older people with disabilities living in care homes, when more safeguards were warranted.

As previously noted, the only recourse through which a care home tenant can dispute the eviction is mandatory mediation, which can lead to poor outcomes for tenants when adequate steps are not taken to address power imbalances. Also many care home tenants have mobility problems, cognitive difficulties and other impairments, yet they have less time than other tenants to seek advice and to obtain legal assistance.

Very importantly threats of eviction under s. 148 could be used by housing providers to make care home tenants more compliant and prevent them from raising legitimate complaints. The Human Rights Commission was also told that the LTB may not always apply the Code principles of the duty to accommodate to the point of undue hardship when considering a landlord's application to evict a tenant for reasons relating to a Code ground.

(ix) Special housing issues -- mental health

Among the many groups of older adults who experience age related discrimination in housing, those with mental health conditions are particularly vulnerable. Aging adds another important layer they can experience in seeking and retaining housing over the life course. The Psychiatric Patient Advocate Office in Ontario (PPAO), in its brief to the Ontario Human Rights Commission on housing discrimination, for example points out that tenancy is often refused because many landlords and housing providers incorrectly assume that the person with mental health condition will be a "problem". They note:

*"Due to the vulnerability of and discrimination against many mental health consumers, there is often a power imbalance between consumers and housing providers, allowing particular landlords to mistreat consumers with little or no consequence. For instance, landlords will harass residents, ignore valid complaints and permit substandard living conditions for people with a mental illness due to negative attitudes and stereotypes. The paucity of available housing ensures individuals are afraid to speak out against improper landlords or to leave and seek alternate accommodation."*²⁹⁶

Geriatric nurses, housing advocates, and social workers have pointed out that older adults with acute mental health problems who are leaving hospital or whose medications have been modified are vulnerable in their return to housing. They may be discharged from hospital early, left without supports and not given the chance to stabilize, thereby running the risk of falls, confusion, or confrontations with others, each matters that can lead to an eviction.²⁹⁷

Another issue for mental health consumers is confidentiality of personal health information. One commonly raised question is what information can or must be shared with landlords as part of the screening process. In addition, landlords sometimes release confidential health information to third parties without the consent of the resident. The PPAO notes, for example, that some landlords will call a resident's doctor with the goal of taking him or her to hospital in circumstances that clearly do not require this intervention.²⁹⁸

Section 27(4) of the RTA permits a landlord to enter a rental unit if written notice is given at least 24 hours before the time of entry to determine if the rental unit is in a good state of repair, fit for habitation and complies with health, safety, housing and maintenance standards.

The PPAO points out that this can be extremely subjective and is susceptible to abuse; landlords may use this provision to harass tenants, especially mental health consumers, and impose their own values on tenants and their living conditions.²⁹⁹

The PPAO emphasizes the importance of building awareness and knowledge. The PPAO notes

“The Residential Tenancies Act is also silent about the training of the [Landlord Tenant] Board. Members of the Board encounter numerous people from many different walks of life, including those with mental illness. Accordingly, Board members should receive initial and ongoing training respecting mental illness. A culture of understanding and acceptance of mental illness is essential if we are to be an inclusive and caring community.”³⁰⁰

Part VI Access to Justice

“Access to justice is a huge obstacle in the administration of both civil and criminal justice for older persons.”³⁰¹
Advocacy Centre for the Elderly, 2008

Older adults in Ontario experience a wide range of barriers to enforcing their rights, most of which are structural and systemic.

A. The general issues

The Law Commission of Ontario points out that older adults may experience a variety of barriers in accessing the legal system and enforcing their rights. Older adults may be unaware of their legal rights, particularly when it comes to such issues as their rights as residents of retirement homes.³⁰² They may also experience physical barriers in attempting to access the legal system, including a lack of accessible transportation or services. For older adults in care homes, the care home staff may be their main link to external resources. Fixed incomes and the limited breadth of Legal Aid Ontario coverage can be impediments to justice. The Advocacy Centre for the Elderly points out that court proceedings are often lengthy and there are an insufficient number of lawyers practicing elder law and knowledgeable about areas of law affecting older adults.

However, there are many more considerations affecting access to justice. For example, the legal process often pits an individual against someone with whom they have an ongoing relationship - a landlord or home care agency – so that many people who face real and serious barriers are reluctant to file complaints. This means that they will often wait until they have already suffered substantial harm before trying to deal with it. Formal and informal advocates can face significant challenges when acting for older adults and advocating for them in systems on which they are dependent or will need. There is the ever-pressing need to address ‘conflict’ while recognizing the reality that the older client must continue to use the service of the service provider with whom they are having conflict. There can be also challenges in dealing with “experts” and other professionals when acting for the older client.

B. Information sources

Although public legal information has made important strides to make the law more understandable and accessible to many, it is still geared to the functionally literate person. That leaves many older adults, including older and more recent immigrants, at significant disadvantage. Written information is helpful for some, but does not meet the needs of older adults whose cultural background has traditionally used oral communication to share information.

Increasingly in many parts of Canada, public information on the law and government information about services and entitlements has been shifting from people sources to virtual sources such as the Internet. The Special Senate Committee on Aging notes that a reliance on web-based information assumes a basic level of literacy and people's ability to access the internet.³⁰³ Many older adults, particularly older women, do not have access to or cannot use the Internet. In 2007, about one third (33.8%) of all men aged 65 and over and less than one quarter (23.1%) of all women aged 65 and over in Canada accessed the Internet at home and only about 1% of seniors used computers in public places like libraries.³⁰⁴ Internet use still is largely limited to higher income seniors and those with higher education.

C. Complexity of the law

Many areas of housing are exceedingly complex. For example, Toronto's Rent Geared to Income Guide which explains the law for staff and directors of staff or directors of co-operative and non-profit housing providers is 213 pages.³⁰⁵ The Advocacy Centre for the Elderly's manual for practitioners on long term care and retirement homes now runs over 600 pages. The Landlord and Tenant Board website includes twelve different forms (including one to determine if one's housing is covered by the RTA in the first place). Most of these have filing fees attached.

Other Canadian research has indicated the incredible complexity and frustrations of working through social assistance systems and seeking housing if one is an older sponsored immigrant whose sponsorship has broken down. The person tries to navigate both immigration and social assistance systems, facing significant procedural, language and cultural barriers along the way.³⁰⁶

D. Legally sanctioned power imbalances

In the Ontario Human Rights Commission consultation on housing discrimination, tenant advocates raised important concerns about tenants with mental illnesses (which can include older adults), who are vulnerable to eviction and homelessness when they are unable to effectively assert their rights under the RTA before the Landlord and Tenant Board. For example, they may not understand the legal issues at stake in a hearing at the Landlord and Tenant Board. There is no provision to appoint a legal case worker or litigation guardian to act on the behalf of a tenant who is mentally incapable of filing an application and pursuing a remedy at the Board. This interferes with the ability of tenants with mental illnesses to enforce their rights, including defending themselves against eviction. Tenants may not properly recollect events, understand the legal process, remember to attend at hearings or retain legal representation until after an eviction order has been enforced. These issues are equally pressing and relevant to many older

adults who mental capability is deteriorating and who are facing evictions. Community social workers (where they exist) and health care providers who may be in contact with the older adult rarely have knowledge about these systems and procedures.

E. The issue of time

Timely access to justice is essential for any group, but has special import for older adults and those with precarious or deteriorating health. Time is important for older adults in two ways—first in terms of having adequate time to recognize there is a problem, know where to turn for help and support, and to be able access that assistance in a timely manner. Thus many short timeframes in areas such as housing evictions will work to the systemic disadvantage of the most vulnerable older adults.

Secondly, procedural processes that entail delay will also work to the systemic disadvantage of older adults and may effectively negate their rights. Where the administrative process is lengthy, whether that is in the human rights field or other areas, it may be many months or even years before a decision is made on whether the complainant will receive basic procedural entitlements, such as a hearing before an independent and impartial board to determine if their rights were violated.³⁰⁷

There is a lack of recognition that this delay may effectively mean no remedy for the older individual.³⁰⁸ For example, in the recent human rights case, *Banghart v. Elgin Condominium Corporation No. 1*, 2009 HRTO 13, the Tribunal turned down an application to expedite the case, although the complainants were aged eighty-eight and eighty-four.³⁰⁹ Age alone should not be the determining factor, but it can be part of group of factors that affect effective use of existing legal remedies. It is not only the original case in which this is determinative, but also if either side seeks a review or appeal of the case. Older adults will tend to be disadvantaged whenever cases are delayed, reviewed or appealed.

In many cases the person is expected to use the administrative remedy as a last resort. This approach makes sense if the issue can be addressed properly at a more direct level. However for many of the issues that older adults experience, the “paper remedies” have little, if any, foundation in fact. Older adults or others acting on their behalf may be forced to go through processes that will have no real result but delay.

F. Limited jurisdictions of Ombudsman and Coroner

Unlike other Canadian jurisdictions, the Ombudsman Ontario office has limited jurisdiction over the health care sector, which means that there is less opportunity to question the procedural fairness within health systems in the province.³¹⁰ The Ombudsman’s jurisdiction within the area of health and housing includes fourteen Community Care Access Centres (CCACs), the Health Services Appeal and Review Board, the Health Professions Appeal and Review Board,

fourteen Local Health Integration Networks, and the Long Term Care Branch. The Ombudsman Ontario office does not have jurisdiction over hospitals, which constitute a significant area of provincial health care budgets.³¹¹ Jurisdictions related to housing include the Ministry of Municipal Affairs and Housing, and the Landlord and Tenant Board.

It has been noted that any watchdog agency such as a provincial ombudsman will automatically be limited in its function. It can examine the functioning of government departments and ministries within a business model, but treats each department as separate (i.e., as silos). As such, it is unable to identify the interaction effects among ministries.³¹² These are all important considerations because health and housing law, policy and practice issues affecting older adults often involve an interplay of responsibility between ministries.

Jurisdictional policies can facilitate other potential areas of vulnerability for older adults in the context of housing and health. For example, Ontario has a process for coroners to investigate the deaths of seniors in long term care. However, deaths of residents in retirement homes do not need to be reported to the coroner in the same manner as deaths in long-term care homes even though some retirement homes serve a similar older adult population and are used as *de facto* long-term care homes. Recognizing this gap, in 2009 the Advocacy Centre for the Elderly in its brief to government recommended that Bill 115 (An Act to Amend the Coroners Act) include an amendment to section 10(2.1) so that it could include deaths of residents of retirement homes.³¹³

There are wide swaths of health law, policy and health care in which older adults are the primary the recipients or “beneficiaries”. Where there are problems in the health care system, omissions, lack of protections, or where the existing processes are basically ignored, these legal and social gaps disproportionately affect older adults.

G. Nondisclosure of rights and lack of effective recourse

One of the common themes in many parts of health related law, policy and practice in Canada is the “illusion of recourse”, which is simply the fact that review and appeal routes on health matters may exist on paper but do not actually function. For example, it has been pointed out that while there is a review process for the Community Care Access Centres, the CCAC staff often do not let the clients know about this and clients are not informed how to exercise their rights.³¹⁴ Moreover, while a person has the right to appeal a CCAC decision to the Health Services Appeal and Review Board,³¹⁵ only termination of services can be appealed, not the quality of the services.³¹⁶ The Health Services Appeal and Review Board also states that they cannot deal with bill of rights issues.³¹⁷ Thus, older adults may have a bill of rights, and “rights” for community care services, yet they lack real mechanisms for the enforceability of those rights.

Continuing Legal Education of Ontario (CLEO)’s publication on Home Care Bill of Rights explains the clients rights. It states that if the individual has gone to the CCAC for a review and has not

received satisfaction, the person may consider suing the CCAC for breach of contract. This is a highly unlikely response for older adults in need of publicly funded home care,³¹⁸ given that Legal Aid does not cover these types of matters. CLEO notes that community law clinics offer free legal aid advice, although not all of them cover home care issues.³¹⁹ There is also the broader issue of whether there are any appropriate legal remedies in contract law for breach of the clients' rights in the first place.³²⁰

H. Seeking remedies: ageism in the context of human rights law

1. The problem of under- inclusion in Canadian human rights law

Age as a protected ground in human rights law, a necessary but not necessarily sufficient step.

In general, older adults have not had the same level of protection in provincial or territorial human rights law or federal human rights law in Canada as other vulnerable groups. Although considerable attention has been given in law to the Canadian Charter of Rights and Freedoms as "the mechanism" for rights protections, the Charter only applies to "government" action. Provincial and territorial human rights laws have a much broader scope in that they cover both public (that is, government) and private bodies.

Age is still not a uniformly included protected ground in human rights law with respect to discrimination in "services, facilities and accommodation ordinarily available the public" in some Canadian jurisdictions (for example, Alberta³²¹ and Newfoundland and Labrador).³²² Age was only added as a protected ground in this particular area within British Columbia's human rights law in 2007/8, when "age" was also expanded to cover all persons aged 19 and over. Prior to that, British Columbia's "age protection" only covered ages 19 to 64.

Alberta does not include age as a protected ground in tenancy under the provincial human rights law. Similarly, Newfoundland and Labrador does not include age protection for occupancy of a dwelling unit, or anywhere except employment. Even there, the age protection only covers people aged 19 to 65. New Brunswick includes age as a protected ground in services available to the public but does not provide age protection in contracts.³²³

As a result, for many years older adults in many parts of Canada have been excluded from human rights protections or had to try to seek redress "through the back door" under other protected grounds such as mental or physical disability. In effect, this simply reinforces the stereotypes about older adults as being mentally or physically disabled and dependent. Moreover, even under disability grounds sections, older adults' circumstances may not come within the scope of the law.

2. Potential under-inclusion in disability

Discrimination issues affecting adults in later life often reflect an intersection of their status as older adults with other conditions such as physical disability. Section 10 (1) (a) of the Ontario's Human Rights Code defines disability as: *any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness* [emphasis added].

The definition section on disability then goes on to offer illustrative examples "and, without limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a guide dog or other animal or on a wheelchair or other remedial appliance or device."

Other types of disabilities covered by Ontario human rights law are: a condition of mental impairment or a developmental disability; a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language; a mental disorder, or an injury or disability for which benefits were claimed or received under the insurance plan established under the *Workplace Safety and Insurance Act, 1997*.

These definitions will cover some older adults' circumstances, but not all. While court cases emphasize that human rights legislation is to be read in an expansive and purposeful manner, and case law has expanded the human rights understanding of disability to include "social handicap", on its face this definition of disability may fail to include some disabling conditions that arise by virtue of aging. Yes, in some cases there may be an identifiable "illness" or bodily injury *per se* (as might be considered for the case for a stroke or "brain attack") causing the disability. In other cases there may not. Instead it may "simply be aging" --- bodies wearing out, as is often the case with osteoarthritis, significantly affecting mobility and the person's abilities to carry out day to day activities. Given that these types of disabilities are much more common among older women, the current definition may leave loopholes and a wide gender gap.

Another gap within Ontario's human rights law is it that only speaks of "past and presumed disabilities". Section 10 (3) of the Code states

"The right to equal treatment without discrimination because of disability includes the right to equal treatment without discrimination because a person has or has had a disability or is believed to have or to have had a disability. " (emphasis added)

However s. 10(3) would not cover common situations such as a landlord's failure to rent to older tenants because he or she believes that the older person applying for tenancy will develop some form of disability or will become a burden (perceived future events).

The issue of discrimination, disability and perceived future events has come to the attention of the courts. For example, the Supreme Court of Canada considered the meaning of the word “handicap” under the *Quebec Charter of Rights and Freedoms* in the context of employment in *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montreal (City)*; *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, (the “Mercier” case).³²⁴ The Justices identified that courts should adopt a multidimensional approach as opposed to a strict bio-medical approach that considered the socio-political dimension of the term. The emphasis should be on human dignity, respect and the right to equality rather than merely on the biomedical condition. The Court pointed out that a handicap may be real or perceived, and a person may have no limitations in everyday activities other than those created by prejudice and stereotypes.

While *Mercier* can be informative to the discussion of ageism and disability, the complainants in the case had actual health conditions but no functional limitations. Older adults seeking or wanting to maintain their housing may or may not have a condition or functional limitation at the time of application. Their situation is based on the assumption that they will develop some form of disability in the future even if it does not exist now. Some jurisdictions such as Manitoba have expressly identified perceived disability as included in the meaning for disability for the purposes of protection from discrimination under the human rights law.³²⁵

3. The problem of intersecting identities

One of the many challenges that older adults face in the context of discrimination cases, is that their circumstances often reflect an intersection of factors, such as age, gender and disability, or race, family status, or age and mental disability. Older women with disabilities are especially vulnerable to discrimination as a result of the combined effect of advanced age, severity and occurrence of disability, and their socio-economic status (many have spent a lifetime outside of the paid workforce and therefore have limited income sources).³²⁶ Meyer-Harrington notes that “to be old, female, and poor is a triple jeopardy”. In these circumstances, it is less important to separate any one element as the “cause” of the discrimination and look at how the factors combine to leave older individuals or the group disadvantaged.³²⁷

The Ontario Human Rights Commission has for the past decade explicitly recognized the importance of intersecting identities.³²⁸ While complainants are not required to only list one ground on which they believe they have experienced the discrimination, the actual interpretation and analysis in human rights cases tends to fall back to the position of applying only one entry point into analysis – older people, for example, are likely to be seen as either old or disabled. However this oversimplifies and reduces what are actually very complex systems of oppression. Canadian Research Institute for the Advancement of Women points out that prioritizing one identity entry point (i.e. gender) or one relation of power to the exclusion of others (i.e. race, class) misrepresents the full diversity of people’s lived realities. Social categories such as race,

class, gender, sexualities, abilities, citizenship, and Aboriginality among others, operate relationally; these categories do not stand on their own, but rather gain meaning and power by reinforcing and referencing each other.³²⁹

4. The burden of responsibility

In the human rights area, the traditional perspective has been that “accommodation” is a joint process. There is considerable responsibility of the person claiming the “difference” to help the other party understand how he or she might be accommodated in order to access and benefit from the entitlement in question. The challenge for many older adults in the context of housing and the health care system in particular is that the systems are very complex. The individual may know what his or her special circumstances are. However, the joint responsibility presupposes that the person also knows the housing or health care system well and the available resources, which is often not the case. As a result he or she may not be able to identify ways in which accommodation may be accomplished.

5. System changes: human rights law

There have been recent changes in the human rights law system in Ontario. In particular there has been a shift from the Human Rights Commission as “gatekeeper” to “direct access” to the Human Rights Tribunal.³³⁰ Although this lauded by some³³¹ as avoiding screening, reducing backlogs and giving direct access, it creates significant disadvantages for many vulnerable groups, including older adults. In part, this is because the human rights tribunal process is a complex administrative law process with many procedural and evidentiary requirements. Only 40% of new claimants have legal counsel.

Some groups such as the Accessibility for Ontarians with Disabilities Act Alliance (AODAA) have identified a number of major weaknesses and limitations in the changes including (a) it had not decreased the backlogs; (b) the lack of administrative fairness; (c) the technical rules; (d) lack of representation; and (e) the general complexity.³³²

The AODAA notes

“The Tribunal has a new, longer, more detailed application form than in the past. It is not safely completed without a lawyer. Once in the front door, the rules set up a series of demanding procedural steps and exacting time-lines, leading to a hearing. All of these are very risky to navigate without being represented by a lawyer.”

They point out

“...Given the rules that the tribunal has adopted, a discrimination claimant would be foolhardy to try taking on the Human Rights Tribunal process without a law-

*yer. ...There are detailed procedures, they are complex and they serve as a trap for the unrepresented....anyone who goes before that tribunal unrepresented goes forward at their own peril. They need to have legal representation...We warned the tribunal and all the plain language in the world in their rules or their forms don't remove that need."*³³³

They further express concern that the Ontario Human Rights Commission is losing its capacity for education, and raising awareness at a time in which the international stage is calling for capacity development.³³⁴

Conclusion

Throughout this paper, a number of themes have arisen. First, ageism and the law is not as much about chronological age *per se*, as it is the social construction of aging. Ageism reflects the way that society (including its laws or absence of laws, its policies, and practices towards older adults or adults generally in that society) is structured to include older adults or leave them at the margins. Much of the law as it relates to older adults is represented by *what is not there*, such as *lack* of regulatory safeguards in the type of housing in which they live, and the *lack of* effective redress.

Second, ageism frequently intersects with other statuses such as socio-economic, as well as gender, disability, or race to create the negative effects seen in later life. Efforts that focus only on the age component of ageism to the exclusion of these other intersecting identities are unlikely to produce a rich framework for understanding aging and the law and the effects of the law on older adults. Understanding the role of and the intersection of gender with ageism is essential. Many of the areas in which the law has disproportionate impact on older adults' lives are at transitional points such as widowhood.

Third, ageism is very wide ranging in its manifestations. This is particularly evident in the ways that housing laws are structured (especially which interests are captured in those laws) and in many health care practices. Also, when taken together, 'small issues' that individually might not seem to present a disproportionate burden on older adults, can reflect a wider spread societal pattern of devaluing, subordinating, marginalizing and facilitating the invisibility of older adults. As a result, substantive equality and social justice are often illusory.

Fourth, guiding principles for responding to older adults in the context of law and policy, such as independence, participation, security, dignity, and respect for diversity, can be valuable starting points. However, any guiding principles in this area must be able to take into account both the life of the mentally capable, independent individual and the person whose mental capability, physical or social resources may be deteriorating. They are both older adults, and they may be the same person at different points in life. Guiding principles must also

be able to acknowledge interdependence --the ongoing relationships that older adults may have with others, including family and service providers. Finally, older adults experience innumerable barriers in terms of access to justice, reflective of the subordination of not only their interests, but those of many other marginalized persons. Efforts to address these barriers are a necessity, but they will not be sufficient to assuring a more inclusive and more responsive legal and social system that includes older adults.

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³ Amanda Phelan. Elder abuse, ageism, human rights and citizenship: implications for nursing discourse. . (2008) *Nursing Inquiry*, 15(4), 320–329.

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⁵ R.L. Rubenstein. The third age. In R.S. Weiss & S. A. Bass (eds.) *Challenges of the third age . Meaning and purpose in later life*. Oxford University Press. New York. (2002) p. 29-55 at 30.

⁶ Bernice L. Neugarten. Age groups in American society and the rise of the young-old. (1974). *Annals of the American Academy of Politics and Social Sciences*, 187-198.

⁷ J.S. Habil. The Fourth Age: A Period of Psychological Mortality? Max Planck Institute for Human Development, Berlin and Research Group of Psychological Gerontology, Department of Psychiatry, Medical School, Free University, Berlin Presented at the Harnack-Haus Forum, Biomolecular Aspects of Aging: Social and Ethical Implications. December 2000.

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¹⁰ Andrew Wister, Andrew Sixsmith, Ray Adams, and Daniele Sunden. *Factbook on Aging in British Columbia*. 5th edition. Simon Fraser University, Vancouver British Columbia. 2009.

¹¹ Statistics Canada. *Portrait of Seniors in Canada, 2006*. Table 4.1.3 Marital status, by age group, 1981 and 2001. Online : www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf Accessed September 15, 2009.. [Hereafter referred to as "Portrait"], pg. 15

¹² Statistics Canada. Population by sex and age group, by province and territory (Number, both sexes).

¹³ Alain Bélanger, Laurent Martel and Éric Caron-Malenfant. (2005). Statistics Canada. Population Projections for Canada, Provinces and Territories 2005-2031. Online: www.statcan.gc.ca/pub/91-520-x/91-520-x2005001-eng.pdf Accessed September 15, 2009.

¹⁴ Statistics Canada. Population by sex and age group, by province and territory, 2008. Online www40.statcan.ca/l01/cst01/demo31a-eng.htm Accessed September 15, 2009.

¹⁵ In 2001, at least three Ontario smaller size communities (Elliott Lake, Tilsonburg and Coburg) each had 20 to 25 percent of its population as seniors, the highest proportion of seniors in the country. Mid size communities such as Orillia and Collingwood also exceeded the average (over 15% of their population was seniors). Portrait, n. 11. Chart 1.9 Percentage of population comprised of seniors, selected towns¹ with populations under 25,000, 2001, p.11 and Chart 1.8 Percentage of population comprised of seniors, selected towns¹ with populations of 25,000 or more, 200, p.20.

¹⁶ Robert Moulias, [Espace Ethique AP-HParis (Paris, France)]. (2009) The ethical need for a semantic consensus on a good use of the good words in gerontology. Presentation IAGG. Conference Paris, France

¹⁷ Portrait, n. 11

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- ²⁰ Portrait, n. 11 Table 4.1.3 Marital status, by age group, 1981 and 2001.
- ²¹ Portrait Table 4.1.3, Marital status, by age group, 1981 and 2001
- ²² Portrait, note 11, pp. 22-23
- ²³ Portrait, note 11, p. 25
- ²⁴ Portrait, note 11, p. 25
- ²⁵ Portrait, note 11, p. 24
- ²⁶ Statistics Canada (2005). Projections of the Aboriginal populations, Canada, provinces and territories 2001 to 2017 Catalogue no. 91-547-XIE. Online: www.statcan.ca/english/freepub/91-547-XIE/91-547-XIE2005001.pdf Accessed September 15, 2009.
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See for example:

- Waterloo North Condominium Corp. No. 198 v. Donner (1997) 36 O.R. (3d) 243, (Ont. Ct. G.D.), the court declined to declare that an 85 year old women with a hearing-ear dog must abide by the "no pet" bylaw of the condominium.
- Ganser v. Rosewood Estates Condominium Corp. January 15, 2002 [unreported]. Online at Alberta Human Rights Commission. www.albertahumanrights.ab.ca/legislation/Panel_Decisions/panel_decisGanser.asp In Ganser, an 87 year old woman with macular degeneration and several other disabling conditions had her parking space in the condominium unit reassigned to another unit owner. The loss of the parking space was the result of changes to the bylaws, which now required the owner of any parking space to hold a valid driver's license. Previously, the woman had exclusive use of this parking stall. Her friends and her granddaughter frequently used the space when they came to help her at home and in the community.
- Williams v. Strata Council No. 768 (2003), 46 C.H.R.R. D/326, 2003 BCHRT 17 (senior with arthritis). See also, Konieczna v. Owners Strata Plan NW2489 (No. 2) (2003), 47 C.H.R.R. D/144, 2003 BCHRT 38 (involving a woman with severe allergies).
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- ²¹⁵ ONPHA, 2009, note 213 p. 10-11
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- ²⁴¹ Landlord and Tenant Board. Relief from eviction: refusing or delaying an eviction. Interpretation guideline #7. Online: www.ltb.gov.on.ca/en/Law/116335.html Accessed September 15, 2009.
- ²⁴² MacNeil et al. v. 976445 Ontario Ltd. (June 6, 2005), London Docket No. 04-1465 (Div. Ct.)
- ²⁴³ Spencer, 2005 note 235.
- ²⁴⁴ S. 11 (2) of Manitoba's *Residential Tenancies Act*, S.M. 1990-91, c. R119 expressly acknowledges that land -lords can make rules "concerning the tenant's use, occupancy, or maintenance of the rental unit or residential complex or service and facilities." However, according to Manitoba law, the rule must be in writing, be made known to the tenant, and be reasonable in all the circumstances.
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See also Resolutions at CHF Canada's 2005 annual meeting. Online <http://www.chfcanada.coop/eng/pages2007/resolution.asp?y=2005&r=L3> Accessed September 15, 2009.

²⁵⁷ Waterloo Region Housing. Visitor and guest policy, p. 1. Online: [www.region.waterloo.on.ca/web/region.nsf/97dfc347666efede85256e590071a3d4/A1B65D8247DB3DB3852571BC0050AE8A/\\$file/WRH_Visitor_and_Guest_Policy.pdf?openelement](http://www.region.waterloo.on.ca/web/region.nsf/97dfc347666efede85256e590071a3d4/A1B65D8247DB3DB3852571BC0050AE8A/$file/WRH_Visitor_and_Guest_Policy.pdf?openelement) Accessed September 15, 2009.

²⁵⁸ OHRC, Rental housing, note 226.

The commission notes: The rules seem to be aimed at “boyfriends” or partners whose incomes were not considered by the housing provider when calculating the subsidy amount.

²⁵⁹ OHRC, Rental housing. Note 258, p. 15.

²⁶⁰ (July 2005). Rent-Geared-to-Income Guide. Social Housing Program Administration, City of Toronto; s. 3:7.

Online: www.toronto.ca/housing/social_housing/rgi/rgi-guide-july2005revision.pdf

²⁶¹ Tamar Lewin, Volatile mix in housing: elderly and mentally ill. New York Times. Monday, August 3, 1992. Online: www.nytimes.com/1992/08/03/us/volatile-mix-in-housing-elderly-and-mentally-ill.html?pagewanted=all Accessed September 15, 2009.

²⁶² The terminology used in Ontario is mixed mandated buildings and seniors mandated buildings.

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²⁶³ Mental Health and Seniors Pilot Project Comparative Analysis. See

http://www.torontohousing.ca/mental_health_framework#mh_seniors Accessed September 15, 2009.

²⁶⁴ Mental Health, note 264

²⁶⁵ *Residential Tenancies Act, 2006*, O.R. 516/06, “Care service “ Reg 2 (2)

²⁶⁶ *Residential Tenancies Act, 2006*, O.R. 516/06, Reg 2 (1)

²⁶⁷ The package is to include a list of the different types of accommodation provided and the alternative packages of care services and meals available as part of the total charge; the charges for the different types of accommodation and for the alternative packages of care services and meals; minimum staffing levels and qualifications of staff; details of the emergency response system, if any, or a statement that there is no emergency response system; a list and fee schedule of the additional services and meals available from the landlord on a user pay basis; internal procedures, if any, for dealing with complaints, including a statement as to whether tenants have any right of appeal from an initial decision, or a statement that there is no internal procedure for dealing with complaints.

²⁶⁸ RTA, s. 140 (2)

²⁶⁹ Lisa Nerenberg. Elder abuse prevention. Emerging trends and promising strategies. New York, NY : Springer Publishing. 2007, p. 227.

²⁷⁰ Judith Wahl & Pauline Rosenbaum. (March 2007). Written Submission to the Ontario Seniors’ Secretariat concerning Ontario’s Consultation on Regulating the Retirement Home Industry, Advocacy Centre for the Elderly. pg. 3 Online:

www.advocacycentreelderly.org/pubs/rh/ACE_Submission_to_Ontario_Seniors'_Secretariat_on_Retirement.pdf

[Hereafter ACE, Retirement homes] Accessed September 15, 2009.

Also: ACE- LCO, 2008, note 128, p. 28.

²⁷¹ ACE, Retirement homes, note 270. Also ACE- LCO, 2008, note 107.

²⁷² ACE, Retirement homes, note 270. Also: ACE- LCO, 2008, note 107.

²⁷³ ACE, Retirement homes, note 270.

²⁷⁴ ACE, Retirement homes, note 270, p. 4

²⁷⁵ ACE, Retirement homes, note 270.

²⁷⁶ Mahoney, note 278

²⁷⁷ RTA, s. 117

²⁷⁸ RTA, s.149

²⁷⁹ Elinor Mahoney (1997) Disabling tenants’ rights. Osgoode Hall Law Journal. 35 (4)711-720. (1997)Online: www.ohlj.ca/archive/articles/35_34_mahoney.pdf Accessed September 15, 2009. In this article Mahoney is referring to Ontario’s Tenant Protection Act. 1997 (the predecessor to the current tenancy law and which was in effect

from June 17 1998 to January 30, 2007) . However the current Residential Tenancies Act, S.O. 2006. C. 17 Part IX Care Homes. s. 148 (1) has a similar provision.

²⁸⁰ ACO-OSS, 2007, p. 3

²⁸¹ Residential Tenancies Act, S.O. 2006. c. 17 Part IX Care Homes. Mandatory mediation. S. 148 (3) states “If a dispute arises, the dispute shall be sent to mediation before the Board makes an order. “

²⁸² Mahoney, note 278.

²⁸³ Mahoney, note 278.

²⁸⁴ Ontario Human Rights Code. R. S.O. 1990 c. H 19, s. 1 and 2. (1)

²⁸⁵ ACE, Retirement homes, note 270.

²⁸⁶ ACE, Retirement homes, note 270. Also Romano, L., Wahl, J., & Meadus, J. (2008). The law as it affects older adults. Submission to the Law Commission of Ontario by Advocacy Centre for the Elderly. p. 11. Online: www.advocacycentreelderly.org/pubs/Law_as_it_Affects_Older_Adults_July_2008.pdf. Accessed September 15, 2009 [Hereafter ACE-LCO, 2008]

²⁸⁷ ACE, Retirement homes, note 270.

²⁸⁸ Isthatallegal. (April 2007). Residential landlord and tenant law (Ontario) Chapter 2 - Special and Exempt Premises. Online : www.isthatlegal.ca/index.php?name=special_exempt_tenant_law Accessed September 15, 2009.

²⁸⁹ Residential Tenancies Act, 2006, O.R. 516/06, s. 3 (1)

²⁹⁰ See Residential Tenancies Act, 2006, O. R. 516/06, Reg s.3(4).

²⁹¹ Paulsen v. Terra Property Management Ltd [2007] B.C.H.R.T.D. No. 471. Online : www.bchrt.bc.ca/decisions/2007/pdf/dec/471_Paulsen_v_Terra_Property_Management_and_others_2007_BCHR_T_471.pdf

This was an application by the respondent not for profit property management company to dismiss the case. The Tribunal dismissed several parts of the complaint, but did permit the complainant to pursue the discrimination on marital status argument. No information available on the final result.

²⁹² See Jung v. Toronto Community Housing Corp [2007] O.J. No. 4363 and Jemiola v. Firchuk [2007] C.C.S. No. 15254.

The Advocacy Centre for Tenants Ontario (ACTO) acted as intervenor in the case involving Alba Torres a woman and her three children were being evicted as unauthorized occupants after her husband, who signed the rent cheques, moved out of the apartment. Before the Tribunal could reach a decision, a settlement was reached and the woman was recognized as the sole tenant at the same rent. The human rights complaint was withdrawn.

ACTO was also retained by the Women's Legal Education and Action Fund (LEAF) and the Centre for Equality Rights in Accommodation (CERA) to intervene in an Ottawa Divisional Court appeal with very similar facts. In this case, after the woman's husband had left, the landlord pressured her to sign a new lease at almost double the rent that her husband had paid. ACTO's appeal emphasized international human rights law and sex equality issues. The appeal was successful, but the court did not address ACTO's equality arguments under the Canadian Charter of Rights and Freedoms. The landlord was ordered to repay the tenant what she had paid in excess of the original rent.

²⁹³ See Jung v. Toronto Community Housing Corp [2007] O.J. No. 4363 and Jemiola v. Firchuk [2007] C.C.S. No. 15254

²⁹⁴ Ford v. Lavender Co-operative Housing Assn (No.3) . [2009] B.C.H.R.T.D. No. 38. Online: www.bchrt.bc.ca/decisions/2009/pdf/jan/38_Ford_v_Lavender_Cooperative_No_3_2009_BCHR_T_38.pdf Accessed September 15, 2009.

²⁹⁵ RTA, s. 148 (2)

²⁹⁶ Psychiatric Patient Advocate Office. Position brief for the Housing Consultation to the Ontario Human Rights Commission. 2007. Online: www.ppaio.gov.on.ca/pos-hou.html Accessed September 15, 2009. [Hereafter PPAO]

²⁹⁷ Personal communication, Lorell Pride RN. Geriatric Outreach Program, Fraser Health.

²⁹⁸ PPAO, note 295.

²⁹⁹ PPAO, note 295.

³⁰⁰ PPAO, note 295.

³⁰¹ ACE-LCO, 2008, note 286.

³⁰² Law Commission of Ontario. (May 2008). *The Law As It Affects Older Adults, Consultation Paper*:
Online: www.lco-cdo.org/en/documents/OlderAdultsMay08/documents/ConsultationPaper-OlderAdultsFINAL.pdf
Accessed September 15, 2009.

³⁰³ Special Senate Committee on Aging (April 2009) Canada's Aging Population: Seizing the Opportunity . p. 87
Online: www.parl.gc.ca/40/2/parlbus/commbus/senate/com-e/agei-e/rep-e/AgingFinalReport-e.pdf Accessed
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³⁰⁴ Statistics Canada. Table 358-0124 - Canadian Internet use survey, Internet use, by location of access, sex and
age group, every 2 years (percent), CANSIM (database).

³⁰⁵ Rent geared to income guide. (2005) . Social Housing Program Administration, City of Toronto. Online:
www.toronto.ca/housing/social_housing/rgi/rgi-guide-july2005revision.pdf Accessed September 15, 2009.

³⁰⁶ Charmaine Spencer. Immigration, capacity and abuse. Report for the Vanguard Collaborative and Law Founda-
tion of BC. (2009).

³⁰⁷ Ontarians with Disabilities Act ODA Committee. The Immediate Need for the Ontarians
With Disabilities Act - Now Is The Time For Action. Online: <http://www.odacommittee.net/brief98c.html#why> Ac-
cessed September 15, 2009.

Note : Ontario did enact Ontarians with Disabilities Act, 2001, S.O. 2001, c. 32 which was replaced by the Acces-
sibility for Ontarians with Disabilities Act, 2005, S.O. 2005, c. 11.

³⁰⁸ See for example *Banghart v. Elgin Condominium Corp. No. 1* [2009] O.H.R.T.D. No. 11

³⁰⁹ *Banghart v. Elgin Condominium Corporation No. 1*, 2009 HRTD 13.

³¹⁰ ACE-LCO, 2008, note 286.p. 34

³¹¹ Ombudsman Ontario. Online: www.ombudsman.on.ca/

³¹² John Stapleton (November 2007). Why is it so tough to get ahead? How our tangled social programs pathologize
the transition to self-reliance. Metcalf Foundation. Online:
www.metcalfoundation.com/downloads/John%20Stapleton%20-%20Why%20is%20it%20so%20tough%20to%20get%20ahead.pdf Accessed September 15, 2009.

“Government watchdogs, such as ombudsmen and auditors, are charged with making governments and
government-funded agencies accountable for their actions. Unfortunately, auditors and watchdog agen-
cies of various sorts operate within the constraints of the prevailing government “business model.” This
model sees departments, ministries and agencies as “silos”, responsible for their own particular piece of
the “business.” Auditors and watchdogs don’t necessarily look at the overall negative effects that gov-
ernment businesses are having on their clients. ... It is simply not within their mandate to do so.”

³¹³ Jane R. Meadus and Lisa Romano, L. (March 26, 2009). Written Submission to the Standing Committee on Jus-
tice Policy: Bill 115, An Act to Amend the Coroners Act. Advocacy Centre for the Elderly. Online:
www.advocacycentreelderly.org/pubs/Bill_115_-_Coroners_Amendment_Act_-_March_2009.pdf Accessed Sep-
tember 15, 2009.

³¹⁴ ACE –LCO, note 107, p. 18. Online:
www.advocacycentreelderly.org/pubs/Law_as_it_Affects_Older_Adults_July_2008.pdf Accessed September 15,
2009.

³¹⁵ Health Services Appeal and Review Board. Online : www.hsarb.on.ca/english/default.htm Accessed September
15, 2009.

³¹⁶ *M.A.M. v. Community Care Access Centre of Peel*. HSARB. October 28, 2008. p. 6. Online:
www.hsarb.on.ca/scripts/MOHShowUploadedFile_Public.asp?File_ID=2078

Also : *J.C. v. Community Care Access Centre Grey Bruce*. File LT 7113. HSARB. February 27, 2004. Online:
www.hsarb.on.ca/scripts/MOHShowUploadedFile_Public.asp?File_ID=1206 Accessed September 15, 2009.

³¹⁷ *M.A.M.* note 316. Similarly see: *GAW v KFL & A Community Care Access Centre*. File LT7239. Online:
www.hsarb.on.ca/scripts/MOHShowUploadedFile_Public.asp?File_ID=1434

- ³¹⁸ Community Legal Education Ontario. Home Care Bill of Rights. 2008. Online: www.cleo.on.ca/english/pub/onpub/PDF/health/hc-bor.pdf Accessed September 15, 2009 [Hereafter CLEO]
- ³¹⁹ CLEO, note 318.
- ³²⁰ Contract remedies typically include : (1) compensatory damages (2) consequential and incidental damages (3) fees and costs (4) liquidated damages (5) specific performance (6) punitive damages ; (7) rescission and (8) re-forming the contract . There is the possibility of an injunction, to stop an ongoing breach.
- ³²¹ *Human Rights Citizenship and Multiculturalism Act*, c. H-14 RSA 2000
- ³²² S. (6) (1) A person shall not deny to or discriminate against a person or class of persons with respect to accommodation, services, facilities or goods to which members of the public customarily have access or which are customarily offered to the public because of the race, religion, religious creed, political opinion, colour or ethnic, national or social origin, sex, sexual orientation, marital status, physical disability or mental disability of that person or class of persons.
- ³²³ *Human Rights Act*, R.S.N.B c. H-11 s. 4 (3)
- ³²⁴ *Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montreal (City); Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Boisbriand (City)*, [2000] 1 S.C.R. 665.
Facts of the two cases: In *Mercier*, a police officer with Crohn’s disease was fired. Crohn’s disease is a long standing inflammation of the intestine, which can be aggravated by stress and other factors; and the severity varies from individual to individual. Another complainant in *Mercier* had an anomaly of the spinal column, and was turned down for employment as a horticulturalist. The condition was asymptomatic, but was perceived by the prospective employer as increasing the risk for future incapacity.
- ³²⁵ Manitoba Human Rights Commission. Defining physical and mental disability. Policy # L-5 *Policy and Procedures Manual*, p. 1-4. Online: www.gov.mb.ca/hrc/english/publications/policies/L5.pdf Accessed September 15, 2009.
- ³²⁶ Ontario Human Rights Commission. An Intersectional Approach To Discrimination- Addressing Multiple Grounds in Human Rights Claims. 2001. Online: www.ohrc.on.ca/en/resources/discussion_consultation/DissIntersectionalityFtnts/pdf Accessed September 15, 2009.
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- ³²⁷ M. Meyer-Harrington. “Gender, race and the distribution of social assistance: Medicaid use among the frail elderly”. (March, 199 4), *Gender and Society*, 8 (1), 8-28.
- ³²⁸ Ontario Human Rights Commission. An Intersectional Approach To Discrimination- Addressing Multiple Grounds in Human Rights Claims. 2001. Online: www.ohrc.on.ca/en/resources/discussion_consultation/DissIntersectionalityFtnts/pdf Accessed September 15, 2009.
- C.A. Parks, T.L. Hughes, and A.K. Matthews. Race/ethnicity and sexual orientation: Intersecting identities. *Cultural Diversity and Ethnic Minority Psychology*, Educational Publishing Foundation, 2004.
- ³²⁹ Canadian Research Institute for the Advancement of Women. Intersectional Feminist Frameworks An Emerging Vision 2006. Online: www.criaw-icref.ca/CRIAW%20Focus/The%20IFFs-%20An%20Emerging%20Vision_e.pdf
- ³³⁰ See: “Barbara Hall contradicts Attorney General’s claim she supports his human rights reform proposal.” April 13, 2006. www.cleonet.ca/external.php?external_url=http://dawn.thot.net/dawn-ohrc8.html Accessed September 15, 2009.
- Urban Alliance on Race Relations rejects the ‘direct access’ model to the Ontario Human Rights Commission. Online www.opseu.org/campaign/ohrc/ohrcpressrelease.pdf Accessed September 15, 2009.
- ³³¹ See Justice for children and Youth. BILL 107 – Human Rights Code Amendment Act. Qualified support for the direct access model June 20, 2006. Online www.jfey.org/PDFs/Bill_107_Brief.pdf and Advocacy Centre for Tenants Ontario. Online : www.acto.ca/docs/LR_HumanRightsReform_MediaBackgrounder_0107.pdf
- ³³² Accessibility for Ontarians with Disabilities Act Alliance. (AODAA) Brief to standing committee on government agencies reveals broken government commitments on reforms to human rights enforcement. (February 12, 2009).

Online: www.aodaalliance.org/strong-effective-aoda/02122009.asp Accessed September 15, 2009. [Hereafter AODAA]

See also: Native Women's Association of Canada and Ontario Native Women's Association. The proposed "direct access" model equals less access to human rights for the most marginalized and disadvantaged in Ontario! Online: www.nwac-hq.org/documents/NWACONWA_Joint_Submission_SCJPBill107.pdf Accessed September 15, 2009.

³³³ AODAA, note 332.

³³⁴ United Nations Department of Economic and Social Affairs Division for Social Policy and Development Programme on Ageing Report of the Expert Group Meeting "Rights of Older Persons" Convened in preparation for the report of the Secretary-General to the 64th session of the General Assembly 5-7 May 2009, Bonn, Germany.