THE UNITED STATES, CANADA, AND THE UNITED KINGDOM – A COMPARATIVE ANALYSIS OF HEALTHCARE POLICIES AND THEIR IMPACT ON THE ELDERLY

Lance H. Rose, LFACHE and Rachel V. Rose

PART I: INTRODUCTION

Like an aging car, an aging person can be an expensive proposition requiring difficult decisions. Consider a car that may have run problem-free for years. After having the car for a long time and maintaining it regularly, the car owner realizes that car is starting to encounter malfunctions. The owner takes the car to a mechanic, who “treats” the car. The owner pays the bill. Each time, a different system in the car breaks down and the repairs become more costly. The owner might notice that the waiting times to see the mechanic or the waits for the completed repairs are longer. Finally, the mechanic and the owner determine that the cost of keeping the car far exceeds the benefit. Ultimately, the owner must chose between keeping the car, while continuing to pay for repairs, or trading the car in for a new one.

Now, apply the scenario of a car to a person. Whether a United States, Canadian, or United Kingdom citizen, the senior encounters longer wait times and disparate treatment compared to

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1 Lance H. Rose, MHA, MS, LFACHE, a former hospital chief executive officer, has over forty years of healthcare experience, and has served on several boards including the following: American Hospital Association (Region II Policy Board), Capital Blue Cross of Pennsylvania, Pennsylvania Trauma Systems Foundation, and the Hospital and Health-system Association of Pennsylvania. Rachel V. Rose holds an MBA from Vanderbilt University, has fifteen years of experience in various facets of the healthcare industry, and graduated with a JD from Stetson University College of Law (May 2010). At this time, the authors would like to thank the following individuals: Pamela Burdett and Sally Waters, JD, MLS at the Stetson University College of Law Library for their research assistance; and Lisa Webley, LLB Hons (Law with French Hons) (Birm) MA (Westmin) PhD (Lond) DiplEJF (Limoges) PgDiplLP (CoL Chester) FHEA FRSA, Reader in Law, University of Westminster for her time and insights.
a younger counterpart.\textsuperscript{2} Cancer treatment is representative of the notion that medical treatment for seniors (aged 65 and older) becomes increasingly disparate compared to younger citizens as a person ages.\textsuperscript{3} Seniors are under-represented in clinical trials, have difficulty obtaining access to high-quality care in cancer care units, and experience longer wait times.\textsuperscript{4} Therefore, the purpose of this article is to show that even though a disparity in healthcare treatment of the elderly exists, presently each country’s respective age discrimination law is not triggered.

A factor contributing to these disparities is the cost benefit of providing expensive care to an individual in the later stages of his or her life. In the United States, Congress is proposing a reduction in Medicare expenditures of up to $500 billion over the next ten years.\textsuperscript{5} If this comes to pass, the only outcome will be an even greater negative impact on seniors’ access to care because fewer funds will be available for treatment, resulting in the rationing of care.\textsuperscript{6}


\textsuperscript{3} Id.


\textsuperscript{6} Linda Gorman, \textit{Rationing Care: Oregon Changes Its Priorities}, National Center for Policy Analysis, No. 645 (Feb. 19, 2009), \url{http://www.ncpa.org/pub/ba645} (indicating that the Oregon Plan is the “first government healthcare program in the world that has drawn up a formal procedure for rationing.”).
The concept of rationing of care is not new to Canada or the United Kingdom. Wait lists are considered a rationing device that “reconcile[s] the differences between supply and demand that arise when coverage is universal and those demanding – patients or their agents – face zero price at the point of demand.” In essence, wait lists serve as signals to both the supply and demand sides of healthcare.

The older the population, the greater the utilization of healthcare services. The United States, Canada, and the United Kingdom, as well as other countries worldwide, are all experiencing the phenomenon of an increasing senior population, the members of which have access to government health plans. The problem is that exhaustion of the trusts that fund these plans is projected in the next 10-20 years because less tax income is being derived from wage earners and more people are utilizing the system. Another problem is that seniors often encounter more complex conditions, such as cancer, or have co-morbid conditions that make treatment more expensive.

In the United States, the Medicare Trust Funds fail the short-term adequacy test because assets are expected to be at 98% in 2014, reaching only 40% by 2018. Canada faces a similar problem. Because funds are managed by each province, certain provinces see the annual impact of inadequate revenues on

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7 Richard F. Davies, MD, PhD, Waiting Lists for Health Care: A Necessary Evil?, 160 CMAJ 10, 1469-1470 (May 18, 1999) (indicating that although prolonged waiting “does not reduce the cost of performing a procedure, long waiting lists will reduce spending only if fewer procedures are ultimately done.”); Sofia Dimakou, et al., Identifying the Impact of Government Targets on Waiting Times in the NHS, 12 Health Care Manag. Sci. 1 (2009) (describing that wait lists function as a “non-price” rationing device).

8 Dimakou, ibid. at 1.


12 D. Roter, The Outpatient Medical Encounter and Elderly Patients, 16 Clinics in Geriatric Medicine 1, 95-107 (2000).

treatment availability. In the Canadian system, total provincial health care spending was approximately C$83 billion in 2004-2005. Likewise, the United Kingdom estimates coincide with the United States. The costs are projected to be £102.3 billion and the National Health Service (NHS) allocations to Primary Care Trusts (PCTs) are more than 4% away from the projections. This means that there is insufficient funding to ensure redistribution in line with the weighted capitation formula recommendations. Overall, all three countries are experiencing a similar occurrence. The aging population that is entitled to healthcare services is costing more and resuitantly experiencing a disparity in treatment compared to younger members of the population.

The United States, Canada, and the United Kingdom all have laws protecting citizens from being discriminated against on the basis of age. Part II of this article assesses access to care issues for seniors. Using the United States as an example, Part III considers the denial of care in the context of potential triggering of age discrimination laws. Finally, the authors conclude that despite

16 Gavin Thompson, NHS Expenditure in England, p. 7, 14, SN/SG/724 (House of Commons Library) (2 Jun. 2009), http://www.google.com/#hl=en&q=total+NHS+expenditure+2008&aq=f&aqi=g1&oq=&fp=b36c7832dbb01be6 (Primary Care Trusts (PCTs) manage all of the primary care health services that include general practitioners, opticians, pharmacists, mental health services and NHS walk-in clinics. 80% of the budget is controlled by PCTs).
17 Id. at 14.
the existence of age discrimination laws, for various reasons, seniors presently have limited or no recourse.

**PART II: SENIORS’ ACCESS TO CARE ISSUES**

The United States, Canada, and the United Kingdom are facing similar situations regarding health care access for seniors. In order to appreciate the intricacies of each country’s health system, it is necessary to review the respective historic processes and developments. Economics associated with treating an aging population and distribution of healthcare services in relation to rationing of care are two other considerations that impact seniors’ access to healthcare. Therefore, the purpose of this section is to provide an overview of the intricacies of the various health care systems and how the economic factors impact the distribution of healthcare services and ultimately access to care.

**HEALTHCARE SYSTEMS OVERVIEW AND COMPARISON**

1. **The United States**

The U.S. health system’s origins and functions were strongly influenced by Europe, although the education of physicians and the practice of medicine are largely a result of historical development within the U.S. coupled with a free enterprise philosophy. This philosophy continues to distinguish the United States’ health system from its counterparts in Canada and the United Kingdom.

In the United States, ownership of the health care system is primarily private. Privately owned hospitals are divided into non-profit (also referred to as not-for-profit) and investor owned for-

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20 *Id.*
profit hospitals. Of total U.S. hospitals, 51% are non-profit, 15.3% are investor owned for-profit, 3.7% are owned and operated by the federal government, and 19.5% are owned by county and city governments.

Unlike Canada and the United Kingdom, there is no nationwide system of government-owned facilities open to the general public in the U.S., although there are local government-owned and operated medical facilities mainly at the county and/or city level. The United States Department of Defense operates medical treatment facilities and hospitals (the Military Health System), to provide care to active duty military personnel. The federal Veterans Health Administration (VA) operates hospitals and clinics open only to veterans at no cost, though veterans seeking medical care for conditions not incurred while on active duty are charged for the care provided. The Veteran’s Administration is a federal integrated healthcare system delivery model. The Veteran’s Administration owns its hospitals and clinics, employs or contracts with physicians, negotiates pharmaceutical and medical device prices, and provides a wide range of medical care to veterans who qualify for medical care benefits. Another example of a United States federal integrated healthcare delivery model is the Indian Health Service that operates facilities open only to Native Americans from recognized tribes.

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22 *Id.*


In the instance of the VA and Indian Health Service, government-owned facilities include both clinics and hospitals.

Another aspect unique to the United States is its position as a leader in medical innovation. In 2004, the healthcare industry spent three times as much as Europe per capita on biomedical research. In 2006, the United States accounted for three quarters of the world’s biotechnology revenues and 82% of world research and development (R&D) spending in biotechnology. The amount of financing by private industry increased 102% from 1994 to 2003. Most medical research is privately funded. As of 2003, the National Institutes of Health (NIH) was responsible for 28% – about $28 billion – of the total biomedical research spent annually in the United States, with the majority of remaining funding coming from private industry.

Spending on healthcare in the United States continues to outpace both Canada and the United Kingdom. Current estimates put U.S. healthcare spending at between 15.3 and 17 percent of the GDP. The U.S. health share of GDP is predicted to follow this upward trend and reach 19.5% by 2017. Of each dollar spent on healthcare in the United States, 31% goes to hospital care, 21% goes to physician services, 10% goes to pharmaceuticals, 8% goes to long-term care, 7% to administrative costs and 23% to all other categories (diagnostic laboratory

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27 Id.
31 Id.
services, pharmacies, medical device manufacturers, etc.). 34 These percentages, when translated into data published by the Office of Actuary of Centers for Medicare and Medicaid Services, showed total health care spending in the United States, including both historical and future projections, reached $2.26 trillion, up from $2.1 trillion the previous year. 35

Seniors account for the majority of healthcare expenditures. On average, seniors spend far more on healthcare costs than either working adults or children. 36 This is because seniors have more severe chronic illnesses with more intense healthcare needs, especially in the last two years of life. 37 But the timing of these healthcare expenditures does not equate to better patient outcomes. Yet, hospitalization in an acute care setting accounted for half of the spending for Medicare beneficiaries in the last two years of life. 38

The pattern of spending by age was stable for most ages from 1987 through 2004, with the exception of spending for seniors age 85 and over. 39 Spending for this age group grew less rapidly than other groups over this period. 40

How are these expenditures funded? In the United States, as well as in Canada and the United Kingdom, doctors and

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38 *Id.*
39 *Id.*
40 *Id.*
hospitals are generally remunerated by out-of-pocket payments from patients and insurance companies (both private and government) in return for services rendered.\textsuperscript{41} In 2004, private insurance paid for 36\% of personal health expenditures, private out-of-pocket payments constituted 15\%, the federal government accounted for 34\%, state and local governments (11\%), and other private funds were 4\%.\textsuperscript{42} In 2007, a study showed that 59.3\% of Americans received their health insurance through an employer.\textsuperscript{43} All government health programs in the United States (mainly Medicare for those 65 and older and Medicaid – a federal plan for the indigent that is administered by individual states) have restricted eligibility.

This contrasts with the Canadian and United Kingdom health care system where eligibility is open to all legal residents regardless of age or income level.\textsuperscript{44} As a result, Americans without health insurance coverage at some point during 2007 totaled about 15.3\% of the population, or 45.7 million people.\textsuperscript{45} This phenomenon of being uninsured does not exist in Canada or the United Kingdom; however, it is notable that those two systems also have a private payer component for those who can afford it.\textsuperscript{46}

Individuals with private insurance may be limited to medical facilities that accept the particular type of insurance they carry.\textsuperscript{47} Visits to facilities or providers outside the insurance program’s “network” are usually either not covered or the patient must bear a cost of service that is significantly higher than the co-

\textsuperscript{41} Supra n. 13.


\textsuperscript{44} Supra n. 13.


\textsuperscript{47} America’s Health Insurance Plans, \texttt{http://www.ahip.org/} (last accessed Dec. 29, 2009).
pay required when utilizing contract facilities and providers.\textsuperscript{48} An exception applies in emergency situations. Those with governmental insurance (Medicare and Medicaid) are generally not limited to specific providers although providers (hospitals and physicians) are not mandated to participate with any specific insurance plan, including Medicare and Medicaid.\textsuperscript{49}

In the United States, options for private insurance coverage other than traditional forms of health insurance include: Health Maintenance Organizations (HMO’s) and Preferred Provider Organizations (PPO’s), which are generally referred to as managed care organizations.\textsuperscript{50} A PPO covers health care delivered by either in-network or out of network providers, but the enrollee’s cost is higher when using out of network providers.\textsuperscript{51} In an HMO, health care is covered for services delivered by contract providers (such as doctors and hospitals) in the network.\textsuperscript{52} There is usually a requirement that a patient be seen by a primary care physician (often referred to as a “gatekeeper”) to get a referral to a specialist. This process is similar to the government processes in place in both the Canadian and United Kingdom health systems.\textsuperscript{53}

United States government-funded insurance programs directly cover 27.8% of the population.\textsuperscript{54} These programs cover

\textsuperscript{48} Ibid.
\textsuperscript{52} Ibid.; Dahm, supra n. 31 at 425-426 (indicating that U.S. physicians practicing in an HMO setting were more akin to Canadian and British cohorts).
\textsuperscript{54} Supra n. 41.
the elderly, the disabled, children, veterans, some indigent, and the federal Emergency Medical Treatment and Active Labor Act (EMTALA) that mandates public access to emergency services regardless of the ability to pay.\(^{55}\) Public funding accounts for between 45% and 56.1% of U.S. healthcare spending.\(^{56}\) In 2007, Medicaid provided health care coverage for 39.6 million low-income Americans (although Medicaid covers approximately 40% of America’s poor), while Medicare provided health care coverage for 41.1 million senior and disabled Americans.\(^{57}\) While 41.1 million might seem like a staggering figure, it pales in comparison to the projected 2031 Medicare enrollment of nearly 77 million when the baby boom generation is fully enrolled.\(^{58}\)

The prescription drug coverage component of health care insurance plans is handled separately by both private and government programs. While in the United States, most private insurance plans have a prescription coverage option for an additional fee. The Medicare Modernization Act of 2003 expanded Medicare’s coverage to include a prescription drug plan, Medicare Part D, to provide prescription coverage for Medicare beneficiaries.\(^{59}\) However, this also carries an additional cost to the beneficiary. This scenario parallels that of the United Kingdom,
where the National Health Service (NHS) also provides prescription coverage with an additional cost to some beneficiaries.\textsuperscript{60} By contrast, there is prescription drug coverage under the Canadian health plan only for citizens aged 65 years and older and individuals on social assistance.\textsuperscript{61}

Overall, per-capita spending on health care by the U.S. government ranked it among the United Nations ten highest member countries in 2004.\textsuperscript{62} But, the per capita expenditure on U.S. citizens was still below that of both Canada and the United Kingdom.

2. Canada

The Canadian healthcare system was built province-by-province. In 1947, Saskatchewan became the first province to institute a publicly funded healthcare plan with other provinces following.\textsuperscript{63} By 1971, a provincial-federal partnership plan providing healthcare was in place.\textsuperscript{64} Although this universal partnership is in place, there are some differences between the provinces. This model is similar to the United States Medicaid structure, whereby the federal government sets the mandates, but


\textsuperscript{61} Canada Health Insurance, \textit{About Drug Coverage}, \url{http://www.canada-health-insurance.com/aboutdrugcoverage.html} (last accessed Dec. 29, 2009) (“Those who are eligible for full drug coverage after paying a small deductible of a few dollars remain the same throughout most of Canada: individuals on social assistance and those 65 years of age and older. For the rest of Canadian citizens, partial drug coverage is available from every provincial government. Many government plans require individuals under 65 years of age to pay a yearly deductible in order to receive 100% coverage.”).


\textsuperscript{64} \textit{Ibid}. 

the individual states have latitude in how they structure the program to meet the needs of their populations.65

In the Canadian partnerships, the federal government sets national standards for healthcare, provides financial support for provincial and territorial programs, and directly provides services to certain populations.66 The federal Canadian healthcare system is collectively referred to as Medicare, and covers the entire population, whereas in the United States, Medicare only covers seniors 65 and over and other qualified recipients.67 These populations include the military, veterans, people living on reservations, and federal penitentiary inmates.68 The ten provincial and three territorial governments administer and finance health care services.69 Their health insurance plans are required to meet the five principles set forth in the Canadian Health Act of 1984.70 The five principles include the following: the plans must be available to all eligible Canadian residents, comprehensive in coverage, accessible, portable among all provinces, and publicly administered.71

The main source of health care financing in Canada is taxation by the provincial, territorial, and federal governments.72 These government entities collectively account for approximately 70% of total health expenditures.73 Financing occurs predominately through provincial taxes (income tax, payroll tax, and sales tax) and federal transfer payments, which are funded by

68 Ibid.
69 Ibid.
71 Ibid.
73 Ibid.
federal income taxes. Additionally, some provinces raise supplementary health revenues through earmarked taxes known as premiums. Private financing accounts for 27% of healthcare financing and is split between out-of-pocket payments (15%) and private health insurance (12%). The remaining 3% of expenditure comes from social insurance funds, mainly health benefits through workers’ compensation, and charitable donations targeted to research, health facility construction, and hospital equipment purchases.

The Canadian Health Act of 1984 stipulates that provincial healthcare plans must provide for medically necessary or required services to their residents. These services include virtually all hospital, physician (including dental surgery performed in a hospital), and diagnostic services. Services excluded from these plans include most dental care, most vision care, long-term care, home care, and pharmaceuticals prescribed outside of hospitals.

In 2005, 33.8% of all prescription drugs, 21.7% of all vision care and 53.6% of all dental care was funded through private health insurance, most of which was employment-based rather than privately purchased.

Provinces, the federal government, and municipal governments provide other benefits to seniors, low-income individuals, and other groups. Many Canadians obtain private insurance to cover dental care, outpatient prescription drugs, rehabilitation services, and other benefits. “These out-of-pocket payments make up the second most important source of funds for health care and the single most important source of financing for

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75 Id.
76 Id.
77 Canadian Health Act of 1984, supra n. 69.
78 Id.
79 Supra n. 71.
private health goods and services, namely vision care, over-the-counter medication, and complementary and alternative medicines and therapies. Also, about 20% of all prescription drugs are financed in this way.  

As indicated earlier, the third largest source of financing (12%) is complementary private insurance. Although largely employment based and paid for by employees and employers, private health insurance is supported through tax expenditure subsidies. Private health insurance that attempts to provide a private alternative, or faster access, to medically necessary hospital and physician services is prohibited or discouraged by a range of provincial regulations. The provinces of British Columbia, Alberta, Manitoba, Ontario, Prince Edward Island, and Quebec prohibit the purchase of private health insurance for Canadian Medicare services. This prohibition was challenged in Quebec in a case dating from 1997, in which a patient, along with his physician, sued Quebec after a year-long wait for hip-replacement surgery. In June 2005, the Supreme Court of Canada ruled invalid the long standing prohibition on private health insurance for services that are available under Quebec’s public health care plan. Although the decision was specific to Quebec, the implication of the ruling was that provincial governments cannot ban private care unless they guarantee that the public system will meet patients’ needs without excessive waits.

In delivering health care services, primary health care is provided by general practitioners and family practitioners, who are privately employed and work in small-group practices. These

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81 Id.
83 Supra n. 71.
86 Id.
practices serve as the first point of contact; they are the gatekeepers to higher levels of specialist care and medical treatment. This model mirrors the HMO model available in the United States, which also requires a referral from the patient’s primary care physician. In the Canadian system, as well as the U.S. system, patients have freedom of choice in selecting a family physician. Over half of the physicians in Canada are general or family practitioners, compared to the United States in which only about a third of doctors are generalists.

In Canada, physicians are paid on a fee-for-service basis and remit health care claims directly to the provincial or territorial insurance plan to receive payment. Fee schedules are negotiated between the provinces and the provincial medical association. This is similar for physicians in the United States when negotiating with private insurance companies. The exception in the U.S. is that the individual physicians or group practices negotiate directly with each insurance plan. A vast difference exists between Canada and the United States in relation to federal and state plans (Medicare and Medicaid). In the United States, the government dictates the reimbursement rate and provides physicians with a set fee schedule that is non-negotiable. In the instances of Medicare

87 Woodard, supra n. 73 at 81.
89 Kao-Ping Chua, supra n. 62.
93 Simon LI, supra n. 45.
and Medicaid, U.S. physicians have the option to participate or not to participate, although most do accept patients and the pre-set rate. 95 This means that U.S. physicians are not required by law to participate in Medicare or Medicaid programs, however, because of the large number of patients covered by Medicare in particular, the majority of physicians, at this time, accept the government’s pre-set reimbursement rate.

Virtually all secondary, tertiary, and emergency care, as well as the majority of specialized ambulatory care and elective surgery, is performed within hospitals. 96 This same process holds true in the United Kingdom. In the United States, however, much if not most of ambulatory care and elective surgeries are carried out in free-standing surgery centers or outpatient clinics. Hospitals are generally operated as nonprofit institutions by community boards of trustees, voluntary organizations, or municipalities. 97 Canadian hospitals are relatively autonomous in carrying out their function with control over their resources and spending, but must comply with annual global operating budgets set by the provincial governments. 98

This is akin to how some U.S. hospitals function, except that in the United States, each hospital operates under its own budget and not by a government mandate. The exception in the United States is if the hospital is operated as a government entity, such as a Veteran’s hospital. 99 The U.S. also has a number of private investor-owned hospitals. 100 Conversely, in the United Kingdom, most of the hospitals are publicly owned and operated by the government under the National Health Service (NHS).

which is controlled by the Department of Health. Local hospital trusts are generally responsible for hospitals and budget management within their service area, but are not subject to the NHS. This exemplifies a “command and control” system, in which the government not only finances most care but is also heavily involved in managing the delivery of services, a departure from both the Canadian and U.S. approach.

3. The United Kingdom

The United Kingdom has had some form of public-funded health care, as well as social care, for nearly 400 years. The current publicly-funded health care system, the NHS, provides universal health care to residents in the United Kingdom. It is the responsibility of the national Department of Health in each country (England, Northern Ireland, Scotland, and Wales) to make policy decisions and set the health budget, while the purchasing of services is the responsibility of regional bodies. The provision of health services is the responsibility of local public providers. Healthcare is mainly administered through public provision and financed through public funds. The NHS accounts for 86% of

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total health expenditures in the United Kingdom. It is mainly financed by general taxation (76%), but also by national insurance contributions (19%) and user charges (5%).\textsuperscript{107} Ancillary mechanisms that generate revenues are the provision of prescription drugs, dentistry services, and fees charged to private patients who use NHS services.\textsuperscript{108}

Private health insurance is a mix of for-profit and not-for-profit insurers primarily in the provision of supplementary insurance.\textsuperscript{109} “Private insurance offers a choice of specialists, avoidance of queues for elective surgery and higher standards of comfort and privacy than the NHS.”\textsuperscript{110} In addition to the NHS hospitals, private investor-owned hospital companies, such as Hospital Corporation of America (HCA) own and operate private hospitals in the UK.\textsuperscript{111} These hospitals primarily accept patients who have private insurance or who pay out-of-pocket, although they do contract with the NHS to treat NHS patients in certain circumstances. Private insurance covers 12% of the population and accounts for approximately 1% of total health expenditure.\textsuperscript{112} People also pay directly out of pocket for some services – for example, in the private sector. These direct out-of-pocket payments account for over 90% of total private expenditure on healthcare.\textsuperscript{113}

In contrast, healthcare in the United States is mainly privately provided and privately financed, while Canada is a hybrid of private provision financed by public funds.\textsuperscript{114} The share of public financing for these systems is 44.7% for the United States,
69.6% for Canada, and 83.7% for the United Kingdom. In 2007, total health spending accounted for 8.4% of the GDP in the United Kingdom as compared to 10.1% in Canada and 16% in the United States.

The United Kingdom has a system of generalists, primary care delivered by general practitioners (GP) or family practitioners (FP) who deliver primary care based on the location of their residence. This office is generally referred to as “the surgery.” Every individual enrolled in the NHS in the United Kingdom is enrolled with a GP or FP. The key roles of GPs and FPs are to provide primary care and to act as a gatekeeper for access to specialty care. These same roles exist in the Canadian system as well as in Health Maintenance Organizations (HMO) in the United States. In these instances the individual cannot seek specialty services without a referral from their GP or FP.

Technically, most GPs and FPs are self-employed providers who contract to administer services to the NHS. Physicians are paid directly by local bodies (Primary Care Trusts (England), Primary Care Partnerships (Northern Ireland), Health Boards (Scotland), and Local Health Boards (Wales)) through the combination of methods made up of salary, capitation, and fee-for-service. Private providers of GP services set their own fee-for-service rates and are not generally reimbursed by the public system. This differs from Canada and the United States where private providers are paid by the publicly financed portion of the system either through negotiated rates (Canada) or by government

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117 Supra n. 106.
118 Ibid.
119 Supra n. 52.
120 Supra n. 65.
established rates in the United States under Medicare and Medicaid.\textsuperscript{121}

Despite the structure of each country’s respective health care system, in the United States, Canada, and the United Kingdom, seniors are covered by government initiatives. The main difference is that the United States has a specific program, Medicare, that was passed in 1965 specifically to provide government health insurance to seniors.\textsuperscript{122} Overall, having government coverage does not equate to lower costs of care or to equal access to the healthcare system.

**THE ECONOMICS OF TREATING SENIORS**

Managing costs associated with spending on seniors is not an easy task. In general, the longer people live, the more healthcare costs are incurred. In the United States, Medicare spending is projected to rise from 2.6 percent of GDP in 2005 to 9.2 percent of GDP in 2050.\textsuperscript{123} In 2006, total health care expenses for the 38 million seniors were $333.3 billion or $100 billion higher than inflation-adjusted expenses for 1996.\textsuperscript{124} This translates, per person aged 65 and older in 2006, to $4,032 (median annual healthcare expenditure). The outliers, 25\textsuperscript{th} percentile, had expenses under $1,752.00 annually and the 75\textsuperscript{th} percentile had expenses over $9,289.00.\textsuperscript{125}

An example of this increase can be observed when seven of the most common chronic illnesses in the United States are analyzed in the context of life expectancy and healthcare

\textsuperscript{121} Ibid.
\textsuperscript{125} Ibid.
spending.\textsuperscript{126} Cancer results in a reduction of life expectancy of 2.1 years with an average increase in total healthcare spending equaling $1,787.00 annually and $16,672.00 over a lifetime.\textsuperscript{127} Thus, a decrease in life expectancy does not necessarily impact healthcare spending in a significant way.

Canada is facing a similar situation. Per capita spending “is greatest for Canadians under the age of one and those aged 65 or older.”\textsuperscript{128} Compared to the C$2,000.00 per person for the remainder of the population, seniors accounted for C$8,969.00.\textsuperscript{129} On a macro level, Canadian seniors accounted for nearly 44% of total provincial and territorial government expenditures.\textsuperscript{130} This figure has not significantly changed since 1998 because seniors, as a percentage of the population, have remained constant at around 13%.\textsuperscript{131} Nevertheless, providing care to 44% of any population is expensive.

In the United Kingdom, total health spending contributed to 8.4% of GDP in 2007.\textsuperscript{132} In 2005, 8.1 million seniors accounted for 16.0% of the total population.\textsuperscript{133} The numbers of seniors are expected to increase annually reaching 10.6 million – an increase of 32% - by 2021.
RATIONING OF CARE AND THE DISTRIBUTION OF HEALTHCARE SERVICES

Whether in the United States, Canada, or the United Kingdom, the rationing of care and the distribution of healthcare services to the elderly raise potential age-based legal discrimination claims. Seniors appear “particularly susceptible to rationing efforts.” Recognizing the need to curtail rising healthcare costs – especially in relation to seniors – and improve access for society as a whole, allocation and rationing are two methods of controlling the distribution of healthcare resources.

Two predominant schools of thought seek to justify rationing care, or in essence, discriminating against seniors because of their age. First, some argue that senior health care represents “an investment of scarce resources with few returns” because of the possibility that a senior has “less chance of achieving a successful clinical outcome.” Second, others justify withholding expensive medical treatment to seniors based on the notion of waning productivity based on a return on investment theory, fundamentally indicating that healthcare dollars are better invested in younger members of society because they have greater potential to contribute to society at large.

Whether a cancer patient lives in the United States, Canada, or the United Kingdom, there is evidence that ageism, in cancer

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138 Supra n. 93, at 1853.
treatment for example, is a commonality seniors face. In the United States and Europe, more than 60% of new cancer cases and more than 70% of cancer related deaths occur in seniors. Overall, senior cancer patients are undertreated and underrepresented in clinical trials.

The United States

Age-related disparities in healthcare are a reality. In the United States, senior women account for nearly 50% of all breast cancer cases, yet only 8% of those patients receive chemotherapy. Furthermore, a study at the University of Pennsylvania revealed that “breast cancer patients in their 50s were almost four times more likely to be offered chemotherapy than patients in their 70s.” Another study indicated that while colorectal and prostate cancer increased with age until 74, mammography screening decreased after age 59.

A broader range of cancer types and the utilization of cancer surgery in seniors revealed that seniors have significantly decreased odds of receiving surgical intervention. Lung, liver, breast, pancreas, esophageal, gastric, sarcoma, and rectal cancers


143 Supra n. 139 at p. 2.


145 Supra n. 141.

showed a disparity of surgical treatment between seniors and the rest of the population.\textsuperscript{147} The only cancer type where no differences were indicated was colon cancer.\textsuperscript{148} As the population of U.S. seniors increases, critical questions need to be addressed. A “provocative question remains: Is the observed use of cancer directed surgery in the elderly due to judicious, evidence based selection or discrimination based on age, ethnicity and tumor stage?”\textsuperscript{149} Whether the types of cancer treatment received by seniors or inclusion in cancer treatment trials is analyzed, the evidence shows that an age-based disparity exists.\textsuperscript{150} “In the U.S. population of patients with cancer, 49% of breast cancers occurred in patients who were 65 or older, whereas only 9 percent of patients enrolled in [Southwest Oncology Group] SWOG-sponsored studies of breast cancer were 65 or older.”\textsuperscript{151} This question is not unique to the United States, for Canada and the United Kingdom are facing a similar dilemma.

\textbf{Canada}

As in the United States, seniors in Canada are faced with disparities in cancer service utilization and inclusion in clinical trials.\textsuperscript{152} Despite the Food and Drug Administration’s recommendation that seniors not be excluded from clinical trials,\textsuperscript{153} “the underrepresentation of elderly patients in cancer treatment trials is a persistent problem.”\textsuperscript{154} Ageism is not limited to clinical trials; it exists in all facets of healthcare from routine to

\textsuperscript{147} Id.
\textsuperscript{148} Id.
\textsuperscript{149} Id.
\textsuperscript{151} Hutchins et al., \textit{id.} at 2064.
\textsuperscript{152} Townsley, \textit{supra} n. 1.
\textsuperscript{154} \textit{Supra} n. 151 at 3803.
The realization that seniors are faced with disparate treatment is also present in the United Kingdom. “Age rather than individual need determines clinical priorities.”\textsuperscript{158} This was substantiated by the Association of Community Health Councils’ study of waiting times at more than 200 emergency rooms.\textsuperscript{159} Here, the disparity in wait times was stunning: 2 hours 51 minutes (under 60) versus 4 hours 34 minutes (over 60).\textsuperscript{160} Ageism in cancer treatment produced similar results.

In England, women 70 and older account for the highest incidence of breast cancer.\textsuperscript{161} Yet, seniors with breast cancer are less likely to receive a diagnostic needle biopsy, triple assessment, radiotherapy, chemotherapy, or axillary node surgery.\textsuperscript{162} As shown in the only UK study known to have evaluated disparity of

\begin{thebibliography}{9}
\bibitem{155} Ibid.
\bibitem{156} Ibid. at 3805.
\bibitem{157} Ibid.
\bibitem{159} Ibid.
\bibitem{160} Ibid.
\bibitem{162} \textit{Id.} at 1197.
\end{thebibliography}
treatment in seniors with breast cancer, it is significant that the same disease management was not disseminated to seniors as to younger women, and age, rather than tumor status, was the defining factor.\textsuperscript{163}

Collectively, seniors in the United States, Canada, and the United Kingdom all experience disparity of treatment. The question remains: Do seniors have protection under relevant age discrimination laws and if so, will utilizing the law create a change in the delivery of healthcare services? After all, “[h]ealth is not an absolute condition, but is assessed by reference to age and other factors.”\textsuperscript{164}

\textbf{PART III: DENYING SENIORS CARE AND IMPLICATING AGE DISCRIMINATION LAWS}

The US, Canada, and the UK all have age discrimination regulations that protect citizens from unfair or unequal treatment in a variety of contexts based upon their age. The question is whether or not the law applies to healthcare treatment when the government guarantees it. The following Table is illustrative of the nuances between each system.

\textsuperscript{163} Id. at 1202.
Table 1 – Comparison of Coverage, Disparity in Accessing Care, and the Implications of Discriminating Against the Elderly on the Basis of Unequal Medical Treatment

The United States

The purpose of this section is to analyze the age discrimination laws in the respective countries and their impact on seniors who receive disparate care in comparison to their younger counterparts. While a brief mention of relevant age discrimination law in Canada and the United Kingdom is provided, by way of example, the United States will be the primary focus. Because in the United States, age discrimination, like race discrimination, may be invoked by statute and may raise constitutional issues. The ultimate question is whether an age discrimination claim based on
either a statute or the Constitution might prevail in the context of disparity of healthcare treatment to seniors?

**Canada**

The fundamental objective of the Canadian health system as set forth in the Canada Health Act is “to ensure that all residents of Canada have reasonable access to medically necessary insured services without direct charges.”\(^{165}\) Thus, the “government’s goal was to ensure that every Canadian citizen would have access to medically necessary healthcare services on a pre-paid basis.”\(^{166}\) In Canada, the federal Charter of Rights and Freedoms (“Charter”) provides a framework for analyzing age discrimination.\(^{167}\) In 1982, the Canadian Charter of Rights and Freedoms, that included a relevant provision prohibiting age discrimination was enacted.\(^{168}\) Section 15 sets forth:\(^{169}\)

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

2. Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.


\(^{166}\) *Id.*


\(^{168}\) *Id.*

\(^{169}\) *Id.*
In order to effectuate the legislative purpose of the extremely broad language, the new human rights guaranteed “equal benefit of the law” plus “equal protection.” Furthermore, §15(2) relays that the express equality rights should not be interpreted to preclude differential treatment targeted at assisting disadvantaged groups. The Canadian Supreme Court interpreted the Canadian Bill of Rights to only apply to government burdens and not as an equality guarantee in the context of government benefits. Along the same lines, §32 narrows the reach of the “Charter” by making it applicable only to Canada’s federal government. Provincial statutes have jurisdiction over private employment discrimination.

Unlike the United States, which has separate federal age discrimination legislation, Canada has no legislation comparable to the Age Discrimination in Employment Act or Age Discrimination Act of 1975. To the contrary, like the United States, Canada is a federation with a federal government and states (in Canada referred to as provinces). Some issues are federal matters and others are provincial matters. Also analogous to the United States is the propensity of the Canadian judiciary to employ a rational basis test similar to the United States. Section 1 of the “Charter” subjects rights to “such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.” In the context of rationing of healthcare resources that have been challenged pursuant to §15 of the “Charter,” Canadian courts have held that the state is required to “take measures to meet its

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171 Id.
173 Kesselman, supra n. 17.
constitutional obligations and to subject the reasonableness of these measures to evaluation.”\textsuperscript{176}

Canada’s primary vehicle for addressing age discrimination is the Charter of Rights and Freedoms. When adjudicating human rights violations in the context of healthcare resources, Canada has implemented a balancing test that has, so far, tipped the scales in favor of rationing of resources, even if it means some are left out.

**The United Kingdom**

Domestic discrimination law in the United Kingdom has evolved over more than 40 years since the first Race Relations Act in 1965.\textsuperscript{177} Subsequently, other personal characteristics besides race have been afforded protection from discrimination and similar conduct, sometimes as a result of domestic initiatives and sometimes through implementing European Directives.\textsuperscript{178} European Directives play a significant role in England’s laws because of the requirements of the European Union (EU) and recently ratified Treaty of Lisbon.\textsuperscript{179}

The European Union, which the United Kingdom signed onto as a member in 1973 with some reservations, plays a unique

\textsuperscript{176} Soobramoney v. Minister of Health, 1988 (1) SA 765 (CC) (considering healthcare rationing as a pivotal element in a rights-centered approach based on the concept of human interdependence); Treatment Action Campaign Case, 2002 (5) SA 721 (CC), paragraphs 25, 38, 126 (engaging in close evaluation of the rational basis of the Government in restricting HIV treatment to a pre-set number of research facilities).


\textsuperscript{178} Id. at paragraphs 3-4 (including the Equal Pay Act 1970; the Sex Discrimination Act 1975; the Race Relations Act 1976; the Disability Discrimination Act 1995; the Employment Equality (Religion or Belief) Regulations 2003; the Employment Equality (Sexual Orientation) Regulations 2003; the Employment Equality (Age) Regulations 2006 as legislation that the Equality Bill replaces); Department for Business, Enterprise and Regulatory Reform, EU Employment-Related Directives for Which the Department for Business, Enterprise and Regulatory Reform (BERR) has UK Responsibility, www.berr.gov.uk/whatwedo/ (last accessed Dec. 29, 2009) (“Discrimination on grounds of sexual orientation, religion or belief, disability and age in employment and vocational training is prohibited by Directive 2000/78/EC.”).

The emphasis will be placed not on the EU, but rather on the Council of Europe and the European Convention on Human Rights (ECHR).

The Council of Europe was founded in 1949. Although the UK was reluctant to join the Council, ironically, in 1950, the ECHR was drafted by English lawyers. The Council is responsible for both the ECHR and the European Court of Human Rights. The European Court of Human Rights was established and held its first case in 1959. Since 1 November 1998, a single full-time European Court of Human Rights was established by Protocol No. 11, which consolidated the roles of three entities that were originally responsible for enforcement obligations. The European Court of Human Rights in Strasbourg is the only international court with jurisdiction over claims brought by individuals.

Prior to 1998, England had not given effect to the ECHR in domestic law. That changed, when the Human Rights Act 1998 was passed by Parliament. When interpreting the Convention, courts are required to consider any “judgment, decision, declaration, or advisory opinion of the European Court of Human Rights.” Strong interpretive power is granted to the courts, and in return, the courts have the duty of reading and giving effect to legislation in a way that is compatible with the Convention. If legislation is found to be incompatible with the Convention, the UK court is not permitted to repeal the Act, rather, a declaration of

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180 Although the European Union has a separate human rights document (Charter of Fundamental Rights of the European Union), the ECHR has defined human rights and fundamental freedom guarantees in Europe.


183 Id. (worth noting is that a court in a member state may refer questions to the ECHR and an individual may also bring a claim directly in the ECHR).


185 Id; see, Section 3 of the Human Rights Act (1998).
incompatibility is issued. This has no legally binding significance, but can have political consequences.  

After the court declares incompatibility, legislation can be introduced by a UK government minister to remedy the conflict with the Convention. The Human Rights Act 1998 tasks judges with applying the ECHR, which “strengthens the judges’ constitutional role of protecting the rights of individuals against the executive.” As Lord Steyn suggests, courts may have to make difficult decisions when weighing one right against another to discern whether a restriction on a certain right is necessary in a democratic society.

A residual regulation stemming from a Directive in relation to the ECHR is the Employment Equality (Age) Regulation 2006 which addresses age discrimination only in the employment setting. While there is no law that currently addresses age discrimination in a healthcare or social care setting, Parliament is currently debating The Equality Bill that would extend age discrimination to other areas, including healthcare.

The Equality Bill, which has passed through the House of Commons and is currently undergoing a second reading in the House of Lords, is aimed at “harmonizing discrimination law, and to strengthen the law to support progress on equality.” Expanding on the Human Rights Act of 1998, the Bill will replace all existing equality legislation, including the Equal Pay Act.

One of the major goals of the Bill is to ban age discrimination in providing goods, facilities, or services, in order to impede

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186 Webley, ibid at Section 14.6.1; see, Section 4 of the Human Rights Act (1998).
187 Webley, supra n. 183 at 464.
189 Manchester Older People’s Network, A Rough Guide to Tackling Age Discrimination (July 2004).

**The United States**

Like Canada and the United Kingdom, seniors in the United States are experiencing a disparity in healthcare treatment. Typically, in the United States, when a group of individuals with a similar characteristic (here, age) experiences discrimination, a constitutional claim of equal protection or substantive due process violation is pursued. It may also be possible to bring a discrimination claim because of a Congressional legislative initiative. By way of analogy, the Civil Rights Act of 1964 gave minorities a statutory right to bring a claim for discrimination based on a variety of characteristics, including race. Similarly, the Age Discrimination Act of 1975 was passed to give older individuals statutory recourse for age discrimination.

Although age discrimination in medical treatment is experienced by United States seniors, as recipients of federal financial assistance in the form of Medicare, there is no ability to prevail either under the Age Discrimination Act of 1975 or via a constitutional claim for age-based treatment disparity. Because age is not given the same status as race or gender in judicial Constitutional review, and a key statutory exclusion precludes Medicare recipients from bringing claims, it appears as though seniors have no recourse.
THE CIVIL RIGHTS ACT 1964

Passed more than forty years ago, the Civil Rights Act of 1964 laid the foundation for federal protection from discrimination based on race, color, national origin, religion, or sex.\textsuperscript{194} At its core, the Civil Rights Act of 1964 was designed to promote equality.\textsuperscript{195} Comprised of eleven individual titles, only three out of the eleven have received heightened legislative or judicial focus.\textsuperscript{196}

Within less than a decade, Congress passed several legislative initiatives, including the Age Discrimination in Employment Act of 1967 (ADEA),\textsuperscript{197} the Education Amendments of 1972 (Title IX),\textsuperscript{198} and the Age Discrimination Act of 1975.\textsuperscript{199} “Designed in significant part to complement and reinforce the provisions of the 1964 Act, … opportunities [were created] for millions of people previously blocked in their quest for the ‘American Dream’ by discrimination on the basis of race, color, national origin, religion, sex, and age.”\textsuperscript{200} Several provisions, including Title VI and Title VII of the Act, have been construed by the U.S. Supreme Court to permit disparate impact suits.\textsuperscript{201}

\textit{Griggs v. Duke Power Company}, a landmark 1971 Supreme Court decision confirmed the permissibility of disparate impact suits.\textsuperscript{202} The Court’s opinion paved the way for a claimant to recover for employment discrimination based on the defendant

\textsuperscript{199} Id. at 983; Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964) (Title VI (Nondiscrimination in Federally Assisted Programs), “prohibits discrimination under any program or activity receiving Federal financial assistance” against an individual “on [the] ground of race, color, or national origin.” Title VII (Equal Employment Opportunity) prohibits employment discrimination on the basis of race, color, religion, sex, or national origin).
using practices that “disproportionately screen out members of a
group protected by the Act if the practice cannot be shown to be
job related or consistent with business necessity, even though there
is no evidence of intent to discriminate.” This judicial doctrine
was codified by Congress in the Civil Rights Act of 1991.

At first glance, this conclusion appears to be inconsistent
with the 1976 equal protection case, Washington v. Davis. In
Washington, the Supreme Court considered whether the
requirement of a written exam for Washington, D.C. police force
applicants was unconstitutional based on the discriminatory impact
on black test takers. The petitioners argued that the test
“excluded a disproportionately high number of minority applicants,
and that its use therefore constituted race discrimination [because
approximately four times as many blacks as whites failed the
test].” In this instance, the Court recognized that “an invidious
discriminatory purpose may often be inferred from the totality of
the relevant facts, including the fact, if it is true, that the law bears
more heavily on one race than another.” The Court went on to
say the following, which reconciles the Equal Protection Clause
with the holding in Griggs:

We have not held that a law, neutral on its face and
serving ends otherwise within the power of
government to pursue, is invalid under the Equal
Protection Clause simply because it may affect a
greater proportion of one race than of another.
Disproportionate impact is not irrelevant, but it is
not the sole touchstone of an invidious racial
discrimination forbidden by the Constitution.

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203 Days, supra n. 194 at 983; Id. at 431.
206 Id.
207 William A. Kaplin, American Constitutional Law: An Overview, Analysis, and
Integration, 248 (Carolina Academic Press, Durham, NC, 2004).
208 426 U.S. at 242.
Standing alone, it does not trigger the rule...that racial classifications are to be subjected to the strictest scrutiny and are justifiable only for the weightiest of considerations.\(^{209}\)

Because it was unproven that government officials had the intent to discriminate when the test was adopted, even though more blacks failed the test, the Court could not rely on a discriminatory purpose or racial classification. There was a job necessity – basic literary competence of police force members; therefore, only rational basis scrutiny and not strict scrutiny was applied.\(^{210}\) Unlike race, which is subject to the strictest scrutiny when being evaluated, age discrimination was not found to be “suspect” and only received “rational basis review.”\(^{211}\) Therefore, despite the promising strides made in other areas of discrimination, at this juncture, it appears that seniors have no recourse.

### THE AGE DISCRIMINATION ACT 1975

The Age Discrimination Act of 1975 (ADA 1975) is a Federal law prohibiting discrimination by health care and human service providers receiving funds from the U.S. Department of Health and Human Services (DHHS), and is enforced by the Office for Civil Rights (OCR) of DHHS.\(^{212}\) Although enacted in 1975,

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\(^{209}\) 426 U.S. at 242.

\(^{210}\) For an explanation of the difference between rational basis and strict scrutiny see *Palmore v. Sidoti*, 466 U.S. 429 (1984) (indicating that classifications based on race are subject to the highest scrutiny and to pass constitutional muster, they must be justified by a compelling governmental interest and must be ‘necessary ...to the accomplishment’ of an identified legitimate purpose); *Brown v. Board of Education*, 347 U.S. 483 (1954) (eradicated the “separate but equal” doctrine pronounced in *Plessy v. Ferguson*, 347 U.S. 483 (1954)). *See generally*, Kaplin, *supra* n. 206 at 271-275.

\(^{211}\) *Kimel v. Florida Board of Regents*, 528 U.S. 62 (2000) (applying the remedial rationale as addressed in *City of Borne v. Flores*, 521 U.S. 507 (1997), the court held that the Congress’ application of the ADEA (29 U.S.C. §621 et seq.) to the states was outside the scope of Fourteenth Amendment enforcement. The Court also noted that age discrimination is not a “suspect” class in the context of equal protection via the Fourteenth Amendment and receives only rational basis review).

The purpose of the Act is to “prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance.”\footnote{Age Discrimination Act of 1975, 42 U.S.C. §6101 (1976). For a complete historical overview of the ADA 1975, see Peter H. Schuck, The Graying of Civil Rights Law: The Age Discrimination Act of 1975, 89 Yale L. J. 27 (Nov. 1979). Worth noting is the author’s position prior to the time he wrote this article. While serving as Deputy Assistant Secretary for Planning and Evaluation, Department of Health and Education and Welfare (HEW), he participated in HEW’s implementation efforts of the Age Discrimination Act of 1975.} More importantly, it excludes coverage from programs or activities “established under authority of any law” that employs age criteria as a condition to benefits or participation,\footnote{Id. § 6103(b)(2).} in addition to certain employment-related programs or activities.\footnote{Id. § 6102 (c)(2).}

The Department of Health, Education and Welfare estimated “that the ADA will apply to nearly 100,000 public and private entities that receive federal financial assistance, and to as many as 450,000 sub-recipients (that is, those who secure aid from the direct recipients).”\footnote{Schuck, 89 Yale L. J. at n. 16 (Nov. 1979) (covering entities ranging from hospitals, schools, public transit, and legal services. Private organizations such as the Junior Chamber of Commerce or senior citizen’s clubs if federal assistance was received either directly or indirectly.)} Perhaps this was based on the 1971 White House Conference on Aging that honed national attention on the needs of seniors.\footnote{White House Conference on Aging, II, Final Report: Toward a National Policy on Aging (1971) (suggesting multiple changes in domestic policies impacting seniors).} While changes in governmental policy affecting seniors were suggested, the sequence of long-term demographics indicated an increase in the number and proportion of American seniors.\footnote{Brotman, The Aging of America, Nat’l J., Oct. 17, 1975 at 1662; Bureau of Census, U.S. Department of Commerce, Historical Statistics of the United States (1975); Bureau of Census, U.S. Department of Commerce, Social and Economic Characteristics of the Population 1978, p. 17 (1979).} Additionally, seniors, because of their numbers, constituted a substantial political force.
As previously indicated, “the ADA is the off-spring of—indeed, is expressly modeled upon—Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, or national origin in federally assisted programs.” While Congress stressed that the ADA 1975 does not only protect seniors, but everyone throughout their life, Congress clearly had seniors in mind.

The impetus of the ADA 1975 is to ban age-based discrimination by recipients of federal financial assistance. Courts have concluded in non-ADA 1975 settings that Medicare and Medicaid are federal assistance programs. Logically, it should follow that the same interpretation would apply in relation to the ADA 1975. After all, a hospital that receives federal grants or accepts payment for treating Medicare beneficiaries falls within the ADA 1975’s ambit. Furthermore, the Civil Rights Act of 1987, “which amended the ADA [1975] along with several other statutes imposing comparable antidiscrimination prohibitions on recipients of federal financial assistance, an entire program or entity will come within the ADA’s reach so long as some part of that program or entity receives federal assistance.”

Although the preamble of the ADA 1975 sets forth the goal that “[i]t is the purpose of this [Act] to prohibit discrimination on the basis of age...,” the ADA 1975 model regulations contain

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220 Schuck 89 Yale L. J. at 29 (Nov. 1979).
221 See e.g., H.R. REP. NO. 67, 94th Cong., 1st Sess. 16 (1975) (Older Americans Amendments of 1975 ‘aimed at eliminating age discrimination at all levels’); 121 CONG. REC. 9212 (1975) (remarks of Rep. Brademas) (relaying that the act is principally intended to thwart prejudice against seniors).
224 Usery at 531 F.2d at 236.
226 Eglit, 26 Hous. L. Rev at 872.
227 Usery, 531 F.2d at 238.
exclusions. More important than what the ADA 1975 intended to cover is what it does not cover. Section 304(b)(2) of the Act provides:

The provisions of this title shall not apply to any program or activity established under authority of any law which (A) provides any benefits or assistance to persons based upon the age of such persons; or (B) establishes criteria for participation in age-related terms or describes intended beneficiaries or target groups in such terms.

In 1965, President Lyndon B. Johnson signed Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act into law. Essentially, “Medicare is a system of federal health insurance and medical financial support for the aged and disabled.” Medicare was enacted primarily to extend health insurance coverage to Americans aged sixty-five and older because senior citizens constituted the group most likely to be living in poverty without health insurance. Because Medicare falls within the exclusion of Section 304(b)(2), seniors utilizing Medicare who experience disparate medical treatment because of their age, would not be governed by the Act. Therefore, seniors

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230 Social Security Amendments of 1965, “TITLE XVIII – HEALTH INSURANCE FOR THE AGED”, Pub. L. No. 89-97, §1801, p. 311 (Jul. 30, 1965) (prohibiting federal interference with the administration of health services by stating “Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency or person.”).
232 Dechene, id.
have no recourse under the ADA 1975. As previously explained, because age is not given the same level of scrutiny as race, rational basis would apply and as long as there was a legitimate government interest, such as rationing care to contain costs, the claim would fail.233

Perhaps the only straw left to grasp onto is to claim a violation of Procedural Due Process under the Fifth or Fourteenth Amendment of the United States Constitution. For example, in *Mathews v. Eldridge* a Fifth Amendment procedural due process challenge was brought against the methods used to “effectuate a termination of disability benefits under a federal disability program.” 234 *Goldberg v. Kelly* is a case where the Court upheld the Fourteenth Amendment procedural due process rights of welfare recipients whose benefits terminated. 235 Still, it is more likely a court would uphold a claim against termination of Medicare benefits, if there is no provider to treat the recipient, rather than not receiving the same treatment as a result of age discrimination. 236

**CONCLUSION**

The United States, Canada, and the United Kingdom are all experiencing a rise in the number of seniors. All three countries have problems with seniors receiving disparate healthcare in relation to their younger counterparts, as evidenced by cancer scenarios. Given the language of each respective country’s age discrimination laws, in certain circumstances, seniors have a cause of action against those entities where ageism is apparent. Disparity of medical treatment because of age discrimination is not one of them at this time.

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236 See generally, Rachel V. Rose, *Poor Prognosis: the End Game Scenario that May Arise Through the Use of the Contracts Dispute Act of 1978 or Physician Exodus from Medicare*, (2009) (ms., copy available by contacting author at rrose@law.stetson.edu).
Will seniors use their political leverage through their numbers to impact policy and make such claims viable? The impact on government practices remains to be seen. It is, however, a step in a positive direction to see countries, such as the United Kingdom, enhance their laws to protect seniors. In sum, at the present time, age discrimination in the treatment of seniors exists and there appears to be no protection by the government.