JOURNAL OF INTERNATIONAL AGING LAW & POLICY

VOLUME 4 FALL 2010

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AGE DISCRIMINATION, EUROPE AND ITALY

ELISA FOIS[1]

INTRODUCTION

General assumptions and references to casual stereotypes often determine a difference of treatment between individuals and groups on the basis of age. Such attitudes subject individuals to unjustified discrimination[2] that, in as much as they are denied equality of treatment and respect, violate their fundamental right to respect for their human dignity.

What is human dignity? The principle of respect for human dignity is at the origin of any national or international text on the protection of fundamental rights. It is a conceptual principle which is present throughout the proclamation of such rights[3] and which is

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[1] Elisa Fois graduated in 2005 from the Law School of the University of Torino, 105/110, with a Public Compared Law final dissertation, entitled "Freedom of Religion in Germany." After having spent a period of 4 months in Australia, she spent 2 years in a lawyer and notary practice in Italy and began her activity as translator for juridical documents, Opinions of Advocate Generals of the Court of Justice of the European Communities in particular. Thanks to a fellowship awarded by the University of Basel, Switzerland, in academic year 2007-2008, she took part in a post-graduate exchange program between the University of Basel and the Italian Ministry of Foreign Affairs at the Faculty of Law in Basel. There, she was involved in several academic activities, such as Moot Court and Eucor Seminar, and attended classes in Human Rights Law, European Law and International Law. In 2008 she did a three-month internship at the Council of Europe, Strasbourg, Department of Human Rights and Legal Affairs, Secretariat of the Framework Convention for the protection of National Minorities. In 2009 Elisa Fois began working for the European Documentation Centre in Città Studi S.p.A., Italy, dealing with issues such as European Integration, and European law relevant in the textile sector. Since February 2010, thanks to a "Master dei Talenti della Società Civile" fellowship, co-financed by Città Studi and Fondazione CRT and Fondazione Goria, Torino, Italy, she is working on a one-year research program concerning International and European legislation relevant to the textile setor.

[2] The non-discrimination and equality principles are strongly linked. The principle of equality, in law and in fact, requires that equal situations are treated equally and unequal situations differently. Failure to do so will amount to discrimination unless an objective and reasonable justification is proved. The concept of equality in law and in fact was introduced by the International Court of Justice in its leading case concerning national minorities, PCIJ, Minorities Schools in Albania, Advisory Opinion, 6 April 1935, XXXIV Session, Series A-B, No. 64, 19.

[3] Article 1 of the EU Social Charter enshrines this principle. Human dignity is inviolable, there can be no exception, nor can any limit be imposed, even where law and order is concerned. Article 1 states that "Human dignity is inviolable". It must be respected and protected. The

considered as the necessary source for the individualization of every human being's nature, identity and origin.[4] It is actually on the basis of human dignity that Rinaldo Bertolino and Viola ground the essence of all the fundamental rights.[5] Human dignity is even deemed to be the guideline of all human rights philosophy in western countries.[6]

The importance of the concept of human dignity permits us to understand how necessary not only its protection is, but also its promotion. Human dignity has been defined as the process that permits an individual to acquire his own identity, the result of the union of culture and human nature, the possibility for a man to become a person.[7] Along the lines of these considerations, Bertolino highlights the fact that human dignity formed the foundation of the constitutional State post-World War II.[8] The justification of every fundamental right is found in the concept of human dignity. Because human dignity created the law and its administration, juridical order itself must serve fundamental rights. Although specific instruments guaranteeing every single human being the complete attainment of his or her identity do not exist (as for instance there does not exist an instrument able to guarantee good health), the concept of human dignity imposes on the States

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explanation on Article 1 - human dignity -clarifies its meaning and scope. The dignity of the human person is not only a fundamental right in itself but constitutes the real basis of fundamental rights. The 1948 Universal Declaration of Human Rights enshrined human dignity in its preamble: "*Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.*" In its judgment of 9 October 2001 in Case C-377/98 *Netherlands v European Parliament and Council* [2001] ECR I-7079, at grounds 70 — 77, the Court of Justice confirmed that a fundamental right to human dignity is part of Union law. It results that none of the rights laid down in this Charter may be used to harm the dignity of another person, and that the dignity of the human person is part of the substance of the rights laid down in this Charter. It must therefore be respected, even where a right is restricted.

[4] Jean Bernard Marie, Patrice Meyer Bisch, *La liberté de conscience dans le champ de la religion,* 2002 Université de Fribourg, Université Robert Schuman, Strasbourg."[...]La culture d'un homme n'est pas son extérieur, elle est son processus même de subjectivation, la «mise en culture» du sujet lui-même , le capital qui lui permet de déployer ses libertés, droits et responsabilités [...] ». p. 15

[5] See Rinaldo Bertolino, *La libertà religiosa e gli altri diritti umani,* Milano, Giuffrè, 1996 p. 12.

[6] See J. Joblin, *L'Eglise et le droit de l'homme: un regard historique et perspective d'avenir,* in Cons. Pont. « Justice et Paix », pp. 46, 47.

[7] See P. Häberle, *Le libertà fondamentali nello Stato Costituzionale,* Roma, 1993, p. 230.

[8] See R. Bertolino, *La libertà religiosa*.

the guarantee of all the conditions necessary to facilitate this formation process. Therefore, it permissively imposes positive obligations on the States. Guarantees aimed at the respect of the external sphere[9] of an individual permits his or her interior sphere to be protected and free to move towards the search of an identity and a feeling of belonging.[10]

The whole international order and the modern constitutional systems chose this approach,[11] characterized by the consciousness that human rights do not need better protection, but need to be enforced somehow with their violation being strictly punished. Potentially, any kind of discrimination leads to a breach of human rights and consequently of the individual human dignity. Any form of discrimination is therefore prohibited by any enlightened country in specified provisions.

European Community Law enshrined in its general principles and values the respect and the promotion of human dignity. The Framework Directive on Equal Treatment in Employment and Occupation (2000/78/EC) (hereinafter: the 'Directive') represents one of the instruments that the Member States have to implement in order to promote human dignity and fight against discrimination.

One of the Directive's prohibited grounds is age. Starting from the analysis of the Directive, this study focuses on its implementation in Italy with specific regard to the issue of age discrimination. An emergent and often underestimated issue, age discrimination is the specific object of this study. Older people

[9] External sphere of an individual may be defined as the part of life in which the individual interacts within a community, takes part in its activities, expresses and compares himself with the other members. The external sphere is the dimension in which human beings can consider their interior sphere as a common element, it allows human beings to create their social identity, to empower their interior identity and leads them to the choice of belonging to a community or group in preference to another. This is the context in which "cultural rights" are invoked. These rights aim at guaranteeing the conditions necessary in order to facilitate the individual during his formation process, in as much as the interior sphere and the external one are reciprocally dependent of his completeness.

[10] Berttolino, supra n. 5 at 33. 2d.

[11] Berttolino, supra n. 5 at 33. 2d.

offer remarkable potential value to business, the economy, and society. Unfortunately, they often represent an untapped and discriminated resource, as many public policy measures and private workplace practices pose serious barriers to work, both paid and unpaid.

Age discrimination is worth separate analysis, because particular issues distinguish it from the other grounds. Namely, there are no fixed characteristics that define particular age groups, nor do age-based assumptions by others about individuals of particular ages remain static. Age distinctions based upon unfair assumptions and stereotypes are undesirable. But, other age-based distinctions find their origins in rational considerations that are not incompatible with the recognition of individual dignity, therefore, serving valuable social and economic objectives, while being designed to benefit or protect age groups.

Controlling the need to establish a framework is the need to distinguish between circumstances where the use of age is legitimate, and where it is age discrimination. By way of example, the Directive aims to provide a legal framework able to reflect the different situations that can arise in circumstances where a danger of discrimination exists. Member States were required to transpose the Directive by December 2003. Therefore, against this background, this article will focus on the implementation of the Directive in Italy with particular emphasis on age discrimination in the labor market.

Why specifically in the labor market? Unjustified age discrimination often deprives individuals of equal access to work opportunities. In this context, the right to age equality transcends the right to work. Access to the labour market and right to work are significant expressions of the principle of human dignity, in as much as an individual can develop and express his own identity through his working activity.

The importance of the right to work is proved by its incorporation in the main international human rights instruments,[12]

[12] Art. 26 of the U.N. International Covenant on Civil and Political Rights requires equal treatment and protection against discrimination, and guarantees rights such as the right to life (art. 6) and freedom from cruel or degrading treatment (art. 7). The UN International Covenant on Social,

and in the European Charter of Fundamental Rights and Freedom. Considering the importance of the interests concerned, the demographical changes in Italy and the actual conditions of the Italian labour market, a precise analysis of human dignity in relation to these societal considerations is as necessary as ever before.

WHY AGE DISCRIMINATION

As introduced above, psychological studies and research demonstrate that the human mind naturally tends to use stereotypes. Using stereotypes means attributing homogeneous characteristics such as gender, jobs, background, religion and age to particular groups of people. In the last century, unjustifiable stereotypes led to the development of concepts such as sexism, racism, and xenophobia. Today age is listed as a ground of discrimination and therefore the correspondent term "ageism" has entered into modern language.[13] Nonetheless, there is something peculiar with the concept of age and the neologism ageism, something that distinguishes it from the other grounds of discrimination.

First, unlike the other equality grounds, there are no fixed characteristics that define particular age groups. Moreover, an individual's age will not remain fixed, and his belonging to a particular group will not necessarily last a long time. Long ago J.H. Sheldon documented that older people are not a homogenous group.[14] In 1997 Walter and Maltby, using ageism, defined the older-people-group as a homogenous one.[15] More recently, Ilmarian considered that individual differences in functional ability

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Economic and Cultural Rights guarantees the right to work (art. 6), to favourable work conditions (art. 7), right to an adequate standard of living (art. 11), to the highest attainable standard of health (art. 12) and to education (art. 13).

[13] S. Cuomo, "Le discriminazioni di età nella letteratura manageriale", in Over 45, Quanto conta l'età nel mondo del lavoro, M. C. Bombelli and E. Finzi (eds), p. 160.

[14] J.H. Sheldon, 'The Social Medicine of Old Age Report of an Inquiry in Wolverhampton (Oxford University Press, 1948) at p. 2.

[15] A. Walker and T. Maltby, 'Ageing in Europe, (Open University Press, 1997) AT p.9.

vary according to age within an occupational group.[16] Age limits and parameters have traditionally been accepted and used as a rational instrument for employment purposes, since age is frequently considered as a proxy regarding performance, commitment, productivity, flexibility and availability.

When such classifications mean to divide and describe society, they can be considered useful and functional, but what about employment purposes? Some empirical characteristics can be useful in order to identify possible applicants for a job and restrict the research, but many of them will be completely unjustifiable.[17]

When is it that a distinction based on homogeneous characteristics attributed to a particular group stops being an objective, useful selection tool and turns into discrimination? When are characteristics able to form a group that can be considered the main and exhaustive criteria to identify skills and competences? These questions refer to any kind of discrimination that can occur in the labour market, but with particular emphasis on age. Thus, different considerations must be raised.

The natural inclination of human beings to use stereotypes in evaluating other people led recruiting experts to refer to age criteria regularly and automatically, as if age was the direct representation of future labor performance. Age is a characteristic used to define a group, but its peculiarities make it necessary to evaluate each situation individually. The tendency to refer to stereotypes affects human resources and employment processes as a whole because the person is not considered as an individual, but rather as part of a preconceived notion. Excluding possible candidates because of a stereotype impacts the general labor market by depriving it of a potential positive contribution.

While the exploitation of human resources is a desirable good practice, a hurried and superficial recruitment procedure can neither be accepted nor justified.

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[16] J. Ilmarian, 'Ageing Workers in Finland and in the European Union: Their situation and the Promotion of Their Working ability, Employability and Employment', (2001) Vol. 2, No 4 *Geneva papers on Risk and Insurance, pp. 623-641.*

[17] Arcuri L. Cadinu M.R. (1996) "gli stereotipi", il Mulino, Bologna

Older people who could potentially contribute in a very decisive way to the labor market, and to society in general, often encounter serious difficulties in access and participation. This creates a need to look beyond traditional ageing stereotypes in order to benefit from the growing numbers of older citizens; given appropriate policies and workplace practices, many older citizens would, in fact, choose to work longer.

The exclusion *a priori* of an individual from the selection process is discriminatory when the use of age as a proxy refers only to the most common superficial consideration. Examples include: people over 45 years old being less flexible and less motivated in job performance, thinking only about retirement pension and not worth any kind of investment, and the actual competences of the individual concerned. The use of age-based distinctions is justified when it is the consequence of a genuine occupational requirement or when it is objectively necessary to achieve a legitimate aim and is proportionate to the aim sought. When this is not the case, age-based treatment disparities rooted in generalized assumptions or unacceptable stereotypes constitute a violation of the fundamental right of respect for human dignity.

The change concerning life expectancy is one of the factors that caused the emergence of this stereotype and simultaneously is the element that proves its inopportunity. Some citizens over age 45 will certainly be awaiting the deserved retirement time, but many will surely also want to maintain an invigorating contact with the labour world, which contributed so much to form their identity. To this extent it is clear how inopportune it is to identify the needs and the aspirations of an individual by simply referring to a stereotyped element such as age.

Since satisfying individual needs is impossible, a compromise will have to be found, but using general assumptions to exclude individuals potentially perfect for a particular post is certainly not acceptable. In this context, the recruitment and human resources staff will have to evaluate each worker personally, on the basis of his personal motivation, enthusiasm and

skills. Age can be taken into account for other reasons, but definitely not for motivation. These considerations address the issue that concerns practices that need to be adopted in the employment and promotion process.

In this context, the superficial use of stereotypes based on age neglects the fact that older groups are not characterised by homogeneity, which is to say that the superficial reference to the age-group results in unacceptable and hasty definitions.[18] Due to the unfounded use of stereotypes, analysis concerning the existence of age-discrimination behaviours, praxis and acceptance will have to be more precise than for other groups.

When dealing with age discrimination, all the circumstances of the case will have to be evaluated and considered as factors determining the possible justification of differential treatment or assumption based on age. Moreover, the particular legislation should be evaluated by taking into account a wide variety of policy tools. These tools include education, training programmes and the encouragement of best practices.

The Framework Equality Directive requires all EU member States to introduce such legislation, making it the most relevant legal instrument in the European Union age equality strategy.[19] The general provisions of the Directive had to be implemented by Member States by 2 December 2003, but Article 18, because of its particular nature and the necessity to take account of the particular existing conditions in the States, permitted a delay to 2 December 2006 before implementing the provisions concerning age discrimination.

Italy did not take advantage of the delay period and age discrimination was explicitly regulated by means of Legislative Decree no. 216, 9 July 2003. The Decree introduced the new specific prohibition of discrimination, defining its application, exceptions and remedies. The European legislation and the

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[18] See Supra n.16.

[19] Council Directive 2000/78 establishing a general framework for equal treatment in employment and occupation (Official Journal L 303/16, 2 December 2000): http://europa.eu.int/eur-lex/en/index.html

Equality Directive combined with the Italian labour market, and the current legal landscape in Italy followed. Studies that have already been done with reference to the demographical changes and the recruitment process will provide a forum for explanations.

EUROPEAN LEGISLATION AND THE EQUALITY DIRECTIVE

A fundamental step in any strategy concerning age equality is the introduction of legislation able to prohibit any unjustified form of age discrimination in employment and able to provide effective remedies for those who suffer such discrimination. EU Member States are bound by Article 19 of the Treaty on the functioning of the European Union[20] and by Article 21 of the Charter of Fundamental Rights of the European Union[21] to the non-discrimination principle.

Against this background, the Framework Directive on Equal Treatment in Employment and Occupation (2000/78/EC) represents the acknowledgement of the problem of age discrimination at the European level. The Directive 2000/78 was adopted on the basis of Article 13 EC (now article 19 of the Treaty on the functioning of the European Union).

The objectives of the Directive in terms of age are set out in the recitals,[22] and in particular they include, "the need to take

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[20] Article 19 "Without prejudice to the other provisions of this Treaty and within the limits of the powers conferred by it upon the Community, the Council, acting unanimously on a proposal from the Commission and after consulting the European Parliament, may take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation".

[21] Article 21 is formulated as follows: "1. Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited. 2. Within the scope of application of the Treaties and without prejudice to any of their specific provisions, any discrimination on grounds of nationality shall be prohibited".

[22] The first , fourth, eighth and twenty-fifth recitals in the preamble to the directive are worded as follows:

'(1) In accordance with Article 6 of the Treaty on European Union, the European Union is founded on the principles of liberty, democracy, respect for human rights and fundamental freedoms, and the rule of law, principles which are common to all Member States and it respects fundamental rights, as

appropriate action for the social and economic integration of elderly and disabled people."[23] By reference to the Employment Guidelines of the European Council, the Directive also refers to "the need to pay particular attention to supporting older workers, in order to increase their participation in the labour force."[24]

According to Article 1, the purpose of the Directive is to formulate a general framework for combating discrimination on the grounds of religion or belief, disability, age or sexual orientation as regards employment and occupation, with a purpose of implementing in the Member States, the principle of equal treatment. To this extent, the Directive focuses on Equal Treatment in Employment and Occupation in as much as the negative impact of age stereotypes and prejudice is particularly marked in the context of employment. For the purposes of the Directive, the "principle of equal treatment" shall mean that there

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guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms and as they result from the constitutional traditions common to the Member States, as general principles of Community law.

…

(8) The Employment Guidelines for 2000 agreed by the European Council at Helsinki on 10 and 11 December 1999 stress the need to foster a labour market favourable to social integration by formulating a coherent set of policies aimed at combating discrimination against groups such as persons with disability. They also emphasise the need to pay particular attention to supporting older workers, in order to increase their participation in the labour force.

…

(25) The prohibition of age discrimination is an essential part of meeting the aims set out in the Employment Guidelines and encouraging diversity in the workforce. However, differences in treatment in connection with age may be justified under certain circumstances and therefore require specific provisions which may vary in accordance with the situation in Member States. It is therefore essential to distinguish between differences in treatment which are justified, in particular by legitimate employment policy, labour market and vocational training objectives, and discrimination which must be prohibited.'

[23] Recital 6 of the Directive states as follows: 'the Community Charter of the Fundamental Social Rights of Workers recognizes the importance of combating every form of discrimination, including the need to take appropriate action for the social and economic integration of elderly and disabled people'.

[24] Recital 8 of the Directive states as follows: 'The Employment Guidelines for 2000 agreed by the European Council at Helsinki on 10 and 11 December 1999 stress the need to foster a labor market favorable to social integration by formulating a coherent set of policies aimed at combating discrimination against groups such as persons with disability. They also emphasize the need to pay particular attention to supporting older workers, in order to increase their participation in the labor force'.

shall be no direct or indirect discrimination whatsoever on any of the grounds referred to in Article 1.[25]

This recognises that both younger and older workers have rights to age equality. It is not only concerned with ensuring formal equality, but also with combating age-based disadvantages and upholding basic rights. The Directive contains a variety of recitals and provisions that concern age and identifies the areas in which age is not applicable. To this extent, Article 3 of the Directive[26] states that it is not to refer to national provisions laying down retirement ages and does not include social security or social protection schemes payments.

On the contrary the Directive covers all types of workers, including employees, self-employed, agency staff, partners and those undertaking vocational training; it applies to all stages of

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[25] Article 2 of Directive 2000/78, headed 'Concept of discrimination', states in subparagraphs 1 and 2(a) that:
'(1) For the purposes of this Directive, the "principle of equal treatment" shall mean that there shall be no direct or indirect discrimination whatsoever on any of the grounds referred to in Article 1.
(2) For the purposes of paragraph 1:
(a) direct discrimination shall be taken to occur where one person is treated less favourably than another is, has been or would be treated in a comparable situation, on any of the grounds referred to in Article 1.'

[26] Article 3 of Directive 2000/78, headed 'Scope', provides as follows:
'1. Within the limits of the areas of competence conferred on the Community, this Directive shall apply to all persons, as regards both the public and private sectors, including public bodies, in relation to:
(a) conditions for access to employment, to self-employment or to occupation, including selection criteria and recruitment conditions, whatever the branch of activity and at all levels of the professional hierarchy, including promotion;
(b) access to all types and to all levels of vocational guidance, vocational training, advanced vocational training and retraining, including practical work experience;
(c) employment and working conditions, including dismissals and pay;
(d) membership of, and involvement in, an organisation of workers or employers, or any organisation whose members carry on a particular profession, including the benefits provided for by such organisations.
2. This Directive does not cover differences of treatment based on nationality and is without prejudice to provisions and conditions relating to the entry into and residence of third-country nationals and stateless persons in the territory of Member States, and to any treatment which arises from the legal status of the third-country nationals and stateless persons concerned.
3. This Directive does not apply to payments of any kind made by state schemes or similar, including state social security or social protection schemes.'
4. Member States may provide that this Directive, in so far as it relates to discrimination on the grounds of disability and age, shall not apply to the armed forces.

employment from recruitment, training, pay, benefits, promotion and dismissal to post-employment discrimination; it prohibits direct discrimination, indirect discrimination, harassment and victimisation; it extends to individuals of all ages and outlaws discrimination against the young as well as the old and enables complaints to be made in employment tribunals for unlimited compensation.

However, despite the expansiveness of the scope of the Directive in general and the laudable aspirations contained in the recitals, the provisions on age discrimination are considerably thinned by a number of permitted derogations and "justifications of differences of treatment on grounds of age."[27] In this context, in exceptional cases, age might be a "genuine occupational requirement" (GOR) for a particular job position. Basically, when it can be demonstrated that it is objectively necessary to achieve a legitimate and proportionate aim, the use of age criteria is permitted in circumstances which otherwise would constitute direct or indirect discrimination.[28]

In order to distinguish between genuine occupational requirements and unfair and discriminatory stereotypes, the "objective justification" test must be applied. This test needs to be applied in both a rigorous and flexible manner, according to both Articles 4 and 6[29] of the Directive.

By its case law the European Court of Justice has clarified the content of the directive, its interpretation, and its scope. In the following cases the Court set general principles and interpreted the scope of the Directive. Thus *Mangold*, *Felix Palacios de la Villa*, and *Birgit Bartsch* can be considered leading cases.

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[27] Article 4(1) provides as follows: 'Notwithstanding Article 2(1) and (2), Member States may provide that a difference of treatment which is based on a characteristic related to any of the grounds referred to in Article 1 shall not constitute discrimination where, by reason of the nature of the particular occupational activities concerned or of the context in which they are carried out, such a characteristic constitutes a genuine and determining occupational requirement, provided that the objective is legitimate and the requirement is proportionate'.

[28] See article 2(2) , a) and b) of the Directive.

[29] Article 6 (1) provides as follows: 'Notwithstanding Article 2(2), Member States may provide that differences of treatment on grounds of age shall not constitute discrimination, if, within the context of national law, they are objectively and reasonably justified by a legitimate aim, including legitimate employment policy, labor market and vocational training objectives, and if the means of achieving that aim are appropriate and necessary'

a) Mangold[30]

The *Mangold* case has been defined as a "central case" on anti-discrimination law.[31] Questions concerning, inter alia, the interpretation of Article 6 of Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation were submitted to the Court. The national court was uncertain whether national rules lowering the age at which it was authorised to conclude fixed-term contracts, with no objective justification, were compatible with Article 6 of Directive 2000/78. Due to this it decided to stay the proceedings and to refer the case to the Court of Justice for a preliminary ruling. Among other questions, the national court asked if Article 6 of the Directive 2000/78 was to be interpreted as precluding a provision of national law which, like the provision at issue in this case, authorises the conclusion of fixed-term employment contracts, without any objective reason, with workers aged 52 and over, contrary to the principle requiring justification on objective grounds.

The Court submitted that the national court sought, in essence, to ascertain whether Article 6(1) of Directive 2000/78 must be interpreted as precluding a provision of domestic law such as that at issue in the main proceedings which authorises, without restriction, unless there is a close connection with an earlier contract of employment of indefinite duration concluded with the same employer, the conclusion of fixed-term contracts of employment once the worker has reached the age of 52. If so, the national court asked what conclusions must be drawn from that interpretation. In this regard, the Court underlined the purpose of

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[30] Judgment of the Court (Grand Chamber) of 22 November 2005. Werner Mangold v Rüdiger Helm. Reference for a preliminary ruling: Arbeitsgericht München – Germany. European Court reports 2005 Page I-09981.

[31] The Mangold Case, Content and Prospects, Matthias Mahlmann, ERA, Trier (http://www.era.int/web/fr/resources/5_2341_2709_file_en.3709.pdf).

Directive 2000/78, which is to lay down a general framework for combating discrimination on any of the grounds referred to in that article, which include age, as regards employment and occupation.

The Court stressed that with specific regard to differences in treatment on the basis of age, Article 6(1) of Directive 2000/78 provides that the Member States may provide that such differences of treatment "shall not constitute discrimination, if, within the context of national law, they are objectively and reasonably justified by a legitimate aim, including legitimate employment policy, labour market and vocational training objectives, and if the means of achieving that aim are appropriate and necessary." According to subparagraph (a) of the second paragraph of Article 6(1), those differences may include inter alia "the setting of special conditions on access to employment and vocational training, employment and occupation … for young people, older workers and persons with caring responsibilities in order to promote their vocational integration or ensure their protection" and, under subparagraphs (b) and (c), the fixing of conditions of age in certain special circumstances.

As it reviewed the documents presented by the national court, the Court recognized that the purpose of the legislation at issue was plainly to promote the vocational integration of unemployed older workers, in so far as they encounter considerable difficulties in finding work. As a rule, such an objective "objectively and reasonably" justifies, as provided for by the first subparagraph of Article 6(1) of Directive 2000/78, a difference of treatment on grounds of age laid down by Member States. In the Court's analysis it still remains to be established whether, according to the actual wording of that provision, the means used to achieve that legitimate objective are "appropriate and necessary." In this respect, the Court affirmed that the Member States unarguably enjoy broad discretion in their choice of the measures capable of attaining their objectives in the field of social and employment policy.

However, the Court also pointed out that in so far as such legislation takes the age of the concerned worker as the only criterion for the application of a fixed-term contract of

employment, regardless of any other consideration linked to the structure of the labor market in question or the personal situation of the person concerned, in order to attain the objective pursued it must be considered to go beyond what is appropriate and necessary. The Court considered that the observance of the principle of proportionality requires every derogation from an individual right to reconcile, so far as it is possible, the requirements of the principles of equal treatment with those of the aim pursued.[32] In light of these considerations the Court stated that such national legislation cannot be justified under Article 6(1) of Directive 2000/78.

The Court underscored that the principle of non-discrimination on grounds of age must be regarded as a general principle of European Community law. Consequently, observance of the general principle of equal treatment, respective of age in particular, cannot be conditioned upon the expiration of the period allowed to the Member States for the transposition of a directive intended to establish a general framework for combating age discrimination. In particular, this case concerns the organization of appropriate legal remedies, the burden of proof, protection against victimization, social dialogue, affirmative action, and other specific measures necessary to implement such a directive. Therefore, it is the responsibility of the national court to guarantee the full effectiveness of the general principle of non-discrimination in respect to age, setting aside any provision of national law which may conflict with Community law, even where the prescribed period for transposition of that directive has not yet expired.

b) Félix Palacios de la Villa[33]

This case concerned the interpretation of Article 13 EC and Articles 2(1) and (6) of Council Directive 2000/78/EC of

[32] See, also, Case C-476/99 Lommers [2002] ECR I-2891, paragraph 39.

[33] Judgment of the Court (Grand Chamber) of 16 October 2007 Félix Palacios de la Villa v. Cortefiel Servicios SA. Case C-411/05.

27 November 2000 establishing a general framework for equal treatment in employment and occupation. Parties to the case were Mr. Palacios de la Villa and his employer, Cortefiel Servicios SA (Cortefiel). The dispute concerned the automatic termination of Mr. Palacios de la Villa's employment contract because he had reached the age-limit for compulsory retirement set by national law.

In this case the national court asked the Court if the principle of equal treatment, which prohibits any discrimination whatsoever on the grounds of age and is laid down in Article 13 EC and Article 2(1) of Directive 2000/78, precludes a national law pursuant to which compulsory retirement clauses contained in collective agreements are lawful, where such clauses provide as sole requirements that workers must have reached normal retirement age and must have fulfilled the conditions set out in the national social security legislation for entitlement to a retirement pension under the national contribution regime.

The Court explained that by its first question, the referring court asked, essentially, whether the prohibition of any age-based discrimination in employment and occupation must be interpreted as precluding national legislation pursuant to which compulsory retirement clauses contained in collective agreements are regarded as lawful, where such clauses provide as sole requirements that workers must have reached retirement age, set by the national legislation, and must fulfill the other social security conditions for entitlement to draw a contributory retirement pension.[34]

By making reference to Article 2(1) and (2)(a) of Directive 2000/78, the Court affirmed that national legislation, such as that at issue in the main proceedings, according to which the fact that a worker has reached the retirement age laid down by that legislation leads to automatic termination of his employment contract, must be regarded as directly imposing less favorable treatment for workers who have reached that age as compared with all other persons in the labor force. Such legislation therefore establishes a difference in treatment directly based on age, as referred to in Article 2(1) and

[34] Paragraph 48

(2)(a) of Directive 2000/78.[35] Nonetheless, it is clear from the first subparagraph of Article 6(1) of the directive that such inequalities will not constitute discrimination prohibited under Article 2 "if, within the context of national law, they are objectively and reasonably justified by a legitimate aim."

In this case, it is clear from the referring court's explanations that, first, the compulsory retirement of workers who have reached a certain age was introduced into Spanish legislation in the course of 1980, against an economic background characterized by high unemployment, in order to create, in the context of national employment policy, opportunities on the labor market for persons seeking employment. The Court therefore maintained that an objective such as that referred to by the legislation at issue must, in principle, be regarded as "objectively and reasonably" justified "within the context of national law." It remains to be determined whether, in accordance with the terms of that provision, the means employed to achieve such a legitimate aim are "appropriate and necessary."

In this regard the Court recalled that as Community law stands at present, the Member States and, where appropriate, the social partners at the national level, enjoy broad discretion in their choice, not only to pursue a particular aim in the field of social and employment policy, but also in the definition of measures capable of achieving it. It is for the competent authorities of the Member States to find the right balance between the different interests involved, ensuring that the national measures laid down in that context do not go beyond what is appropriate and necessary to achieve the legitimate aim pursued by the Member State concerned.

[35] Paragraph 50 - 51

c) Birgit Bartsch[36]

This case concerned the interpretation of Article 13 EC, of Council Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment and occupation, and of general principles of Community law. The dispute arose between Mrs. Bartsch and Bosch and Siemens Hausgeräte Altersfürsorge GmbH, a company provident fund, with regard to the latter's refusal to pay Mrs. Bartsch a survivor's pension.

The referring court asked whether primary law of the European Communities contains a prohibition of discrimination on the basis of age (this prohibition must be applied by the Member States), even if the allegedly discriminatory treatment is unconnected to Community law. If this was answered in the negative, the court wished to ascertain whether, in circumstances such as those at issue in the main proceedings, such a link to Community law arises from Article 13 EC or from Directive 2000/78, even before the time-limit allowed to the Member State concerned for transposition has expired.

In answer to that question, the Court (Grand Chamber) ruled as follows:

> The application, which the courts of Member States must ensure, of the prohibition under Community law of discrimination on the ground of age is not mandatory where the allegedly discriminatory treatment contains no link with Community law. No such link arises either from Article 13 EC, or, in circumstances such as those at issue in the main proceedings, from Council Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment and occupation, before the time-limit allowed to the

[36] Judgment of the Court (Grand Chamber) of 23 September 2008. Birgit Bartsch v. Bosch und Siemens Hausgeräte (BSH) Altersfürsorge GmbH., Case C-427/06

Member State concerned for its transposition has expired.

AGEING POPULATION, ITALIAN CASE

INTRODUCTION:

According to a rational definition, "adult age" is the phase of the evolution process characterized by the absence of any development or substantial change[37]. The concept of age can be defined by referring to three different temporal dimensions:

Historical age: the time when an individual lives.
Chronological age: the time of life from birth to death.
Social age: the meaning that society attributes to a particular age according to roles, calendars and obligations. As far as we are concerned, in this paper we'll be dealing with the notion of "social age" as above defined.

Every society makes reference to the concept of "social age" and uses age to place individuals in a system of roles and human resources.[38] Such a system, which can be as useful as functional, ends up creating stereotypes which, on their side, can potentially result in a discrimination phenomenon. In the Italian labour market, the use of stereotypes referring to people over 45 is diffused. To this extent, such stereotypes often identify elderly people as not flexible, not motivated, and lacking "modern" skills, such as the knowledge of foreign languages and computer abilities. Although these affirmations have never been pronounced by any

[37] Luciano Abburrà, Elisabetta Donati, 'Ageing: verso un mondo più maturo. Il mutamento delle età come fattore di innovazione sociale'. Istituto Ricerche Economico Sociali del Piemonte. www.ires.piemonte.it. P. 64

[38] Ibidem pag 70

member of a human resources staff, these assumptions are unofficially well-recognized.[39]

At the same time and considering the demographic situation in Italy, according to which the ageing of the population increases constantly and exponentially, people over age 45 will be required to work longer in order to support the welfare system.

These considerations highlight a big contradiction: on one hand it will become necessary for people over age 45 to work longer, and, on the other hand, since they are objects of damaging stereotypes, they'll be given less space and fewer opportunities. This tendency and diffused practice will affect the human dignity of older individuals, with negative consequences as previously mentioned. Thus, an analysis of this concerning phenomenon and its causes is as necessary as ever before.

The causes that led to this contradiction are manifold, and are to be found in social, psychological, cultural and juridical aspects and considerations. In particular, causes are undoubtedly found in demographical changes, in the change of life expectancy and, consequently, in the modern perception of age and ageing.

Apparently, Italy is the country where, more than any other European country, the ageing of the population is causing significant effects.[40] It is one of the oldest populations in the country, and, by 2050, more than one out of three Italians will be over the age of 65.[41] Possible and probable consequences of such an occurrence could result in a slow-down in economic activities, pressure on the sustainability of social protection systems and labour shortages in certain occupations. To this extent, age discrimination in the labour market is of particular importance in Italy, in as much as the level of public spending on pensions is still one of the highest in Europe and OECD countries. Therefore, maintaining older workers in the labour market will be of particular importance.

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[39] S. Cuomo, See footnote 12 at p.3.

[40] A. Russo, R. Salomone, M. Tiraboschi, "Invecchiamento della popolazione, lavoratori "anziani" e politiche del lavoro: riflessioni sul caso italiano, giuridico in una prospettiva comparata per la gestione "flessibile" del personale", in *Collana ADAPT*, Working Paper, n. 7, 2000.

[41] OECD (2004), page 32.

Nonetheless, there is some evidence that older workers in Italy are experiencing a number of difficulties in the labour market. Improving their skills and employability should become an essential policy objective. Therefore, it is important to take new appropriate measures to encourage older workers to remain in the labour market and to improve their working conditions.

This part begins by introducing, first, the Italian demographical situation and second, the labour market and the employment rate.

a) Demographical change

Italy is the European country with the highest percentage of old people, with 19.8% of the total population made up of people over age 65. The percentage of people age 80 and over is increasing too, as they make up 5% of the total population.

After the baby boom of the 1960's and early 1970's, the total fertility rate declined brusquely, falling below the rate of 2.1% at the beginning of 1980, and reaching 1.24% in 2000. These rates are among the lowest in the world. At the same time, longevity has increased significantly. In 2000, life expectancy at birth was 76.3 years for men and 82.4 years for women. Life expectancy is projected to further increase an extra1.4 years for men and to 88.1 years for women in 2030, with most of the projected rise being concentrated among elderly cohorts.[42]

Although an increase of fertility rates is expected in the future, the dependency ratio (number of individuals 65 and over as a proportion of population aged 20-64) will more than double by 2050. According to ISTAT (the National Statistical Office) forecasts, when the baby boom generations retire the new generations will be just half the size.[43] Finally, immigration policy will also shape the outlook for population growth. It is predicted that the net migration flows will remain constantly positive; around

[42] The population projections used in this report are based on the main variant of the population projections produced by the Italian Statistical Office (ISTAT) (2006)

[43] Ibidem

120,000 persons.[44] The consequences of this demographic structure will lead to the increase of public expenditure in a country where these expenditures are already considerably high.

b) The labour market and the employment rate

Indeed, the consequences of the data above are not supported by the characteristics of the Italian pension system, which is particularly expensive, and still encourages early withdrawal from the labour market.[45] As a consequence, older workers in Italy tend to exit the labour market earlier than in most of the other European and OECD countries.[46] In the past, the main policy goal was to curb youth unemployment. Nonetheless, a policy that encouraged withdrawal from the labour force of older workers in order to make room for younger workers turned out to be counter-productive. Indeed, the employment rate for those aged 55-64 in Italy was 31.4% in 2005, about 10 percentage points below the European average.[47] Further, Italy is also one of the countries where the gap between the employment rate of older men and women is the largest.

As a consequence, inactivity represents a big issue in Italy, more than in other European countries, and retirement is the main reason for inactivity among Italian males aged 50 to 64.[48] This situation is even worse for older women, for whom the employment rate is 20.8%, the lowest in the EU.[49] To be

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[44] Among OECD countries, Italy has a low but growing share of foreigners in the total population and labour force. In 1998, the population share of foreigners in Italy was only 2.1%, while that of Switzerland was 19% (OECD, 2001a, Chapter 5). This share was only 1.1 % in 1988.

[45] OECD (2003)

[45] http://www.laboratoriorevelli.it/_pdf/wp67.pdf

[46] OECD. It is helpful to have a broad picture of the main status characterising older people in Italy and in OECD countries on average. The decline in employment of both men and women from the 50-54 age groups accelerates when reaching the age groups 55-59 and 60-64. These drops are almost translated one-to-one into a rise of retirement flows. This contrasts strongly with the OECD average, where the transition from employment to inactivity is not so pronounced.

[47] OECD (2004).

[48] Id.

[49] Id. Family responsibilities are the major factor behind inactivity of Italian women, even among those aged 50 to 64, a result that seems to support the still highly prevalent traditional separation of family tasks between men and women. These low participation rates also stem from different causes across regions. It is mainly due to relatively early exit and retirement for males in

underlined is the fact that this inactivity also includes those people who are potentially active.[50] OECD reports show that, if the employment policies adopted by Italy were different, then the effective labour supply would be much higher.[51] In addition, there are important regional differences in labour market outcomes and the presence of a large underground economy. As anticipated above, the causes of these deep effects have been analysed in correspondence with the Italian pension system, whose structure was deemed to be at the origin of the data illustrated above.

AGE DISCRIMINATION IN THE ITALIAN LABOUR MARKET

According to research conducted by the Bocconi University of Milan, 1,600,000 Italian citizens over age 45 report having been discriminated against in the labour market, and 500,000 of them report having been fired on age grounds. This part will focus on the analysis of the elements that prove the existence of a tendency to discriminate against individuals according to their age in the labour market.

Referring to the private sector, a study conducted by Cuomo shows how difficult it is for people over 45 who have lost their jobs to find new ones. The analysis of a number of cases demonstrates how often people over 45 lost their jobs not because of human or competences incompatibility, but only on the basis of their higher costs to the employer compared to the ones of younger

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the Northern regions and to low employment rates in general for females and for all persons in the Mezzogiorno (Southern Italy).

[50] OECD: Total "mobilisable" labour supply is measured on the basis of estimates of "excess" inactivity and "excess" unemployment, relative to international benchmarks. Contributions to the total mobilisable labour supply are broken down by four different groups: youths (15-24); prime-age (25-49) men; prime-age women; and older (50-64) workers.

[51] This is the second highest rate in the OECD area after Turkey (OECD, 2003b). The average OECD rate of mobilisable labour supply is 12%. In Italy, nearly all (90%) of these mobilisable resources can be found in inactivity. Older workers account for 40% of this excess inactivity compared to 29% for the OECD average. This suggests that there is room in Italy for large improvements in participation rates, particularly among people aged 50-64.

people. To be underlined is the fact that the recruitment process comprehends the evaluation of skills, knowledge, and experience, but also takes into account the major costs that characterize a potential older worker. Therefore, the modern attitude is to balance experience with cost cutting. Moreover, in addition to these objective factors there is no doubt that in this process grave stereotypes, such as that younger people are more motivated, flexible and productive, also are taken into account. The above mentioned counterbalance could indeed result as acceptable or necessary to some extent, but not when the evaluation of the experience and the personal value of a potential worker is overlooked because of stereotypes and prejudices.

In his study, Cuomo referred to the position and the perception of the so called "head hunters," who deal with the recruitment process and whose position is that age is not a discrimination element, because competence-vacancy is the only important factor in their decision and evaluation process. They consider age as an added value in many sectors (organisation, administration and control managing), and they then identify alleged age limits in other sectors, 50-55 for insurance, banks and pharmaceutical sectors, 35 in the investment banking, counselling, communication and fashion. Further, head hunters then admit the existence of two main phenomena able to determine a discriminatory perception: the internationalisation process that characterizes modern companies, and their consequent re-assessment. The re-assessment of the companies is due to their internationalisation, and this process can possibly lead to the exclusion of older workers, since it requires new and different skills, such as mobility and the knowledge of foreign languages.[52] These considerations are even more dangerous in the fight against age-discrimination, in as much as the importance of such discrimination is not only ignored, but even hidden by other reasons.

In the recruitment sector, the reflections concerning age discrimination are still at a very low level and no project or

[52] See Footnote 39.

structure exists to face discrimination properly. While gender is the object of a wider and deeper consideration (taking also into account the more substantial legislation on the matter) by the private sector, age is still characterized by a general unconsciousness towards the importance of the matter. These conclusions, winding ups and considerations are the result of the following data collection and analysis: Taking into account a national newspaper referring to September in 1993, 1998, 2003, and April 2004, 5,189 vacancy notices have been analysed. Out of them, 42.4 % provided an age limit. Considering that Italian legislation deems age exposure violation of privacy and of the principle of fair opportunities, this data is extremely important. In 87% of the 2,202 vacancy notices having age limits, the age required is under 44. Only 13.1% of these vacancy notices ask for people age 45 and over. On the basis of this data, it can be concluded that vacancy notices in newspapers promote young people over older people. 43.7% of the vacancy notices regarding posts in a company explicitly require a particular age. Concerning posts out of the companies, the percentage decreased to 36.1%. It can be concluded then that age is a factor that is less considered out of the companies.

Further, among the percentage of the vacancy notices that listed an age limit, 39.7 % refer to operational posts. The percentage is 42.3% for posts with no responsibility and 48.4% for post with responsibility. Ninety-three percent of the vacancy notices for operational posts required people under 44 years old. This percentage decreased to 83.3% for posts requiring responsibility. It can be concluded that the percentage of jobs with age limits increases in accordance with the responsibility required. This is proof of the connection that is made between age and factors such as commitment and responsibility. Apparently, the higher the responsibility gets, the less people over 45 are penalized. The data expressed shows that the production, the projecting, and development sectors are less discriminatory, while

the transport, communication and the general tertiary sectors are more discriminatory than the others.

In its research OECD collected data from three of the associations that most represent the Italian labour market: Confindustria (the principal employers' association representing, mainly industrial firms), Confcommercio (employers organisation representing small businesses and services), and Confartigianato (an organisation representing self-employed craft and trade workers). According to Confindustria, the current strategy of Italian firms is to favour younger workers (Confindustria, 2002). Confindustria stresses the need to improve older workers' human capital and to integrate more fully older people into the labour force; however, it also considers that this can be possible only in the conditions of a less rigid labour market and lower social contributions. This consideration is actually evidence of the perception that older workers represent too high a cost for the employers. On their sides, Confcommercio and Confartigianato refer to older people as a valuable source for the transmission of specific skills to younger workers and as tutors for them.

ITALIAN LEGAL FRAMEWORK

A general principle of equality is laid down in Article 3[53] of the Italian Constitution,[54] whilst Article 37[55] safeguards equal treatment and mentions age only as a minimum limit for salaried workers. This general principle is enshrined in two ordinary laws, namely in the Statuto dei Lavoratori[56] (Worker Statute – Act no. 300/1970, Article 15) and legislative decree no. 216 of 9 July 2003

[53] Article 3 [Equality](1) All citizens have equal social status and are equal before the law, without regard to their sex, race, language, religion, political opinions, and personal or social conditions. (2) It is the duty of the republic to remove all economic and social obstacles that, by limiting the freedom and equality of citizens, prevent full individual development and the participation of all workers in the political, economic, and social organization of the country.

[54] http://www.quirinale.it/costituzione/costituzione.htm

[55] Article 37 [Equality of Women at Work]: (1) Working women are entitled to equal rights and, for comparable jobs, equal pay as men. Working conditions have to be such as to allow women to fulfil their essential family duties and ensure an adequate protection of mothers and children. (2) The law defines a minimal age for paid labour. (3) The republic establishes special measures protecting juvenile labour and guarantees equal pay for comparable work.

[56] http://www.italianlang.org/Statuto%20dei%20Lavoratori.htm

that implements the European Directive 2000/78/EC,[57] establishing a general framework for equal treatment in employment and occupation.

The Statuto dei lavoratori is the name given to Law No. 300 of May 20, 1970, containing "rules on the protection of the freedom and dignity of workers and of trade union freedom and union activity in the workplace, and rules on the public employment service." Originally, the Worker Statute was limited to the prohibition of discrimination on grounds of political orientation, religion, race, language, and sex.

The legislative Decree no. 216 of 9 July 2003 amended the Worker Statute by introducing the provisions of non-discrimination on grounds of age, disability, sexual orientation and personal beliefs. As an expression of the implementation of the European Directive, the legislative Decree introduced in the Italian legal framework was the completion of the content of the Worker Statute.

Indeed, from a formal point of view, the Worker Statute and the Decree are compatible and complementary to each other.[58] Both of the two pieces are formal expressions of the general principle laid down by the Constitution. The scope of the principle of prohibition of discrimination enshrined in the Worker Statute is then integrated and widened by the legislative Decree integration.

A legislative effort made to face the alarming employment situation was given in 2003 with the introduction of legislative decree No. 276, the so called Biagi law.[59] The purpose of this

[57] http://ec.europa.eu/employment_social/news/2001/jul/directive78ec_en.pdf

[58] http://www.laboratoriorevelli.it/_pdf/wp67.pdf

[59] http://www.parlamento.it/leggi/03030l.htm. The main aspects covered by the law are the following:

- **Article 1** is concerned with harmonising and increasing the efficiency of public and private work intermediaries. A Legislative Decree (297/2002) has already been passed prior to the reform to enable private employment agencies to compete and co-operate with public agencies. The article simplifies the procedure of job placement.
- **Article 2** is concerned with the promotion of lifelong learning through apprenticeships, a new work training contract to facilitate reintegration of job-seekers and orientation training whereby the trainee is hired on a fixed term contract.

legislative change was to reduce certain elements of rigidity present in the Italian labour asset and to prohibit some sort of discrimination in the access to employment. Further it introduced new contractual schemes intended to facilitate the entry or return to the labour market primarily of disadvantaged groups including young and older people.

In the European legislative context, the *Mangold* case is worthy of mention, again, given its significant implications at the national level, namely the duty for member States to revise national provisions contemplating differential treatment. Italy is concerned in so far as, after the adoption of Legislative decree no. 276/2003, it concerns special contracts which make explicit reference to age. In this context, these contracts are not necessarily unlawful, but, in respect to the European Case Law, they need to be subject to the proportionality test in order to be valid.[60] Therefore, what is explained above clarifies that until not long ago Italian legislation provided only a general principle prohibiting discrimination. It is because of the obligations to respect and to

- **Article 3** authorises the government to reform current conditions for part-time work. The reform aims at defining new rules to give sufficient protection to part-time workers (delay of notice, overtime payment, etc.) while encouraging parties to engage in such contracts instead of precarious work arrangements in the hidden economy. The current rules impose unnecessary obstacles on the possibility to work reduced hours. Reduced social contributions may be granted for part-time contracts with workers from disadvantaged categories (youth and older job-seekers).
- **Article 4** regulates non-standard forms of employment such as on-call work, "continuous co-ordinated collaborations" (or so-called Co-co-co contracts) and job sharing. The law provides a new framework for fixed-term work arrangements that consist of either wage and salary work or "work missions" (more akin to self-employment). Other occasional forms of work like baby-sitting, private tuition, gardening and house cleaning, will also be easily regularised through a system of coupons available from the social security institution.
- **Article 5** supports active collaboration of employers' and workers' representatives through the setting up of bilateral institutions with common goals in the area of job placement, training and labour-contract design.
- **Article 8** reinforces the control system of INPS, INAIL (*Istituto nazionale per l'assicurazione contro gli infortuni sul lavoro*) and the Ministry of Labour and Social Policies, by increasing co-ordination among them and supplementing financial controls and sanctions with a policy of prevention and information.

[60] That is the case with Article 13 of legislative Decree no. 276/2003 which allows temporary work agencies to derogate from the principle of equal treatment in the case of disadvantaged workers, including those up to the age of 25 and those over the age of 50 who are or are about to become unemployed. O. Bonardi, "le clausole di non regresso e il divieto di discriminazione per motive di eta' secondo la corte di giustizia", *Rivista italiana di diritto del lavoro*, no. 2, 2006, p. 266.

adapt to Community Law that Italy had to introduce age as a possible ground of discrimination.

Hence, by means of Legislative Decree no. 216, 9 July 2003, Italy complied with the European standards and introduced age discrimination in its legislation. The Decree was published in the Official Journal No. 187 of 13 August 2003 and came into force on 28 August 2003. Article 1 of the Decree no. 216, 9 July 2003[61] mentions age in the provision promoting equal treatment of people in occupation and employment. In accordance with the European Directive, the Decree refers both to direct and indirect discrimination, whose definition is given in Article 2, and it applies to both the public and private sectors (Article 3 (1) of the Decree). It covers access to employment, self-employment and occupation (including selection criteria and recruitment conditions), and all aspects concerning occupation and working conditions, including career development, dismissals and pay. The prohibition applies to all natural and legal persons, not only the employer, but also trade unions and employers' organisations. Nonetheless, the Decree implementing the European Directive was criticised because it was considered too weak an instrument for the transposition of the provisions of the European directive.

One of the leading Italian trade union confederations (CGIL),[62] which initially supported a campaign in favour of legislation transposing the directive, reacted by pointing out its disappointment in the content and strength of the Decree. In particular, CGIL defined it as a technically mediocre legislation. A lot of expectations were put on this new legislation, and its limited elaboration and scarcely widened scope led to these negative reactions. The point that raised the most concern was the issue of the burden of proof. In this respect, apparently, the Decree does not comply with Article 10 (1) of the Directive, which is formulated as follows: "[It] shall be for the respondent to prove

[61] http://www.giustizia.it/cassazione/leggi/dlgs216_03.html
[62] http://www.cgil.it/org.diritti/homepage2003/indexdir.htm

that there has been no breach of the principle of equal treatment. . . ." Therefore, it explicitly clarifies that the burden of proof is not an issue of concern for the alleged victim of discrimination.

Differently, Article 4 (4) of the Decree provides that in order to prove the existence of discriminatory behaviour the plaintiff must provide the Judge with elements that are to be evaluated in accordance with Article 2729 (1) of the Civil Code[63]. This Article determines a reversal of the burden of proof, which is crucial in such a context where the possible difficulties which the discriminated employee can encounter, must be taken into account. In particular, the probable reluctance of colleagues to testify against the employer, and the lack of documentary proof typical of these situations must be considered.

The provisions laid down in the decree have been criticized because of their vagueness and lack of effectiveness. The decree has been defined as a failure[64] because of the potential value that it could have had and because of its minimal contribution to the improvement of the conditions of access to work for the citizens. Moreover, there is no mention in the decree of the fact that all the norms in contrast with the principle of non-discrimination as laid down in the Directive should be abrogated, including the provisions of collective agreements, individual employment contracts, enterprise regulations, and provisions regulating autonomous employment.[65]

[63] Artiche 4 (4), states as follows: " *Il ricorrente, al fine di dimostrare la sussistenza di un comportamento discriminatorio a proprio danno, può dedurre in giudizio, anche sulla base di dati statistici, elementi di fatto, in termini gravi, precisi e concordanti, che il giudice valuta ai sensi dell'articolo 2729, primo comma, del codice civile.* "

[64] http://www.cinziaricci.it/nosilence/archivio191.htm

[65] http://www.laboratoriorevelli.it/_pdf/wp67.pdf

CONCLUSIONS

Older people offer potential value to businesses, the economy and society. Nonetheless, the traditional respect towards their experience and knowledge seems to have been replaced by stereotypes that pose for them serious barriers to have access to or to re-enter the labour market and have the opportunity to develop their role in society. Using discriminatory stereotypes is unacceptable in a civilized society. States and society in general are obliged to look beyond traditional stereotypes about ageing in order to benefit from the growing numbers of older citizens, many of whom would, in fact, choose to work for longer given appropriate policies and workplace practices.

The importance of age discrimination and of the loss of resources and social contribution it can lead to cannot be ignored; legislation, policies and actions concerning this issue have not yet been effectively adopted. Italy does not yet have a comprehensive anti-age discrimination framework. Compliance with European anti-discrimination law and the consequential adoption of legislation against discrimination represents, with no doubt, a step in that direction, but legislation cannot suffice in such issues.

Age discrimination and discrimination in general must be faced and fought also on other levels, such as sociological and cultural. The most common stereotypes lead to the perception of older people as a burden for society. This attitude can be dismantled only by referring also to the social and cultural level. History has a very important role too in this fight, in as much as it can give evidence of the value of experience and knowledge. The research and data explored in this paper show how deeply Italy will have to deal with this matter in the very near future, taking into particular account the demographical changes. Age discrimination can be defeated by improving social understanding, legal awareness and cultural development. This is all necessary in order to guarantee human dignity, an undeniably essential element of any society grounded upon universal human rights.

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[1]

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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a younger counterpart.[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.[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.[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.[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.[6]

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[2] Anthony F. Jerant, MD, et. al., *Age-Related Disparities in Cancer Screening: Analysis of 2001 Behavioral Risk Factor Surveillance System Data*, 2 Annals of Family Medicine 5 (2004); K. Lavelle, et al., *Non-standard Management of Breast Cancer Increases with Age in the UK: a Population Based Cohort of Women >65 Years*, 96 British Journal of Cancer 96, 1197-1203 (2007), www.bjcancer.com; Townsley, C. Pond, B. Peloza, J. Kok, K. Naidoo, D. Dale, C. Herbert, E. Holowaty, S. Straus, L. Siu, *Analysis of Treatment Practices for Elderly Cancer Patients in Ontario, Canada*, 23 Journal of Clinical Oncology 16, 3802-3810 (June 1, 2005); *Legal-Dictionary*, http://legal-dictionary.thefreedictionary.com/Senior+Citizens (last accessed Dec. 29, 2009) ("Elderly persons, usually more than sixty or sixty-five years of age.").

[3] *Id.*

[4] Townsley, *Analysis*, *supra* n. 1, at 3802, 3806; Laura F. Hutchins, et al., *Underrepresentation of Patients 65 Years of Age or Older in Cancer-Treatment Trials*, 341 New England Journal of Medicine 27, 2061-2067 (Dec. 30, 1999), www.nejm.org; D. Papamichael, et al., *Treatment of the Elderly Colorectal Cancer Patient: SIOG Expert Recommendations*, Annals of Oncology (Oct. 15, 2008); Sofia Dimakou, et al., *Identifying the Impact of Government Targets on Waiting Times in the NHS*, 12 Health Care Manag. Sci. 1-10 (2009).

[5] Lori Montgomery, *Report: Bill Would Reduce Senior Care*, Wash. Post (Nov. 15, 2009), www.washingtonpost.com/wp.dyn/content/article/2009/11/14/AR2009111402597.html (last accessed Dec. 22, 2009).

[6] Linda Gorman, *Rationing Care: Oregon Changes Its Priorities*, National Center for Policy Analysis, No. 645 (Feb. 19, 2009), 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.[7] 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."[8] In essence, wait lists serve as signals to both the supply and demand sides of healthcare.[9]

The older the population, the greater the utilization of healthcare services.[10] 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.[11] Another problem is that seniors often encounter more complex conditions, such as cancer, or have co-morbid conditions that make treatment more expensive.[12]

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.[13] 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.

[9] Gravelle H., Smith P., Xavier A., *Performance Signals in the Public Sector: the Case of Health Care*. 55 Oxf. Econ. Pap. 81-103 (2003).

[10] Vegda K., X Nie J., Wang L., Tracy, C.S., Moineddin, R.,and Upshur R. E.G., *Trends in Health Services Utilization, Medication Use, and Health Conditions Among Older Adults: a 2-year Retrospective Chart Review In a Primary Care Practice*, 9 BMC Health Services Research 217 (2009), http://www.biomedcentral.com/1472-6963/9/217 (last accessed Dec. 29, 2009).

[11] Social Security Administration, *Medicare Trust Report* (2009).

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

[13] Social Security Administration, *Status of Social Security and Medicare Programs*, http://www.ssa.gov/OACT/TRSUM/index.html (last accessed Dec. 29, 2009).

treatment availability.[14] In the Canadian system, total provincial health care spending was approximately C$83 billion in 2004-2005.[15] 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.[16] This means that there is insufficient funding to ensure redistribution in line with the weighted capitation formula recommendations.[17] Overall, all three countries are experiencing a similar occurrence. The aging population that is entitled to healthcare services is costing more and resultantly 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.[18] 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

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[14] International Comparisons of Health Care – Overviews of Selected Health Care Systems, http://www.libraryindex.com/pages/1862/International-Comparisons-Health-Care-OVERVIEWS-SELECTED-HEALTH-CARE-SYSTEMS.html (last accessed Dec. 29, 2009).

[15] Department of Finance Canada, *Federal Support for Health Care: The Facts*, (2004), http://www.fin.gc.ca/facts-faits/fshc7-eng.asp (last accessed Dec. 29, 2009).

[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.

[18] Age Discrimination Act 1975, 42 U.S.C. § 6101 *et seq*. (available at www.sba.gov/idc/groups/public/documents/sba_homepage/), The Employment Equality (Age) Regulations 2006, SI 2006 No. 1031, (available at http://www.opsi.gov.uk/si/si2006/20061031.htm); Can. Const. (Constitution Act, 1982) pt. I (Canadian Charter of Rights and Freedoms), § 15. *See also* Marc L. Kesselman, *Putting the Professor to Bed: Mandatory Retirement of Tenured University Faculty in the United States and Canada*, 17 Comp. Lab. L.J. 206, 216-218 (1995) (providing a comparison of U.S. and Canadian age discrimination laws. Of particular note is the emphasis on The Canadian Charter of Rights and Freedoms, whereby Section 32(1) limits the Charter's reach of applicability to federal and provincial governments. Private employment discrimination is governed by provincial statutes).

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,[19] 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.[20] 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-

[19] Raffel M.W., Raffel N.K., *The U.S. Health System – Origin and Functions* 1, (4th ed., Delmar Publications Inc. 1994).

[20] *Id*.

profit hospitals.[21] 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.[22]

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.[23] 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.[24] The Veteran's Administration is a federal integrated healthcare system delivery model.[25] 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.[26] 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

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[21] American Hospital Association, *Fast Facts on U.S. Hospitals*, http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html (last accessed Dec. 13, 2009).

[22] *Id.*

[23] Indian Health Service, *The Indian Health Service Fact Sheet*, http://info.ihs.gov/CHSasp (last accessed Dec. 13, 2009).

[24] United States Department of Veterans Affairs, *VA Healthcare Overview*, http://www4.va.gov/healtheligibility/ (last accessed Dec. 29, 2009).

[25] Deputy Secretary W. Scott Gould, Remarks, *Leadership VA Graduation Ceremony, Baltimore, MD* (Nov. 20, 2009) (available at http://www1.va.gov/opa/speeches/2009/09_1120_gould.asp).

[26] Congressional Budget Office, *Quality Initiatives Undertaken by the Veterans Health Administration* (Aug. 2009), http://www.cbo.gov/ftpdocs/104xx/doc10453/08-13-VHA.pdf (last visited Dec. 29, 2009).

tribes.[27] 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.[28] 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.[29] The amount of financing by private industry increased 102% from 1994 to 2003.[30] 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.[31]

Spending on healthcare in the United States continues to outpace both Canada and the United Kingdom.[32] Current estimates put U.S. healthcare spending at between 15.3 and 17 percent of the GDP.[33] 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.*

[28] Trish Groves, *Stronger European Medical Research*, 336 British Journal of Medicine 341-342 (2008) (available at http://www.ncbi.nlm.nih.gov/pubmed/18276671).

[29] *Stats from 2007 Europ.Fed.of Pharm.Indust.and Assoc.*, http://212.3.246.100/Objects/2/Files/infigures2007.pdf (last accessed Dec. 13, 2009).

[30] Neil Osterwell, *Medical Research Spending Doubled Over Past Decade*, MedPage Today, (Sept. 20, 2005) (available at http://www.medpagetoday.com/PublicHealthPolicy/HealthPolicy/tb/1767).

[31] *Id.*

[32] Lisa L. Dahm, *Healthcare Systems and Quality of Care: Do International Measurement Standards Exist*, 20 Temp. Int'l & Comp. L.J. 395, 405, 412 (2006) (showing that in 2003, Canada spent 9.9% of its GDP on healthcare and the United Kingdom spent 7.7% of its GDP on healthcare).

[33] World Health Organization, *World Health Statistics 2009*, http://who.int/whois/whostat/2009/en/index.html (last accessed Dec. 13, 2009).

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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[34] Centers for Medicare and Medicaid Services, *National Health Expenditure Data: Overview*, http://www.cms.hhs.gov/nationalHealthExpendData/o1_Overviewasp, (last accessed Dec. 13, 2009).

[35] Office of the Actuary in the Centers for Medicare and Medicaid Services, *National Health Expenditures, Forecast Summary and Selected Tables*, http://www.coms.hhs.gov/NationalHealthExpendData/Downloads/proj2007.pdf (last accessed Dec. 13, 2009).

[36] Micah Hartman, Aaron Catlin, David Lassman, Jonathan Cylus, and Stephen Heffler, *US Health Spending by Age, Selected Years Through 2004*, (Nov. 6, 2007) (available at http://content.healthaffairs.org/cgi/content/abstract/27/1/w1?rss=1).

[37] John E. Wennberg, Elliott S. Fisher, David C. Goodman, and Jonathan S. Skinner, *Tracking the Care of Patients with Severe Chronic Illness: the Dartmouth Atlas of Health Care 2008*, The Dartmouth Institute for Health Policy and Clinical Practice (May 2008), ISBN 978-0-9815862-0-5.

[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.[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%.[42] In 2007, a study showed that 59.3% of Americans received their health insurance through an employer.[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.[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.[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.[46]

Individuals with private insurance may be limited to medical facilities that accept the particular type of insurance they carry.[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-

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[41] *Supra* n. 13.

[42] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health: United States 2007*, http://www.cdc.gov/nchs/data/hus/hus07.pdf (last visited Dec. 13, 2009).

[43] Kaiser Family Foundation, *Health Insurance Premiums Rise 6.1 Percent in 2007, Less Rapidly Than in Recent Years but Still Faster than Wages and Inflation* (Sept. 11, 2007), http://www.kff.org/insurance/ehbs091107nr.cfm (last visited Dec. 13, 2009).

[44] *Supra* n. 13.

[45] U.S. Census Bureau, *Income, Poverty and Health Insurance Coverage in the United States: 2007* (August 2008), http://www.census.gov/prod/2008pubs/p60-235.pdf (last accessed Dec. 13, 2009).

[46] Simon LI, *Health Care Financing Policies of Canada, the United Kingdom and Taiwan*, Research and Library Services Division Legislative Council Secretariat, (Dec. 7, 2006) available at http://www.legco.gov.hk.

[47] America's Health Insurance Plans, http://www.ahip.org/ (last accessed Dec. 29, 2009).

pay required when utilizing contract facilities and providers.[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.[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.[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.[51] In an HMO, health care is covered for services delivered by contract providers (such as doctors and hospitals) in the network.[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.[53]

United States government-funded insurance programs directly cover 27.8% of the population.[54] These programs cover

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[48] *Ibid*.

[49] Hariri S., Bozic K.J., Lavernia C., Prestipino A., Rubash H.E,. *Medicare Physician Reimbursement: Past, Present, and Future*, 89 J Bone Joint Surg Am. 2536-2546 (2007); *see* Hariri S., Bozic K.J., O'Connor M.I., Rubash H.E., *Medicare Part B: Physician Participation Options*, 90 J. Bone Joint Surg Am 2282-2291 (2008).

[50] California Office of the Patient Advocate, *What Is An HMO?*, http://www.opa.ca.gov/report_card/hmowhatis.aspx (last accessed Dec. 29, 2009).

[51] Hurley R.E., Strunk B.C., White, J.S., *The Puzzling Popularity of the PPO* (2004), www.content.healthaffairs.org/cgi/pmidlookup?view=long&pmid=15046131 (last accessed Dec. 13, 2009).

[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).

[53] Piterman L., Koritsas S., *Part I – General Practioner-Specialist Relationship*, 35 Internal Medicine Journal 7, 430-34 (2005) (available at http://www3.interscience.wiley.com/journal/118713524/abstract?CRETRY=1&SRETRY=0).

[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,

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[55] Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §1395dd.

[56] Thomas M. Selden and Merrile Sing, *The Distribution of Public Spending for Health Care in the United States, 2002*, 27 Health Affairs 5 (Jul. 29, 2008), http://content.healthaffairs.org/cgi/reprint/hlthaff.27.5.w349v1 (last accessed Dec. 13, 2009); Centers for Medicare and Medicaid Services: Emergency Medical Treatment and Active Labor Act, http://cms.hhs.gov/EMTALA/ (last accessed Dec. 13, 2009).

[57] *Unsettling Scores: A Ranking of State Medicaid Programs*, p. 15, http://w.citizen.org/hrg/medicaid/assets/reports/2007UnsettlingScores.pdf (last accessed Dec. 13, 2009); *supra* n. 41.

[58] Centers for Medicare and Medicaid, *U.S. Department of Health and Human Services Statistics* (2006), http://www.cms.hhs.gov/CapMarketUpdates/Downloads/2006CMSstat.pdf (last accessed Dec. 13, 2009); Heathfield S., *Baby Boomers Definition*, http://humanresources.about.com/od/glossaryb/g/boomers.htm (last visited Dec. 29, 2009) ("Baby Boomers is the name given to the generation of Americans who were born in a "baby boom" following World War II. The Boomers were born between 1944 and 1964.").

[59] Agency for Healthcare Research and Quality, *Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Section 1013: Priority Topics for Research* (Oct. 2006), http://www.ahrq.gov/about/mmarsrch.htm (last accessed Dec. 29, 2009); Kaiser Family Foundation, *Key Implementation Dates for the Medicare Prescription Drug Benefit*, http://www.kff.org/medicare/mma_timeline.cfm (last accessed Dec. 29, 2009).

where the National Health Service (NHS) also provides prescription coverage with an additional cost to some beneficiaries.[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.[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.[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.[63] By 1971, a provincial-federal partnership plan providing healthcare was in place.[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

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[60] Martha Ann Holt, *International Prescription Drug Cost Containment Strategies and Suggestions for Reform in the United States*, 26 Boston College International & Comparative Law Review 2, p. 325, 335 (2003).

[61] Canada Health Insurance, *About Drug Coverage*, 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.").

[62] World Health Organization, *Core Health Indicators: Per Capita Government Expenditures on Health at Average Exchange Rate*, http://www.who.int.whois/database/core/core_select_process.cfm?strlS03_select=ALL&strIndicator_select=nha&intYear_select=latest&fixed=indicator&language=english (last accessed Dec. 13, 2009).

[63] Kao-Ping Chua, AMSA Jack Rutledge Fellow 2005, *Canadian Health Care Fact Sheet*, http://www.amsa.org/studytours/CHS_FactSheet.pdf (last accessed Dec. 14, 2009).

[64] *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

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[65] Centers for Medicare and Medicaid Services, *Overview Medicaid Program – General Information*, http://www.cms.hhs.gov/Medicaidgeninfo/ (last accessed Dec. 29, 2009).

[66] Kaiser Family Foundation, *International Health Systems: Canada*, http://kaiseredu.org (last accessed Dec. 14, 2009).

[67] The Department of Health and Human Services, USA, Centers for Medicare and Medicaid, *Medicare and You 2010*, p. 12 (2010).

[68] *Ibid*.

[69] *Ibid*.

[70] Canada Library of Parliament, *The Canadian Health Act of 1984: Overview and Options*, Current Issue Review, 94-4E, pp.2, 6-8 (May 16, 2005), www.parl.gc.ca/information/library/prbpubs/944-e.pdf (last accessed Dec. 14, 2009).

[71] *Id*.

[72] European Observatory on Health Systems and Policies, *Health Systems in Transition – HIT Summary: Canada* (2005), http://www.euro.who.int/observatory (last accessed Dec. 14, 2009).

[73] *Ibid*.

federal income taxes.[74] 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%).[75] 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.[76]

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.[77] Services excluded from these plans include most dental care, most vision care, long-term care, home care, and pharmaceuticals prescribed outside of hospitals.[78] 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.[79]

Provinces, the federal government, and municipal governments provide other benefits to seniors, low-income individuals, and other groups.[80] 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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[74] Christel A. Woodward & Catherine A. Charles, *The Changing Faces of Health Care in Canada in Healthcare Reform Around the World*, 78, 91-92 (Andrew C. Twaddle ed., 2002).

[75] *Id*.

[76] *Id*.

[77] Canadian Health Act of 1984, *supra* n. 69.

[78] *Id*.

[79] *Supra* n. 71.

[80] Margaret Somerville, *International and Comparative Health Law and Ethic: A 25-Year Retrospective as a Tribute to Professor Bernard Dickens*, 32 J.L. Med. & Ethics 731, 738 (2004).

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."[81]

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.[82] 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.[83] 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.[84] 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.[85] 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.[86]

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.*

[82] Canadian Institute of Health Information, *Exploring the 70-30 Split: How Canada's Health Care System is Financed* (2005), http://www.healthreports.cihi.ca (last accessed Dec. 14, 2009).

[83] *Supra* n. 71.

[84] Steinbrook, R., *Private Health Care in Canada*, 354 New Eng. J. Med.16, 1661-1664.

[85] *Chaoulli v. Quebec*, 2005 S.C.C. 035 (June 9, 2005), http://www.lexum.umontreal.ca/scs-scc/rec/html/2005scc035.wpd.html (last accessed Jan. 6, 2010) (claiming violation under the Canadian Charter of Rights and Freedoms and the Quebec Charter of human Rights and Freedoms, a physician and his patient contested the prohibition against purchasing private insurance).

[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.[87] In the Canadian system, as well as the U.S. system, patients have freedom of choice in selecting a family physician.[88] 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.[89]

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.[90] Fee schedules are negotiated between the provinces and the provincial medical association.[91] This is similar for physicians in the United States when negotiating with private insurance companies.[92] 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).[93] In the United States, the government dictates the reimbursement rate and provides physicians with a set fee schedule that is non-negotiable.[94] In the instances of Medicare

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[87] Woodard, *supra* n. 73 at 81.

[88] Inglehart J.K., *Revisiting the Canadian Health Care System*, 342 New Eng. J. Med. 26, 2007-2012 (June 2000).

[89] Kao-Ping Chua, *supra* n. 62.

[90] Canadian Institute for Health Information, *Physicians in Canada: Average Gross Fee-for-Service Payments*, Institute of Health Economics, www.ihe.ca/publications/health-db/ (last accessed Dec. 29, 2009); *Health Care Systems – Managed Health Care v. Fee-for-Service*, www.faqs.org/health/ (last accessed Dec. 29, 2009) ("Under the fee-for-service method, doctors and hospitals got paid for each service they performed.").

[91] Canadian Institute for Health Information (2001) pp.7-8; *Canada's Health System At a Glance* (2002); Marchildon G. P., *Health Systems in Transition: Canada* (2005), http://www.euro.who.int/Document/E87954.pdf#search=%22Health%20Systems%20in%20Transition%3A%20Canada.%22 (last accessed Dec. 29, 2009).

[92] Spears C., *Negotiating Insurance Contracts – Is There Any Hope?*, 32 Urologic Clinics of North America 3, 271-73 (2005).

[93] Simon LI, *supra* n. 45.

[94] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (Dec. 19, 1989); Centers for Medicare and Medicaid Services (CMS), *Medicare Claims Processing*

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),

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Manual, Chapter 4 – Part B, (Revised Apr. 8, 2008) (available at http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf).

[95] Peck B., *Is Opting Out of Medicare the Answer?* 92 Bull. Am. Coll. Surg. 8-11 (2007).

[96] Fox M., *U.S. Hospital Services Vary Widely Across US*, Reuters (April 2, 2009), www.reuters.com/mobile (last accessed Dec. 29, 2009).

[97] American Hospital Association, http://www.aha.org (last accessed Dec. 29, 2009).

[98] *Comparing the U.S. and Canadian Health Care Systems*, http://nber.org/aginghealth/fall07/w13429.html (last accessed June 6, 2009).

[99] United States Department of Veterans Affairs, *History of the Department of Veterans Affairs – Part 9*, http://www1.va.gov/opa/feature/history/history9.asp (last accessed June 10, 2009).

[100] American Hospital Association, http://www.aha.org (last accessed Dec. 29, 2009).

which is controlled by the Department of Health.[101] 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.[102]

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.[103] The current publicly-funded health care system, the NHS, provides universal health care to residents in the United Kingdom.[104] 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.[105] Healthcare is mainly administered through public provision and financed through public funds.[106] The NHS accounts for 86% of

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[101] United Kingdom Department of Health, *NHS Constitution for England*, http://www.dh.gov/uk/en/Publlicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093419 (last accessed Sept. 5, 2009).

[102] Flood C.M., *Profiles of Six Health Care Systems: Canada, Australia, The Netherlands, New Zealand, the UK, and the US* (April 2001), http://www.parl.gc.ca/37/1/Parlbus/commbus/senate/com_e/Soci_e/rep_e/volume3verl_e.pdf (last accessed Dec. 14, 2009).

[103] Greengross P., Grant K., Collini E., *The History and Development of the UK National Health Service 1948-1999*, 2nd ed., p. 5, http://www.dfidhealthc.org/publications/country_health/nhs/NHS_history.pdf (last accessed Dec. 14, 2009).

[104] Rivett G., *From Cradle to Grave, 50 Years of the NHS*, Kings Fund (1998), www.nhshistory.net (last accessed Sept. 5, 2009).

[105] The Kaiser Family Foundation, *International Health Systems: The United Kingdom*, http://www.kaiseredu.org/topics (last accessed Dec. 14, 2009).

[106] Institute of Chartered Accountants of England and Wales, *NHS Funding Need Not Damage Business Health* (Mar. 14, 2008), http://www.icaew.com/index.cfm?route=100799 (last accessed Sept. 5, 2009).

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%).[107] Ancillary mechanisms that generate revenues are the provision of prescription drugs, dentistry services, and fees charged to private patients who use NHS services.[108]

Private health insurance is a mix of for-profit and not-for-profit insurers primarily in the provision of supplementary insurance.[109] "Private insurance offers a choice of specialists, avoidance of queues for elective surgery and higher standards of comfort and privacy than the NHS."[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.[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.[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.[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.[114] The share of public financing for these systems is 44.7% for the United States,

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[107] Boyle S., *The UK Health Care System*, LSE Health and Social Care, London School of Economic and Political Science (Feb. 2008).

[108] *Ibid*.

[109] *Ibid*.

[110] The Commonwealth Fund, *The United Kingdom Health System*, (available at www.commonwealthfund.org).

[111] The Hospital Corporation of America (HCA, Inc.), www.hcahealthcare.com (last accessed Dec. 29, 2009).

[112] *Supra* n. 67.

[113] *Ibid*.

[114] Greengross, *supra* n. 102 at 5.

69.6% for Canada, and 83.7% for the United Kingdom.[115] 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.[116]

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.[117] 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.[118] 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.[119] In these instances the individual cannot seek specialty services without a referral from their GP or FP.[120]

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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[115] Propper C, *Expenditure on Health Care in the UK: A Review of the Issues*, 22 Fiscal Studies 2, 151-183 (2001), http://www.ifs.org.uk/fs/articles/0037a.pdf (last accessed Jan. 6, 2010).

[116] OECD Health Data 2009, *How Does the United Kingdom Compare*, p. 1 (2009), http://www.oecd.org/health/healthdata (last accessed Dec. 14, 2009).

[117] *Supra* n. 106.

[118] *Ibid*.

[119] *Supra* n. 52.

[120] *Supra* n. 65.

established rates in the United States under Medicare and Medicaid.[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.[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.[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.[124] This translates, per person aged 65 and older in 2006, to $4,032 (median annual healthcare expenditure). The outliers, 25th percentile, had expenses under $1,752.00 annually and the 75th percentile had expenses over $9,289.00.[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

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[121] *Ibid.*

[122] Centers for Medicare and Medicaid Services, *Medicare History Outline*, http://www.cms.hhs.gov/History/01_Overview (last accessed Dec. 14, 2009).

[123] Rand Health, *Future Spending and Medical Care Spending of the Elderly*, p. 1, www.rand.org (last accessed Dec. 14, 2009) (listing seven chronic diseases as stroke, COPD, hypertension, coronary heart disease, cancer, diabetes, acute myocardial infarction).

[124] Steven R. Machlin, MS, *Trends in Health Care Expenditures for the Elderly Age 65 and over: 2006 versus 1996*, Statistical Brief #256, Agency for Healthcare Research and Quality, Rockville, MD, p. 1, 5 (Aug. 2009).

[125] *Ibid*.

spending.[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.[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."[128] Compared to the C$2,000.00 per person for the remainder of the population, seniors accounted for C$8,969.00.[129] On a macro level, Canadian seniors accounted for nearly 44% of total provincial and territorial government expenditures.[130] This figure has not significantly changed since 1998 because seniors, as a percentage of the population, have remained constant at around 13%.[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.[132] In 2005, 8.1 million seniors accounted for 16.0% of the total population.[133] The numbers of seniors are expected to increase annually reaching 10.6 million – an increase of 32% - by 2021.

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[126] *Supra* n. 122.

[127] *Ibid.* at 4 (representing 2005 dollars).

[128] Canadian Institute for Health Information, http://www.ihsglobalinsight.com/SDA/SDADetail7718.htm (last accessed Dec. 14, 2009).

[129] *Ibid.*

[130] *Ibid.*

[131] *Ibid.* (projecting the percentage of seniors to rise over the next 25 years and reaching 23% by 2031).

[132] *OECD Health Data 2009 - How Does the United Kingdom Compare*, (June 2009).

[133] Simpson L., and Gavalas V., *Population Forecasts for Oldham Borough, With an Ethnic Group Dimension* (May 27, 2005) CCSR, University of Manchester; *see also*, *Population Forecasts for Oldham – People Aged 65 Years and Over* (Mar. 2006), http://www.oldham.gov.uk (last accessed Dec. 14, 2009); Di Carlo, *Human and Economic Burden of Stroke*, 38 Age and Ageing 4-5 (2009).

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."[134] 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.[135]

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"[136] because of the possibility that a senior has "less chance of achieving a successful clinical outcome."[137] Second, others justify withholding expensive medical treatment to seniors based on the notion of waning productivity based on a return on investment theory,[138] fundamentally indicating that healthcare dollars are better invested in younger members of society because they have greater potential to contribute to society at large.[139]

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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[134] George P. Smith, II, *The Elderly and Health Care Rationing*, 7 Pierce L. Rev. 171, 173 (Apr. 2009).

[135] David C. Hadon and Robert H. Brook, *The Health Care Resource Allocation Debate: Defining Our Terms*, 266 J. AM. MED. ASS'N 3328 (1991) (comparing allocation and rationing); *see generally*, Marilyn Chase, *Too Often, The Elderly Don't Get the Drugs or Care They Need*, Wall St. J., Sept. 24, 1999, at B1 (relaying that healthcare for the elderly is disparate because of the undertreatment of many medical conditions).

[136] Andrew H. Smith and John Rother, *Older Americans and the Rationing of Health Care*, 140 U. PA. L. REV. 1847, 1849-50 (1992).

[137] Jessica Dunsay Silver, *From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the "Hidden" Rationing of Medical Care*, 37 CATH. U. L. REV. 993, 1014-15 (1998).

[138] *Supra* n. 93, at 1853.

[139] *See* John F. Kilner, *Who Lives? Who Dies?: Ethical Criteria In Patient Selection*, 79-80 (Yale University Press 1990).

treatment for example, is a commonality seniors face.[140] In the United States and Europe, more than 60% of new cancer cases and more than 70% of cancer related deaths occur in seniors.[141] Overall, senior cancer patients are undertreated and underrepresented in clinical trials.

The United States

Age-related disparities in healthcare are a reality.[142] In the United States, senior women account for nearly 50% of all breast cancer cases, yet only 8% of those patients receive chemotherapy.[143] 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."[144] Another study indicated that while colorectal and prostate cancer increased with age until 74, mammography screening decreased after age 59.[145]

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.[146] Lung, liver, breast, pancreas, esophageal, gastric, sarcoma, and rectal cancers

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[140] Dockter L. and Keene S., *Ageism in Chemotherapy*, 6 The Internet Journal of World Health and Societal Politics 1 (2009) (defining ageism as "any attitude, action, or institutional structure, which subordinates a person or group because of age or any assignment of roles in society purely on the basis of age."), quoting, Traxler, A.J., *Let's Get Gerontologized: Developing a Sensitivity to Aging. The Multi-Purpose Senior Center Concept: A Training Manual for Practitioners Working with the Aging*, Springfield, IL: Illinois Department of Aging (1980).

[141] Aapro M.S., Kohne C.H., Cohen H.J., Extermann M., *Never Too Old? Age Should Not be a Barrier to Enrollment in Cancer Clinical Trials*, 10 Oncologist 198-204 (2005).

[142] A. Jerant, P. Franks, J. E. Jackson, and M. Doescher, *Age-Related Disparities in Cancer Screening: Analysis of 2001 Behavioral Risk Factor Surveillance System Data*, 2 Annals of Family Medicine 5, 481-487 (2004), www.annfammed.org (last accessed Dec. 14, 2009) (exploring the connection between colorectal cancer screening, breast cancer screening, and age).

[143] *Supra* n. 139 at p. 2.

[144] L. Dockter & S. Keene, A*geism in Chemotherapy*, 6 The Internet Journal of Law, Healthcare and Ethics 1 (2009).

[145] *Supra* n. 141.

[146] Pascal R. Fuchshuber, *Age and Cancer Surgery: Judicious Selection or Discrimination?*, 11 Annals of Surgical Oncology 951-952 (2004).

showed a disparity of surgical treatment between seniors and the rest of the population.[147] The only cancer type where no differences were indicated was colon cancer.[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?"[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.[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."[151] This question is not unique to the United States, for Canada and the United Kingdom are facing a similar dilemma.

Canada

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

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[147] *Id*.
[148] *Id*.
[149] *Id*.
[150] L. Hutchins, J. Unger, J. Crowley, C. Coltman, K. Albain, *Underrepresention of Patients 65 Years of Age or Older in Cancer-Treatment Trials*, 341 New Eng. J. Med. 27, 2061-2067, www.nejm.org (last accessed Dec. 12, 2009) (analyzing 16,396 patients consecutively enrolled in 164 Southwest Oncology Group treatment trials between 1993 and 1996); *Ibid.*
[151] Hutchins et al., *id*. at 2064.
[152] Townsley, *supra* n. 1.
[153] Food and Drug Administration, *Guideline for the Study of Drugs Likely to be Used in the Elderly*, http://www.fda.gov/cder/guidance/old040fn.pdf (last accessed Dec. 15, 2009).
[154] *Supra* n. 151 at 3803.

cancer treatments.[155] As one study of 1,505 patients indicates, "age, when analyzed either as a binary or as a continuous variable, was significantly associated with whether the patient received treatment."[156] Overall, in Canada, as in the United States, senior status remains a significant predictor for disparity in treatment, even when other variables such as sex and distance to providers are considered.[157]

The United Kingdom

The realization that seniors are faced with disparate treatment is also present in the United Kingdom. "Age rather than individual need determines clinical priorities."[158] This was substantiated by the Association of Community Health Councils' study of waiting times at more than 200 emergency rooms.[159] Here, the disparity in wait times was stunning: 2 hours 51 minutes (under 60) versus 4 hours 34 minutes (over 60).[160] Ageism in cancer treatment produced similar results.

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

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[155] *Ibid*.

[156] *Ibid*. at 3805.

[157] *Ibid*.

[158] Jenny Hope, *NHS Makes Over-60s Wait Longer in Casualty*, Daily Mail (Mail Online), http://www.dailymail.co.uk/news/article63762/NHS-makes-60s-wiat-longer-casualty.html (last accessed Jun. 13, 2009) (quoting Paul Burstow, Liberal Democrat shadow minister for older people).

[159] *Ibid*.

[160] *Ibid*.

[161] Lavelle K., Todd C., Moran A., Howell A., Bundred N., Campbell M., *Non-standard Management of Breast Cancer Increases with Age in the UK: a Population Based Cohort of Women > 65*, 96 British Journal of Cancer 1197-1203 (2007), www.bjcancer.com (last accessed Dec. 11, 2009).

[162] *Id*. at 1197.

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.[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."[164]

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.

[163] *Id*. at 1202.

[164] George P. Smith, II, *Allocating Health Resources to the Elderly*, Elder Law Review, Annual, (2002).

Country	Federal Health Insurance Coverage for Seniors	Access to Care Disparity	Relevant Age Discrimination Law
United States	Medicare (specific to seniors and qualifying disabled)	Yes	The Age Discrimination Act of 1975; Civil Rights Restoration Act of 1987
Canada	Medicare (available to all citizens)	Yes	Charter of Rights and Freedoms
United Kingdom	NHS (available to all citizens)	Yes	The Equality Bill

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.

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[165] Health Canada, Canada Health Act Overview, http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2002/2002_care-soinsbk4_e.html (last accessed Jan. 6, 2010).

[166] *Supra* n. 31.

[167] Can. Const. (Constitution Act, 1982) pt. I (Canadian Charter of Rights and Freedoms), § 15 (available at http://www.efc.ca/pages/law/charter/charter.text.html).

[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."[170] 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.[171] Along the same lines, §32 narrows the reach of the "Charter" by making it applicable only to Canada's federal government.[172] 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.[173] To the contrary, like the United States, Canada is a federation with a federal government and states (in Canada referred to as provinces).[174] 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."[175] 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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[170] *Bliss v. Attorney General of Canada*, [1979] 1 S.C.R. 183, 190-91.

[171] *Id.*

[172] Can. Const. (Constitution Act, 1982) pt. I (Canadian Charter of Rights and Freedoms), § 32. For the Canadian Supreme Court's ruling that the "Charter" does not apply to private litigation with no government connection, see *Railway Workers, Local 580 v. Dolphin Delivery Ltd.*, [1986] 2 S.C.R. 573.

[173] Kesselman, *supra* n. 17.

[174] Zmira Hornstein, Sol Encel, Morley Gunderson, David Neumark, *Outlawing Age Discrimination: Foreign Lessons, UK Choices*, p. 33.

[175] Syrett K., *Deference or Deliberation: Rethinking the Judicial Role in the Allocation of Healthcare Resources*, 24 Med. & L. 309, 320 (2005).

constitutional obligations and to subject the reasonableness of these measures to evaluation."[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.[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.[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.[179]

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

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[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).

[177] Houses of Lords, *The Equality Bill – Explanatory Notes*, paragraph 3, http://www.publications.parliament.uk/pa/ld200910/ldbills/020/en/10020x--.htm#index_link_1 (last accessed Dec. 15, 2009).

[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.").

[179] Treaty of Lisbon, www.europa.eu/../index_en.htm (last accessed Dec. 29, 2009).

role in privacy issues and human rights.[180] 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.[181] The Council is responsible for both the ECHR and the European Court of Human Rights.[182] 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.[183]

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."[184] 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.[185] 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.

[181] *European Court of Human Rights – some Facts and Figures: 1959-2009*, http://www.echr.coe.int/ECHR/EN/Header/The+Court/Introduction/Information+documents/ (last accessed November 20, 2009).

[182] Council of Europe, www.coe.int/ (last accessed November 20, 2009).

[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).

[184] Lisa Webley, *Complete Public Law: Text, Cases, and Materials*, chapter 14, Section 14.6.1 (2009); *see*, Section 2 of the Human Rights Act (1998).

[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.[186]

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."[187] 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.[188]

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.[189]

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 "harmoni[zing] discrimination law, and to strengthen[ing] the law to support progress on equality."[190] Expanding on the Human Rights Act of 1998, the Bill will replace all existing equality legislation, including the Equal Pay Act.[191] 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.

[188] Lord Steyn, *Deference: a Tangled Story*, [2005] Public Law 346 at 355.

[189] Manchester Older People's Network, *A Rough Guide to Tackling Age Discrimination* (July 2004).

[190] Equality Bill, HL Bill 20, 54/5, www.services.parliament.uk/bills/2009-10/equality.html (last visited Dec. 15, 2009) ("Baroness Royall of Blaisdon has made the following statement under section 19(1)(a) of the Human Rights Act 1998: In my view the provisions of the Equality Bill are compatible with the Convention rights.").

[191] Government Equalities Office - Equality Challenge Unit, *The Equality Bill Fact Sheet* (2008), www.ecu.ac.uk/law/equality-bill (last accessed Dec. 15, 2009) (indicating that the bill was mentioned by the Queen during her 2008 speech to Parliament for introduction into Parliament in 2009).

unjustifiable negative age discrimination.[192] Clause 5, which addresses age, "replaces a provision in the Employment Equality (Age) Regulations 2006."[193] What will happen once this legislation becomes effective remains to be seen.

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.

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[192] *Id.*

[193] House of Lords Explanatory Notes, Clause 5, paragraph 58, http://www.publications.parliament.uk/pa/ld200910/ldbills/020/en/10020x-a.htm#index_link_20 (last accessed Dec. 15, 2009).

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.[194] At its core, the Civil Rights Act of 1964 was designed to promote equality.[195] Comprised of eleven individual titles, only three out of the eleven have received heightened legislative or judicial focus.[196]

Within less than a decade, Congress passed several legislative initiatives, including the Age Discrimination in Employment Act of 1967 (ADEA),[197] the Education Amendments of 1972 (Title IX),[198] and the Age Discrimination Act of 1975.[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."[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.[201]

Griggs v. Duke Power Company, a landmark 1971 Supreme Court decision confirmed the permissibility of disparate impact suits.[202] The Court's opinion paved the way for a claimant to recover for employment discrimination based on the defendant

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[194] Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (1964). For a comprehensive account of the legislative history, see generally Bureau of Nat'l Affairs, *The Civil Rights Act of 1964: Text, Analysis, Legislative History: What It Means to Employers, Businessmen, Unions, Employees, Minority Groups* (1964).

[195] Drew S. Days, III, *Feedback Loop: The Civil Rights Act of 1964 and Its Progeny*, 49 St. Louis U. L.J. 981, 995 (2005).

[196] Pub. L. No. 88-352, 78 Stat. 241 (1964).

[197] 29 U.S.C. §§ 621-634 (2000).

[198] 20 U.S.C. § 1681 (2000).

[199] 42 U.S.C. §§6101-6107 (2000).

[200] Days, *supra* n. 194 at 981-82.

[201] *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).

[202] *Griggs v. Duke Power Company*, 401 U.S. 424 (1971).

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."[203] This judicial doctrine was codified by Congress in the Civil Rights Act of 1991.[204]

At first glance, this conclusion appears to be inconsistent with the 1976 equal protection case, *Washington v. Davis*.[205] 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.[206] 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]."[207] 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."[208] 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.
[204] Civil Rights Act of 1991, Pub. L. No. 102-166, 105 Stat. 1071 (1991).
[205] *Washington v. Davis*, 426 U.S. 229 (1976).
[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).

[212] 42 U.S.C. §6101 (1976); Department of Health and Human Services, *Fact Sheet – Your Rights Under the Age Discrimination Act* (Jun. 2006).

implementation occurred four years later.[213] The purpose of the Act is to "prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance."[214] 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,[215] in addition to certain employment-related programs or activities.[216]

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)."[217] Perhaps this was based on the 1971 White House Conference on Aging that honed national attention on the needs of seniors.[218] 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.[219] Additionally, seniors, because of their numbers, constituted a substantial political force.

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[213] Department of Health and Education and Welfare, 44 Fed. Reg. 33, 768-80 (Jun. 12, 1979) (codified at C.F.R. § 90 as required by the ADA 1975, 42 U.S.C.A. § 6103 (a)(1) (West 1979)).

[214] 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.

[215] *Id*. § 6103(b)(2).

[216] *Id*. § 6102 (c)(2).

[217] 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.)

[218] White House Conference on Aging, II, *Final Report: Toward a National Policy on Aging* (1971) (suggesting multiple changes in domestic policies impacting seniors).

[219] 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).

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."[220] While Congress stressed that the ADA 1975 does not only protect seniors, but everyone throughout their life, Congress clearly had seniors in mind.[221]

The impetus of the ADA 1975 is to ban age-based discrimination by recipients of federal financial assistance.[222] Courts have concluded in non-ADA 1975 settings that Medicare and Medicaid are federal assistance programs.[223] 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.[224] Furthermore, the Civil Rights Act of 1987,[225] "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."[226] Again, it would seem that seniors, as Medicare recipients, fall under the ADA 1975's purview.

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…,"[227] 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).

[222] Howard Eglit, *Health Care Allocation for the Elderly: Age Discrimination by Another Name?*, 26 Hous. L. Rev 813, 871 (Oct. 1989).

[223] *Usery v. Tamiami Trail Tours, Inc.*, 531 F.2d 224, 234-236 (5th Cir. 1976) (test based on holding in *Weeks v. Southern Bell Tel. & Tel. Co.*, 408 F. 2d 228 (5th Cir. 1969); *Diaz v. Pan Am. World Airways, Inc.*, 442 F.2d 385 (5th Cir.), cert. denied, 404 U.S. 950 (1971).

[224] *Usery* at 531 F.2d at 236.

[225] Civil Rights Restoration Act of 1987, 100 Pub. L. 259, 102 Stat. 28.

[226] Eglit, 26 Hous. L. Rev at 872.

[227] *Usery*, 531 F.2d at 238.

exclusions.[228] 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.[229]

In 1965, President Lyndon B. Johnson signed Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act into law.[230] Essentially, "Medicare is a system of federal health insurance and medical financial support for the aged and disabled."[231] 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.[232] 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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[228] *The Age Discrimination in Employment Act of 1967*, 90 Harv. L. Rev. 380, 388-99 (1976).

[229] 42 U.S.C. § 6103(b)(2) (1976).

[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.").

[231] James C. Dechene, *Public Health Care Reimbursement Programs*, Practicing Law Institute, Commercial Law and Practice Course Handbook Series, PLI Order No. A4-4428, Sept.-Oct. 1993, WL 6172533 at p. 151, (reviewing reimbursement under leading government (federal and state) programs that provide reimbursement for healthcare services); *see* Pub. L. No. 89-97 (1965) (establishing Medicare by way of the Social Security Amendments which added Title XVIII to the Social Security Act, 42 U.S.C. §§ 1395).

[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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[233] *Supra* n. 210.

[234] *Mathews v. Eldridge*, 424 U.S. 319 (1976); Kaplin, *supra* n. 206 at 300.

[235] *Goldberg v. Kelly*, 397 U.S. 254 (1970).

[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.

A DISCUSSION OF FEDERAL ELDER RIGHTS LAW IN MEXICO

Dr. Eduardo Garcia Luna[1]

JIALP: How is the healthcare system in Mexico structured?

Dr. Garcia Luna: Mexico is comprised of both a public and a private sector. Of the 4,000 hospitals, 1,000 are public (75% of the beds) and 3,000 are private. Hospitals in Mexico do not have uniform services as are the norm in the United States. Examples include laboratories, radiographic equipment, or even types of healthcare staff. In addition, there are over 20,000 primary care facilities.

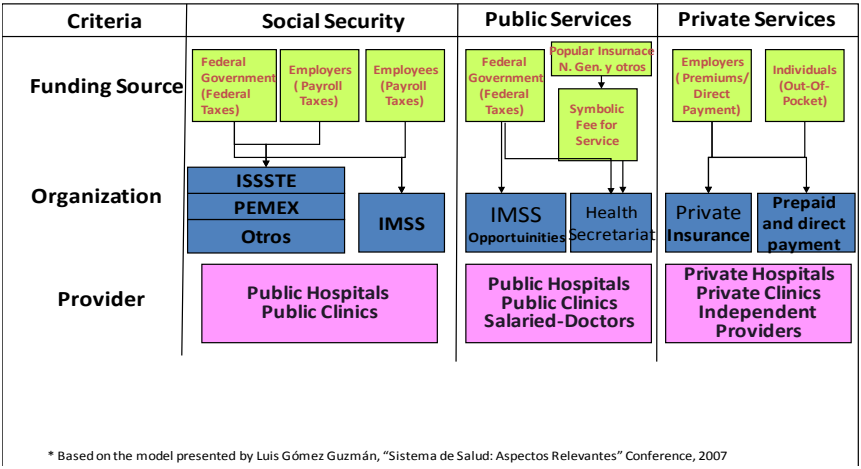
In response to a Mexican government quality initiative, the National Health Program emerged. The Undersecretary for Innovation and Quality is responsible for implementing three key objectives of the National Health Program:

1. To diminish inequalities in health;
2. To ensure fair financing; and
3. To improve the health status and to improve responsiveness.

The Secretary of Health is responsible for ultimate oversight. Overall, the Mexican Healthcare System is broken down into social, public, and private services.

[1] Eduardo Garcia Luna, MD, Director of Health Sciences, University of Monterrey (Universdidad de Monterrey), Mexico.

Mexican Healthcare System Structure *



* Based on the model presented by Luis Gómez Guzmán, "Sistema de Salud: Aspectos Relevantes" Conference, 2007

JIALP: In Mexico, what ages fall into the category of elder or senior?

Dr. Garcia Luna: In Mexico, an elder or senior is considered 65 years of age and over.

JIALP: What are the plans that allow elderly people to have access to health services and home healthcare?

Dr. Garcia Luna: The official Public Health Plans are described in the National Program of Health 2007-2012. The section of the Public Health Plans that considers the elder population is entitled *Intervention by Group of Age*. Overall, the National Program of Health has five main objectives:

1. Improve the health condition of people;

2. Reduce the gap in health among groups of the population by engaging in focalized interventions in vulnerable groups of marginal communities;
3. Provide health services with quality and security;
4. Stop the impoverishment of the population derived from health expenditures; and
5. Assure that health promotion decreases poverty levels and promotes social development.

Recently, some programs have been created to complete these objectives. One of them is the National Strategy for health promotion and prevention of diseases. This strategy has many different components. One such component is to lower the economic impact of diseases and injuries in persons, families, and communities. This is achieved through specific interventions among people and through the construction of a healthier environment.

Specifically, the *Intervention by Group of Age* describes services offered as a package of health promotion services and prevention of some diseases. The package is made available through any institution incorporated to the National Health System. This considers intervention in four different areas: health education, nutrition, health control, and prevention and disease protection.

JIALP: What are the limits of access and level of coverage for elders?

Dr. Garcia Luna: Elders have the right to access quality social security health services, according to Article 33 of the General Health Law. They also have the right to the benefits such as opportune diagnosis and treatment, coverage for chronic diseases and tumors. Disabilities are the main focus of elders in relation to health education and preventive services. Additionally, hospitals classified as level two and level three must have geriatric services.

In Mexico, there are medical units and civil organizations that provide medical, mental, and physical health care for elders.

According to Article 10 of the Federal Elder Rights Law, this age group constituency has the right to the following services.

1. Be examined at least once a year and receive required treatment;
2. Be treated confidentially and actively participate in decisions impacting their own health; and
3. Access to appropriate nutrition and facilities.

The National Institute for Elders (Instituto Nacional de las Personas Adultas Mayores or INAPAM in Spanish) is a public entity that enforces and assures the law is carried out. It also coordinates and promotes public action strategies for elder health attention. The INAPAM strives to improve elders' social development by promoting job generation and just retributions. According to Article 28 of the Federal Elder Rights Law, the Institute has, among others, the following attributes:

1. To impulse State and social actions for the elders human development. This means to promote actions to value activities and capacities they have, in economic and social terms;
2. To protect, attend and orient this group;
3. To be the organism that analyzes and evaluates policies toward elder people;
4. To promote participation of the society in activities, policies and programs towards the Elderly group;
5. To develop and publish campaigns to strengthen the values of solidarity and support to elderly people;
6. To promote and support geriatric services and research; and
7. To promote and support the love, comprehension, and respect of values in the next generations for this group.

Overall, the Mexican government's purpose in passing the Federal Elder Rights Law was to protect elders in multiple facets including healthcare delivery.

JIALP: What is the Nuevo Leon State's Situation and how does it relate to healthcare of the elders?

Dr. Garcia Luna: The Nuevo Leon State is influenced by the Elder Rights Law that was enacted in July 2005 for the protection and support of elders. Its primary function is to describe the duties the Health Sector has for the elder portion of the population. There is a Technical Committee, created by the State Government, that attends to elders. This Committee is comprised of the State Secretary of Health, the President of the State Family Integral Development Agency (DIF-NL), and other public and private organizations.

JIALP: What are the differences between the elderly and the rest of the population in terms of healthcare?

Dr. Garcia Luna: There are no differences in terms of how services are provided; however, the coverage of psychological services is something that differs between elders and the rest of the population. In terms of healthcare generally, there is a strong gap between demand for services and available delivery capacity impacting access. Our country (Mexico) and state (Nuevo Leon) have a proportionately high distribution of youth in the population. Therefore, the gerontologic vision is still in developmental stages. Meanwhile, the geriatric (elder) population uses most of the acute care hospital beds. Overall, it is difficult to balance policy with actual utilization of services because of the imbalance between elders as a portion of the overall population and the amount of healthcare services consumed.

JIALP: Is there anti-age discrimination legislation in Mexico in favor of the elderly with respect to the rendering of healthcare services in relation to the rest of the population?

Dr. Garcia Luna: Yes. The House approved the law, which prevents and eliminates discrimination towards the elderly. In a similar action, the Senate also passed the Social Development General Law that establishes vigilance and follow-up mechanisms for public funds assigned to social programs. Accordingly, discrimination against people with different economic conditions, sexual preferences, xenophobia, age, or disabilities is prohibited. Included is the creation of an organism that regulates the activities of protection and promotion of this norm. This legislation has a figure known as "public sue," which is not common in Mexico. With the advent of the figure, any person or organization can denounce acts, omissions, or practices that can harm an individual. This law protects groups identified as vulnerable including the elderly, natives, and disabled people. Politician Gilberto Rincon Gallardo was one of the main promoters.

JIALP: Is health care provided equally between the elderly and the rest of the population?

Dr. Garcia Luna: Because there is limited access to funds to pay for healthcare, tough decisions must be made. The result is limited access to services for elders. According to the Health General Law, Health National Plan, Prevention and Elimination of Discrimination Law, Federal Law of Elderly People Rights, Nuevo León State Law of Elderly People Rights, all people should be treated equally. In reality, however, there are differences. Some healthcare facilities do not have appropriate access for elder or disabled citizens. This shows the level of underdevelopment of physical facilities in public units. Private healthcare providers have high costs for older people, and in many of them there is a policy to deny insurance for the elderly. In Intensive Care Units decisions are made usually that favor other groups under 60 years.

JIALP: Given the limited economic resources and efforts by the government to protect the interests of elders, what is the best way to reconcile these competing interests?

Dr. Garcia Luna: The tendency in the demographic evolution of Mexico clearly presents the necessity to reconcile the needs and rights of elders with those of the younger population. Another element in balancing the interests is the gap between current and required installed capacity. By capacity I mean facilities and equipment resources, and also human and professional ones. Mexico will need at least ten years to train people in the different health related professions and areas to attend the needs of the elderly. Additionally, few people are interested in pursuing a degree in the medical field. Even though budgetary allocations were granted, the lack of human resources will take its toll in the process.

There is also a lack of real commitment from the executive and legislative in the different levels of government (federal, state and municipal) toward healthcare attention of these groups of the population; it is generally not as politically profitable to attend the needs of younger groups as those of older ones. Good laws should be aligned with proportional efforts to enforce and fund whatever is necessary. If it is not done, there will not be a real impact on society.

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ALL IN THE COMMUNITY: THE IMPACT OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS ON ISRAEL'S SOCIAL SECURITY SYSTEMS

By
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> *[I]t is important to recognize that older persons are a heterogeneous group, encompassing both people who are major contributors to the development of society, as well as those who are in need of care and support. Regardless of their individual situations, it is critical that older persons not be marginalized, but rather brought into the mainstream of social and economic development. A fundamental way to guard against marginalization is to promote and protect the rights of older persons.*[2]

PART I: INTRODUCTION

For centuries, treaties and covenants have defined obligations among and between nations. From agreements about the use of force, to treatment of civilians during times of war and unrest, international treaties have sought to manage the way peoples interact across territories and among themselves. Particularly, covenants governing human rights have become more numerous in the past few decades. Human rights treaties cover a number of subjects such as healthcare, the treatment and education of women and children, discrimination, economic policy, and cultural and social issues. Among the various concerns that have given rise to the creation of international covenants, one segment of the world population has seemingly remained excluded—the elderly.

Currently, the only treaty that specifically, albeit very generally, acknowledges the treatment of aged[3] citizens is the International Covenant on Economic, Social and Cultural Rights (ICESCR). The ICESCR is a multilateral treaty adopted by the

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[2] Follow-up to the International Year of Older Persons: Second World Assembly on Ageing, UN A, 64th Sess., UN Doc. A/64/127, ¶ 6 (2009).

[3] The ICESCR does not define "aged" or "elderly." There is no definitive age at which one is deemed "aged" or "elderly" and the definition while vary from country to country. For purposes of this paper, "aged" is meant to encompass individuals past middle age.

United Nations General Assembly on December 16, 1966, which came into force on January 3, 1976.[4] It obligates its signatories to work toward granting economic, social, and cultural rights to individuals, particularly rights to health, education, and an acceptable standard of living. The ICESCR specifically addresses the treatment of women and children, but does not *specifically* address the needs of groups also traditionally thought to need special protection, like the elderly.[5]

Other than Article 9,[6] which sets forth the right to social security[7] and requires parties to establish "social insurance" to care for risks associated with, among other things, old age, the ICESCR:

> [D]oes not contain any explicit reference to the rights of older persons, although Article 9 dealing with 'the right of everyone to social security, including social insurance,' *implicitly* recognizes the right to old-age benefits. Nevertheless in view of the fact that the Covenant's provisions apply fully to all members of society, it is clear that older

[4] United Nations, *United Nations Treaty Collection*, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (accessed September 2009).

[5] Matthew C. R. Craven, *The International Covenant on Economic, Social, and Cultural Rights: A Perspective on its Development* 25 (Professor Ian Brownlie ed., Oxford 1995). *See* Craven's footnote, 149 on page 25: "It was argued during the drafting of article 9 that the rights of the elderly should be provided for in a separate convention. *See e.g.* Mehta (India), E/CN.4/SR.282, at 10 (1952)."

[6] *See* The Economic, Social and Cultural Rights of Older Persons: General Comment 6, UN CESCR, 13th Sess., UN Doc. E/1996/22, (1995), which lists other conventions/sessions/meetings, etc., that specifically discussed the needs of the aging population. Broad concern for aging populations has been expressed in a number of international settings, however no separate instrument has been created to deal specifically with elder care on the international scale.

[7] The ICESCR does not explicitly define social security. However, it appears as though Article 9 contemplates systems that promote general social welfare and social insurance. Thus, social security, in the context of ICESCR, has a broader base of coverage than the United States' Social Security system.

> persons are entitled to enjoy the full range of rights recognized in the Covenant…."[8] (emphasis added).

It is incorrect to assume that, because there is no treaty or covenant specifically covering elder care, the aged in various populations are not cared for or that their needs are not contemplated by their governments and rule of law. Many cultural and religious communities, separate from or together with the government, take measures to care for the older persons among them. This article examines how Israel, a signatory to the ICESCR, uses its government-regulated social security system, along with the practices of its diverse religious and cultural communities, to care for its growing aged population. The question is, essentially, whether Israel's social security systems, both government-administered and community-based, are effective in meeting the goals and mandates of the ICESCR.

Part II introduces the ICESCR and some historical analysis of Article 9 (similar to a "legislative history" of a statute), noting again that there is no provision named specifically for care of aging citizens, unlike Article 10, which expressly considers the physical and mental welfare of children. Part III discusses Article 9 of the ICESCR as it relates to Israel and attempts to address what steps, if any, Israel has taken to implement measures related to the social security component of Article 9 into its domestic legal order. This last inquiry is especially relevant given ICESCR's non-discrimination clause in Article 2(2) of the Covenant and Israel's struggle with equal access to resources for its (predominately) Jewish and (minority) Arab populations. Part IV examines both the government's formal and Israeli Arab communities' informal (and formal) treatment of social security—specifically, where the government's systems might not work in practice as well as they are intended to work in theory and cultural and community responses to the proper care for their elderly citizens. In sum, this

[8] The Economic, Social and Cultural Rights of Older Persons: General Comment 6, UN CESCR, 13th Sess., UN Doc. E/1996/22, 2 (1995).

article inquires into Israel's efforts to comply with ICESCR's obligations and how, in the meantime, outlying cultural groups modify the current system of elder care, or create their own, to ensure their elder population is protected.

PART II:
THE ICESCR: THE COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS; CREATION OF THE COVENANT; AND ARTICLE 9

The Committee on Economic, Social and Cultural Rights (CESCR) (hereafter, Committee) was established under ECOSOC[9] Resolution 1985/17 on May 28, 1985.[10] Its main purpose was to "carry out the monitoring functions assigned to the United Nations Economic and Social Council."[11] Essentially, the Committee is "the body of independent experts that monitors implementation of the ICESCR by its States parties."[12]

All State parties are obliged to submit regular reports to the Committee on how economic, social, and cultural rights are being implemented in its domestic laws for its citizens. States must report initially within two years of accepting the ICESCR and thereafter every five years.[13] The Committee examines each report and addresses its concerns and recommendations to the State party in the form of "concluding observations."[14]

> The Committee's role in the development of the Covenant is of particular importance for two main reasons. First, in contrast to the position with

[9] The ECOSOC, Economic and Social Council, is the principal UN Organ charged with coordinating economic, social and related work of the 14 UN specialized agencies, functional commissions, and five regional commissions.

[10] Office of the United Nations High Commissioner for Human Rights-Committee on Economic, Social and Cultural Rights, http://www2.ohchr.org/english/bodies/cescr/ (accessed October 2009).

[11] *Id.*

[12] *Id.*

[13] *Id.*

[14] *Id.*

> respect to most other international treaties, human rights treaties are not so much reciprocal agreements dependent for their force upon mutual acceptance, but rather 'unilateral' or 'objective' undertakings which require some process of 'collective enforcement.' The Committee is essentially charged with that task. Secondly, human rights treaty norms by their nature are phrased in such a general manner that further development and normative clarification are necessary. This is nowhere more apparent than in the case of the ICESCR which suffers, not merely from the generality of its norms, but also from the fact that there is little national or international case law relating to economic, social, and cultural rights that might assist in the process of 'normative development.'[15]

During its 39th Session, held November 5-23, 2007, the Committee noted continuing problems with the implementation of social security schemes, namely, very low levels of access—approximately 80% of the global population lacks access to formal social security.[16] At the same session, the Committee also noted that the importance of social security rights has always been a concern in international law, especially in the areas of human rights law and humanitarian law.[17] In fact, broad concern about social security systems is interwoven briefly in many Declarations, Conventions, and conferences from 1941 to the present.[18]

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[15] Craven, *supra* n. 5, at 4.

[16] UN CESCR, 39th Sess., at ¶ 7, UN Doc. E/C.12/GC/19 (2008).

[17] *Id.* at ¶ 6.

[18] *See* Declaration Concerning the Aims and Purposes of the International Labour Organization (ILO), annex to the Constitution of the ILO, section III (f); International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), article 5 (e) (iv); Convention on the Elimination of All Forms of Discrimination against Women, articles 11, para. 1 (e) and 14, para. 2 (c); and Convention on the Rights of the Child, article 26;

Though the ICESCR was first conceived of in the 1940's and entered into force in early 1976, it is still regarded as a "relatively 'new' human rights instrument."[19] In 1947, it was decided that an "International Bill of Rights" would be drafted and consist of three documents: a non-binding declaration of a general nature, a convention of more limited scope, and a document of methods of implementation.[20] During the course of the next year, the then newly created Commission met numerous times and finally, after much revision, completed the non-binding declaration.[21] On December 10, 1948, the General Assembly adopted this document as the Universal Declaration of Human Rights (UDHR).[22] Many critics believe that the underlying philosophy of the UDHR is "primarily 'western' and 'liberal,' with a preference for civil and political rights"; however, the UDHR does recognize a number of economic, social, and cultural rights.[23]

The General Assembly also requested that the Commission on Human Rights give priority to drafting a Covenant on human rights and measures of implementation.[24] During its fifth and sixth sessions, the Commission examined a draft Covenant consisting of a variety of civil and political rights.[25] In 1950, the Commission decided that, because additional time was needed to discuss economic, social, and cultural rights and consult the various specialized agencies involved, it would be preferable to adopt an initial draft Covenant limited to civil and political rights.[26] Thus, it was decided that at the next Session, a separate document would be

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For explicit mention of the right to social security, *see* American Declaration of the Rights and Duties of Man, article XVI; Additional Protocol to the American Convention on Human Rights in the Area of Economic Social and Cultural Rights (Protocol of San Salvador), article 9; European Social Charter (and 1996 revised version), articles 12, 13 and 14; International Labour Conference, 89th session, report of the Committee on Social Security,

resolutions and conclusions concerning social security.

[19] Craven *supra* n. 5, at 1.

[20] *Id.* at 16.

[21] *Id*. at 17.

[22] *Id*.

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.* at 18.

drafted covering specifically economic, social, and cultural rights.[27] From the early 1950s until the ICESCR was adopted, the Commission met several times to work on the draft Covenant, but vacillated between bundling economic, social, and cultural rights together with civil and political rights, or treating them as a distinct category of rights with their own obligations.[28] After fifteen years of meetings, debates, and general indecision, on December 16, 1966, the General Assembly adopted the ICESCR[29] and opened it for signature. It entered into force following the deposit of the 35th instrument of ratification on January 3, 1976.[30] As of November 2009, there are 160 parties and 69 signatories to the Covenant. The signatory and party countries represent a broad range of social, political and legal systems.[31]

The ICESCR consists of a preamble and thirty-one articles separated into five parts.[32] This paper is most concerned with Part II, Article 2 and Part III, Article 9. Part II of the Covenant consists of the general clauses that are applicable to all the substantive provisions found in Part III—most notable is the non-discrimination clause in Article 2(2).[33] Part III of the Covenant is the core of the document and details the rights it protects, including generally the right to work (Article 6), the right to fair conditions of employment (Article 7), the right to join and form trade unions (Article 8), the right to social security (Article 9), the right to protection of the family (Article 10); the right to health (Article 12), and the right to culture (Article 15).[34]

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[27] *Id*.

[28] *Id.* at 18 and 19.

[29] *Id*. at 22.The International Covenant on Civil and Political Rights and its Optional Protocol was also adopted and opened for signature on the same day.

[30] *Id.*

[31] *Id.* at 23.

[32] *Id*. at 22.

[33] *Id.* The general applicability of the non-discrimination clause will be discussed further in the subsequent sections.

[34] *Id*. at 22-23.

Part III, Article 9 of the ICESCR acknowledges "the right of everyone to social security including social insurance."[35] It requires State parties to provide some form of a social insurance scheme to protect people against the risks of sickness, disability, maternity, employment injury, unemployment or old age; to provide for survivors, orphans, and those who cannot afford health care; and to ensure that families are adequately supported.[36] Benefits from such a scheme must be adequate, accessible to all, and provided without discrimination.[37] Article 9 does not mandate the specifics for procedural implementation of social security measures; both contributory and non-contributory schemes are allowed as are community-based and mutual schemes.[38]

PART III
THE ICESCR AND ISRAEL

Because the ICESCR is non self-executing, in order for the mandates of the Covenant to have an impact on individual persons, it is largely up to individual state parties to adopt its measures into their own domestic laws through legislation.[39] The ICESCR forms part of the domestic laws of Afghanistan, Costa Rica, Ecuador, and Luxembourg.[40] Israel, however, has not adopted measures of the ICESCR into its domestic law, but has passed the National Security Law (Revised 1995), the National Health Insurance Law, and the Draft Basic Law: Social Rights[41] all of which help regulate Israel's formal social security programs. Citizens must also be able

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[35] *International Covenant on Economic, Social and Cultural Rights* pt. II, art. 9 (Dec. 16, 1966), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en

[36] Craven *supra* n. 5, at 22-23.

[37] UN CESCR, 39th Sess., at ¶ 7, UN Doc. E/C.12/GC/19 (2008).

[38] *Id.* at paragraph 5.

[39] *See* Craven *supra* n. 5, at 27 (and footnotes). "Generally, in order for the Covenant to have 'direct applicability,' it either has to be positively adopted (whether automatically or by incorporation) into domestic law or form part of domestic law by virtue of expressing rules of customary international law."

[40] Craven *supra* n. 5, at 28 and footnotes.

[41] These laws are discussed in greater detail in latter portions of Part II and in Part III.

to rely on the legal proceedings (domestic and international, though domestic would be preferable due to concerns over lack of enforcement of international tribunals). To date, only Japanese courts[42] have heard cases with causes of action rooted in ICESCR mandates.[43]

Concern over the implementation and protection of economic, social, and cultural rights is highly relevant to Israel—a country whose unique past and origins continue to be a source of conflict.[44] Israel's Committee reports and responses to the

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[42] The Optional Protocol to the International Covenant on Economic, Social, and Cultural Rights was adopted by the General Assembly on December 10, 2008 and opened for signature on September 24, 2009. *Supra* n. 6. Upon entry into force, the Optional Protocol will afford victims of violations of economic, social, and/or cultural rights the ability to present their complaints before the CESCR. *Id*. Because the Optional Protocol provides an international forum for individual complaints of violations, there is likely to be more activity within these international "courts," once the Optional Protocol is ratified.

[43]http://www.tomeika.jur.kyushuu.ac.jp/intl/jailpdf/003_Osaka%20High%20Court%20Judgment,%2027%20October,%202005.pdf. The central issues in this case included: the Nationality Requirement in the National Pension System; the non-self-executing character of Article 2(2) of the ICESCR; and interpretation of Article 26 of the International Covenant on Civil and Political Rights as it relates to Social Security.

[44] "Following World War II, the British withdrew from their mandate of Palestine, and the UN partitioned the area into Arab and Jewish states, an arrangement rejected by the Arabs. Subsequently, the Israelis defeated the Arabs in a series of wars without ending the deep tensions between the two sides...On 25 April 1982, Israel withdrew from the Sinai pursuant to the 1979 Israel-Egypt Peace Treaty. In keeping with the framework established at the Madrid Conference in October 1991, bilateral negotiations were conducted between Israel and Palestinian representatives and Syria to achieve a permanent settlement. Israel and Palestinian officials signed on 13 September 1993 a Declaration of Principles (also known as the "Oslo Accords") guiding an interim period of Palestinian self-rule. Outstanding territorial and other disputes with Jordan were resolved in the 26 October 1994 Israel-Jordan Treaty of Peace."

"In addition, on 25 May 2000, Israel withdrew unilaterally from southern Lebanon, which it had occupied since 1982. In April 2003, US President Bush, working in conjunction with the EU, UN, and Russia - the "Quartet" - took the lead in laying out a roadmap to a final settlement of the conflict by 2005, based on reciprocal steps by the two parties leading to two states, Israel and a democratic Palestine. However, progress toward a permanent status agreement was undermined by Israeli-Palestinian violence between September 2003 and February 2005. An Israeli-Palestinian agreement reached at Sharm al-Sheikh in February 2005, along with an internally-brokered Palestinian cease-fire, significantly reduced the violence. In the summer of 2005, Israel unilaterally disengaged from the Gaza Strip, evacuating settlers and its military while retaining control over most points of entry into the Gaza Strip."

"The election of HAMAS in January 2006 to head the Palestinian Legislative Council froze relations between Israel and the Palestinian Authority (PA). Ehud Olmert became prime minister in March 2006; he shelved plans to unilaterally evacuate from most of the West Bank following an Israeli military operation in Gaza in June-July 2006 and a 34-day conflict with Hizballah in Lebanon in June-August 2006. Olmert, in June 2007, resumed talks with the PA after HAMAS seized control of the Gaza Strip and PA President Mahmoud Abbas formed a new

Committee's inquiries indicate that the international community remains concerned about the great cultural strife between Israeli Jews and Arabs.[45]

Israel has a population of approximately 7,233,701 of whom 9.9% are age 65 and over.[46] Life expectancy is approximately 79 years for men and 83 years for women.[47] Israel's population is 76.4% Jewish (both ethnically and religiously)--of that percentage, 67.1% are Israel-born.[48] The non-Jewish population of Israel (approximately 23.6%) is predominately Arab.[49] Arab Muslims comprise about 16% of the population and Arab Christians approximately 1.7%.[50]

A. Israel's Initial State Report

Since becoming a signatory to the ICESCR in 1991, Israel has submitted State Reports for the Committee's assessment in 1998, 2001, and 2003. During its Nineteenth Session in 1998, the Committee considered Israel's initial Report on the rights included in Articles 1 through 15 along with a list of replies to questions presented at the 31st - 33rd Committee meetings.[51]

Israel presented a lengthy three-part Report to the Committee on January 20, 1998.[52] Part II of Israel's initial State Report dealt with Article 9 of the ICESCR, namely, how Israel

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government without HAMAS. In September 2008, Olmert resigned in the wake of several corruption allegations, but remained prime minister until the new coalition government under former Prime Minister Binyamin Netanyahu was completed in late March 2009, following the February general election." Source: https://www.cia.gov/library/publications/the-world-factbook/geos/is.html#top.

[45] *Infra* notes 64-74 and accompanying text.

[46] Central Intelligence Agency, *World Factbook, Israel*, https://www.cia.gov/library/publications/the-world-factbook/geos/is.html#top (accessed November 2009).

[47] *Id.*

[48] *Id.* (as of 2004).

[49] *Id.*

[50] *Id.*

[51] UN CESCR, 19th Sess., at ¶ 227, UN Docs. E/1999/22. E/C, 12/1998/26. (1999).

[52] Implementation of the International Covenant on Economic, Social and Cultural Rights, Initial Report: Israel, UN CESCR, 26th Sess., E/1990/5/Add.39(2); (1998).

incorporated its obligations under the Covenant into its domestic laws and society.[53] Israel's report under Article 9 began by listing related international conventions to which it is bound.[54] The report proceeded with a description of the then current social security schemes in place in Israel.[55] Two areas of the initial report are of relevance here—old-age benefits and long-term care. The State report presented data on coverage, nature of benefits, method of financing, and government participation in its discussion of old-age benefits available to aged Israeli citizens.[56] Acknowledging the special importance of long-term care for the elderly, Israel discussed the role of its Long-Term Care Insurance (LTCI) scheme, which was designed to provide help to the elderly with performing daily functions.[57] Under the LTCI system, senior citizens entitled to participation in the program "receive long-term care services from a basket of services defined by law, which includes: assistance of care-givers in the performance of everyday functions in the home and household management, care in day-care centres for the elderly, laundry services, etc."[58] According to Israel's report, approximately 80% of Israeli seniors received primary care from family members. The LCTI system was created, not to replace informal long-term care traditionally provided by family members, but to complement family care and the existing system of service prior to 1986 when the LCTI system was enacted.[59] Later in its report, Israel emphasized that its social security schemes are intended to be equally accessible to all Israeli

[53] *Id.*

[54] Israel (at the time of its 1998 State report) was party to the ILO Social Security (Minimum Standards) Convention, 1952 (No. 102); the ILO Maintenance of Migrants' Pension Rights Convention (No. 48); and the ILO Equality of Treatment (Social Security) Convention (No. 118).

[55] Formal public Israeli security schemes will be discussed in detail in Part III of this paper.

[56] *Supra* n. 51, at ¶¶ 263-269. The details of old-age benefits available to Israeli citizens will be discussed further in Part III.

[57] *Id.* at ¶ 303.

[58] *Id.*

[59] *Id.* at ¶¶ 304 and 305.

citizens.[60] Here, the report lists sectors of the population to which these benefits apply—the elderly, the disabled, the poor, divorced and separated women, children, and the unemployed.[61] The report does not acknowledge any discriminatory practices that have the effect of hampering the minority Arab population's access to social security benefits. As will be noted below, the Committee was especially concerned about Israel's treatment of Arab citizens.

The Committee then considered Israel's initial report and voiced its concerns on a number of issues related to social security benefits and equal access to said benefits. Along with Israel's report, the Committee also considered the reports of several non-governmental organizations.[62] The Committee began by recognizing the positive efforts Israel had taken to implement Articles 1-15 of the ICESCR. Taking specific notice of Israel's 1995 enactment of the National Health Insurance Law, which "provides for primary health care and ensures equal and adequate health services for each citizen and permanent resident of Israel," the Committee also recognized as positive Israel's 1996 amendment of the National Health Insurance Law.[63] This 1996 amendment "enabled housewives to receive the minimum old-age pension while remaining exempt from contributions."[64]

The bulk of the Committee's comments on Israel's report dealt with its concerns about proper and equal implementation of the Covenant.[65] It acknowledged that many of its concerns stem from Israel's issues with its own national security measures and policies.[66] The Committee found that the rights set forth in the ICESCR had not been given "constitutional recognition in Israel's

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[60] *Id.*

[61] *Id.* at ¶ 310.

[62] *Id.* at ¶ 229. These NGO reports were available to the Committee during its discussions with Israel during the 19th Session.

[63] *Id.* at ¶ 230, 256.

[64] *Id.* at ¶ 230.

[65] The Committee's areas of concern covered a number of other issues which will not be discussed in this paper, such as: issues with employment; closures restricting movement of people and good between Israel, the Gaza Strip, Jerusalem; and land use disputes, among other problems.

[66] *Id.* at ¶ 233.

legal system, other than in the then current, 'Draft Basic Law: Social Rights.'"[67] The Committee was of the opinion that the Draft Basic Law[68] "did not meet the requirements of Israel's obligations under the Covenant."[69]

Discrimination was at the heart of the Committee's concerns. In paragraphs 236 through 239, the Committee addressed unequal access to economic, cultural, and social, and legal resources for Arab citizens.[70] In the Committee's opinion, the "excessive emphasis upon the State as a 'Jewish State'" resulted in discrimination and marked the non-Jewish population as second-class citizens.[71] The Committee continued:

> The Committee notes with concern that the Government of Israel does not accord equal rights to its Arab citizens, although they comprise over [nineteen] per cent of the total population. This discriminatory attitude is apparent in the lower standard of living of Israeli Arabs as a result, inter alia, of lack of access to housing, water, electricity, and health care and their lower level of education.[72]

The Committee ended its comments with a list of its suggestions and recommendations. Of interest to the subject of equal access to social security and social services to Israel's aging

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[67] *Id*. at ¶ 235.

[68] "Israel has no constitution, [instead], the Knesset is incrementally legislating a set of Basic Laws that will serve as chapters in a future constitution. A Basic Law has higher legal status than ordinary legislation. So far, the Basic Laws enacted by the Knesset are intended to delineate the activities of the main state authorities: the Government, the Knesset, the President, etc. In 1992, about a year after Israel ratified the international human rights covenants, the Knesset enacted two Basic Laws concerning civil rights: 'The Basic Law: Human Dignity and Liberty;' and 'The Basic Law: Freedom of Occupation.'" Noga Dagan-Buzaglo, *Social Rights in Israel: Inferior Legal Status and Insufficient Budgets*, http://www.adva.org/UPLOADED/rights-short.pdf (2007).

[69] *Supra* n. 51, at ¶ 235.

[70] *Id*.

[71] *Id*. at ¶ 236.

[72] *Id.* at ¶ 236.

population are the suggestions iterated in paragraphs 259 and 260. Here, the Committee urges Israel to incorporate the rights enumerated in the ICESCR into its own domestic law[73] and "ensure equality of treatment of all Israeli citizens in relation to all Covenant rights."[74]

Although the Committee acknowledged general, far-reaching problems with discrimination and unequal access to resources for Israeli citizens, nowhere in its assessment of Israel's report did it recognize specific issues facing aged citizens. It expressly recognized the plight of women and children, land use, unemployment, and educational resources.[75] Most of the issues over which the Committee expressed its deepest concerns would have a direct impact on aging populations. For example, high unemployment rates among non-Jewish citizens likely affect their later access to social security/pension systems. One must assume, then, that the Committee's suggestions and recommendations for full implementation of the ICESCR would have at least an incidental effect on improving access to social services for the elderly.

B. Israel Responds to the Committee's Prior Concerns

In its concluding observations, following Israel's initial State Report, the Committee requested further information and replies to its concerns on several matters discussed during the 31st, 32nd, and 33rd Committee meetings.[76] Israel submitted its addendum on May 14, 2001. The additional report first addressed the Committee's concerns over the applicability of the ICESCR to the West Bank and Gaza Strip, among other issues.[77] It then

[73] *Id*. at ¶ 259.
[74] *Id*. at ¶ 260.
[75] *Supra* n. 51 at ¶¶ 240, 247-251, 255, 257.
[76] *Id.* at ¶ 272.
[77] Also addressed in Israel's addendum to the Committee: the status of disadvantaged populations in eastern neighborhoods of Jerusalem; provision of basic resources to "unrecognized villages;" and the status of a nomadic tribe called the Jahalin Bedouins.

replied to a number of problems the Committee posed following the 1998 initial report, namely the Committee's concern of equality for non-Jewish citizens and how "excessive emphasis upon the Jewish character of the State may encourage discrimination."[78] Israel showed that it had addressed the Committee's concern about discriminatory treatment and impact by discussing the Government of Israel's decision in October 2000.[79] According to the addendum, the Government of Israel took the following position:

> The Government of Israel regards itself as obligated to act to grant equal and fair conditions to Israeli Arabs in the socio-economic sphere, in particular in the areas of education, housing and employment.
>
> The Government of Israel regards the socio-economic development of the Arab-sector communities of Israel as contributing toward the growth and development of all of Israel's society and economy.
>
> The Government shall act for the socio-economic development and advancement of the Arab-sector communities and to reduce the gaps between the Arab and Jewish sectors...[80]

The addendum noted that "gradual implementation of this decision has already begun, but its full realization still awaits the passage in the Knesset of the Annual Budget Law for 2001. This decision

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[78] Additional Information Submitted by States Parties to the Covenant following the Consideration of their Reports by the Committee on Economic, Social and Cultural Rights, UN CESCR, UN Doc. E/1989/5/ADD.14, ¶ 33 (2001).

The full list of these "Principal subjects of concern," is found in paragraphs 9-31 of the Committee's concluding observations on Israel's 1998 initial report. Israel's reply to the Committee addressed, *inter alia*, land use, employment, social services for women and children, and gaps in educational services and achievement.

[79] *Id.*

[80] *Id.*

reflects the Government's appreciation that progress in closing the gaps between Jews and Arabs has not been satisfactory during the past years."[81]

C. Israel's Second State Report

Israel submitted its second periodic State Report for the Committee's consideration during its 2002 substantive Session on October 16, 2001.[82] The report followed the format of the ICESCR, addressing each of the Articles 1 through 15 and detailing Israel's continued efforts to implement the purpose of the Covenant in areas of concern.[83] Beginning in paragraph 205 of its 2001 report, Israel addressed Article 9's "right to social security" provision of the ICESCR.[84] Under Israel's "old-age benefits" branch of its social security scheme, Israel noted some changes in benefits for married, non-working women ("housewives").[85] Later in the report, Israel discussed the status of its Long-term Care Insurance Law.[86] The report noted specifically that "the Law [had] a very favourable impact on the lives of tens of thousands of dependent elderly and their families."[87] In an attempt to further improve this successful program, the report noted that long-term care insurance had been under re-examination in the hopes of establishing "a more equitable and efficient allocation of resources for the benefit of the dependent elderly population."[88]

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[81] *Id*. at ¶ 34. Additionally, this section of the addendum addressed the role of the Arabic language and the status of other programs in the process of development which would benefit other Israeli minority populations.

[82] Second Periodic Reports Submitted by States Parties Under Article 16 and 17 of the Covenant, 30th Sess., UN CESCR, UN Doc. E/1990/6/Add. 32 (2001).

[83] *Id.*

[84] *Id.* at 63.

[85] *Id*. at ¶ 207.

[86] *Id*. at ¶ 226.

[87] *Id.*

[88] *Id.* at ¶ 227. "One of the results of this re-examination has been the introduction in March 2000, of the short-term nursing benefit, a new and unique benefit paid for a period of 60 days, mainly to patients having acute functional difficulties."

Specifically addressing the issue of equality in social security, the report noted that there had been "positive changes enhancing equality in social security": eradicating distinctions between "housewives" and other women where old-age benefits, survivors' benefits, and disability insurance are concerned; better benefits for disabled citizens; payment of maternity allowance to fathers; expanding the definition of "single-parent family"; and expanding the definition of "self-employed."[89] Finally, addressing the Committee's concern about access to social security benefits for Arabs living in the eastern neighbourhoods of Jerusalem, Israel's report included several tables showing the number of benefit recipients and contributions collected from residents in that particular region.[90]

The Committee responded to Israel's second State Report in its concluding observations following its 29th meeting held on May 23, 2003.[91] Israel's efforts to implement the Multiyear Plan for the Development of Arab Sector Communities (2000) were viewed as positive and, intended to "close the gap between Jews and Arabs by promoting equality in the enjoyment of economic, social, and cultural rights."[92] Specifically, the Committee recognized Israel's affirmative actions regarding disadvantaged minority groups--the Arab Druze, Circassian, and Bedouin communities.[93] Also notable was increased access to Israel's courts for all regardless of citizenship or residency, particularly that "plaintiffs seeking remedy for alleged violations of economic, social, and cultural rights have access to and can make use of the judiciary system, which provides opportunities for the justiciability of the rights enshrined in the Covenant."[94]

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[89] *Id*. at ¶¶ 228-230.

[90] *Id*. at 68-69.

[91] Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant, 30th Sess., UN CESCR, UN Doc. E/C.12/1/Add.90 (2003).

[92] *Id*. at ¶ 4.

[93] *Id*. at ¶ 5.

[94] *Id*. at ¶ 6. Later in its concluding observations, however, the Committee still expressed concern over the fact that Israel had not fully "incorporated [the Covenant] directly into the domestic

The Committee remained concerned about unequal treatment between Jews and non-Jews, namely the Arab and Bedouin populations, where enjoyment of economic, social, and cultural rights were at issue.[95] The Committee renewed its opinion that "the excessive emphasis upon the State as a 'Jewish State' encourages discrimination and accords a second-class status to its non-Jewish citizens."[96] Evidence of what the Committee viewed as a persistent problem was found in the "lower standard of living of Israeli Arabs as a result, inter alia, of higher unemployment rates, restricted access to and participation in trade unions, lack of access to housing, water, electricity and health care and a lower level of education, despite the State party's efforts to close the gap."[97]

Under its final suggestions and recommendations, the Committee listed, among others, the recommendation that the ICESCR enjoy incorporation into Israel's legal domestic order to ensure proper and systematic enforcement of the Covenant's rights.[98] The Committee also strongly encouraged Israel to continue taking action against unequal treatment of certain Israeli citizens in relation to rights protected by the Covenant.[99] Finally, the Committee requested that Israel submit its third periodic State party report for the Committee's consideration by June 30, 2008.[100]

PART IV
ISRAELI ARAB COMMUNITIES' ALTERNATIVES AND SUPPLEMENTS TO FORMAL SOCIAL SECURITY SCHEMES

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legal order" and thus the Covenant could still not be directly invoked before Israeli courts. *Id.* at ¶ 13.

[95] *Id.* at ¶ 16.

[96] *Id.*

[97] *Id.*

[98] *Id.* at ¶ 29.

[99] *Id.* at ¶ 32.

[100] *Id.* at ¶ 47. According to the State report records accessible from the United Nations Human Rights website, Israel had not yet submitted its third periodic State report.

This section examines whether Israel's social security schemes are applied without discrimination to all aged citizens as the ICESCR mandates; whether there are areas or instances where these formal schemes fail (for example, during times of war or general civil unrest); and where they have failed or been applied discriminatorily, how cultural and/or religious communities have worked to create their own systems of care for their aged populations that supplement or provide alternatives to the Israeli government's formal social security system.

Israel's government-supported social security system has both a "social insurance" prong and a "social assistance" prong.[101] Most social security schemes in Israel are public and are regulated by the National Security Law (Revised 1995). The Law combines two kinds of arrangements: insurance-based rights, proportionate to the premiums paid (social insurance);[102] and arrangements aimed at assisting people in need (social assistance).[103] The stated purpose of this legislation has been articulated by Israel's Supreme Court: "The purpose is to guarantee sufficient living resources to the insured, their dependants and their survivors, every time their income decreases or disappears due to one of the reasons enumerated in the law, such as injury on the job, unemployment, birth, death, etc."[104]

Israel's current system, administered by its National Insurance Institute (NII), appears to have been crafted to accommodate many different sectors of its population.[105] The system provides: maternity benefits; old-age benefits; disability benefits; survivor's benefits; employment injury benefits; income

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[101] U.S. Social Security Administration—Office of Policy, *Social Security Programs Throughout the World: Asia and the Pacific, 2006*, http://www.ssa.gov/policy/docs/progdesc/ssptw/2004-2005/asia/israel.html (2006)

[102] *Infra* n. 105.

[103] *Supra* n. 51 at, ¶ 254.

[104] *Id*. (citing the Israeli Supreme Court's opinion in C.A. 255/77 *The National Insurance Institute v. Almohar*, P.D. vol. 29 (1) 11, 13-14).

[105] First and current laws: 1953 (national insurance), implemented in 1954; 1955 (survivor pensions); 1957 (old-age pensions), with 1996 amendment; 1970 (disability insurance); 1974 (pensions), with 1977, 1979, and 1981 amendments; 1980 (long-term care insurance); 1980 (income support); 1982 (benefits); and 1988 (benefits). *Supra* n. 91.

support benefits; and child allowances.[106] Under the social insurance scheme, coverage extends to "all persons residing in Israel aged 18 or older."[107] Under the social assistance scheme, coverage extends to "all persons residing in Israel aged 20 or older (aged 18 or older for certain groups)."[108]

A. ***Community-Based Methods of Elder Care and Israel's Old-Age Pension System***[109]

[106] *Supra* n. 78.

[107] Exclusions: Persons who immigrated to Israel when aged 60 to 62, depending on the month of birth.

[108] Exclusions: Persons living in institutions whose maintenance is paid entirely by the state, the Jewish Agency, a local authority, or religious institution; persons serving in the regular army and their spouses; members of a kibbutz or cooperative village; vehicle owners (unless disabled in the legs or dependent on the vehicle for medical reasons); and students in higher education. *Supra* n. 101.

[109] **Old-age Pension System:**

Social insurance: The retirement age for the earnings-tested pension is age 66 (men) or age 61 (women); the pensionable age (absolute age for receiving the pension, without an earnings test) is age 70 (men) or age 66 (women).

The retirement age for the earnings-tested pension is rising gradually to age 67 (men) or age 62 (women), and the pensionable age (absolute age for receiving the pension, without an earnings test) is rising gradually to age 70 (men and women).

Reduced pension: The pension is reduced until age 70 (men) or age 65 (women) if income from work exceeds between 57% and 76% of the national average wage (according to the number of dependents). The national average wage is NS7,383 (July 2006).

Must have 5 years of coverage in the last 10 years or a total of 12 years of coverage; insured women who are widowed, divorced, deserted, married to an uninsured husband, or unmarried and aged 56 or older at the time of immigration are exempt from the qualifying period, as are women who received a disability pension for the 12 months preceding age 60.

Earnings test: The pension is reduced or suspended until the insured is of pensionable age if income from work exceeds 57% (for a single person) or 76% (for a person with dependents, according to the number of dependents) of the national average wage. There is no earnings test if the insured is of pensionable age. The national average wage is NS7,383 (July 2006).

Deferred pension: Paid between the earnings-tested age and the pensionable age to persons who were previously ineligible to receive the pension because of the earnings test.

Dependent's supplement (earnings-tested): Paid for a dependent spouse or child.

Seniority increment: The increment is paid for years of coverage exceeding 10 years. A housewife is not eligible.

Special old-age benefit (social assistance): A government-financed pension for new immigrants not insured because of their age at the time of immigration and insured persons who emigrated from Israel then returned and do not satisfy the qualifying period condition at the pensionable age.

Income support benefit (social assistance): Must have 24 months of continuous residence (12 accumulative months for new immigrants), subject to an earnings and employment test; incapable of providing self with earned income sufficient for subsistence.

Both the old-age pension system and long-term care system pertain to the social insurance and social assistance schemes. Under the regulation of the NII, Israel's Long-term Care Insurance (LTCI) scheme provides services to aging citizens who must depend on others to help them perform daily tasks such as dressing, eating, washing, and being mobile in their homes.[110] Those individuals who qualify for these benefits "receive long-term care services from a basket of services defined by law which includes: assistance of care-givers in the performance of everyday functions in the home and household management, care in day-care centres for the elderly, laundry services, etc."[111] The benefit[112] is paid to the organization providing the services, and not directly to the elderly person.[113] Enacted in 1986 as a new chapter of the National Insurance Law (Chapter 6E), the benefit's purpose, from the outset, "was not to finance existing formal services, but to complement the then-existing system of service provision in terms of scope and quality, as well as to enhance the family's role as primary care-giver."[114] Israel viewed LTCI as the first stage of implementation as an additional element in the broader spectrum of long-term care, both institutional and non-institutional.[115]

Research indicates that the primary provider of long-term care for elderly Israelis is the family, and thus, family is an integral

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A partial benefit is payable to individuals whose combined income from employment and benefits is less than the minimum income level for subsistence.

Benefits are payable abroad under bilateral agreement.

[110] *Supra* n. 51, at ¶ 306.

[111] *Id.*

[112] "Under the law, two rates of benefit are provided: the first, equivalent to a full disability pension, or 10 hours of care per week, for an elderly person who has become dependent to a large extent on the help of others for the performance of everyday functions or who is in need of supervision; and the second rate, equivalent to 150 per cent of a full disability pension, or 15 hours of care per week, for an elderly person who has become completely dependent on the help of others for the performance of everyday functions or who is in need of constant supervision. In any event, payment of the benefit is not higher than the recompense for the actual hours of care provided." *Supra* n. 50 at ¶ 306.

[113] *Id.* at ¶ 303.

[114] *Id.* at ¶ 304.

[115] *Id.*

resource.[116] Since the law was first implemented, hundreds of service-providers have been set up and consolidated, about half of them public non-profit organizations and half commercial profit businesses. In many cases, the hours of care covered by LTCI are not sufficient, and the elderly persons' families supplement these with additional hours of care paid for privately from their own pockets, often by the same companies. In any case, the care provided by outside help,[117] whether it is financed totally or only partially by social security, does not take the place of the family in the care of the elderly person, but only eases its burden of care.[118]

B. Article 2(2)—ICESCR's Prohibition of Discrimination

Part II, Article 2(2) of the ICESCR prohibits discriminatory application of the rights it is intended to protect. As signatories, each State party "undertake[s] to guarantee that the rights enunciated in the present Covenant [are] exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin,

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[116] *Id.* at ¶ 305. Israel's report stated further that "prior to the implementation of the law in 1988, approximately 80 per cent of the elderly dependent in functional activities of daily living were receiving care from family members, while formal services provided by Government and public agencies covered a much lower proportion of the aged. The legislators of LTCI were interested in encouraging the continued provision of informal care provided by the family, and thus did not exclude from eligibility for benefit individuals who were receiving adequate care from informal sources, thus recognizing the implied costs of this informal care."

[117] One example of government-sponsored/financed "outside help" is Israel's Counselling Service for the Elderly and Pensioners. Created in 1972 by the NII, this service provides a "group of friendly home visitors organized to visit elderly people who [are] unable to come themselves to the local branches of the NII in order to receive aid and advice. The service is based on the work of volunteers, themselves elderly, who belong to and are supervised by the system which supplies the welfare services, but are not tied to its formal procedures. Thus, they may act as informal mediators between the system and the needy elderly." *Id.* at ¶ 308.

"The aim of the service is to improve the services provided to the elderly by the NII and not to limit itself to the granting of monetary pensions only. The NII recognized the need to place an informal system of advice and mediation not connected with bureaucratic procedures at the disposal of the elderly and pensioners in order to ensure that pensioners maximize the use of their social security rights and welfare services in the community. The project proved itself, and today operates in all NII local branches through the country." *Id.* at ¶ 309.

[118] *Id.* at ¶ 307.

property, birth or other status."[119] Thus, social security, which Article 9 of the ICESCR is intended to protect, must be administered to State parties' populations in a non-discriminatory fashion.

In its 1998 report to the Committee, Israel affirmed its commitment to providing equality in social security.[120] Israel's unique formation and history have resulted in unequal application of and access to many of its welfare laws for its non-Jewish/Arab citizenry. This disparity is even more apparent where social security is concerned. As previously noted, many of the Committee's initial inquiries and concluding observations, related to application of Article 9 as well as other Covenant rights, have dealt directly with unequal access to and benefit from governmental programs.[121] The Committee has remained concerned over Israel's lack of legislative measures to implement rights to social security. [122] In its State report to the Committee in 1998, Israel noted several legislative measures undertaken to ensure implementation of the ICESCR, namely Article 9's right to social security mandate.[123] This portion of the Report specifically acknowledged the elderly as a "vulnerable group" needing "careful attention and allocation of resources."[124] The Report stated that, through the Long-Term Care Insurance Law of 1998, Israel "provides personal care services at home and in day centres to over 8% of its elderly population."[125]

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[119] *International Covenant on Economic, Social and Cultural Rights* pt. II, art. 2(2) (Dec. 16, 1966), http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en

[120] "The Government endeavors to ensure that the right to social security, which is both inherent and explicitly guaranteed by law, is indeed enjoyed by all, and the measures it takes in this respect are detailed below. Furthermore, it reviews legislative measures to improve the situation of various sectors of the population." *Supra* n. 51, at ¶ 311.

[121] *Supra* Part II and accompanying footnotes.

[122] *Supra* n. 78.

[123] *Supra* n. 51, at ¶¶ 321-328.

[124] *Id.* at ¶ 323.

[125] *Id.* According to the Report, the Long-Term Care Insurance Law of 1988, "provides personal care on the basis of personal entitlement, thus enabling even severely disabled elderly people to remain at home, with dignity and in familiar surroundings, as long as they are able, and reduces the burden of care borne by the family."

In an effort to combat poverty, Israel noted that it had continued to expand its Law for Reducing the Scope of Poverty and Income Gaps, which it stated was "aimed at increasing protection of the most vulnerable social groups."[126] Recent legislation, the Report continued, had resulted in "significantly increased benefits paid to the elderly, the disabled, as well as single-parent families."[127] The Report finally discussed the 1995 implementation of a National Health Insurance Program.[128] This Program, according to Israel's report, marked the establishment of "a more equitable system of health tax" with "low contribution rates set for all elderly recipients of old-age pensions."[129] Israel concluded this section of the report by noting that "the effectiveness of [the National Health Insurance Program] will be measured to a large degree by the degree of equity in the access to quality health care for poor and other marginalized groups, which will be carefully monitored during the next few years."[130]

Responding to the Committee's Concluding Observations in its initial State Report, Israel's 2001 Addendum report addressed the ICESCR's implementation into Israeli domestic order through the draft Basic Law: Social Rights.[131] In its Concluding Observations to Israel's initial State Report, the Committee expressed concerns that the wording of this draft law did not meet

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[126] *Id*. at ¶¶ 325 and 326. Throughout its report, Israel consistently regards its aged population as a "vulnerable group."

[127] *Id.*

[128] *Id.* at ¶ 327.

[129] *Id.*

[130] *Id*. See also ¶ 328: Further review of trends and changes in Israeli national legislation and court decisions, at the time Israel's 1998 Report was submitted to the Committee, is available in the National Insurance Institute's report, *Summary of Developments and Trends in Social Security – 1996*, submitted to the International Social Security Association (ISSA).

[131] *Supra* n. 67, at ¶ 32. The Basic Law: Social Rights states in pertinent part, section 3: "*Social Rights*--Every citizen has the right to a dignified, humane existence, which includes the right to work, to fair work and salary conditions, to free education, to an appropriate level of social security, health insurance, and social welfare, the right to appropriate housing, and to quality of environment.

These rights shall be exercised subject to reasonable restrictions and subject to the financial ability of the state, but in such a manner as befits the values of the State of Israel as a Jewish democratic state." The Knesset and The Jewish Agency for Israel, http://www.huka.unitedapps.com/a490.html?rsID=0 (accessed February 2010).

the requirements of States' obligations under the ICESCR.[132] In response to this concern, Israel's 2001 addendum addressed the status of the draft Basic Law:

> The draft Basic Law: Social Rights is no longer pending in the Knesset. The future of such legislation is not clear. However, the rights protected by the Covenant are a part of the ongoing public debate in Israel and appear in regular curricula of law faculties. Moreover, economic, social and cultural rights are increasingly recognized as constitutional rights in Israeli jurisprudence.[133]

In its 2003 State Report, Israel again addressed concern over lack of legislation implementing social security rights into its domestic laws. Under its section, "Combined public and private social security schemes," the 2003 Report specifically addressed Israel's pension system and its Long-Term Care system.[134] The Long-Term Care Insurance Law, according to Israel's Report, had a positive impact on "tens of thousands of dependent elderly and their families."[135] Acknowledging the positive effects of this law and in an effort to improve the "equitable and efficient allocation of resources for the benefit of the dependent elderly population," since its initial State Report, long-term care insurance became the focus of a "comprehensive re-examination."[136] Aside from the introduction of the short-term nursing benefit[137] in March 2000, the Report did not provide details of what this "comprehensive re-

[132] *Supra* n. 51-54 (and accompanying text).

[133] *Supra* n. 77, at ¶ 32. The addendum stated that, further details on the status of legislation implementing ICESCR into Israel's domestic law would be submitted with Israel's second periodic State Report.

[134] *Supra* n. 51, at ¶¶ 224-227.

[135] *Id*. at ¶ 226.

[136] *Id.*

[137] The Report briefly described this new benefit as "a new and unique benefit paid for a period of 60 days, mainly to patients having acute functional difficulties."

examination" entailed.[138] Overall, it appears as though Israel has taken measures to create workable social security schemes and has, according to its reports to the Committee, made efforts to equalize access to social security benefits. Continued social and civil unrest in Israel, however, especially along the West Bank and Gaza Strip, has consistently presented obstacles in accessing social services especially for non-Jewish, mostly Arab, citizens. Discriminatory residency requirements[139] have also had a negative impact on Arab/Palestinian's access to and qualification for social services. As noted above, residency and citizenship are qualifying factors for Israel's social security system. Furthermore, the stated goal of Israel's social assistance prong of its social security system is to provide aid to families to encourage at-home, familial care for the elderly.[140] Thus, if an Arab/Palestinian family has been separated due to physical border closures or citizenship requirements, this likely has a detrimental impact on care for the Arab/Palestinian elderly.

Noting the legal and formal obstacles to social security and social assistance, informal support systems have become a necessary function of Arab society and culture in Israel. As the elderly Arab population grows, finding alternative ways to

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[138] *Id.*

[139] *See* supra n. 51, at ¶ 246. Here, the Committee expressed concern over the effects of Israel's Permanent Residency Law: "The Committee expresses its concern at the effect of the directive of the Ministry of the Interior, according to which Palestinians may lose their right to live in the city if they cannot prove that East Jerusalem has been their "centre of life" for the past seven years. The Committee also regrets a serious lack of transparency in the application of the directive, as indicated by numerous reports. The Committee notes with concern that this policy is being applied retroactively both to Palestinians who live abroad and to those who live in the West Bank or in nearby Jerusalem suburbs, but not to Israeli Jews or to foreign Jews who are permanent residents of East Jerusalem. This system has resulted in, inter alia, the separation of Arab families and the denial of their right to social services and health care, including maternity care for Arab women, which are privileges linked to residency status in Jerusalem. The Committee is deeply concerned that the implementation of a quota system for the reunification of Palestinian families affected by this residency law involves long delays and does not meet the needs of all divided families. Similarly, the granting of residency status is often a long process and, as a result, many children are separated from at least one of their parents and spouses are not able to live together."

[140] *Supra* nn. 116-117.

effectively care for them has become increasingly important.[141] One way that Arab populations in Israel care for their elderly is through a multigenerational family framework.[142] In Israel, "Arab nuclear families…usually occupy several households in the same village" in close proximity to one another—"children and grandchildren …are actively involved in the lives of their parents/grandparents."[143] Because of the multigenerational structure of most Arab families in Israel, many Arab families are reluctant to utilize or rely upon a formal system of elder care, such as that offered by the Israeli government to qualifying citizens, because the notion of formal extra-familial support is often a foreign concept.[144]

In an attempt to acknowledge the positive aspects of both informal multigenerational care of the elderly and formal care, ESHEL—The Association for the Planning and Development of Services for the Aged in Israel—has developed initiatives[145] aimed at providing community services for the elderly Arab population.[146] Among these community services are social clubs for elderly Arabs, [147] day-care centers,[148]and the supportive

[141] As of May 2003, "[O]nly 6% of all elderly [in Israel] were Arabs, even though Arabs constitute 20% of Israel's total population. However, the number of elderly in the Arab population is expected to increase more rapidly than in the Jewish population. At the end of 2001 there were 38,500 Arab elderly, but their number is expected to reach 92,100 by 2020. This will represent a nearly 2.5 fold increase in absolute numbers (and will be 2.5 times greater than the increase in the number of Jewish elderly)." Faisal Aziaza, PhD & Jenny Brodsky, MA, *The Aging of Israel's Arab Population: Needs, Existing Responses, and Dilemmas in the Development of Services for a Society in Transition*, 5 IMAJ, 383 (2003).

[142] *Id*. at 385.

[143] *Id.*

[144] *Id*. at 386.

[145] These initiatives have been undertaken in cooperation with various government agencies, municipalities, and local authorities.

[146] *Id*. at 385.

[147] According to Azaiza's article, in May of 2003 there were 68 social clubs for elderly Arabs, visited by close to 4,000 people which accounts for approximately 11% of the Arab elderly population. *Id*.

[148] Also, 15 day-care centers had been established for the Arab elderly, primarily for those who are disabled, which served about 950 people or about 2.5% of the total Arab elderly population. *Id*.

community program.[149] All of these measures work alongside Israel's formal social security systems and are vital to those individuals who do not qualify for, or otherwise cannot obtain access to, government programs.

CONCLUSION

As a party to the ICESCR, Israel has agreed to protect its citizens' economic, social, and cultural rights. Furthermore, it has agreed to provide access to services that create and protect these rights without discrimination. This undertaking is even more salient given Israel's past and current civil unrest. Though Israel appears to have taken steps toward incorporating the ICESCR's protections into its domestic laws, efforts have stalled along the way and budget cuts continue to work against drafting Basic Laws on social rights. The heterogeneity of Israel's citizenry is what makes it historically unique. Yet, at the same time, this religious/cultural diversity, paired with discriminatory practices and laws, has hindered progress where the ICESCR's mandates are concerned.

To ensure that vulnerable segments of Israeli society, specifically the elderly of minority non-Jewish populations, enjoy basic care and some access to social services, many communities have maintained ties to traditional multigenerational care, while some have learned to embrace formal systems of care, when and where they are available. Once the ICESCR's protections are fully integrated into Israeli domestic law, many of the disparities in access to social services, namely social security, would likely slowly disappear.

[149] "The supportive community program's main goals are to improve the quality of life of the elderly living in the community and to proved specific services to meet needs that otherwise are not adequately addressed. The supportive community program supplies four services: special medical services (physician house calls and ambulance service); an emergency call service; a neighborhood facilitator (simple home repairs and social support); and social activities."*Id*.