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MICHIGAN'S DUTY TO PROVIDE ACCESS TO HEALTH CARE

GARY A. BENJAMIN* AND SHAAKIRRAH R. SANDERS**

I. INTRODUCTION

In the year 2000, the World Health Organization (WHO) conducted an assessment of the world’s health systems.1 This report

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found that while the "United States Health system spends a higher portion of its gross domestic product than any other country [, it only] ranks 37 out of 191 countries according to performance." Such findings should come as a shock, considering that the United States boasts the best health care system in the world. However, many of our nation's citizens are unable to gain access to that system, and the United States Supreme Court declined to rule that health care is a fundamental right.

As most health care professionals know, this is more than a legal argument. The American health care system is both inefficient and cruel. It is inefficient in that about 25 percent of the health care dollar is spent on administrative overhead, while countries with less complex health care insurance systems spend at most 11 percent. This is the largest cost factor in the American system. Yet, with all that money spent, the health care statistics in the United States, and particularly in Detroit, which boasts three major health systems including, many hospitals, people are dying prematurely. To put it mildly, we are not getting our moneys' worth! Our system only provides the best health care in the world for those who can gain access.

In our Western Civilization such cruelty should not be allowed. Every religious organization in the country that has spoken out on health care has called for universal coverage. For example, as the Bishops of the Catholic Church wrote:


2. Press Release, World Health Report 2000, World Health Organization Assesses the World's Health Systems, available at http://www.who.int/whr2001/2001/archives/2000/en/press_release.htm (last visited July 7, 2004). It has been estimated that the "United States spends one out of every seven dollars in its economy on health care. This figure probably will be increasing to one out of every six dollars in the next couple of years. This is a fifty percent greater share of our total economic productivity ... each year devoted to health care than any other industrialized country." E. Richard Brown, Keynote Address: Allocation of Health Resources in the Clinton Administration, 16 WHITTIER L. REV. 3, 3 (1995).
One’s ability to live a fully human life and reflect the unique dignity that belongs to each person is greatly affected by health. Not only for individuals, but likewise for society at large, health issues take on important significance because of the intimate role they play in personal and social development. Complex in their ramifications and universal in their relevance, these issues are of concern to us all – rich and poor, young and old.

For the Church, health and the healing apostolate take on special significance because of the Church’s long involvement in this area and because the Church considers health care to be a basic human right which flows from the sanctity of human life.  

Yet with all the moral authority of the churches; with the general approval of all the polls; and with all the pressure of the costly, cruel, inefficient system this country has built, somehow this nation has been unable to create anything that provides health care for all. This article argues that Michigan’s constitution guarantees a right to basic health care for its citizens. By guaranteeing such a right, Michigan can and should provide for the basic health needs of all of its residents.

II. HEALTH CARE CRISIS IN THE UNITED STATES AND MICHIGAN

Current statistics show that “the United States spends an estimated $1.4 trillion on health care and is projected to spend as much as $1.8 trillion in 2005, which is twice as much per person than any other industrialized country.” Despite the fact that the WHO found that the United States has one of the most responsive health systems,


in 2002 over 43 million Americans lacked health insurance of any kind.\textsuperscript{6} Among those 43 million uninsured Americans were 8.5 million children.\textsuperscript{7} A comparison of ethnic groups reveals that Hispanics were least likely to have health insurance,\textsuperscript{8} followed by African-Americans,\textsuperscript{9} Asians,\textsuperscript{10} and Caucasians.\textsuperscript{11} Health care coverage also


\textsuperscript{8} See Health Insurance Coverage: 2002, supra note 6. 67.6 percent of Hispanics reported having health insurance. \textit{Id.} This was 12.2 percent lower than any other racial or ethnic group. See Press Release, \textit{U.S Census Bureau, supra note 7}. However, this number is unchanged from 2001. \textit{Id.}

\textsuperscript{9} See Health Insurance Coverage: 2002, supra note 6. 79.8 percent of African Americans reporting a single race were insured. \textit{Id.}

\textsuperscript{10} \textit{Id.} 81.6 percent of Asians who reported a single race were insured.
varied among the different age groups\textsuperscript{12} and whether one was a member of the foreign-born population.\textsuperscript{13} The Institute of Medicine has found that the lack of health insurance coverage is a major factor in poor health outcomes.\textsuperscript{14}

"The number and percentage of people covered by government health insurance programs rose in 2002, from 25.3 percent to 25.7 percent, largely from an increase in the number and percentage of people covered by Medicaid (from 11.2 percent to 11.6 percent)."\textsuperscript{15} While Medicaid insured 14.0 million people living in poverty, 10.2 million remain uncovered by any type of health insurance in 2002.\textsuperscript{16} Workers were more likely than non-workers and the unemployed to have health insurance; however, among those in poverty, workers were more likely to be uninsured than those who lack employment.\textsuperscript{17} Most disturbingly, "[t]he number and percentage of people covered by employment-based health insurance dropped in 2002, from 62.6

\begin{itemize}
\item \textsuperscript{11} Id. 89.3 percent of non-Hispanic whites reported having health insurance.
\item \textsuperscript{12} "Young adults (18 to 24 years old) were less likely than other age groups to have health insurance coverage – 70.4 percent in 2002, compared with 82.0 percent of those 25 to 64 and, reflecting widespread [M]edicare coverage, 99.2 percent of those 65 and over." Health Insurance Coverage: 2002, supra note 6. In 1994, 26.7 percent of young adults aged 18-24 lacked coverage. See Current Population Report 1994, supra note 6.
\item \textsuperscript{13} The proportion of the foreign-born population without health insurance was 33.4 percent, while only 12.8 percent of those born in America lacked health insurance. See Health Insurance Coverage: 2002, supra note 6.
\item \textsuperscript{14} Care Without Coverage: Too Little, Too Late, INSTITUTE OF MEDICINE, xi (National Academy Press, 2002).
\item \textsuperscript{15} Id. Among the entire population of 18 to 64 years old, 82 percent of workers had health insurance compared with 74.3 percent of non-workers. Id. Among those in poverty, 52.6 percent of workers had insurance compared with 61.9 percent of non-workers.
\item \textsuperscript{16} Id. This represents 30.4 percent of people in poverty. In 1994, the number of poor without coverage was 1.1 million, representing 29.1 percent of those in poverty. See Current Population Reports 1994, supra note 6.
\item \textsuperscript{17} Health Insurance Coverage: 2002, supra note 6.
\end{itemize}
percent to 61.3 percent." Moreover, "[c]ompared with 2001, the proportion who had employment-based policies in their own name decreased from 56.3 percent to 55.2 percent in 2002."19

Michigan's health care statistics are worse. Michigan ranks among the top ten states with the highest number of uninsured people in the years 2002 and 2003, as 2.5 million people under the age of 65 were uninsured for more than six months.20 That number includes 130,000 children21 and one out of every four people under the age of 65 in Michigan.22

As with national statistics, ethnic minorities, including Hispanics and African-Americans, are more likely to be uninsured in Michigan than the Caucasian population.23 Only 25 percent of Caucasians were uninsured, compared with 44.2 percent of Hispanics, 42.5 percent of African-Americans, and 33 percent of other minorities.24 "Families in Michigan with incomes at or below 200

18. Id.

19. Id. Thus, for the second year in a row, the overall decrease in coverage was attributed to a drop in the percentage of people covered by employment-based health insurance. See Press Release, U.S. Census Bureau, supra note 7.


22. See The Uninsured: A Closer Look, Michiganders without Health Insurance, FAMILIES USA, available at http://www.familiesusa.org/site/DocServer/Michigan.pdf?docID=3687 (last visited July 7, 2004). This number amounts to 28.7 percent of Michigan's under 65 population. Id. There is some dispute among health care analysts as to how many people in Michigan are uninsured at any one time. The most conservative number the authors have seen is in excess of one million people without health insurance for a full year. The higher number is based on a shorter period of lack of insurance.

23. See The Uninsured, supra note 22.
percent of the federal poverty level were much more likely to be uninsured than families with incomes above 200 percent of poverty.”

Strikingly, 73.6 percent of Michigan’s uninsured are members of working families.

Within the city of Detroit, Michigan’s largest city, over 52 percent of Detroit residents are either uninsured or Medicaid eligible and only 35 percent have private insurance. Access to health care has also become a major issue. For example, in the past ten years, twenty primary care clinics and four hospitals within the City of Detroit have been closed. Detroit has not had a publicly owned

24. Id. “Despite the fact that people of color are far more likely to be uninsured, white, non-Hispanics made up the largest category of people (1,717,000) under the age of 65 without health insurance for all or part of the two-year period.”

25. Id. “200% of the Federal Poverty Level (FPL) amounted to $19,146 a year for single adults and $32,320 a year for a family of four in 2003.”

26. Id. More than half of those are full-time, full-year workers. A Fundamental Health Care Concern: Coverage, 2002, Guide to Michigan Nonprofit Hospitals and Health Care Issues, available at http://www.mha.org/nonprofitguide/coverage.htm (last visited July 7, 2004). “[Eight] out of 10 of the uninsured are from working families where insurance is not offered or when it is offered, the employees may not be able to afford the premiums to participate in the plans.” One in Three: Non-Elderly Americans Without Health Insurance, supra note 20.

27. Strengthening the Safety Net in Detroit and Wayne County, DETROIT HEALTH CARE STABILIZATION WORKGROUP, 5, available at http://www.michigan.gov/documents/ReportofDetroitHealthCareStabilizationWorkgroup_1_70764_7.pdf (last visited July 14, 2004). According to the report, 280,000 Wayne County residents, including Detroiters, are uninsured, 390,000 residents are Medicaid eligible, and 25,000 are Plus Care eligible. Id. Compared with state statistics, 22.5 percent of Michigan residents are uninsured or Medicaid eligible and 63 percent have commercial insurance. Id.

hospital since Detroit General was sold to Detroit Medical Center ("DMC") in 1981. HMOs serving Medicaid clients in Detroit and Wayne County lost a combined $9.6 million in calendar year 2001. As a result, private practitioners are also abandoning the city.

The loss of primary care clinics and physicians can be directly attributed to action taken by Michigan in the mid-1990's. At that time, Michigan established a "managed care" system for Medicaid and took bids from HMOs to cover Medicaid patients. The lowest bidder won which led Michigan to have the lowest capitation rate in the country. As a result, HMOs could not pay the bills they received and clinics could not survive in a business climate where about one-third of the clientele had no insurance and another one-third had Medicaid, which did not pay enough to cover overhead.

In other Michigan cities, major providers of primary care are Federally Qualified Health Clinics (FQHCs). Detroit has only nine of these clinics, yet in 2002, when the Detroit health care crisis was building, the federal government denied all three applications for new FQHCs in the City of Detroit. These denials were contrary to promises of the federal government to put more clinics in Detroit. As a result, primary care for citizens of Detroit is decreasing as the need increases.

In Detroit, the Area Agency on Aging recently published findings regarding the health of Detroit residents over the age of 50.

29. See An Assessment of the Safety Net in Detroit, Michigan, supra note 28, at 10 & n.9. The DMC is one of three major providers of health care in Detroit, the other two being the St. John Health System (SJHS) and the Henry Ford Health System (HFHS). The three are roughly equal in size, but the DMC serves more people who are uninsured or under-insured.


31. See id. at 4. "The loss of primary care capacity has left Detroit with inadequate resources." Id.

32. Other cities have more primary care clinics. In Michigan, Saginaw has 10 and Grand Rapids has nine FQHC's. St. Louis has 18, Cincinnati has 14, San Antonio has 17, and Columbus, Ohio has 10. Even Denver has 40 and Chicago has over 50. Atlanta has over 30 and San Francisco has 12.
It found that for the 50 to 59 year old age group, the mortality rate was 122% higher than in the rest of the state. This means that for 100 persons in that age category who die outside of Detroit, there are 222 who die in Detroit. The infant mortality rate is also twice as high in Detroit, and the mortality rate for those who are 60 to 74 is 48% higher in Detroit. For all of Michigan's investment in health care, the statistical evidence shows that the system is failing the citizens of Detroit.

Recently, it was reported that approximately 45,000 young adults and caregivers are targeted for Medicaid cutbacks. While Michigan "spends over $7 billion on Medicaid ... [s]pending on the health care program has swelled by 40 percent in four years and the caseload has grown to the point that better than one in every seven Michiganders now gets Medicaid." Michigan is clearly making efforts today to take care of its citizens through the Medicaid program and other planned initiatives such as the bulk buying of pharmaceuticals. None of these efforts, however, will take care of all Michiganders. It is clear that radical changes need to be made, as Michigan's health care system cannot continue to operate as it currently has been. If Michigan's Constitution provides for access to health care for all, as will be discussed below, it is just as clear that Michigan is failing to meet that duty.


35. Id.


37. Id.
III. GUARANTEE OF HEALTH CARE UNDER MICHIGAN'S CONSTITUTION

Even though the United States Supreme Court declined to recognize a universal right to health care under the federal constitution, Michigan is free to guarantee such a right under its own constitution. Article 4, section 51 of the Michigan Constitution declares that "[t]he public health and general welfare of the people of the state are ... of primary public concern." That same section mandates Michigan's legislature to "pass suitable laws for the protection and promotion of the public health." The legislative history of this section reveals that at least one delegate believed that "[e]very citizen of Michigan is entitled to good health.... In fact, good health can be considered a right."

Michigan case law contains few references to article 4, section 51. Of the few cases that do make reference to this section, none

38. Indeed, it has long been established that "[a] state court is free to read its own state constitution more broadly than the United States Supreme Court reads the federal constitution, or to reject the mode of analysis used by the United States Supreme Court in favor of a different analysis of the state's corresponding constitutional guarantee." Doe v. Dept. Social Services, 187 Mich. App. 493, 468 N.W.2d 862 (1991), rev'd 439 Mich. 650, 487 N.W.2d 166 (1992) (citing City of Mesquite v. Aladdin's Castle, Inc., 455 U.S. 283, 293 (1982); Prune Yard Shopping Center v. Robins, 447 U.S. 74, 81 (1980)). See also People v. Thompson, 424 Mich. 118, 379 N.W.2d 49 (1985). As was explained by the Supreme Court of Hawaii:

[w]hile this results in a divergence of meaning between words which are the same in both the federal and state constitutions, the system of federalism envisaged by the United States Constitution tolerates such divergence where the result is greater protection of individual rights under state law than under federal law.


39. MICH. CONST. art. IV, § 51.

40. Id.

41. THE STATE OF MICHIGAN CONSTITUTIONAL CONVENTION 1961 OFFICIAL RECORD (Austin (1964)).

make reference to universal access to health care. For example, in *City of Gaylord v. Gaylord City Clerk*[^43] and *Gregory Marina, Inc. v. City of Detroit*,[^44] it was held that the government may act in the public interest regarding health issues. In *Perry v. Kalamazoo State Hospital*,[^45] *Hamilton v. Reynolds*,[^46] and *Coen v. Oakland County*,[^47] it


[^44]: A mandamus was sought and questions were certified to the Michigan Supreme Court whether the constitution permitted Michigan municipalities to issue tax-exempt municipal bonds to finance acquisition of industrial buildings. *City of Gaylord*, 144 N.W.2d at 463-64. The court noted that article 4, section 51 limited "the powers of the legislature and of government generally to such legislative acts and such governmental powers as exhibit a public purpose." *Id.* at 467-68. The court ruled that "[t]he right of the public to receive and enjoy the benefit of the use determines whether the use is public or private" and held that the benefits resulting from the industrial building in question would be general to the public. *Id.* at 471.

[^45]: An action was brought challenging the validity of Detroit's right to construct a marina on the Detroit River. *Gregory Marina, Inc.*, 144 N.W.2d at 504. In holding that the city had such a right, the Michigan Supreme Court reasoned that while determinations of what constitutes a public purpose should be made by the legislature, not the court, "the construction of a marina by the city of Detroit clearly meets the test of a public purpose which the courts have taken upon themselves to formulate." *Id.* at 515-517. Therefore, the city could restrict use of the marina and "[n]either the construction nor the operation of a marina by the city of Detroit will violate the constitutional prohibition against expenditures of money or other property for other than public purposes." *Id.* at 517-18.

[^46]: An action was brought against a state mental hospital alleging violations of the duty to provide care, treatment and custody of one of its patients. *Perry*, 273 N.W.2d at 422. Citing MCL § 691.1407, which provides immunity from "tort liability in all cases wherein the government agency is engaged in the exercise or discharge of a governmental function," the court held that "the operation of a public hospital was a 'governmental function.'" *Perry*, 273 N.W.2d at 423. Reasoning that "the care, treatment and custody of mental patients at a public hospital are activities intended to promote the general public health and are exercised for 'the common good of all,'" the court ruled that defendants are immune from liability from any alleged negligence in performing that function. *Id.* at 424. The court specifically cites article 4, section 51 as support for its conclusion at footnote 4 of the case. *Id.* at 423 n.4.
was held that immunity should be granted in malpractice and other negligence actions involving health care facilities owned and operated by Michigan. In *Coen*, the court wrote:

We conclude that the provision of mental health services by defendant Oakland County through defendant clinic involves an activity *impliedly mandated by the state constitution*. Specifically, ... [article 4, section 51 and article 8, section 8] impliedly mandate defendant Oakland County to provide institutions, programs and services to inhabitants suffering from mental handicaps.  

Finally, in *Doe v. Director of the Michigan Department of Social Services*, the Michigan Court of Appeals ruled that pregnant women and their fetuses have constitutionally protected interests under Michigan’s constitution, even though such protections would not be found under the federal constitution. The Michigan Supreme Court

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46. An action in negligence was brought against the director of a psychiatric hospital and a physician at that hospital for the death caused by a patient at that hospital. *Hamilton*, 341 N.W.2d at 153. In finding that defendants were immune from liability, the court reasoned that defendants acted “in furtherance of the state’s constitutional mandate to protect and promote public health and to foster and support institutions for the care of the mentally handicapped.” *Id.* at 154. As a result, defendants were immune from liability. *Id.* at 154-155.

47. Suit was brought against the county, a county health clinic, a county physician, and a county hospital, among others, to recover for injuries in connection with the taking of an antipsychotic drug. *Coen*, 400 N.W.2d at 615-616. Again, the court held that defendants were entitled to immunity, as they were acting within the scope of authority granted to them under Michigan’s statute. *Id.* at 615-17.

48. *Id.* Mich. Const. art. 8, § 8 provides that “services for the care of those who are physically, mentally, or otherwise seriously handicapped shall always be fostered and supported.” *Id.* at 615-16.


50. The court ruled that, pursuant to article 4, section 51 of the Michigan Constitution, Michigan has an interest in the protection of the health of pregnant women and their viable unborn child. *Doe*, 468 N.W.2d at 868-69. Therefore, according to the court, M.C.L § 400.109a, which prohibits public funds from being
later reversed, holding that there was no equal protection violation. The court, however, failed to address the effect of article 4, section 51.\textsuperscript{51}

The cases cited clearly show that article 4, section 51 means something: at the very least, it means that health care is a governmental function. It means that Michigan must provide certain services to those who are physically, mentally, or otherwise seriously impaired. The phrasing of the section is also instructive. “[P]rimary” means of first importance on any list of “concerns.” The legislature “shall” treat health care as such a concern. Even though article four, section 51 does not explicitly require Michigan to provide universal access to health care and even though there is no case law demanding that Michigan do so, it is clear that Michigan’s Constitutional Convention agreed that the state has the primary role in maintaining the health of its residents.

At the time article 4, section 51 was adopted, Michigan had a law that required counties to provide health care to the indigent in county hospitals.\textsuperscript{52} That statute, M.C.L § 331.160, is still in place. However, all county hospitals have been closed, and no system has replaced the county hospital. At the time the Michigan constitution was enacted, it is likely that the delegates, many of whom were elected officials, knew the counties were providing free care in their hospitals. It is also likely that had those delegates been told that Michigan’s

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\textsuperscript{51} The Michigan Supreme Court limited its review of Doe to “whether [section] 109a exceeds the limits of equal protection established by our state constitution.” \textit{Doe, rev’d 487 N.W.2d} at 168. In concluding that it does not, the court reasoned that “we do not see how a decision to offer funds only for childbirth takes away any of the choice that would be available to an indigent woman if the state did not offer funds for childbirth.” \textit{Id.} at 178. Moreover,

... an indigent woman who desires an abortion is not excluded from the Medicaid program. Whether a Medicaid-qualified woman wants to terminate her pregnancy or to carry her fetus to term, she is treated in the same way that any other Medicaid-qualified pregnant woman is treated: she is offered reimbursement for the expenses of childbirth, but not for the expenses of an abortion.

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\textsuperscript{52} M.C.L. § 331.160.
counties would cease to provide care, they would have demanded that *something* replace the lost care.

Michigan counties are also required to administer a public welfare program to grant general assistance, including medical care to persons, including indigents, domiciled in the county – but only in a county medical care facility.\(^{53}\)

Michigan’s legislature did take their mandate seriously. For example, in 1978, following the mandate of article four, section 51, Michigan passed a statute that would establish a statewide health care plan guaranteeing access to health care to “all segments of the population.”\(^{54}\) Given the statistics from Detroit, it is clear that Michigan has failed in this effort.

Considering the fact that a vast majority of Michigan residents, especially those within the City of Detroit, are underinsured or uninsured, a Michigan court must, at the very least, find that Michigan has failed to maintain the public health. In making such a finding, Michigan courts may rely on Michigan’s constitution and

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53. M.C.L. § 400.55. The text of the statute reads in part:

   The county department shall administer a public welfare program ...
   [t]o grant general assistance, including medical care to any person domiciled in the county who has a legal settlement in this state. General assistance may also be granted to a person who has a legal settlement in this state but not domiciled in the county and a recoupment may be made when appropriate in the manner provided in cases of emergency hospitalization under this act[;) ...
   [t]o administer categorical assistance including medical care[;] ...
   [t]o supervise and be responsible for the operation of the county infirmary and county medical care facility[;] ...
   [and t]o furnish in all cases, insofar as practicable, care and treatment which will tend to restore needy persons to a condition of financial and social independence.

54. See M.C.L. § 325.2001 *et. seq.* The law requires Michigan to, among other things, “prepare and approve the state health plan not less frequently than once every 3 years[,] ...
   [a]ddress mechanisms to promote adequate access to health care for all segments of the state’s population; [and e]ncourage the rational development and distribution of health care services.” M.C.L. § 325.2010. Though several such plans were presented, the most recent plan was dated 1996 and was intended to cover the period through the year 2000. That plan did not provide for access to health care to all citizens. No state health care plan presently exists, and none has been in place since the 1996 plan.
statutes, as well as international human rights laws guaranteeing a right to health care.

For example, in *Pauley v. Kelly*,55 the West Virginia Supreme Court declined to follow the United States Supreme Court’s holding in *San Antonio Ind. Sch. Dist. v. Rodriguez*56 that public education was not a fundamental right.57 In so holding, the *Pauley* court “cited to the Universal Declaration of Human Rights … [and] noted that the Universal Declaration ‘appears to proclaim education to be a fundamental right of everyone.’”58 Another example of a state court adopting international human rights principles can be found in *Sterling v. Cupp*.59 In that case, the Oregon Supreme Court relied on the United Nations Charter, the Universal Declaration of Human Rights, the International Covenant of Civil and Political Rights, the American Convention on Human Rights, and the Standard Minimum Rules for the Treatment of Prisoners approved by the United Nations Economic and Social Council to invalidate a law allowing female correctional officers to supervise male prison inmates.60 In *Boehm v. Superior Court*,61 the California Court of Appeals relied on the Universal


57. Id. at 35.


60. Id. at 131 n.21.

61 223 Cal. Rptr. 716 (1986).
Declaration of Human Rights to hold that general assistance grants provided by the county "must include an appropriate allowance for each of the basic necessities of life: food, clothing, housing (including utilities), transportation, and medical care."  

The adoption of international human rights law should be employed to give fuller meaning to article four, section 51. As shown, such an application "is not unprecedented nor need it mark a radical departure from current doctrinal interpretation." Rather, Michigan shall have a more complete authority for its holding by placing it within the context of a universal set of standards for human rights protection.

IV. HEALTH CARE SYSTEMS GLOBALLY AND IN THE UNITED STATES

Historically, Americans supported the idea of a national health system that provides universal access to health care. However, the specter of "socialized medicine" or a large bureaucracy is often raised to argue against universal coverage. This is not so in Europe, for as early as the late 19th century, many European countries enacted legislation that would become the foundation of their current system of social services, including health care. Most of these systems are not

62. Id. at 721. See also City of Santa Barbara v. Adamson, 27 Cal. 123, 610 P.2d 436 (1980) (relying on Universal Declaration of Human Rights to invalidate housing statute that infringes on right to privacy); Humphers v. First Interstate Bank, 298 Ore. 706, 696 P.2d 527 (1985)(citing to said Declaration to find a cause of action against a physician for breach of confidential relationship); & American Nat'l Ins. Co. v. Fair Employment and Hous. Comm'n, 32 Cal. 603, 651 P.2d 1151 (1982) (relying on said Declaration to find civil rights violation against person with physical handicap).

63. Park, supra note 58, at 1262-63.

64. Id. at 1263.

65. "From an American perspective, health care should be financed through one or more of the following alternatives: one's own private funds, insurance provided through one's employer or charity." Robert F. Rich, Health Policy, Health Insurance, and the Social Contract, 21 COMP. LAB. L. & POL'Y J. 397, 402 (2000).

66. See infra footnote 67-92 and accompanying text.
as large a bureaucratic nightmare as our own capitalistic system of health insurance. Those who run major health systems in the United States advise that in order to receive payment, their billing departments must use 70 to 80 different forms, use several different computer codes, and apply to different companies. As a result, the payment is often less than the billing. Consumers offer the following as payment: Medicaid, Medicare, private health insurers, HMOs, Workers’ Disability Compensation, auto insurance, liability insurance, and cash— all of which must be handled differently at the provider level. This bureaucratic nightmare is the primary reason the health insurance costs in the United States are the highest in the world.

In Germany, for example, the first national system of compulsory sickness insurance providing “health care services and cash for lost income due to illness[,]” was designed and established in 1883.67 Germany now has a universal health insurance program that is funded by the private sector rather than the government.68 “In Germany, everyone receives medical treatment according to his/her needs and pays money according to his/her wealth.”69 The “health care delivery system ‘is financed through ... [either] private insurers ... or autonomous sickness funds.’”70 German patients have freedom of choice in choosing their physicians and German health care

67. Rich, supra note 65, at 402. Legislation based on the German model was subsequently enacted in Austria, Hungary, Norway, Serbia, Great Britain, Russia, and the Netherlands. Id. The Austrian plan was adopted in 1888, the Hungarian plan was adopted in 1891, the Norwegian plan was adopted in 1909, the British plan was adopted in 1911, and the Dutch plan was adopted in 1913. Id.

68. James B. Roche, Health Care In America: Why We Need Universal Health Care and Why We Need It Now, 13 ST. THOMAS L. REV. 1013, 1028-29 (2001). “[U]nder the German plan a certain percentage of the nation’s national budget is budgeted for health care, and that amount is not exceeded.” Id.

69. Id. at 1029.

70. Id. “[A]utonomous sickness ‘funds are [extremely] similar to ... [the] Blue Cross/Blue Shield programs’ ... prevalent in the United States today. The vast majority of Germans ‘obtain [their] health insurance through [these autonomous] sickness funds’ ... since these funds are mandatory for those who earn ‘below [a] certain income.’” Id.
providers enjoy a greater amount of autonomy than in other public health systems.\footnote{71}{Id.}

Switzerland established employer liability for workplace accidents in the late 1870s.\footnote{72}{Id.} Soon thereafter, a constitutional amendment mandated that the federal government establish sickness and accident insurance.\footnote{73}{Id.} That amendment resulted in Swiss legislation creating eligibility requirements for private and public insurance plans.\footnote{74}{Id.} The insured were guaranteed health care benefits, including drugs and hospitalization, and have a choice among area physicians.\footnote{75}{Id.} Subsidies were also available to provide health care to thinly populated, medically underserved areas.\footnote{76}{Id.}

Recently, a new system of social health insurance was enacted in Switzerland in order to reduce the government’s share of health care costs.\footnote{77}{Id.} This new legislation made insurance compulsory.\footnote{78}{Id.} Moreover, subsidies are only provided for medical benefits, but not for disability income, and premiums may only be subsidized for the

\footnote{71}{Id.}{\it physicians and other health care providers “are allowed to use the resources they are allocated as they see fit instead of having a board or supervisor directing them to what is or is not necessary.” Id.}


\footnote{73}{Id.}

\footnote{74}{Id. at 412.}

\footnote{75}{Id. at 412-13.}

\footnote{76}{Id. at 416.}

\footnote{77}{Donahue, \textit{supra} note 72, at 423. From 1985 to 1995, growth in health care spending outpaced growth in gross domestic product by 22 [percent]. By 1994, the Swiss had achieved the dubious distinction of attaining second place, surpassed only by the United States, both with respect to the percentage of their GNP devoted to health care, 9.9 [percent], as well as with respect to per capita costs. Id. at 430.}

\footnote{78}{Id.}
The new law curtails premium rating and limits insurer expenses to those necessary for economical management.  

Denmark also has a public health care system that provides free medical care to all citizens. In Denmark, "[h]ealth care is seen as a moral right, and citizens are guaranteed the right to free medical treatment, independent of income." The cost of primary health care is covered utilizing a national health insurance program. "While the national government is responsible for funding and cross-regional coordination, much of the financing and control is decentralized to the county level." The Danish health care system is considered to be among the most successful in the industrialized world.

79. Id. at 423-24.  
80. Id. at 425-28 (noting that "under the old law, provider prices are determined by negotiation between providers and insurers. However, both the negotiators and the public authorities with oversight responsibility are urged to bear in mind that while the quality of care should be high, its cost should be as low as possible." In addition, arrangements that could artificially inflate fees are prohibited and cantonal or federal authorities must approve fee schedule arrangements).


82. Id. at 725.  
83. Id.  
84. Id. at 725-26 (noting also that “[t]hree separate bodies exist in Denmark that are directly interested and involved in insurance coverage of health services: the national health insurance program, the county and municipal councils who administer, and in part, pay for the services, and the physicians providing the services”).

85. See Id. at 724 (The system is also considered to be one of the most efficient public health systems, as expenditures are among the lowest in the world. In 1988, the percentage of GDP spent on public health services was 5.4 percent.; see also id. at 726 (less than 10 percent of the primary care is paid for directly out of pocket).
The health care system in the Netherlands has been described as "the best in the world." Since the early 1900s, the Dutch have had a social insurance based approach to health care that is financed by both public and private funds. Workers who earn less than a certain threshold amount are automatically assigned to a sickness fund of their choice, and this sickness fund is paid by the worker according to income. Those workers who make more than the threshold amount may either join a sickness fund or obtain private insurance. "[P]rivate insurers in the Netherlands are not allowed to use factors such as health, age, or occupation when pricing their policies." Thus, the costs of insurance are spread across the country.

Universal health insurance systems have also been adopted in non-European countries. For example, "Japan is the second largest industrialized democracy in the world and was the first Asian nation to institute nationwide health insurance." The Japanese health care

86. See Roche, supra note 68, at 1034; see also Saunders, supra note 81, at 727 (stating that 99.5 percent of Dutch citizens are covered by insurance).

87. Id. (noting that health insurance is assured and guaranteed to everyone, regardless of income).

88. Id. (noting that the amount in 1991 was $35,000 a year).

89. Id.

90. Id.

91. Id.

92. Id. See also Saunders, supra note 81, at 731. The Dutch's approach to health care places reciprocal obligations on all participants in the health sector. Id. at 728-29.

Physicians and hospitals have an obligation to provide medically necessary care for all patients, while the patients have an obligation to pay for such care. Since some low-income individuals cannot pay for such services, they and their employers are obligated to purchase health insurance. Since everyone is obligated to purchase insurance, the insurers are obligated to insure everyone and operate at the lowest possible cost. Therefore, the health insurance funds are non-profit, private sector organizations, regulated as a public utility. Id.
system "is comprised of two broad types of medical insurance coverage: Kokumin Hoken, national health insurance, and Kenko Hoken, employer-based health insurance." Income level, rather than health or age, determines premium rates for national and employer-based insurance plans. Doctors are reimbursed according to a government prescribed fee-for-service schedule and "all medical treatment and surgery has a fixed price regardless of the doctor's skill or reputation." As a result, in 1987 only 6.8 percent of the Japanese GDP was spent on health care.

"Canada has had some sort of universal health insurance since the late 1940s," which began with one province choosing to have universal hospital coverage. The Canadian health care system "is financed by both the national government and the provincial

93. Dana Derham-Aoyama, U.S. Health Care Reform: Some Lessons From Japanese Health Care Law and Practice, 9 Temple Int'l & Comp. L.J. 365, 373 (1995) ("Japan began to address the problem of the collective health of its citizens as far back as the 1870's ... In 1961, a significant uninsured portion of the Japanese population called for the implementation of a universal health system").

94. Id. at 375 (noting that "[t]he national health insurance plan is supported by a mixture of special city taxes, partial payment by subscribers, and by national funding" and the employer-based insurance deducts insurance payments directly from the employee's paycheck); see also Roche, supra note 68, at 1030-1031 (noting that "[e]very member of the nation equally shares the burden of paying for geriatric care by use of a national pooling fund called the Health and Medical Services System of the Elderly"); see generally Aki Yoshikawa, Norihiko Shirouzu, & Mathew Holt, How Does Japan Do It? Doctors and Hospitals in a Universal Health Care System, 3 Stanford L. & Pol'y Rev. 111, 116 (1991).

95. See Derham-Aoyama, supra note 93, at 375. See also Roche, supra note 68, at 1031; Yoshikawa, supra note 94, at 112 & 116.

96. Id. at 377. See also Roche, supra note 68, at 1031; Yoshikawa, supra note 94, at 117-120.


98. Donahue, supra note 72, at 390 (noting that it is believed that the provinces initiated Canada's national health insurance program).

99. See id.
governments.”\textsuperscript{100} However, health care services fall exclusively within the area of provincial responsibility,\textsuperscript{101} and, as in the United States, “the provincial programs of government health insurance ... [must] conform to the federal requirements for a federal subsidy.”\textsuperscript{102} Recent financial cost cutting measures on the national level have prompted provincial governments to contain costs at the local level.\textsuperscript{103} However, Canada continues to successfully balance universal health care between its national and provincial governments, and its health care system remains widely popular among its citizens.\textsuperscript{104}

As other industrialized countries have developed comprehensive systems of social health care insurance, the United States continues to debate “the appropriate role of government in medicine and in health care.”\textsuperscript{105} In the twentieth century, four United

\textsuperscript{100} Roche, \textit{supra} note 68, at 1032. “Similar to Medicaid in the United States where the federal government matches funds spent by the states, the Canadian national government correlates what it spends on the amount spent by the provinces.” \textit{Id.} Recently, however, the Canadian government has reduced its contributions to the provinces with the “enactment of global caps for physician expenditures, caps for contributions to hospitals, and the narrowing of the term ‘medical necessity.’” \textit{Id.}

\textit{See also} Donahue, \textit{supra} note 72, at 402-03.

\textsuperscript{101} Donahue, \textit{supra} note 72, at 389.

\textsuperscript{102} \textit{Id.} at 397.

\textsuperscript{103} Roche, \textit{supra} note 68, at 1032-33. “Measures such as legislating fee schedules for non-hospital providers, the use of ‘caps on total outlays for physician services,’ and the ‘restrict[ion of] payments to individual physicians based on their total income’ have all allowed Canadian provinces to reign in health care costs.” \textit{Id.}

\textsuperscript{104} “Almost seventy-five percent of the Canadian population consider[s] ‘their health care system [to be either] good or excellent’ ... Canadian satisfaction with their health coverage has dropped only six percent from the early 80’s when the amount of GDP spent on health care costs was substantially higher.” Roche, \textit{supra} note 68, at 1033. \textit{See also} Donahue, \textit{supra} note 72, at 401-02.

States presidents proposed some type of national health care plan. First, President Theodore Roosevelt proposed a national universal health care plan in 1912. In the late 1930s, President Franklin D. Roosevelt also proposed some form of national health insurance; both plans were defeated. Then in 1948, President Truman’s proposal for national health insurance was defeated by the American Medical Association’s public relations and lobbying campaign. In the subsequent decades, private health insurance emerged, as well as advocacy for public health insurance for the elderly and the poor, which resulted in the passage of Medicare and Medicaid in 1965.


107. Id.


The defeat of national health insurance proposals in the early 1900’s through 1940 helped to bolster the position of private insurance companies. ... This period witnessed the rise of Blue Cross plans and it was also during this period that Henry Kaiser first introduced his innovative pre-paid group plans, which represented a precursor to the modern managed care system. Id.

109. SEEKING JUSTICE IN HEALTH CARE, supra note 106.

President Truman assigned a high priority to health insurance. He built on the proposals developed in 1938 [by President Roosevelt], and included the following components: expansion of hospitals, increased support for public health, support for maternal and child health services, increased federal support for medical research and education and, most significantly, a single health insurance program to provide coverage for all segments of society. Rich, supra note 65, at 404-05.

110. Id. These programs provided “an entitlement to health insurance coverage for the elderly and for low-income people who meet eligibility standards and work to cushion the effects of decrease in employment-based health care coverage.” Juarez, supra note 4, at 887. “With the passage of the Title XVIII (Medicare) and Title XIX (Medicaid) amendments to the Social Security Act in 1965, the role of the federal government was fundamentally changed. ... These programs represented a major change in the government’s approach to the design, financing, and delivery of health care.” Rich, supra note 65, at 405.
Finally, in the early 1990s, President Clinton’s proposal for universal health care was defeated, despite strong support from the public.  

The difference between the development of the health care systems of the United States and industrialized countries advocating universal health care has been described as a difference in the “social contract” between the State and its citizens.” “In the United States, health care is considered to be a privilege, which is usually expressed as a benefit of employment, while in Europe it is considered to be a ‘right’ of citizenship.” As a result, “[i]nternational law recognizes

111. Id.

The Health and Security Act of 1993 proposed by President Clinton began with the premise that health care was a legal right for all citizens [and] . . . envisioned universal access to health care for all citizens. It utilized principles of managed competition to increase access and quality of health care at the same time. The plan was to restructure the financing and delivery of services through providing incentives to private insurance companies, enabling the formation of small groups and ‘purchasing cooperatives,’ and by increasing the role of government in providing access and services, as required. Rich, supra note 65, at 408. See also Brown, supra note 2, at 6-12.

112. Rich, supra note 65, at 398. “Social contract theory is typically associated with Thomas Hobbes, John Locke, and a liberal traditional that assumes the primacy of individuals.” Wendy E. Parmet, Health Care and the Constitution: Public Health and the Role of the State in the Framing Era, 20 HASTINGS CONST. L.Q. 267, 308 (1993). This theory “stressed that political legitimacy derived from the consent of the governed. . . . [T]he theory postulated that individuals came together from a pre-political state, first to form a social compact in which they agreed to live in society and then a governmental compact in which they granted authority to the government.” Id. at 308-09.

This ‘contract’ between the State and society represents a negotiated agreement between the government and citizens over respective responsibilities and duties. The agreement specifies what benefits government agrees to provide to citizens in return for tax-based financing of these benefits; it also recognizes the role of government in designing and administering the programs, which ultimately provide the desired benefits. Rich, supra note 65, at 397.

113. Id. at 399. “The Framers [of the Constitution] conceived of the Bill of Rights as a source of positive law placing negative constraints on the power of government.” Park, supra note 58, at 1203. Thus, according to American Constitutional jurisprudence, “[s]ocial welfare rights, unlike civil and political rights, are not . . . proper subjects for direct constitutional protection.” Id. at 1199. As a
health care as a fundamental right,”^114 while the United States Supreme Court has held that it is not.^115

result, “the Constitution does not guarantee a right to basic human needs.” Id. at 1198.

114. Saunders, supra note 81, at 711. Under the United Nations’ Declaration of Human Rights, health care is recognized as a fundamental right. Id. at 714. See also Universal Declaration of Human Rights, G.A. Res. 217A, U.N. Doc. A/810, art. 25(1) (1948), which provides:

Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The Universal Declaration of Human Rights, as it was not a treaty, was not asked to be ratified by the United States Senate. Id. The United Nations also created the World Health Organization, which acts “as the main multilateral organization charged with improving world health care through advancement of the international right to health.” Saunders, supra note 81, at 714-715. The Universal Declaration of Human Rights, along with the International Covenant on Social, Economic, and Cultural Rights, and the International Covenant on Civil and Political Rights, “comprise the ‘International Bill of Rights,’ and constitutes the core of international human rights law.” Park, supra note 58, at 1220.

115. Harris v. McRae, 448 U.S. 297, 318 (1980) (citing Maher v. Roe, 432 U.S. 464, 469 (1977)) (“[t]he Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents”). The United States, as a member of the Organization of American States, is bound by the American Declaration of The Rights and Duties of Man, which provides that “every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.” Park, supra note 58, at 1226. The United States is also required to “adopt measures with a view to achieving progressively ... the full realization of the rights implicit in the economic, social, and educational ... standards set forth in the Charter of the Organization of American States.” Id. While the Charter of the Organization of American States and the American Declaration of The Rights and Duties of Man “have, by ratification, become part of the ‘supreme law of the land,’ the ‘self-executing’ treaty doctrine has narrowly circumscribed application of their human rights provisions in the United States courts.” Id. at 1233-34. The ‘self-executing’ treaty doctrine prohibits American courts from “directly enforce[ing] a provision of an international agreement unless it is ‘self-executing’—that is, capable of judicial application without prior implementing legislation by Congress.” Id. at 1234; see also Foster v. Neilson, 27 U.S. (2 Pet.) 253, 314 (1829). It has been
The issue of runaway cost does not pose a problem in those countries that have some form of universal coverage for several reasons. First, the administrative costs are much lower if the bureaucracy is smaller; second, there can be price controls similar to those 'requested' by Blue Cross and other insurers here in the U.S; and finally, there can be some rationing of nonessential health services. "Because the [United States] Constitution does not guarantee a right to basic human needs, state ... governments possess considerable latitude in regulating entitlement to social welfare services," including health care. To date, no state guarantees universal access to health care. Nevertheless, some states have taken the initiative to ensure greater access to health care for its citizenry.

For example, in Hawaii universal health care is nearly achieved by employer mandates, which require all employers to provide health insurance for their employees. Yet even with this system, Hawaii generally has an uninsurance rate of approximately 10%. This plan was initiated before the passage of the Employee Retirement Income Security Act of 1974 ("ERISA"), and currently no other state can implement such a plan without federal approval. Legislation is repeatedly held that the human rights provisions of such international agreements and charters are not self-executing, and therefore, "individuals cannot challenge in federal or state courts governmental violations of rights provided in these treaties." Id. at 1233-34; see also Sei Fujii v. California, 38 Cal. 2d 718, 242 P.2d 617, 620-22 (1952); Doe v. Plyler, 458 F. Supp. 569 (E.D. Tex. 1978), aff'd, 628 F.2d 448 (5th Cir. 1980), aff'd, 457 U.S. 202 (1982), reh'g denied, 458 U.S. 1131 (1982); In re Alien Children Education Litigation, 458 F. Supp. 569 (E.D. Tex. 1978), aff'd, 628 F.2d 448 (5th Cir. 1980), aff'd, 457 U.S. 202 (1982), reh'g denied, 458 U.S. 1131 (1982).

116. Park, supra note 58, at 1198. See also Rory Weiner, Universal Health Insurance Under State Equal Protection Law, 23 W. NEW ENG. L. REV. 327 (2002) (arguing that state constitutions can provide a right to health care); Parmet, supra note 112, at 325 (arguing that the federal constitution left the states responsible for the protection of public health).

117. See Weiner, supra note 116, at 351.

pending in Congress that would allow states to experiment with universal coverage and avoid the preemptive force of ERISA.

Oregon "rations health care" by adopting a state policy to "'keep all Oregonians healthy,' rather than simply providing them with access to health care." Oregon has a three-part plan that achieves this goal. First ... the Oregon Medicaid Demonstration Project ... established the scheme under which medical services would be distributed among Oregon residents. Second, Senate Bill 534 created a high risk, state-subsidized insurance pool for the uninsurable and the chronically ill. Finally, Senate Bill 935 mandated that employers provide employees and their dependents with a minimum level of health insurance.

Oregon also provides tax credits for small business owners who provide medical insurance for their employees. The Michigan legislature is attempting some of these methods, but it does not provide universal coverage.

In Florida, the Health Care Reform Act of 1992 and the Health Care and Insurance Act of 1993 established a two-part managed competition system that seeks to increase access to care for the
uninsured and controls inflation of health care costs. Part one is an incentive program for small employers whereby purchasing groups are created to achieve lower premiums. Part two, which is only to be implemented if universal coverage – or an acceptable level of coverage of state residents – is not achieved, provides that "coverage of a basic health plan will be mandated."

TennCare was established by the Tennessee legislature to open enrollment to all of the state’s Medicaid and uninsured residents with the purpose of defraying the cost of insuring high-risk residents. TennCare also caps the amount spent by both the federal and state governments. As a result, the percentage of insured residents

124. See id. at 893. This managed competition system seeks to blend appropriate aspects of government regulation with competition between health care organizations on quality and cost of services. ... Managed competition is intended to “promote the pooling of purchaser and consumer buying power; ensure informed cost-conscious consumer choices of managed care plans; reward providers for high-quality, economical care; increase access to care for uninsured persons; and control the rate of inflation in health care costs.” Bruce D. Platt, A Summary of the Health Care and Insurance Reform Act of 1993: Florida Blazes the Trail, 21 FLA. ST. U. L. REV. 483, 485 (1993) (footnotes omitted).

125. See Litman, supra note 118, at 894. “The act also creates a state insurance program for Florida residents with incomes up to 250 percent of the federal poverty level who have no private health insurance for the prior year. The individual or the individual and the employer will pay premiums. Providers will be compensated and Medicaid reimbursement rates. Benefits are limited in scope and emphasize primary care and prevention over tertiary care.” Michael J. Chermigna, New Florida Health Reform Plan Is First Large-Scale Test of Clinton’s Managed Competition Theory, 10 HEALTH SPAN 7, 9 (1993).

126. See Litman, supra note 118, at 894.

127. FL. STAT. ANN. § 408.006. See also Litman, supra note 118, at 894.

128. See Litman, supra note 118, at 900. “Among those eligible for coverage under the program were former Medicaid patients, formerly uninsurable patients (on the basis of pre-existing conditions), and people who were not formerly eligible for employer of state-sponsored health coverage.” Id.

129. See id. TennCare’s “budget is set independent of any anticipated number of insured. The number of people that the state can provide coverage for is then calculated from that number. In real terms, the state and federal government agreed on a ... budget” for a given year. Id. at 903. Moreover, “the state cap[s] the
increased by 50 percent, while costs were contained at approximately the rate of inflation. Recently, the governor of Tennessee announced plans to dissolve TennCare's "expanded Medicaid system and drop 430,000 poor and disabled people from the rolls of the health care program." A new state initiated health insurance plan in Maine called Dirigo Health guarantees universal access to health insurance for all of Maine's residents by the year 2009. Under the plan, MaineCare has been "expanded to cover more low income citizens." Moreover, Dirigo Health offers "affordable, quality, comprehensive health benefits to eligible individuals, the self-employed and small businesses (two to fifty employees) in Maine. ... Small business employers who choose to enroll in the plan will get lower rates because of federal support for the program, and employees of participating small businesses or individual enrollees earning lower incomes will get subsidies to help them buy into the plan." "If successful, Dirigo Health will effectively merge the non-group and small-group markets in Maine into a larger risk and payment pool."  

program's growth rate at a rate equal to the expected growth rate of the state economy. In this way the state can effectively reduce the annual growth rate of the health care delivery from approximately 18 percent to under 5 percent." Id.  

130. Id. at 902-03.  


133. Id.  


Last year, the California legislature passed "SB 2, 'Health Care for Working Families,' initiated by state Sen[ator] John Burton and signed into law by then-Gov[ernor] Gray Davis." This bill would, if implemented:

[O]ffer coverage for some 1 to 1.5 million workers and family members over the next two to three years. The employer would pay at least 80 percent of premiums, and possibly 100 percent. Low-wage workers would pay no more than 5 percent of their wages for coverage. The state would also set limits on total co-pays and deductibles.137

With the election of Governor Schwarzenegger, that bill is now in jeopardy, as a referendum will appear on the November ballot to repeal the law.138 Last year, "[a]nother piece of legislation, SB 921, authored by state Senator Sheila Kuehl, would provide a ... single-payer program for all Californians."139

New Mexico has proposed the New Mexico Health Security Act,140 which guarantees to all New Mexican residents health care coverage.141 The legislation proposes the New Mexico Health Care Plan, whereby all beneficiaries "will receive the same comprehensive benefits regardless of age, income, employment or health status."142

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138. See McConnell, supra note 136.

139. Id.


141. Id.
Coverage under the plan "must be at least as comprehensive as the state employees' health plan, and must include doctor visits, hospital stays, prescriptions, preventive care, lab work, and specialist services." Legislation has also been passed to authorize funds for the study of the feasibility of a single-payer system in New Mexico.

These, and other states, have all tried to do something to provide all of their citizens with health care in the recent past. Maine and California acted most recently, but all these efforts, with the hopeful exception of Maine, will not reach the goal of universal coverage.

142. Id.

143. Id.

Current Medicaid long-term care coverage will continue, as well as private long-term care insurance. There is a parity requirement for mental health care benefits. Medicaid mental health coverage will continue. The Commission must develop a plan to coordinate mental health services and to integrate and expand long-term care services into the NM Health Care Plan. NM Health Care Plan members and employers may buy supplemental health insurance, should they wish to do so. Id.

144. See N.M. HB 955 (2003).

V. CONCLUSION

The United States has the greatest health care delivery system in the world. Yet, more people lack access to health care than in any other industrialized nation and the ever-increasing costs of health care have put the health of this nation's citizens in jeopardy. In Detroit, the citizenry are dying at a high rate because of the failure of the health care finance system. Michigan should ensure that every citizen within its borders has a guarantee of basic health care.

States across the country have done studies of their own health care financing systems and have determined that there is enough money in their systems to provide universal health care. Georgia, Missouri, Vermont, Massachusetts, Maine, California, Rhode Island, and others have been the subject of studies that all come to the same conclusion — the reform of our bureaucratically bloated health care finance system can, and would, result in universal health coverage.

In 2002, Michigan spent over $43 billion on health care; however, Michigan's population is less than 10 million and its average health insurance premium for each person is less than $4300. Clearly, there are sufficient funds to provide universal health care for each Michigander. Selling insurance is a privilege, not a right; having health care is a right, not a privilege. Recognizing that there is enough money in the health insurance system to provide universal care is the first step towards creating the political will to act.

Despite the clear mandate from the framers of the constitution, no court in Michigan has been called on, until recently, to recognize a right to universal access to health care. In the spring of 2004, Michigan Legal Services filed suit in the Circuit Court for the County of Ingham, Michigan, against the State of Michigan, Governor Jennifer Granholm, and Janet Olszewski, Director of the Michigan Department of Community Health, in their official capacities. This


147. Id.
class action lawsuit, brought on behalf of Michigan's uninsured, government insured, and underinsured populations, alleges that the State has failed to develop a State Health Care Plan pursuant to M.C.L. § 325.2001.\textsuperscript{148} The most recent of such plans was dated 1996 and was intended to cover the period through year 2000.\textsuperscript{149} The lawsuit asserts that this plan would also fail to survive constitutional muster.\textsuperscript{150}

Michigan's failure to adopt such a plan is in clear violation of state statute. Therefore, even if a Michigan court fails to hold that Michigan's constitution guarantees access to health care, there can be no doubt that Michigan has failed to comply with state laws providing for the protection of public health by, at the very least, having a plan in place to achieve universal access to health care. The trial court dismissed the case on February 2, 2005, ruling that the language of the constitution and statute relied upon in this article was too vague to base a duty on Michigan to provide health care. An appeal is pending.

In 1673 Moliere wrote "The Imaginary Invalid,"\textsuperscript{151} in which Argan uses the services of a physician almost hourly because he believes he is ill.\textsuperscript{152} He is not ill, but the play revolves around his efforts to obtain health care.\textsuperscript{153} Argan attempts to talk his daughter into marrying an oafish son of a physician, so that he could have access to health care.\textsuperscript{154} Ultimately, this solution fails, but Argan complains bitterly about the cost of his care.\textsuperscript{155} In Act One, Scene One he is seen counting up the bills he has received from his apothecary,\textsuperscript{156} and he complains that "you should also be moderate,

\textsuperscript{148} Id.
\textsuperscript{149} Id.
\textsuperscript{150} Id.

\textsuperscript{151} MOLIERE, LE MALADE IMAGINAIRE, (Henri Van Laun trans., 1969).

\textsuperscript{152} Id.

\textsuperscript{153} Id.

\textsuperscript{154} See Id. at 35-55.

\textsuperscript{155} Id.
and not "flay" your patients."¹⁵⁷ He goes on to cry, "gently if you please, if you go on thus, one would no longer care to be ill."¹⁵⁸

Michigan's health care finance system is "flaying" us all. The larger the business the more that business is "flayed" under our present health insurance structure. Many Michiganders cannot afford to be ill, and their employers cannot afford to provide them health insurance. Many die because they cannot find health care. Somehow, Michigan's political leaders must act to solve the problem. Unfortunately it appears that the political system is incapable of such action even though it is mandated to do so by the constitutional and statutory law. It is just such a situation that calls for court intervention. "There is hardly ever a political question in the United States which does not sooner or later turn into a judicial one."¹⁵⁹

Like the civil rights cases of the 1950s and 1960s, health care suits such as the one pending in Ingham County give some hope that the financial system, which is so deadly to so many of our citizens, will change. If we prevail state by state, it will eventually lead to a nationally mandated system guaranteeing universal coverage.

On October 26, 2004 the Detroit News Business Section columnist Christine Tierney wrote about how health care costs handicap GM, and the rest of America's multinational corporations in competing in the 'New World Order.' The reason is that our health care and insurance costs are 50% higher than any competing industrial nation. More and more major CEO's are asking for federal relief because of the fact that our competitors are subsidized by their governments in providing health care. That, combined with the increasing number of retirees who require health insurance from their former employer, means that all of our multinationals are competing with heavy weights tied around their ankles. It is obvious looking at the percentage of our GDP that we spend on health care that the

¹⁵⁶  See Id. at 19.

¹⁵⁷  Id.

¹⁵⁸  See Id. at 21.

United States vaunted 'yankee ingenuity' has not been used in designing the American system.