

# Should Wisconsin finance health care through a special tax and a voucher system?

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## **Historical and Economic Perspective**

Burdening employers with most of the cost of health care is a distinctly American phenomenon. Wage freezes during World War II enticed industries to offer their employees full health insurance coverage as an incentive for employment and a reward for work performance. This benefit continued into the post-war years as well, prompted by the negotiation pressures of powerful labor unions and a general labor shortage.<sup>1</sup>

Ever since, many employers have been paying virtually 100% of the insurance premiums, although more recently the total has gone down to around 70%-80%, a sign of increasing employee participation in their health care coverage.

The linkage of the work place to payment for health care goes way back to the middle ages, when guilds and trade associations voluntarily agreed to set up sickness funds. These funds mainly served the cost of disability, funeral expenses, and some compensations for the widows of

deceased workers. Since in those days most of the disabilities were either directly or indirectly related to the workplace, compensation for their consequences was considered a fair burden to be shared by the workers of the industry and the employers as well.<sup>2</sup> When, in the course of Europe's Industrial Revolution, these sickness funds became widely spread throughout manufacturing, shipping, and mining, employers and workers contributed equal shares to these premiums. In the late 19th and into the early 20th century, these company-based sickness funds became institutionalized by national legislation in most European countries. They had this in common: universal coverage; compulsory participation within the designated trades and industries; the availability of state subsidies for the premiums of the unemployed, disabled, or retired; and government supervision and regulation.<sup>3</sup> In contrast to today's work economy, most of those workers were men, working in factories. Their employment was usually long term, and while the cost of accidents and subsequent disability was high, the care of acute illness was either relatively inexpensive or borne by sectarian charitable or public hospitals.<sup>4</sup> Around 1910, only 4% of German health care

costs were related to hospital care—the current rate is 40%.<sup>5</sup>

## **Our Current Dilemma**

Throughout the United States, and in Wisconsin in particular, manufacturing has shrunk and giant service industries have emerged, health care being the largest. While in those workplaces accidents and resultant disability are still common, they are miniscule compared with the dangers of the 19th and 20th century mining, shipping, and some manufacturing industries. Transfers from job to job, and company to company have become more common. Spouses work part- or full-time as well but do not necessarily share in their family's health care coverage. In addition, employment is no longer our only source of income: there are investments, inheritance, rental incomes, etc. This new constellation of our employment and income economy is one of the forces favoring a switch from the employer-source to a tax-source for financing health care.

Now, an employer may wish to retain the option to use health care coverage as an attractive benefit in a tightly competitive labor market and as an award and an incentive for loyalty. Also, by self-insuring or by organizing their own health care system in

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collaboration with physicians, nurses, and hospital contracts, employers may have a more direct inroad into the cultivation of healthy lifestyles and better health for their workforce in general.

Throughout the past decades, an increased volume of patients and diseases, along with advances in science and technology have permeated the health care systems of all industrialized nations. However, the United States currently spends over 14% of its gross domestic product on health care, contrasted with less than 11% in all those other countries.<sup>6</sup>

In a positive way, our health care industry has become a huge employer, not only for the highly skilled and professionals. It has helped absorb the devastating impact of losing manufacturing jobs and has also supported our efforts to convert welfare recipients into gainful employees by directing them into jobs in hospitals, nursing homes, and homecare settings. On the other side, employers find themselves with this ever-rising burden of benefit costs that curtail the workers' take-home pay, cut into profits, and compromise our competitive standing in the world's markets. Smaller companies especially—the hopeful fountains of new industries and technologies—have been unable to shoulder these costs, reducing or dropping employee health care coverage and compounding the societal burden of the growing number of the un- and underinsured.

Toyota wants to move one of its plants to Canada where the health care cost per car is around \$800, compared to \$1500 in the United States.<sup>7</sup> General Motors

was recently given junk bond rating, allegedly because high health care and retirement costs have compromised its ability to innovate, to improve its products, and to generate profit, much of which goes into large retirement funds. Thus, industry finds itself in the unenviable position of not only funding the majority of private health care but also under the pressure to generate profits, of which the majority serves the private financing of retirement of the population at large.

One response by employers is the imposition of greater deductibles and co-pays on their workforce. This increased burden of out-of-pocket spending, be it via pre- or post-tax dollars, perhaps modified by pre-tax health savings accounts, could lead to a greater reluctance to seek medical help when needed and contribute to an overall reduction of general health.<sup>8,9</sup>

### **A Solution**

A “health care tax,” similar to Medicare's payroll tax, combined with a voucher system can help our dilemma. A recent proposal before the Wisconsin legislature estimates that a 8%-12% payroll tax can meet everyone's health insurance needs. This figure represents a decrease from the current 15% average premium costs for each Wisconsin employer.<sup>10</sup> In contrast to Medicare, however, this tax money will not go into a single, government-run insurance program but instead into a pool from which vouchers could be issued to each worker/family or resident eligible for coverage. Other sources of income beyond payroll could be taxed as well in order to spread this burden more equitably. The vouchers would

be sufficient for a fundamental coverage plan, most likely some version of managed care. Whoever desires additional options such as out-of-plan health care professional coverage, long-term care, and expanded medications financing can do so with voucher co-pays, either out of the employees' pockets or employers' contributions. This will create a mosaic of multi-tiered options, some of which may be more luxurious than others. But such diversity already exists, even within the government-controlled social health insurance programs such as Medicare.

Taxes always imply government involvement, which in the health care scenario may mean that the inevitable increase of health care costs above the ordinary rise of the cost of living has to be absorbed in the form of “health care tax” increases, or it will have to be restructured. Determining spending priorities would require not only bipartisan but also multi-professional and multi-institutional consensus building. This must be hosted by a governance system, separate from government but still regulated by it, akin to a public utility. Models for this can be found in other countries.<sup>11</sup> Health care may end up on annual budgets that can be exceeded only in specified emergencies and with the availability of financial reserves. Under similar pressures to structure and contain health care spending, some of our own large health care systems, and those of other nations as well, engage in an ongoing effort of assessing scientific and technological advances, changes, and innovations to scrutinize their safety and effectiveness, before paying for their use.

To conclude, about 100 years

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ago Wisconsin's academia, legislature, and state medical society were among the first in the nation to propose a comprehensive package of social legislation that included universal health insurance, workmen's compensation, Social Security, and unemployment compensation.<sup>3</sup> Much of this did not pass initially, but some of it became reality under the New Deal.

The spirit of the Progressives that stood behind these efforts should not have died out in our state, but should rise again, to assure an equitable access to health care for all of our residents and this time also to support the economic health of our employers.

## References

1. Quadagno J. *One Nation, Uninsured*. Oxford University Press; 2005.
2. Rubinow IM. *Social Insurance*. New York: Arno & The New York; 1969.
3. Starr P. *The Social Transformation of American Medicine*. New York: Basic Books, Inc.; 1982.
4. Rosenberg CE. *The Care of Strangers*. New York: Basic Books, Inc.; 1987.
5. Amelung V, Glied S, Topan A. Health care and the labor market: learning from the German experience. *J Health Politics, Policy, Law*. 2003;28(4):694-714.
6. Bodenheimer T. High and rising health care costs. part 1: seeking an explanation. *Ann Int Med*. 2005;142(10):847-854.
7. Krugman P. What drove Toyota to Canada? *Milwaukee Journal Sentinel*, 7/28/05.
8. Robinson J. Health savings accounts – the ownership society in health care. *N Engl J Med*. 2005;353(12):1199-1202.
9. Lee T, Zapert K. Do high deductible health plans threaten quality of care? *N Engl J Med*. 2005;353(12):1202-1204.
10. Forster S. State Pool for health benefits proposed. *Milwaukee Journal Sentinel*. 6/15/2005.
11. Reinhardt U, Hussey PS, Anderson G. U.S. health care spending in an international context. *Health Aff*. 2004;23:10-25.

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