Change In Challenging Times:  
A Plan For Extending And Improving Health Coverage

Health care for every American may be the current test of the strength of our convictions, as civil rights was in the 1960s.

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ABSTRACT: Some speculate that Americans are neither politically capable of nor morally committed to solving the health system problems. We disagree. We propose a plan that insures all and improves the value and cost-effectiveness of health care by knitting together employer-sponsored insurance and Medicaid; promoting prevention, research, and information technology; and financing its investments through a dedicated value-added tax. By prioritizing practicality, fairness, and responsibility, the plan aims to avoid ideological battles and prevent fear of major change. By emphasizing the moral imperative for change, especially relative to other options on the policy agenda, it aims to create momentum for expanding and improving health coverage for all.

BY ANY OBJECTIVE STANDARD the U.S. health care system has serious problems, which are getting worse. Since 2000 the number of uninsured Americans has risen by five million, to forty-five million or nearly 16 percent of all Americans.¹ There are more uninsured Americans than the total population of Canada or people living worldwide with AIDS; the uninsurance rate is three times higher than the unemployment rate.² Health insurance matters, according to a recent review by the Institute of Medicine (IOM), which found that uninsured people tend to have worse health outcomes because of delayed and sometimes denied care and are treated differently once in the system.³ The lack of coverage exacts a large personal financial toll, running up debt and contributing to personal bankruptcy.⁴ It also results in billions of dollars in uncompensated care costs that get passed along through the health system.⁵ Uninsurance is perhaps the most important, but not the only, problem in the system. In 2004 the cost of employer-based health benefits increased at a rate five times higher than that of wages; since 2000 the family share of such coverage increased by more than 60 percent.⁶ This

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not only strains the middle class but also limits employers’ willingness to create jobs. For all we pay, we have worse-than-expected health: lower life expectancy than more than twenty other countries, near-epidemics of preventable conditions, and an infant mortality rate that rose in 2002 for the first time in forty years.

Yet as the public policy agenda rolls out for 2005, major health proposals are nowhere in sight. President George W. Bush did not include new ideas for expanding coverage in the State of the Union address or his budget. Also, Congress seems intent on scaling back rather than stepping up federal funding to solve health system problems. This lack of political attention is not for lack of public support. We know that people recognize the problem: Among 2004 election voters, 93 percent were concerned about the availability and affordability of health care. Nor is the inattention due to a lack of policy suggestions. Papers published in *Health Affairs* and other journals, research presented at conferences, and proposals introduced in Congress have put forth myriad options for covering the uninsured. The relative merits of these ideas may be debated, but the policy components to create a seamless, value-oriented health coverage system clearly exist.

The problem, according to some health policy and Washington insiders, is that major change is politically infeasible. It is undeniably difficult to change a system that affects 15.3 percent of the U.S. gross domestic product (GDP), half a million doctors, more than 1,000 health plans, and literally all of our lives. In addition, moving from the current system to one that guarantees coverage requires specific and controversial details. Disaffected people, parties, or interest groups can use those details to make claims of disruption and redistribution that inevitably overwhelm the logical and popular support for change.

A more cynical explanation for the failure of the United States to address its health system problems is that support for change is disingenuous—that we lack the moral conviction necessary to make it happen. This view is most provocatively expressed by Uwe Reinhardt, who argues that our society’s individualism and self-righteousness exceed its compassion and willingness to sacrifice for others. While skeptics consider the sacrifices involved in health reform political fodder for interest-group opposition, cynics believe that there is no real capacity for sacrifice among Americans, or at least the elite who run the country, because they are too self-interested and callous.

As veterans of previous policy battles, we do not underestimate the political challenge involved in making the U.S. health system accessible to all. Nor do we disagree with the assessment that moral conviction has been lacking in past health policy debates. However, we reject the claims that health reform is doomed by political paralysis and an incapacity for Americans to sacrifice for the greater good. At opportune points in U.S. history, pragmatic ideas have overcome seemingly impossible political odds and become policy. We also believe that the perceived disconnect between values and health reform reflects not a lack of conviction but a failure to express that conviction in a policy environment. In most faiths
and value systems, it is wrong to tolerate pain, suffering, and even death that could be prevented with different policy choices. The challenge is to translate these deeply held values into action that ensures a better system and healthier nation.

We propose in this paper a strategy for creating an American right to affordable, valuable health coverage. It consists of a plan to improve the health and health coverage of all. It is designed to minimize the fears that have toppled previous reform efforts: the loss of existing coverage, excessive government involvement, and limitations on choices. It is also designed to move us toward a vision of an improved health care system that values wellness over illness and promotes high-quality care. By putting practicality ahead of ideology, it has the potential to gain widespread support, even in this “divided America.” We also suggest that we cannot rely solely on the health and economic imperatives for change; Americans must agree that it is the right thing to do and be willing to endure some sacrifices to achieve it. Simultaneously highlighting the immorality of inaction and contrasting the imperative for health improvements with other currently debated priorities may create the momentum to, at last, solve one of the largest challenges facing this country.

Plan For A Healthy America

The blueprint for the Plan for a Healthy America consists of three major parts: making coverage affordable for all; encouraging high-quality care to improve the value of our health care dollar; and financing its investment.

- Affordable coverage for all. The heart of the Plan for a Healthy America is making health coverage available and affordable for all. Instead of creating a new system, the plan builds on the two major existing sources of health coverage. Today about 75 percent of Americans are covered through the employer-based system and Medicaid (excluding the elderly, who are insured through Medicare). The employer system would be supplemented by a system modeled on the Federal Employees Health Benefits Program (FEHBP) for those who lack private group insurance options. Medicaid would be simplified and strengthened to fulfill its role as a safety net for all low-income people.

The plan would provide all people lacking job-based insurance with access to the same private health plans offered to federal employees and members of Congress. The FEHBP now insures more than eight million federal employees and their dependents. The Plan for a Healthy America would build on this system. Private insurers offering coverage through the FEHBP would also offer group coverage through a new Healthy America national insurance pool. The pool would be open to anyone who lacks access to job-based insurance—a problem for about 80 percent of all uninsured people. The plan would also help the 6 percent of nonelderly Americans who purchase coverage in the individual market today. This insurance can, in most states, be priced out of reach, written to exclude coverage for key services, or simply denied to those with even mild health concerns.
In addition, all employers would have access to the Healthy America insurance pool, but no employer would be required to join it. Employers with successful health benefit programs could keep them in place without change. But for those employers—especially small businesses—looking to streamline their efforts to provide a choice of health plans, this pool would be an attractive option. Employers could participate only if they enrolled all of their workers; they could not insure only sicker workers in the pool. However, individuals offered coverage through an employer would be free to decline that coverage and enroll in a plan through the pool instead. Reinsurance would be used to prevent unexpectedly high premiums resulting from the enrollment of high-cost people.

Improving access is necessary but not sufficient to ensure seamless, nationwide coverage for all. The affordability of health insurance is overwhelmingly named as the reason why Americans lack health insurance. To address this, the plan would ensure that nobody pays more than a certain percentage of income (for example, 5–7.5 percent) on health insurance premiums. This protection, administered as a refundable tax credit, would apply to employer-based health insurance as well as private insurance obtained through the pool. In addition, employer contributions would continue to be excluded from employees' taxable income, whether employers chose to retain their existing health benefit arrangements or to provide benefits through the new pool. As a result, employers' voluntary contributions toward the cost of health benefits likely would not change substantially.

Medicaid has evolved into a central pillar in the insurance system, recently overtaking Medicare in its spending and enrollment. It now serves about fifty million of the nation's most vulnerable children, low-income parents, people with disabilities, and seniors. Yet eligibility varies from state to state, and major gaps in the program exist; for example, there is no option to cover poor, nondisabled, childless adults. The plan would simplify and extend Medicaid to cover all below a certain income level (for example, 100–150 percent of the federal poverty level). In doing so, it would increase the share of program costs paid for by the federal government so that the state portion of this federal-state partnership program would not increase.

Under the plan, all people would have access to affordable coverage through their employer, the Healthy America pool, and/or Medicaid. In exchange for this guarantee, people would be expected to enroll in a health insurance plan. Those who did not do so would pay an income-related assessment to contribute to the cost of care that they will inevitably use. Medicaid would be available as the default payer for people in that circumstance, with the additional program costs fully offset by the federal government, as indicated above. Through this system, all people in the United States would have a source of coverage.

- **Improving the value of coverage.** It is not enough to expand access to the current system. Americans must also secure better value for their health care dollar through improvements in health care quality, outcomes, and efficiency. The federal
government has an important leadership role to play in realizing these goals. The Plan for a Healthy America focuses on three key value improvements that would produce large returns on investment.

The first priority is to create a national focus on disease prevention and health promotion. The U.S. health insurance system now focuses on treating diseases instead of reducing their incidence in the first place. With no guarantee that enrollees will remain in their plans, insurers have little incentive to invest in keeping enrollees healthy over time. We propose a new model for preventive care and health promotion. Coverage for preventive services would be carved out of private health insurance and financed through a new nationwide preventive benefit. A process for determining and updating the core preventive services would be established, based on recommendations from the U.S. Preventive Services Task Force and other evidence-based guidelines. Physicians and other providers would continue to deliver both preventive and other medical services as they do today, but they would be reimbursed for preventive services by the new benefit. This reimbursement would be based in part on their success at improving community-based health promotion and disease prevention measures. In addition, an aggressive, community-based system would complement existing services through consolidated health promotion and prevention activities. Investments in health information technology improvements (see below) would facilitate integration of preventive care with care for chronic and acute conditions. A major goal of this benefit would be to train people to be better managers of their own health.

The second priority for improvement is to develop better information about what constitutes high-quality, high-value care. Most health research focuses on determining whether a particular medicine or treatment is safe and works. Federal investment in research on the comparative clinical effectiveness and cost-effectiveness of available treatment options would enable patients, providers, and payers to make sensible health care choices—for example, does an over-the-counter drug work as well as a brand-name prescription drug, or what are the relative merits of heart disease treatment options? Congress has begun to make progress on this front. Our plan calls for increased funding for research on comparative effectiveness. It would also implement strong conflict-of-interest protections to ensure that the credibility of the research is beyond reproach. We recommend housing this activity under a new quasi-governmental organization to leverage private funding, facilitate broad public and private participation, and protect controversial findings from political pressure. To further protect the scientific integrity of this organization, we also recommend that it not be directly responsible for promulgating clinical or reimbursement guidelines based on its research findings.

Third, the Plan for a Healthy America would improve health care productivity through information technology (IT). The U.S. health system is in the information “dark ages.” A small fraction of its billions of annual medical transactions are conducted electronically, and only 5 percent of clinicians use computerized patient
Cutting-edge IT, structured to safeguard patients’ privacy, has the potential to dramatically improve health care quality. The use of computerized prescriptions can halve prescribing errors. Also, use of computerized records can dramatically lower days spent in intensive care. It can also reduce total health care costs through administrative and clinical efficiencies. Federal leadership is needed to accelerate these gains. Under the plan, existing programs like Medicare would be used to leverage advancements in clinical IT through demonstrations of reimbursement and programmatic changes specifically designed to encourage the implementation of such technologies and evaluate their impact on health outcomes. In addition, a new health IT infrastructure improvement fund, through grants and loans, would further the widespread adoption of standardized, compatible, and scalable IT solutions.

The potential “return on investment” in each of these areas is substantial. If the preventive benefit could limit the spread of the obesity epidemic, for example, it would greatly slow the growth of health care costs, 27 percent of which, for 1987–2001, was attributed to the rising incidence and cost associated with obesity. Similarly, patients, providers, and payers of care too often make decisions about the choice of therapies without knowing the cost and benefits of one versus another. A recent study suggests that the use of IT could produce net national savings of up to $78 billion per year. These high-value investments are widely recognized by academics, health benefit consultants, and policymakers alike, ranging from Sen. Hillary Clinton (D-NY), a former First Lady, to Newt Gingrich, a former Republican House leader. Although the benefits from these investments are unlikely to be reflected in near-term budget analyses, their inclusion in a plan aimed primarily at ensuring coverage for all Americans is essential since coverage should be improved as well as expanded.

Financing the investment. The Plan for a Healthy America requires an investment. Ensuring that people with modest incomes can afford coverage means sharing the cost of that assistance across the population. In addition, realigning the system toward value-based health care requires federal involvement and funding. Based on estimates for comparable plans, we estimate that the plan would cost $100–$160 billion per year. Even though we anticipate long-run savings from reduced uncompensated care, better health, and improved efficiency, we do not put a dollar value on those savings, to be fiscally conservative. The level of funding needed cannot be achieved through health system efficiencies alone. Nor can it be accomplished by redirecting existing public revenue toward health care. The record-high surplus of $236 billion in 2000 turned into a deficit of $413 billion by 2004. This leaves no responsible choice but to raise revenue to invest in health system improvements.

Because the plan’s health investment benefits all, we think it that should be funded by all through a new, dedicated source. We propose a small value-added tax (VAT). A VAT is a tax on the value of a good or service added in its various stages of production—effectively the difference between what a business sells and
what it buys from other businesses. The United States has no national sales tax, few federal excise taxes, and state sales taxes that are applied to a relatively narrow set of goods. A broad-based VAT in the range of 3–4 percent with targeted exemptions (for example, exempting small businesses, food, education, religion, or health care) would be sufficient to support the plan’s investment. The United States and Australia are the only major economies that do not have a VAT. Although a VAT has relatively higher administrative costs than a typical sales tax, it captures revenue on a broader base. Revenue from the VAT would go to a trust fund and be used exclusively to finance the plan.

A broad-based VAT has several advantages relative to other sources of financing for health reform. Compared with corporate tax increases, it is more difficult to evade because of how it is collected. Compared with a marginal income tax change, it promotes savings since it taxes only consumption. Relative to a payroll tax hike, it has the potential to generate the same revenue at a lower rate. The VAT could (at least in the short run) increase the global competitiveness of U.S. firms by exempting exports from the assessment and applying it to imports as well as domestically produced goods. Also, while consumption taxes generally raise concerns about progressivity, careful design and use can balance out this potential effect. Exempting items such as food lowers the impact on low-income populations. Using the revenues to provide financial assistance for these same low-income families would yield a net gain under our plan. That said, the use of the VAT matters. A large VAT used to replace the federal income tax system, for example, would be highly regressive since it would provide tax relief for high-income people rather than health assistance to low-income people and health benefits to all.

Both the nation and the health system can afford our proposed VAT. Contrary to the popular perception, the United States is among the world’s least-taxed developed countries. Prior to the tax cuts of 2003 and 2004, only Mexico, Korea, and Japan had lower tax revenue as a percentage of GDP among Organization for Economic Cooperation and Development (OECD) countries. In addition, total federal tax revenue—at just 16.2 percent of GDP—is at its lowest level in a half-century. Creating a 3–4 percent VAT would do little to change this. Additionally, although the United States leads the world in its health spending, it trails all other industrialized countries in its government share of spending on health care. Increasing our investments to expand coverage and improve health care value can lead to large benefits in mortality and quality of life. Stated simply, the U.S. government can and must invest more in the health of its people.

Overcoming Political Obstacles

To address the political challenges facing health reform plans, we designed the Plan for a Healthy America to be practical, fair, and responsible—key litmus tests in American politics and society. At the heart of the plan is the belief that the most
urgent and important goal should be to provide health coverage for all. As such, the plan prioritizes those elements needed to achieve its goal but tables excessive details and extraneous issues that could derail it. The comprehensiveness of the Clinton plan in 1994 contributed to its being criticized for creating “59 new Federal programs and 79 new Federal mandates.” In contrast, President Bush issued only principles for the Medicare prescription drug benefit, and the State Children’s Health Insurance Program (SCHIP) contained only broad-brush guidance on many key but controversial elements such as the benefit package. We deliberately defer some major policy decisions in the interest of developing consensus on the essential elements of a framework for change.

We also strove to be practical: Our plan builds on existing structures to fill in the gaps rather than replacing the major sources of insurance coverage. The Plan for a Healthy America would knit together the system to cover the uninsured quickly and efficiently. At the same time, the plan would maintain existing coverage for the 84 percent of Americans who are insured today. In fact, insured people might have more choices since only about 25 percent of workers in small firms offering coverage have more than one health plan option now. While neither ideal nor elegant, this approach prevents disruption of insurance and payment systems that work for the majority of Americans. It also avoids the need to create new institutions that require intellectual, financial, and political capital, as well as time.

Fairness was another guiding principle in the plan design. Health care should be affordable and accessible to all, irrespective of health, age, income, or work status. Improving fairness necessarily means targeting those left out of the system by providing new options and financial assistance. Yet it also means lowering the cost and improving the value of coverage for those that struggle to pay for it today. At a time of rapid increases in premiums and cost sharing, nearly one in three people who have insurance report cost-related access problems. Public policy should promote preventive services and provide information for “smart” benefit designs—lowering costs on the most effective services—as an alternative to arbitrary, high-deductible policies. This approach would improve coverage as it expands it.

Another dominant theme in American culture, embedded in the plan, is responsibility. On the whole, the plan aims to balance what it provides with what it expects from individuals, providers, and payers, recognizing that government alone cannot make the needed changes. At the individual level, in exchange for a seamless, affordable health system, people are expected to obtain coverage or pay into the system that they will inevitably use. Our prevention initiative would also encourage people to take more responsibility for their own health. At the system level, doctors, hospitals, other providers, and payers would be expected to make better use of information and technology, which have the potential to revolutionize care as well as to improve productivity and reduce costs. And at the national level, the plan tackles the difficult issue of financing, necessary to be credible as
well as sustainable. No financing proposal is popular, but a small, dedicated VAT, in our opinion, offers the simplest, most logical, least controversial way to fund our plan.

Lastly, key elements of the plan have bipartisan support. Organizations including conservative think tanks, provider associations, and labor unions have endorsed building on the FEHBP for the uninsured. Similarly, a broad spectrum of analysts, and even insurers, have recognized the merits of using Medicaid for low-income populations and tax credits for higher-income populations to make coverage affordable. In fact, a recent survey of health experts found that about two-thirds (65 percent) believed that creating an FEHBP-type plan should be the top priority in expanding coverage, with the second choice being expanding Medicaid and SCHIP (55 percent). Our proposed financing source, the VAT, has bipartisan support as well. It has been supported by current and former Democratic members of Congress as a source of support for the nation’s health care needs. It has also been discussed by the Republican chair of the House Ways and Means Committee, Bill Thomas (R-CA), because, in his words, “The United States is the world’s largest importer and the world’s largest exporter, and our tax system is out of sync with the rest of the world. We pay their social costs. They don’t pay ours.” Although he was discussing the VAT in the context of Social Security reform, his rationale could easily—and, arguably, more aptly—apply to health reform.

Grounding Health Reform In Values

The Plan for a Healthy America takes on a major challenge: to improve and extend coverage for all. Its success depends in part on its design, as previously outlined, which aims to minimize criticism and maximize its effectiveness. But it is also depends on its ability to make a forceful claim on the political agenda. As with any endeavor that involves sacrifice and change, health system reform must have a clear and strong justification to overcome attacks, obstacles, and competing priorities. We make the case for change on moral grounds.

For most Americans, ensuring access to affordable, high-quality health care is not a question of the political left or right, but a matter of right and wrong. A survey by the Pew Forum on Religion and Public Life found that more than half of all Americans consider universal coverage a moral issue, while only about one-third view it as a political issue. Among the 72 percent who believe that the nation should cover all citizens, more than 60 percent stated that their belief rested on moral grounds. Every major faith tradition decries the unnecessary suffering, worsened quality of life, and premature death resulting from our broken health system. The case for reform also has its roots in our nation’s founding principles, since there is no equal opportunity when life-saving treatment is rationed based on income or insurance status. The challenge is translating these convictions into pressure for improvement.

We believe that this could be accomplished through two types of action. The
first is using data, research, and examples to highlight the urgency of the problem and to create a climate in which inaction is morally unacceptable. The IOM used its comprehensive review of the facts on the uninsured to make the case that the status quo must be rejected.\textsuperscript{52} In the words of its committee chair, “There is no justifiable excuse for delay. Further delay will only lead to more uninsured Americans forgoing care, resulting in more costly illnesses and more premature deaths. Further delay will harm the health of uninsured children, and strain and potentially bankrupt more American families.”\textsuperscript{53} Working with researchers, business leaders, the media, and faith communities, we aim to end tolerance of preventable problems in the health system and compel action.

The plan’s second goal is to add a moral lens to political priority setting. Virtually every public policy action (or inaction) is a reflection of the country’s values.\textsuperscript{54} Choices such as investing in defense versus global health, promoting tax cuts versus Medicaid funding, and steering toward an “ownership” society versus a society of shared opportunity and responsibility all occur as part of the ordinary course of business in Washington. Yet rarely do the public or the media assess the budget or the policy agenda for the values they reflect. As Congress debates major initiatives such as extending the president’s tax cuts or privatizing Social Security, a similar questioning should occur: Are these reforms more urgent, just, and helpful to those in need than reforming our nation’s fractured health system would be? We aim to lead an effort to squarely juxtapose the urgency and moral imperative of health reform with competing congressional and White House priorities.

**Concluding Comments**

We disagree with critics that the lack of health insurance is inevitable or a conundrum that defies solution. This problem has been eradicated in virtually all of the world’s leading countries, including many with considerably less wealth than the United States possesses. In this country we provide universal coverage to our seniors through Medicare. According to public opinion research, Americans want the same right to health care for their children and themselves, and they will make sacrifices to secure it. The challenge is to prove to policymakers that the goal is both urgent and achievable—not an abstract ideal but a real and imminent possibility if anchored in vision, values, and a practical plan.

The Plan for a Healthy America, we believe, is such a plan. It would build on private and public insurance and provide income-related financial assistance, through tax credits and Medicaid, to make coverage affordable.\textsuperscript{55} Individuals would gain equal access to affordable insurance, but they would be expected to take greater responsibility for their own health and health coverage and help finance the improved system. The plan would also invest in prevention, comparative effectiveness research, and IT, recognizing their enormous potential to advance health and improve value. To finance these investments, a small, dedicated VAT would collect a contribution from all—a small price to pay for a health system that
is affordable, accountable, and accessible to all. This plan for change is linked to an effort to heighten awareness of the deadly consequences of inaction and to juxtapose immediate congressional priorities such as Social Security reform with health reform on moral grounds.

Our plan also aims to adhere to the principles of practicality, fairness, and responsibility to overcome political obstacles. It does not contain peripheral issues and excessive details, which potentially erode the consensus needed. At the same time, the plan includes enough health system improvements to gain public and political support. Tens of millions of people work hard to pay for their insurance yet still experience high costs and less-than-optimal care. We include policies to lay the groundwork for better health, more informed health coverage, and improved quality and efficiency. This “bare-bones” approach to constructing the health plan not only enables unusual coalition building, but also helps avoid the ideological warfare that has felled other plans.

The part of the plan that is unavoidably controversial is its call for greater government involvement and investment in the nation’s health and health insurance system. This is necessary because the risk and cost of health care must be spread across the population instead of being borne by individuals, small employers, and providers in the form of uncompensated care, as it is today. Greater government support is also needed to open the door for all to the promise of twenty-first-century health care. Although most health care reform proposals do not include explicit financing sources, we believe that this is part of the problem. Americans have shown a willingness to support targeted assessments to pay for societal benefits.\(^5^6\) In Los Angeles County, people voted to raise their own property taxes to support their public hospitals, and Arkansas enacted a soft-drink tax to help fund its Medicaid program. Without an explicit financing source, reform efforts will likely be opposed by those, like us, who support responsible government budgeting.

The time for this debate may be now. President Bush has put both Social Security reform and tax reform onto the agenda. Both types of reform are similar in size and scope to health reform. Some estimate the cost of Social Security reform to be $1.4 trillion–$2.2 trillion over ten years.\(^5^7\) Also, the simple extension of the president’s tax cuts is estimated to cost $1.8 trillion over ten years.\(^5^8\) Moreover, the most controversial element of the Plan for a Healthy America, its financing source, has already been raised in the context of tax and Social Security reform. We believe that extending and improving health care is the more justifiable and just use of the VAT. While President Bush’s tax changes, which he proposes to extend, overwhelmingly benefited Americans earning the highest incomes (73 percent of the cuts went to the top 20 percent of income earners), two-thirds of the uninsured have incomes below 200 percent of the federal poverty threshold.\(^5^9\) While different estimates project that the Social Security Trust Funds will be exhausted in either 2042 or 2052, medical costs were a factor in fully half of
all personal bankruptcies in 2001. Americans agree that different priorities are in order. When asked to name the single most important issue that Congress should address in 2005, three to fives times as many named health care (10 percent) as named tax reform (3 percent) and Social Security (2 percent). Providing and improving health care for every American may be the current test of our country's strength of conviction, as was enacting civil rights for all in the 1960s and the creation of the New Deal in the 1930s. We believe that with focus, a carefully crafted plan, and a values-based debate, we can meet this challenge.

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NOTES
4. D.U. Himmelstein et al., “Illness and Injury as Contributors to Bankruptcy,” Health Affairs, 2 February 2005, content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.63 (2 February 2005).
40. OECD, Revenue Statistics.
52. IOM, Insuring America’s Health.
55. A longer paper with a more detailed explanation of the plan can be found at the Center for American Progress Web site, www.americanprogress.org.