

Mixed frames of Obamacare: a Critical Discourse Analysis of the Intertwining of Rights and
Market Framing Discourse Surrounding the Patient Protection and Affordable Care Act

Betsy Leimbigler

Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
In fulfillment of the requirements
for the MA in Political Science with a Specialization in International Politics
Faculty of Social Sciences
Department of Political Studies
University of Ottawa

© Betsy Leimbigler, Ottawa, Canada, 2014

Abstract

This thesis investigates the complex relationship between political institutions and health care policy through framing techniques employed in political discourse in the Patient Protection and Affordable Care Act (PPACA). It addresses how rights and market framing interact in the development, passage and further discourses on the PPACA.

President Obama's discourses are analyzed using qualitative critical discourse analysis of five remarks and addresses given between 2009-2013. These speeches are unpacked and categorized to illustrate the change in framing techniques over time.

Three main findings are presented after the analysis portion: market framing is used more frequently in the developmental stages of the PPACA, mixed rights and market framing are largely conveyed through anecdotes, and the "right to affordable health care" is forwarded as an argument. These findings support the main argument that rights and market frames have a high level of interaction in the development of the PPACA.

TABLE OF CONTENTS

1. INTRODUCTION	6
1.1.THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)	6
1.2. FRAMING OF THE PPACA.....	8
1.3. RATIONALE.....	10
1.4. RESEARCH QUESTIONS & RESULTS	12
1.5. PREVIOUS RESEARCH ON THE PPACA AND HEALTH CARE REFORM	14
1.6. METHODOLOGY.....	22
1.6.1. Framing	22
1.6.2. Critical Discourse Analysis.....	23
1.6.3. Speech Selection	24
1.7. CONCLUSION.....	28
2.CHAPTER TWO: LITERATURE REVIEW	31
2.1. FRAMING LITERATURE	33
2.1.1. Defining Framing.....	35
2.1.2. Linking Framing with Social Constructions	36
2.1.3. Health vs. Health Care: Implication of Universality in Rights	38
2.1.4. Framing, Social Constructions and Race	39
2.1.5. Framing in American Political History: the Clinton Years:.....	41
2.2 US HEALTHCARE SYSTEM	45
2.2.1. Before the PPACA	48
2.2.2. After the PPACA	51
2.3. RIGHTS AND MARKET BASED APPROACHES.....	54
2.3.1. Rights approach to health care	55
2.3.2. Rights in the American context.....	57
2.3.3. Different types of market based systems	62
2.4. DISCUSSION AND ANALYSIS ON FRAMING, RIGHTS AND MARKET	67
3. CHAPTER THREE – SPEECH ANALYSIS	73
3.1. CHALLENGES AND LIMITATIONS.....	74
3.2. CATEGORIZATION INTO RIGHTS AND MARKET.....	76
3.3. UNPACKING THE ADDRESSES AND THE REMARKS, 2009-2013	77
3.3.3. Remarks at the Opening Session of a Bipartisan Meeting on Health Care Reform – Speech 288	
3.3.4. Remarks on Health Care Reform: Speech 3	91
3.3.5. Remarks on the U.S. Supreme Court Ruling on the Affordable Care Act – Speech 4 June 28, 2012.....	96
3.3.6. Remarks on the Patient Protection and Affordable Care Act – Speech 5.....	98
CONCLUSION.....	101
4. CHAPTER FOUR: FINDINGS.....	104
4.1. SUMMARY OF RESEARCH QUESTIONS AND ARGUMENTS.....	104

4.2. ANSWERING THE RESEARCH QUESTION AND PRESENTING THE EVIDENCE.....	106
4.3. INCREASED MARKET FRAMING IN EARLY SPEECHES	107
4.4. ANECDOTES: THE MIX OF RIGHTS AND MARKET	108
4.6. THE PERSUASIVE PURPOSE OF MARKET FRAMING TO PASS A BILL	112
4.7. OUTLOOK AND FUTURE STUDY	113
5. REFERENCES.....	117

Figure 1.....	47
---------------	----

List of Tables

Table 1.....	78
Table 2.....	83
Table 3.....	90
Table 4.....	95
Table 5.....	97
Table 6	99

1. INTRODUCTION

1.1. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

On March 23rd, 2010, a landmark piece of health care reform legislation was passed in the United States under the Presidency of Barack Obama: The Patient Protection and Affordable Care Act (PPACA), also commonly known as “Obamacare”. Several sections of this reform bill modify existing programs, such as Medicare, with provisions such as curbing direct spending, giving prescription drug discounts, and addressing the systemic issue of quality and delivery of health care (Schmidt, 2011). Many of these changes were implemented in 2014 with the cooperation of state governments. In its attempts to ensure affordable health care coverage to more Americans, the PPACA was the source of much controversy and resistance in both its initial stages and after its passage. Given the failure of the Clinton health reform plan in the 1990s, and the pressures of the economic downturn, health care became a key component of the presidential debates and subsequently, a major part of candidates’ platforms. In order for this bill to pass, it was important for this contentious topic to be framed in proper terms that could appeal both to Americans as well as to lawmakers, lobbyists, and interest groups. President Obama’s discursive frames are analyzed in this thesis under the assumption that the way in which health care was framed affected the passage of the PPACA, and that two main frames are “rights” and “market” framing.

The PPACA itself seeks to accomplish what is laid out in the very title itself: an act that is meant to protect patients from loss or denial of coverage by insurance companies, and ensure affordability. Over the course of the past decades, several different approaches to health care reform were supported in Congress, including proposals by proponents of universalized coverage or a “single-payer” system. Approximately 48% of Americans receive health care benefits

through their employers, while 30% receive it through Medicare and Medicaid (Obamacare-facts.com, accessed July 2014). The United States health care system is a combination of privatized, employer-based insurance, with a majority of Americans receiving health care from employers through private means.

During its developmental stages, there was discussion and the possibility of health care reform to overhaul the system and ensure universal health care access. However, in creating the PPACA, President Obama decided to work with the existing system and champion an individual-mandate reform bill that would not change the system as much as a single-payer system. As the individual mandate is the less drastic of the two possible options for reform, Democrats widely believed that pursuing reform through an individual mandate rather than advocating a single-payer, universalized system would result in a bill that was more likely to pass. Furthermore, Democrats had widely agreed more or less on a system that would serve as a compromise to appease both Democrats and Republicans (Hacker, 2010). However, much of the criticism about Obamacare was focused on the compromises between single payer and employer-based, as well as the legality of mandating Americans to purchase health insurance.

The passage of the PPACA is a step towards creating more opportunities for Americans to access health care. While the PPACA did not overhaul the system to create a universalized, “single-payer” system, its passage signifies a landmark change in the way health care will be discussed and delivered.

“ObamaCare is a mixed-market approach to health care that embraces both public and private health care and health insurance and uses taxes, subsidies, and a mandate to obtain insurance to help keep uninsured rates low and sustain costs. Like single payer, it also works address underlying health care costs which are one of the major roots of our current health care crisis.” (Obamacare facts, retrieved August 2nd 2014.)

*Note about the name of the Act: The PPACA was signed into law on March 23rd 2010, while the ACA refers to the amended version of the law (health care.gov, retrieved August 2nd 2013).

1.2. FRAMING OF THE PPACA

The drive and the push for a major bill on health care reform has been an item in the American national agenda for decades (Hacker, 2010). Attempts at passing bills on health care reform under various presidential administrations has been met with resistance both within parties and from opposing parties, not to mention the impact of lobbyists and the media – the Clinton Plan in 1993-1994 was the last major attempt which failed to pass (Hacker, 2010). Health care reform is neither a new nor a radical notion, although various approaches have been proposed, including a single-payer system (such as the Canadian system) as well as the individual mandate, which is the basis of the PPACA. This thesis seeks to analyze the way in which the health care reform bill was framed by President Obama through the discourses used in addresses and speeches spanning 2009-2013. In particular, I investigated the way that discourses around rights and market were used. The two framing categories can be generally derived from two mainstream health care systems: single-payer (also known as universal health care) and employer-based (individual mandate.) Discourses advocating for single-payer would more likely fall into the rights category, while the employer-based would connote more market framing. In order to analyze rights and market discourses, framing literature was used to examine in-depth the significance of wording, symbols, and the reasons for which political elites choose to problematize certain issues in certain ways. Looking at speeches before, during and after the passage also

serves to reflect the change in framing techniques employed in President Obama speeches, and allows us to evaluate the ways framing can be used as a technique.

The initial starting point for this thesis was to better understand how and why the PPACA was passed. The central aims of this project are to understand what framing is, how it was used, and what impact this could have had on the passage of the PPACA. This project sought to provide an answer as to how the concept of rights and human rights are conveyed in discussions about American health care policy through the usage of frames. As a researcher, I was interested not only in questions of why health care reform managed to pass in 2010 under the Obama administration, but also the specific context of the United States where market and rights discourses interact in forming health care policy. Throughout the analysis, it became clear that market frames were a major part of the discourses on health care reform. I found that rights and market frames have a high degree of interaction, and that market framing was primarily used to explain and promote health care reform prior to 2010. After the PPACA's passage, the insertion of rights discourses through anecdotes gave way to the emergence of "the right to affordable health care". While discussions on health care in various different nations and international organizations abound, the results from my thesis analysis demonstrate that health care is discussed in specific ways in the United States, using a technique of mixed market and rights frames. The specific context of the United States and its stage in health care policy development result in these unique discourses. In the preliminary study of the speeches, there was also a question of whether there was an increased amount of rights framing, which could have been a contributing factor to the passage of the PPACA. However, the scope of this project is not to evaluate why the PPACA passed, but rather to identify and evaluate the frames used. As such, rights framing was not used as much as market framing, disproving my initial researcher's bias.

1.3. RATIONALE

This thesis is an addition to the literature on framing, health care reform policy, and understandings of rights and market. Notably, the thesis forwards several ideas put forth by Daly's (2011) theoretical framework surrounding welfare development, and Chapman's (1994) collection of works of rights in health care policy. I also build upon Hacker's (2010) historical overview of health care policy reform and Jerit's (2007) views on framing. Layering together relevant sources that exclusively and particularly highlight "rights", "market" discourses and political culture in health care policy creates new literature on the topic of health care and rights, which benefits the future study of the PPACA and the framing used by Presidential administrations. This is important to study, as discourse surrounding welfare and development of health care policy is at the core of a functional and dynamic society. It has an impact on policy creation and formulation. Analyzing political framing within political discourse will further the scope of knowledge on the health care debate, and opens the door to a model that can be used for future study both in the United States and internationally.

In the long term of my research goals, this project represents an important step forward in better comprehending the U.S. health care reform as a historical process which is constructed through framing in rights and market language. This is beneficial not only for adding to the discourse and literature on this increasingly important topic of access to health care, but for future course of study as well. The market-rights interaction symbolizes a unique context of the United States which does not stop only with the passage of the PPACA; the qualitative research on framing and the way it impacts bill passage allows us to evaluate the importance of discourses and methods in which ideas are relayed to the public and to the electorate.

There are many possible approaches to understanding and analyzing the PPACA. Quantitative researchers may look at public opinion data, while qualitative researchers may conduct interviews. If different researchers are given the topic of the PPACA to analyze, each outcome and contribution would be different based on the researcher's background, methodology, and perspectives, and each of these approaches would result in a different contribution. Thus, the contribution that my thesis brings to the scholarship on the PPACA is reflective of my background as a qualitative researcher with specialization in rights, political culture and policy. Speech analysis, historical background as well as the framing and problematization of issues are the central components of to my research questions. My qualitative approach through speech analysis is based on the premise that the statements and speeches delivered by President Obama are framed in a way that reflects the general public opinion on health care. It also supposes that framing health care reform in terms of the economy and solving the deficit is an effective method to pass legislation. Thus, one of the contributions is the finding that the trends seen in Obama's speeches from 2009-2013 are reflective of a framing technique which highlighted the most urgent priority of the time, which was the housing crisis and economic downturn of 2008. The speech show that this was aligned with a necessity to change health care. It also demonstrates that framing an issue in terms of an economic argument has great influence in speeches, which explains why rights language is not employed before the passage of the bill. The fact that rights are mentioned after the bill's passage is reflective of what I call the culture of American health care, where the dominant discourse that emerges is the "right to affordable health care", instead of the "right to health care."

This thesis has been an ongoing research project steeped in questions of right to health care, and why the PPACA was enacted during a time of economy austerity. Throughout the

analysis of the speeches, it has become more clear why the health care bill became so controversial and central to the political climate of Obama's term. My background as a qualitative researcher with a Canadian perspective has influenced my views on the PPACA's development. While the thesis is neutral in tone, my main argument was influenced to have the tendency to highlight more rights language than was actually found in the results. This, of course, is due to the PPACA being framed mainly in market language, largely due to its role as a bill ensuring affordable care; not universalized care.

1.4. RESEARCH QUESTIONS & RESULTS

My main research question is "What were the frames used by President Obama in his speeches through the passage and implementation of the PPACA?" President Obama employed a large amount of market frames with language and motifs highlighting health care as a solution to the economic deficit. He also employed a mixed method of framing which encompassed both market and rights, conveyed primarily through anecdotes. The results of the analysis show an increase in rights approaches after the passage of the PPACA, from more market framing to mixed market and rights. In the first speeches, prior to health care reform bill passage, market framing was the dominant discourse. This progressively shifted to mixed framing, where the concept of a "right to affordable health care" emerged.

Further questions link to the main research question. How are the "rights" and "market" arguments in health care policy development in the U.S. relevant? What is the role of "rights" discourse in policy reform, and how does it interact with market discourse and framing? What is

the literature on “market framing”; are there other ways to conceive of a market frame, such as reference to employer-based or individual-mandate health care systems, or historical background into liberalism? What types of language, constructions, motifs, or notions fall into the market category, and what does the gray zone of overlap between market and rights look like? I found that the overlap constituted a “mixed” frame, where both appeals to rights and appeals to the importance of affordability were interconnected, and that the interaction between rights and market frames shows an increase in rights language after the passage of the PPACA. Prior to this, market language is heavily invoked. After the passage of the PPACA, the mixing of frames through anecdotes is also observed.

One component of the original argument is that rather than just being political strategy or the product of favourable political conditions in Congress, the passage of PPACA signifies and reflects a wider shift in discourse surrounding access to health care, as it reflects the power of framing. Discourses on market and rights are reflected in presidential speeches given on health care reform, which signifies the importance of framing health reform as something that will benefit Americans financially – especially in times of economic austerity. This is seen as one major reason for which the PPACA passed in 2010; the power of lobbyists and interest groups worked together with the Democratic Party platform to craft a bill that would continue to perpetuate the existing private system, given that security of health insurance is tied so closely with employment for so many Americans (Hacker, 2010). This is proven to be true in the analysis portion, which highlights the increased amount of market framing used in political discourse.

The objective of the project is to supplement the literature with a speech analysis and an analytical framework that will link the impacts of the PPACA and frames, looking at the interaction between “rights” and “market” framing. Recurring terminology of these frames in 5 speech-

es given under the Obama administration from 2009-2013 provide empirical data regarding the type of language used in discussions regarding the “right” to health care in the United States. In analyzing the Obama administration's speeches that describe the PPACA, language constructions and motifs that highlight collectivism, an appeal to rights, equality and equal access may be seen alongside ideas that focus solely on market language and economic arguments.

The project has several aspects to it: the literature review, the analysis of the specific context, as well as the data from the analysis of speeches. These follow together coherently to give in-depth analysis of the PPACA and the arguments surrounding its inception to answer the main research questions of how rights and market frames impacted its passage, and how these two frames interact.

1.5. PREVIOUS RESEARCH ON THE PPACA AND HEALTH CARE REFORM

Skocpol (1994) explains framing in the Clinton reform, highlighting the importance of the use of language and symbols in the concept of framing. Later in this thesis, Jerit's (2007) analysis of framing techniques is used to differentiate framing from simply the expression of an idea: framing encompasses a strategic usage of words and symbols to appeal to voters and the electorate. Framing is a technique used by political elites to shape public opinion, and Skocpol's (1994) research demonstrates through a speech analysis how symbolism evoked by Clinton conveyed a sense of universalism, while also engaging citizens. The framing used by President Clinton had as the ultimate goal the generation of favourable public opinion on health care. This is very relevant for the study of the PPACA, as the framing used by President Obama on the PPACA has as the ultimate goal to pass a very different piece of legislation than the Clinton at-

tempt; this act was framed in economic terms and resulted in a much less universalistic system overhaul than the previous health care reform attempt.

The PPACA is not a law that reforms the existing American health care system into a universalistic system, although debate and controversy over its substance resulted in confusion over what exactly it promised. The Frequently Asked Questions section on Obamacarefacts.com includes one question that many citizens certainly would have been curious to ask, given the commentary, media language and attacks on the bill: “is single-payer socialized medicine?” This is dismissed on the website as a buzz word that does not carry real meaning. The PPACA is an act that retains the public and private blend of health care provision prior to its passage; it does not change the system to a single-payer or universalistic system. Rather, one of the main components of the PPACA consists of creating “marketplace exchanges” in each state where Americans will be required to purchase health insurance. Other main components include the removal of practices by insurance companies where pre-existing conditions disqualify consumers from coverage, and making changes to Medicare such as increasing the affordability of prescription drugs, among other changes (Obamacarefacts.com). The PPACA is the result of several decades of health care reform attempts, and constitutes a compromise – it was viewed by advisors as a reform that was not too lofty, but which would accomplish the goal of having more Americans covered by insurance.

Why was the PPACA successful in its passage? Hacker (2010) points out three main reasons that the PPACA was successful in its passage. The first reason is the economic context of the United States in 2008, when the economic recession had a clear link with health care reform. Given that nearly 50% of all health care insurance is provided to Americans through a private, employer-based system, health care reform was made a priority in a time of economic austerity

when job loss can also entail loss of health insurance. The second reason is that the hospital and pharmaceutical industry had an interest in reforming health care, but under their conditions – which explains the more limited impact of the PPACA in comparison with overhauling the system to create a single-payer system. Making the purchase of health care insurance mandatory would be a reform type that would still be in the interest of insurance and pharmaceutical companies, as over 16% millions of Americans had no form of health insurance in 2010 (Kaiser Health News, 2014). The third reason cited by Hacker (2010) was that the democratic party leaders agreed on this health bill as a sort of compromise between far left and right approaches to health care reform, even prior to President Obama’s election.

The history of health care reform since the Clinton reform years shows the shifts in the Democratic Party dynamics. Laying out the difference in opinion over the best type of health care reform allows us to situate the type of reform advocated with either a market or a rights frame. Thus, those more liberal Democrats in favour of a single-payer system where each American would receive health care coverage automatically would be more likely to advance this argument using a rights frame; that is, an appeal to the right to health care. On the other side, those advocating for an individual mandate would be more likely to frame this using market language, in reference to macroeconomics and cost-saving.

When discussing the “rights” framework in terms of the PPACA, it is imperative to keep in mind that the American context is quite different from the way the “right to health care” is framed at the international level, or in other countries. Leary in Chapman’s (2010) “Health care: A human rights Approach” discusses how “rights” frameworks are rarely used at the policy level in the early 1990s. Leary (1994) interestingly notes, “a rights-based approach to health care should be adopted as the fundamental premise of a reformed health care system in the United

States, rather than a market-based approach or a cost-benefit approach or an “ethical obligations” approach” (Leary in Chapman, 1994, p. 87). This suggestion is made in response to the current market-based approach to health care reform. Daly (2011), Chapman (1994), Berns-McGown (2005) and Boychuk (2008), have valuable contributions into both the theoretical framework and in linking together their insights.

There is a wealth of different interpretations and definitions of what constitutes welfare. In conceptualizing welfare, notions of independence and interdependence arise. A fundamental concept of welfare remains as such: “The existence of a “we” and an “our” is not in doubt; rather what is contested is who constitutes the “we” and what obligations or responsibilities members of the particular group have to fellow members and to “others”” (Daly, 2011, p. 30). In the case of the United States, the group that has constituted the “other” has recently been the 50 million uninsured Americans up until the signage of the Patient Protection and Affordable Care Act. However, this did not automatically cause millions of uninsured to be insured overnight; rather, the PPACA marks a shift towards increasing the number of insured Americans – a rights argument conveyed through market language.

Chapman (1994) focuses on the necessity of a societal obligation to ensure health care for Americans. Therefore, the human rights perspective is not about a moral right to care, but about societal obligation. The usage of the term “social obligation” as the framework is thus a linguistic preference, as “rights language has greater political force than the language of societal obligation” (Brock in Chapman, 1994, p. 66). Chapman (1994) suggests a rights based approach to health care over a market-based approach, with the reasoning that entitlement to basic health care should not depend on financial nor employment status, based on the principle that each citizen

would enjoy the same standard for care available to everyone. However, the fact remains that “a human rights approach requires ongoing citizen involvement” (Chapman, 1994, p.17).

“Modern conceptions of human rights formulated at the end of World War II assume a very different conception of the nature of rights and the role of governments than the eighteenth century liberal interpretation still current in the United States” (Chapman, 1994, p.4). The concept of rights in the United States differs from the implied United Nations or other main international bodies’ definition of “human rights.” This is to say that the American concept of “rights” still present in the political culture of the United States focuses on political rights representing protection of individuals from authoritarian governments, which would be considered a threat to human welfare. Health care is seen as a political battle and an on-going debate where the main frames that are most effective are the mixed frame, where market language is used to convey the importance and urgency of reform.

Chapman’s (1994) discourse on health care differs greatly from the policy of health care. The academic discussion surrounding rights may have a very different interpretation than the public policy or political culture discussion of rights, particularly from the conservative campaigns. In the aim of analyzing the importance of rights language in the right to access to health care, the counter arguments are framed in terms of the right to not have health care – as already mentioned in Beechey’s “discourses of rights, needs, entitlements and deservingness”.

The PPACA and discussion about a single-payer system has led several scholars to draw comparisons and contrasts with the Canadian system. In the 1960s, Canada enacted a universal, single-payer system, while the United States followed a different path based primarily on the politics of race in the United States (Boychuk, 2008). Whereas the defining feature for Canada is

the regionalism and politics of language, racial inequality and the politics behind enacting a universal system in such a climate was one major factor that health care development in the United States did not follow the universal system. Boychuk (2008) makes reference to an essential component of understanding health care: that racial and territorial politics do, indeed, play a role in the development of health care policy in the USA. The importance of social policy for the purposes of cohesion in a federation is summed up as follows: “Social programs are crucial in creating direct connections between citizens and their governments, helping provide legitimacy for those governments, as well as helping to foster a sense of community...” (Titmuss in Boychuk, 2008, p.9).

Comparison and contrast between the racial politics of The South in the United States and the cleavages along linguistic lines in Canada brings in a rights perspective to the creation of health care policy in the 1940s-1970s. Boychuk’s (2008) section on existing explanations are of particular importance to this thesis, as he highlights author Martin Lipset in his discussion of how different political cultures between Canada and the US are indeed responsible at least partially for the different types of health care. To support Boychuk’s (2008) discussion on the importance of political culture in developing social policy, Berns-McGown (2005) highlights that political culture is the combination of attitudes and beliefs with historical and current events, which translates into policy and practice – and this is seen as a “shared value”. As such, political culture is a process where events translate into political behaviour. This is one of the more recent and applicable definitions of political culture, validating how attitudes and beliefs serve as a way to create a “norm” political behaviour in the public sphere, thus maintaining a sense of collectivism. Berns-McGown (2005) argues that political culture is a significant determining factor of

policy and of public opinion, and that it is constructed through political symbolism and myths, concluding that the social construct of political culture separates Americans from other countries.

On the topic of political culture, Shaw (2010) refers to political cultures as one of the possible reasons for the United States' particular position as a developed country without universal health care coverage. According to Shaw (2010), there are two main reasons: "The first assumes that the American lack of national health insurance is a function of attitudes or interests that stand opposed to activist government in general or to government involvement in the health care sector in particular" (Shaw, 2010, xv). This highlights the major role that political culture and attitudes play in forming public policy regarding health care. The other main reason that Shaw posits is the involvement of powerful interest groups that play a very strong role in forwarding their interests and blocking the interests of the public. These interest groups include health insurance companies and professional medical associations, such as the American Medical Association. This is referred to as the institutional explanation for why the health care policies in the United States are so complex and contentious, and is mentioned also in Hacker's (2010) work on the PPACA.

The literature on civil rights and language exists to illustrate an important aspect of this thesis, as well as to help in answering questions that are lacking in the current literature. I believe that combining explanations for the American model of health care with literature on language and rights creates a better understanding for the many possible reasons for the development of health care, and also allows us to better understand the PPACA as a process, instead of a bill that passed in 2010 – in reality, the PPACA is tied inextricably from a long history of health care reform attempts which touch on racial politics, political attitudes, and many factors that explain why it was created to amend the existing system. Political culture is also linked with the civil

rights movement and the impact of civil rights on policy development. Policy is affected by political culture shifts, and in this case, it is interesting to note that the discourses on health care reform are framed in a mix of rights and market language. Discourses of rights are contextualized not to human rights, but rather to “rights”, as this also allows for an overlay of critical race theory, and avoids the potential pitfall of discussing human rights and health care in a way that is not suited for the American context.

Discourses on access to health care are employed hand in hand with rights and market framing. Discourses on health care continue to be an important part of addresses and speeches, as health care continues to be an important part of the national agenda. The creation of the PPACA is construed as a marking moment in the history of policy development in the United States, and so it is imperative to ask the question of how rights and market framing played an important role in the reasoning behind its development. The problematization and subsequent enacting of this Act in times of economic austerity brings in a mixed approach to policymaking with “rights” argumentation used after the passage of the PPACA, and market frames used prior to the passage of the PPACA. Discussion on access to health care is grounded in the notion of fundamental, basic rights, but it also contingent on the type of health care reform being promoted. In the case of the PPACA, striving for consensus over making rights argument is seen in the speech analysis, given that the PPACA’s aims were not for universal health care reform, but rather, for making changes to Medicare and ensuring that Americans could purchase affordable health care. The process towards effecting change in health care invokes discussion on personal responsibility, government intervention, and discourses of needs, wants, and necessities – and as proven through the speech analysis, a focus on market framing and a mixed frame representing the right to affordable health care.

1.6. METHODOLOGY

The methodology section addresses three components of the project: framing, critical discourse analysis, and Obama's speech selection.

1.6.1. Framing

The first aspect of the methodology section is the concept of "framing". Chapter 2 highlights several authors that discuss framing and its wider implications in social constructions and impacting electoral behaviour. Framing is a political strategy or technique that politicians use to convey their ideas to the general public (Jerit, 2007). Schenider & Ingram (1993) go beyond framing to discuss the social construction of target populations, which political elites are aware when making addresses. This is very relevant when analyzing President Obama's speeches. Symbolism and language, as well as an awareness of the target population and their favourable reactions to any given framing technique are important aspects of political discourse. The theory behind framing is that frames have a great influence over the way that issues are portrayed; thus, the way that health care was framed is important to analyze to see what kind of political strategy proved effective in passing the PPACA. For this thesis, two juxtaposed frames, market and rights, were used in a qualitative analysis of President Obama's discourses. Most of the discourse on the individual mandate resonated with market framing: words, phrases and notions attributed to economic gains and macroeconomics. Rights framing occurred in a much less systemic way, and when the discourses were invoked, they were often done so through the usage of anecdotes.

The anecdotes were not purely rights-motivated but often brought in elements of market frames in the form of affordability, and the notion of the right to affordable health care.

1.6.2. Critical Discourse Analysis

Critical discourse analysis (CDA) is a method of analysis that includes the usage of language. It is a descriptive type of analysis that takes into account political systems and institutions. “Discourse” is the “social use of language in social contexts” (Fairclough & Fairclough, 2012, p. 81), and interdiscursive analysis of texts allows qualitative researchers to identify words, patterns, and styles. CDA is an effective qualitative method to interpret the five speeches.

I aim to frame rights language and track its change over time, but also to look at alternatives to simply “rights” frameworks through functions of manual interpretation of the 5 main speeches. Alternatives to “rights” discourse include market or mixed frames that arise throughout the speech analysis. Neagu (2013) places importance on language as well as contemporary political discourse. This is relevant for this portion, as using this methodology legitimizes the selection of speeches as an important aspect of understanding rights and market language. Neagu (2013) frames President Obama’s discourse on health care as “politics of business” and explains that the language with which he chooses to discuss health care reflect in individual’s pyramids of need as conceptual metaphors representing investments. This means that discussion on health care would be seen as an investment in personal safety (Neagu, 2013). At the same time, Fairclough & Fairclough (2012) is an excellent base source as they focus primarily on the idea that political discourse is fundamentally argumentative.

Fairclough's (2003) approach to discourse analysis focuses on the assumption that social analysis and research must always take into account language. In discussing the social effects of texts, Fairclough explains that texts influence people and their beliefs, and thus impact the world around us meaningfully. In writing a thesis that analyzes the texts of speeches given, which includes beliefs and attitudes and their relationship to policy, and the way in which ideas are strategically framed, this form of critical discourse analysis is essential (Fairclough, 2003, p. 17).

Finally, Schmidt in Yanow & Schwartz-Shea (2006) focuses on language policy and more specifically highlights the importance of examining conflict of values in opposing camps when it comes to analyzing policy – in this case, the PPACA and the language surrounding it. This legitimizes the usage of sources in this thesis that do not simply describe rights and market frames, the development of the PPACA, but also those that challenge the main authors of the field.

In sum, the methodology of this thesis is a qualitative analysis of five long speeches to categorize the discourses on health care reform into rights and market. In order to do so, an extensive literature review of framing literature, as well as rights, market and comparative systems is required.

1.6.3. Speech Selection

President Obama's speeches were selected for analysis due to the existent literature on speech analysis, legitimizing this type of research. What initially began as a question of "how did President Obama push for the PPACA's passage?" became a more long-term and specific analysis of "what frames did President Obama use throughout the passage and implementation of the

PPACA?” Stemming from this: what does the interaction between the rights and market frames tell us about framing and about the context of healthcare in the United States?

The speeches were selected to act as a source of primary data to analyze what was being said and to answer the main research question: how do rights and market frames interact in President Obama’s speeches supporting the PPACA? The results found that the speeches prior to the passage of the PPACA heavily reflected market discourse and that this is a reflection of the type of health care passage promoted by President Obama; that is, reform that was both public and private, and which was framed as a solution to the economic crisis.

Five long speeches were selected based on their date and length to provide data for the speech analysis, from 2009 until 2013. Selection of the speeches was conducted with the overarching idea that approximately one speech per year from 2008-2013 would both fit the criteria for conducting a speech analysis, and be of an appropriate sample size for a Master’s thesis length of study. The five speeches spanned in length from 1,210-5,558 words, with the average speech length of 2,730 words. The speeches were first and foremost selected based on their relevance and especially length, as short statements (500 words or less) make up a large number of the data retrieved on the database after entering the keywords, and longer speeches and statements provided more material to work with. The first 3 speeches were selected by typing the key words “health care” into the search engine of the American Presidency Project, an online collection of all presidential speeches, statement, exchanges with reporters, and documents circulated to party members. The date range for these key words was January 1, 2008-March 1, 2014. From there, speeches were selected based on 1) relevance and 2) length. Regarding relevance, only speeches with considerable mention of health care either in the titles or throughout the bulk of the speech would be considered. As such, any speech that only vaguely references health care

while focusing on another part of the industry was not selected for speech analysis. Regarding length, statements, remarks and addresses that were at least 1000 words or longer were selected, with a preference for longer statements as this would provide more data to work with.

The last two speeches were selected by typing “Patient Protection” in as the key word from January 1 2010-March 1 2014, given that the name of the bill would be more relevant and more specific in the later time frames than simply “health care”. The same criteria were applied regarding relevance and length. It is important to analyze speeches that have both health care as the central theme as well as speeches long enough for a relevant framing analysis. While the number of speeches selected is small, for the purposes of analyzing framing, a lengthy process of manual analysis was used. Future speech analysis may use a similar method for gathering speeches, but include a wider number of speeches from any given to increase the data size.

Riker’s (1996) analysis of rhetoric in election campaigns is done by summarizing essays and stories into several sentences, which serve as an argument or sentiment. Techniques for studying campaigns as done by Riker (1996) are also transferable to the study of speeches. Given the wide array of information available through the long and short speeches of President Obama, the most important aspect of the speech analysis is ensuring that it stay concise. Riker (1996) acknowledges that summarizing one meaning or argument can be difficult as there is often considerable overlap; however, reducing the amount of words to core ideas is fundamental to studying the speech analysis. Ideally, summarizing should reduce the bulk of the writing to approximately 1/10 of the original writing (Riker, 1996). The speech coding has not been tracked to ensure this, but the main ideas of each speech and sections of relevant paragraphs are included as primary data.

The summarization and categorization of central ideas in the speeches as per Fairclough & Fairclough's (2012) example highlights the concepts which are most important in a given campaign or speech. The way that these ideas are framed are reflective of the discourses that permeate health care reform in the United States, and might give answers as to future reform, as well as illustrating what types of narrative are used in promoting health care reform.

The process of categorizing President Obama's speeches through the market and rights frames is fairly straightforward, given the background on rights vs. market discourses provided in Chapter 2. It is important to keep in mind the distinction of the American health care reform not being an entirely "rights" based approach, but rather a market solution that is channelled using specific terminologies and frames in political discourse that appeals not only to rights, but also the importance of political cohesion, anecdotes, change, and more. Each speech contains areas that do not appear to fit either category upon first glance, but generally have undertones of rights discourse through discourses of "justice" or deservingness, need, and entitlement (Beechey, 2013) – although mentions of entitlement are rarely mentioned. These types of appeals would typically fall under "rights" discourse, while market discourse refers to explicit mention of fixing the economy being a central motivator to health care reform.

The speech analysis is conducted manually by reading each speech and highlighting any instances where claims to "rights" are made, based on the statement or idea meeting the rights criteria outlined in Chapter 2. The same is done for any appeals that are made to "market" framing. The coding by frame identifies whether discourses of rights, market, or other types of framing were used. These types of Presidential speeches, delivered either as statements, addresses, remarks, messages to Congress or comments on Acts, have been selected as they reach an audience of Americans that are politically inclined and work within Congress. Interestingly, over

the course of the speech selection, inaugural addresses that reach a broad audience of Americans did not have enough framing regarding health care to be considered for inclusion. Inaugural addresses significantly reflect political culture, as Erickson (1997) claims they are an expression of cultural features of American politics, and reflect themes of current affairs. This reaffirms the importance of language in shaping inaugural addresses and reflecting American political culture. While none of the speeches selected were inaugural addresses, health care cost and health care quality are referenced twice in President Obama's 2009 inaugural address (New York Times, transcript, 2009). This at least confirms the presence of the topic of health care, and its problematization through the lens of cost and quality in the inaugural address. Its framing remains to be determined in the rights and market categories in the 5 longer speeches.

1.7. CONCLUSION

The aim of this thesis is to analyze the interaction between “market” and the “rights” framing in speeches delivered by President Obama on the topic of the PPACA. In order for this to be accomplished, a literature review of health care policy development culminating in the PPACA, as well as an overview of framing, rights and market, is required.

Chapter two of the thesis highlights significant historical periods regarding health care legislation in the United States. This determines the existence and level of shift in values and priorities of the US federal government administration, to better understand the factors involved in producing such a policy as the PPACA. There exist several key moments in the history of health care policy development in the United States, which include the 1960s and the development of Medicare and Medicaid, the 1990s and the failure of the Clinton administration's health

policy, and most recently, the 2010 passage of the PPACA in an effort of making health insurance coverage accessible to all Americans. Chapter two also discusses framing literature, what the PPACA comprises, and also distinguishes between rights and market frames and systems. It sets the necessary background for the speech analysis chapter.

In order to understand the background of the PPACA, the origins of the development of public welfare policy (Daly, 2011) and the theory of rights (Chapman, 1994) that is inherent to the American political context is essential to analyze. A chronological progression of health care policy passages and rights, as well as an analysis of historical policymaking with dates ranging from 1965-2013, forms the basis of Chapter 2 and gives context to the PPACA. This encompasses a breakdown of the main authors in political culture discourse and the methodology of the “rights” theoretical framework in discourse analysis methodology, as well as framing.

Chapter 3 analyzes the speeches in the Obama Administration time-frame between 2009-2013, categorizing the main arguments and language under “rights” or “market”. This is done through a qualitative analysis of 5 long statements and speeches. The goal and theme of each speech is condensed and organized in chronological order at the beginning of the chapter. Then, the main ideas extracted from each speech are categorized into either market or rights framing, depending on the language and notions used, and organized into five charts. This chapter sees the emergence of a third category, which is “mixed” framing, which arises primarily when anecdotes are used in speeches, as anecdotal portions of speeches have at their base a notion of a right to affordable health care, rather than a “right to health care” or purely market framing.

Chapter 4 comprises the findings and discussion. The type of framing used is shown to change over the time period of 2009-2013. Primarily market framing is found in the first speech-

es, which gives way to the emergence of anecdotes, which take up a significant portion of the speech. This chapter explains the two main findings of the speech framing analysis – first, that the trend from market to mixed rights framing occurs over time, and second, that the right to affordable health care is a dominant discourse which encompasses a mix between rights and market framing. In conclusion, the qualitative research on the speeches demonstrates three trends: the trend from market to rights discourse over the course of 5 years, the emergence of a mixed frame which consists of anecdotes and blended discourses, and finally, the notion of the “right to affordable healthcare” championed by the creators and defenders of the PPACA.

2.CHAPTER TWO: LITERATURE REVIEW

Chapter two forms the basis of the thesis through a thorough overview of scholarship on framing, rights approaches, and market approaches, and the PPACA. Discourse on market framing includes an overview of public/private healthcare systems, and how this has impacted American political culture in regards to health care development. This chapter also encompasses examples of framing through the Clinton health reform example, and the discussion of what the PPACA constitutes.

The chapter is organized into the following structure: The first section provides a clear definition of framing. Throughout the section on framing, several authors and different aspects towards the scholarly study of framing are presented, including political strategies of “framing”, which demonstrate how there can be many “frames”, or techniques to convey ideas to the general public.

The second section provides the overview for the state of the healthcare system in the United States before and after the passage of the PPACA. This section examines the PPACA as an act, and also in the context of a historical process. In articulating the market frame, the context specific example of the Clinton reform plan is an important part of the historical aspect of understanding healthcare before and after the PPACA. The PPACA policy development came to be in the United States through understanding the mixing between private and publically funded and administered systems. The Clinton example highlights the difficulties and barriers faced when trying to push for a change through proposing universalized health care.

The third section explores the two frames that emerge in the scholarship on health care reform in the United States: the “market” and the “rights” frames. These are the two most rele-

vant specific frames that are used when discussing health care policy – the market-based, or “consumer-based” approach, and the rights, or “human rights” approach. These two frames are considered by Audrey Chapman (1994) and other researchers to be the frames that represent opposing sides to health care policy ideology. Keeping in mind the main research question, “what frames did Obama use in his discourse surrounding the development of the PPACA”, these two frames are widely researched in the literature on health care and human rights and will serve as the basis for the analysis of Obama’s speeches in Chapter 3. This will also provide a breakdown of the coding used to assess the usage of these two main frames.

There is a gap in literature which discusses market framing, although it is existent in and consistent with the American health care model. As such, following the interpretation of Chapman’s definitions of “rights” and its link with framing authors, market framing is explained with historical background into the many factors contributing to an employer-based, private system seen in the United States.

An important distinction must be made between a policy, and frames to discuss a given policy. For example, while the entire American healthcare system may not be categorized as a “rights-based” policy, as it does not ensure universal healthcare coverage, there are policies within the structure that are universalistic and can be categorized as a “rights” frame. In the same vein, while the PPACA does not advocate for universalizing healthcare but rather making it more affordable, the policy and the frame must be kept separate. The PPACA as an act that advocates primarily a market-based solution can have both rights and market frames utilized in its implementation. Regardless of whether the PPACA is rights based or market based, the way it is framed is done in regards to the language used by President Obama. While the second section examines the basis of the healthcare model in the United States as the context for which the

PPACA was developed, the rights and market frame must be distinguished from the actual policy itself. This means that a rights-based policy may be framed in market terms, or vice-versa. Indeed the PPACA – a market-based solution – is explained by President Obama using both market and rights framing.

This chapter brings together the many fragmented components of American health care that I have chosen as important in terms of framing, to understand how market and rights framing interact with one another. The theoretical interaction of market and rights in the American context becomes more clear by the end of this chapter. Universal health care is not guaranteed based on citizenship in the United States. Unlike other similarly developed countries, such as Canada – the American health care system differs in that Americans primarily may purchase private insurance, or have it provided through employers, rather than having a universal system covering every citizen. This existing system influences the way politicians discuss health care reform, and the framing techniques around rights that are traditionally associated with universal health care. Chapter 3 then segways into the analysis of what kinds of frames were used in developing the PPACA, and provides the basis for the research question regarding how rights and market frames interact.

2.1. FRAMING LITERATURE

Framing is a technique used by politicians to angle their arguments toward the general public. It is a rhetorical strategy that is used in political discourse and that is relevant in the analysis of how the Patient Protection and Affordable Care Act (PPACA) was presented to the gen-

eral public. Language, words, and symbols are closely linked with framing, as these form the basis for the way citizens interpret messages from politicians. Framing is a very useful concept through which to analyze the political discourse surrounding the passage of the PPACA, because frames influence the way that competing political elites portray issues – in this case, how President Obama portrayed the issue of health care reform. According to Jenifer Jerit (2007), framing is important as it permits elites to shape their policy discussions, which in turn, affect citizen constituents. Approaching the topic from a policy point of view, political actors need to generate favourable public opinion on their policy. A “framing strategy,” therefore, would be a method to generate the most favourable public opinion (Jerit, 2007). As mentioned, framing strategies that have been employed in the realm of health care policy development include the “market-based” and the “rights-based” approaches. Koch (1998) explains, “A frame is a central organizing idea for making sense of an issue or conflict and suggesting what is at stake” (Gamson and Modigliana in Koch, 1998, p. 210). Complex issues can be defined, explained and simplified through framing, and there is a close relationship between public opinion and framing.

The ways in which political issues are portrayed by the media and by political figures have a significant impact on electoral behaviour. Previous research by Kimberly Gross & Paul Brewer (2005), William Jacoby (2000) and Anne Schneider & Helen Ingram (1993) on framing and social constructions indicates that particular importance ought to be placed on the framing discourse of President Obama in his persuasive speeches and statements regarding the PPACA. Research by Jenifer Jerit (2007), Jeffrey Koch (1998) and Theda Skocpol (1994) on the use and effectiveness of framing in the Clinton Health Reform demonstrates the impact and importance of framing in political discourse.

2.1.1. Defining Framing

The notion of framing evokes connotations of political culture, public opinion and political rhetoric. Political culture can be seen as a broad framework into which various frames that target specific issues or groups exist. Framing is more than simply, for example, a political culture, and is more specific than political rhetoric. Because it is a strategy, it takes into account political climates, citizen's reactions towards language and ideas, and the way that these ideas are translated through the media to impact citizens.

Before analyzing framing in previous policy debates, it is important to properly understand and define framing as a concept. Brewer & Gross (2005) interchange the term "framing" with "defining", in the context that politicians define/frame issues in terms of values that the public holds. Framing can thus be interpreted as defining the way that policy controversies will be presented to the public. Jacoby (2000) specifically highlights "issue framing," which involves politicians and political figures concentrating on certain issues, whose messages are disseminated through mass media. Framing is a more tangible way to conceive of public opinion, and is easier to categorize than political culture. Jacoby (2000) distinguishes between general and specific issues framing.

Significant issue framing occurs in the everyday world of political discourse. Jacoby (2000) specifically centers on the framing of government spending; how the public opinion around government spending is separated by partisan cleavages.

Members of different parties use framing to appeal to different groups. Framing is a rational method to influence the way citizens think about issues, and the way people think and feel about issues translates to their voting patterns and political preferences. Because of its link to-

ward understand voting patterns and reactions from citizens, framing is an important aspect to the study of politics and political discourse. As Brewer & Gross (2005) find through their research, citizen's thoughts on policy issues are shaped by frames, specifically ones that highlight "values." Categorizing citizens into different groups reflects the work that Schneider & Ingram (1993) highlight in close relation to framing.

2.1.2. Linking Framing with Social Constructions

Framing literature is quite broad and abstract, while Schneider & Ingram (1993) provide a more concrete area to discuss the way policy is influenced by discourse. Schneider & Ingram (1993) do not focus on framing but highlight an important aspect to it: they explain that in the domain of political science, importance is attributed to variables such as agenda-setting, various populations, and implementation of policy. These factors are significant when politicians determine policy, and different populations are socially constructed and categorized. "The social construction of target populations refers to the cultural characterizations or popular images of the persons or groups whose behaviour and well-being are affected by public policy" (Schneider & Ingram, 1993, p. 334). In short, social constructions of target populations give important insight into the way policy is developed, how resources are allocated to specific groups, and how agendas are set. This notion is of particular interest in discussing target populations of health care benefits across racialized lines. Brewer & Gross's (2005) research on categorizing different groups in society and Jacoby (2000) and Skocpol's (1994) explanations of framing as strategy is complemented by this analysis of target populations, as both framing and socially-constructed target populations are used strategically and have a great influence on the development of policy.

Both the framing and the policy literature operate under the fundamental assumption that “policy is purposeful and attempts to achieve goals by changing people’s behaviour” (Schneider & Ingram, 1993, p. 335). Just as explained in the framing literature, political actors and public officials need to calculate and anticipate reactions from their “target populations”. Schneider & Ingram (1993) split the target population groups into four categories: advantaged groups, contenders, dependents, and deviants. Within these categories are groups of citizens with variable levels of entitlement, poverty, wealth and other factors. Target groups, once identified, can be described by public officials through political discourse to impact the social construction. The groups that are highlighted in the public allocation of resources are most polarizing when highlighted as powerful vs. non-powerful groups, and this dynamic is visible in policy development and framing.

One of the most interesting target groups identified is the category of “dependents,” as this group was deemed to be a deserving group in the United States under Medicare and Medicaid.

For the dependent groups, such as children or mothers, officials want to appear to be aligned with their interests; but their lack of political power makes it difficult to direct resources towards them. Symbolic policies permit elected leaders to show great concern but relieve them of the need to allocate resources (Schneider & Ingram, 1993, p. 338).

This statement may factor into the United States health care policy in alignment with discourses on “rights”, although it fails to make a significant move towards universality, as rights are often interchanged or linked with notions of entitlement, deservingness and need (Beechey, 2013).

“Policy tools refer to the aspects of policy intended to motivate the target populations to comply with the policy or to utilize policy opportunities” (Schneider & Ingram, 1993, p. 338). Policy tools promote techniques for the targeted population to become informed about the policy,

and then to take action and become involved. Interestingly, when directed towards dependent groups, the policy tools may result in stigmatizing labelling. This is a fascinating concept when applied to the development of the PPACA - it relates directly to Chapman's (1994) argument that a rights-based approach to health care requires ongoing citizen involvement. As such, a rights-based approach would claim that all citizens are a deserving targeted population for health care reform, and would not take into account the grouping of target populations. Therefore, it is important to highlight in Chapter 3 whether or not discursive frames on rights or the market include appeals to specific groups or target populations.

2.1.3. Health vs. Health Care: Implication of Universality in Rights

It is equally important to highlight here that while a rights-based approach to health implies universality, rights-framing of health care policy need not necessarily be universal. Rights framing may involve highlighting a particular groups and their entitlement and right to health care. The approach and the notion of the right to health, as highlighted in various areas – the most high-profile of which is the Universal Declaration of Human Rights – implies government ensuring access to all citizens to adequate health. The word “care”, however, makes this more specific. Health care and framing in terms of rights in the United States, on the other hand, may involve appeals that do not include universality but rather highlight specific target groups, such as disadvantaged groups requiring a “right” to health care. In Obama's speeches, any mention of any particular group receiving health care benefits may be construed as a rights framework, even if universality is not implied.

Schneider & Ingram (1993) have a fundamental premise in their evaluation of social constructions of target populations: That there exist powerful and non-powerful groups in society to

whom public policy actors aim to distribute resources. Linking this premise with the policy and framing literature stating that politicians seek to create favourable public opinion on their policy, we can extrapolate that political actors (in this case, President Obama) are aware of appealing to different, socially constructed groups of society. Interestingly, Schneider & Ingram (1993) highlight the specific group of “dependents” as the group most negatively predisposed to government intervention and failing to claim benefits for which they are eligible as a result of their powerlessness.

These grouping methods consistent with policymaking are continually used by public officials. The grouping of target populations has widely affected the outcome of public policies in the United States. Although the scope of the thesis is not to determine the cause or reasons for the development of the PPACA, but rather the discursive frames used by President Obama, it is important to determine whether grouping into target populations reinforced certain discourses on the PPACA – for example, whether rights discourse was used as a frame to highlight to non-privileged groups.

2.1.4. Framing, Social Constructions and Race

Without straying too much from framing literature, the overview of various authors on framing and social construction of various groups pertains to a classic example of a social construction and symbolism in American policy: in relation to race and health care, Boychuk (2008) links the social constructions of target groups and the vast and importance attributed to “race” in health care discussions. The link between framing and socially constructed groups of people is that the way in which language is used by a political figure or “elite” will reflect the attitudes of the general public. The concept of race has impacted the development of health care policy sig-

nificantly in the United States. Boychuk (2008) explains how citizens are able to read through the coded messages when elites discuss social programs, and associate this language with socially constructed figures in their minds.

Politicians say they are talking about social programs, but people understand that they're really talking about race. There is good reason for Americans to understand coded messages about social policy as substitutes for discussions of race, for real linkages between race and social policy exist" (Quadagno in Boychuk, 2008, p. 5).

The linkages between race and health care policy are important to understand for the thesis as these tie into the literature on social constructions of various groups. Social programs are not only practically useful and reflective of the political culture of a nation, as evidenced through the political discourse of its leaders regarding equality and access, but also for increasing life quality for citizens. When Boychuk (2008) discusses race as a topic that is historically relevant to health care, he further demonstrates that politicians use symbols and coded messages – framing strategies, in other words – to create policy.

The purpose of citing these various authors in framing and on topics related to framing: public opinion, values, rhetoric, race and social construction – is to illustrate the complexity of framing and how its usage by political elites is to address groups in society. To link this with the second part of this chapter on rights vs. market frames, it is important to reiterate that rights framings in the American context does not necessarily imply universality of health care or changing the health care system to become universal, but rather discourses of rights are invoked.

Kellstedt (2000) hypothesizes that this “media framing” led the public to express more liberal preferences on racial policy. To go into greater depth, Kellstedt (2000) explains that the reaction of the general public mirrors that of the media: when the media’s messages emphasize the values of individualism, the public generally expresses conservative racial policy prefer-

ences, and when the media message focuses more on egalitarianism, the public is more likely to prefer liberal racial policies. Kellstedt (2000) asks whether eras of American policy preferences about race exist. According to Kellstedt (2000), there is an “ebb and flow” of racial policy preference measured by the role of the national American media in nudging the public towards different directions. This provides a basis for the kind of speech coding that will be used for the PPACA, except that Kellstedt’s (2000) coding is not based in speeches but rather categorizing the general public into two modes of thinking.

2.1.5. Framing in American Political History: the Clinton Years:

As stated in the introduction, framing is understood to be a technique used by politicians to angle their arguments toward the general public.

Health care moved to the top of the national agenda in the Clinton administration. Jacobs in Skocpol (1994) explains how based on polls in the 1960s, surveyed Americans were more receptive than ever to the notion of health care coverage for the elderly, as well as social insurance. President Clinton’s consultants fashioned health care as the most pressing issue in the nation, and framed it in terms of appealing to the public, while the policy elites discussed the financial issue of reforming health care. Generating favourable public opinion was the goal of President Clinton, as evidenced by the language used in his speeches. Public opinion comes from citizen’s experiences with previous administrations and governments, and relates to framing because analysis of the words and language used by Clinton reveals symbolism that appeals to citizen’s beliefs. The example of Clinton’s September Speech to the nation in 1993 is used in Skocpol’s (1994)

analysis. Clinton framed health care reform as an endeavour that would allow “every American” access to health care, symbolized by a “health security card” that every citizen and legal resident would receive (Skocpol, 1994, p. 23). Highlighting that public opinion matters, President Clinton’s focus on social security “for all Americans” illustrates a desire to move towards a universal welfare state. This would be interpreted as a “rights” frame. Clinton evoked symbolism to appeal to citizens, and also used another strategy to bring the health care debate to the forefront: engagement.

A key component of framing is that it is a process reserved to “elites,” or to public figures. The literature on framing has in common the understanding that at its core, framing relates specifically to competing elites portraying issues in different ways. When discussing framing, its impact is meant to be the reaction of the general public and its citizens. Framing refers to elites identifying considerations that work to their advantage. However, “framing permits elites to take advantage of the ambivalence with which most citizens view political issues” (Jerit, 2007, p. 3). Thus, framing takes into account the fact that not all citizens are engaged citizens and that many groups in society may be ambivalent to politics. Framing is not just the attitudes or political culture of a group, but rather, the way in which broad messages are transmitted from political elites or figures, such as President Obama or the notion of the “Obama Administration” to the general public.

Engaging, on the other hand, happens when those who want to make policy change “engage” the opposing side. Engaging occurs between elites. As such, it can be seen how framing and engaging are similar strategies in public debates of opposing sides, with one stark difference: While framing is the strategic creation of ideas to create favourable public opinion, engaging re-

fers to the opposing sides in the debate and how they interact with one another – generally speaking referring to the elites or political figures who engage in the debate.

Thus, while framing and engaging are both dynamic, framing is a unidirectional knowledge sharing from elites to the public, while engaging is a dynamic process in which competing elites engage one another in arguments and policy discussion. For the purposes of analyzing the PPACA and its discursive frames, it will be kept in mind that the rights and market based approaches to health care can be interpreted both as frames as well as engagement strategies. To focus the thesis, the rights vs. market based frames must be conceptualized and highlighted as ideas that impact public opinion, not necessarily the debates between opposing sides. For the purposes of this thesis, these frames are being analyzed in their static sense, as the focus is not on the debate but rather what President Obama's frames were.

Framing is a rhetorical strategy used by politicians in political discourse, while engagement is a part of this strategy. In highlighting the Clinton health plan failure, Jerit (2007) explains how engagement in the debate was in fact more effective in increasing support than framing was, from 1993-1994. In doing so, it is understood that engagement is more effective than framing in the investigation of rhetorical strategy. This is attributed to the fact that political engagement in the debate is more effective at increasing support than framing, and challenges the notion that framing is the optimal rhetorical strategy. Regardless, framing remains an important political and rhetorical strategy to generate favourable opinion through the words, style, and appealing to the general public opinion. Engagement is seen by Jerit (2007) as more effective in this case, by tracking the dynamics of the Health Reform Bill.

Jerit (2007) focuses on the evolution of public policy debate over health care reform, essential in understanding the failure of the Clinton health reform plan. Usage of frames in this policy debate is important in analyzing the PPACA in order to understand how Obama positioned himself and his administration in face of his citizens. Better understanding the framing in previous examples in American history - or as Boychuk (2008) refers to them, “critical junctures” - is an important part of the literature review on framing and rights discourses in this chapter.

The rhetoric surrounding the development of the PPACA and health care reform in the United States in general has been widely attributed to the concept of “rights.” However, breaking down the frames into “rights” and “market” allows researchers to determine to what degree these two competing frames were used, and to appeal to which socially constructed groups in society. By further understanding the role that framing plays in health care reform, researchers may better analyze how health care reform in the United States has been “sold” to the public. Furthermore, the language used and the frames through which politicians “sell” the idea of health care reform over the course of history allows us to understand the political fabric of the United States, and helps to answer broader questions about how political discourse affects electoral behaviour.

Opponents to reform in the United States do not have any new proposal for reform that must be defended, and as such, they are able to channel their energies into formulating arguments that attack policy change. Operating under the dynamic that Clinton reformers increase support when they rebut opponents, Jerit’s (2007) claims that more emphasis was put on defending the proposal rather than rebutting arguments in 1993-1994. Similarly, Brock in Chapman (1994) examines the Clinton policy failure of 1994 from within the President’s Commission on the Right to Health care. Brock (1994) explains that rights language and discourse in public policymaking is important, although nuancing this notion with politically weaker ideas such as “ob-

ligations” is not enough to effect change. This lends further importance to the notion of “rights” framing, instead of language such as “obligations,” to which citizens are not as receptive.

When opposing elites talk about the same considerations, this is referred to as dialogue. When these opposing sides highlight different considerations however, this is considered framing. Jerit (2007) explains that in the 1993-1994 Clinton health care reform bill, the majority of the support’s argumentation focused on framing the bill as security, and less on rebutting the arguments. This type of interaction between frames and engagement further highlight the importance of framing in public discourse, as both framing and engagement are strategies that are used by elites to shape the general public’s opinions.

In the speech coding of Chapter 3, “rights” or “market” frames are attributed to certain key words, themes, and ideas. At this point, after understanding the basis of framing, it important to understand what the United States health care system constitutes: A rights-based approach or a market-based approach? Most of the scholarly discourse on the topic highlights the overwhelming position of the United States as a “market-based” health care economy, juxtaposing it against systems of other nations that highlight values such as universality.

2.2 US HEALTHCARE SYSTEM

The healthcare system in the US is provided to Americans in several different ways, with American citizens generally falling under four main groups comprising their insurance providers. Prior to 2014, the largest percentage of insurance providers were through employment, which made up 48% of the insurance coverage of the American population. This means that 48% of

Americans were insured through their employer, and that depending on the coverage plan, most costs would be covered in the event of an emergency. Medicare and Medicaid, the two publically-funded programs covering older citizens and low-income families in need respectively, provide 15% of insurance coverage each. Finally, the last major group is the uninsured (15%) which may constitute Americans who are unemployed, employed part-time or those with incomes slightly above Medicaid qualification.

Insurance is expensive, and few people can afford to buy it on their own. Most Americans obtain health insurance coverage through an employer, but not all workers are offered employer-sponsored coverage. Also, not all who are offered coverage by an employer can afford their share of the premiums. Medicaid and the Children's Health Insurance Program (CHIP) cover many low-income children, but eligibility for parents and adults without dependent children is limited, leaving many without affordable coverage (Kaiser Family Foundation, 2014)

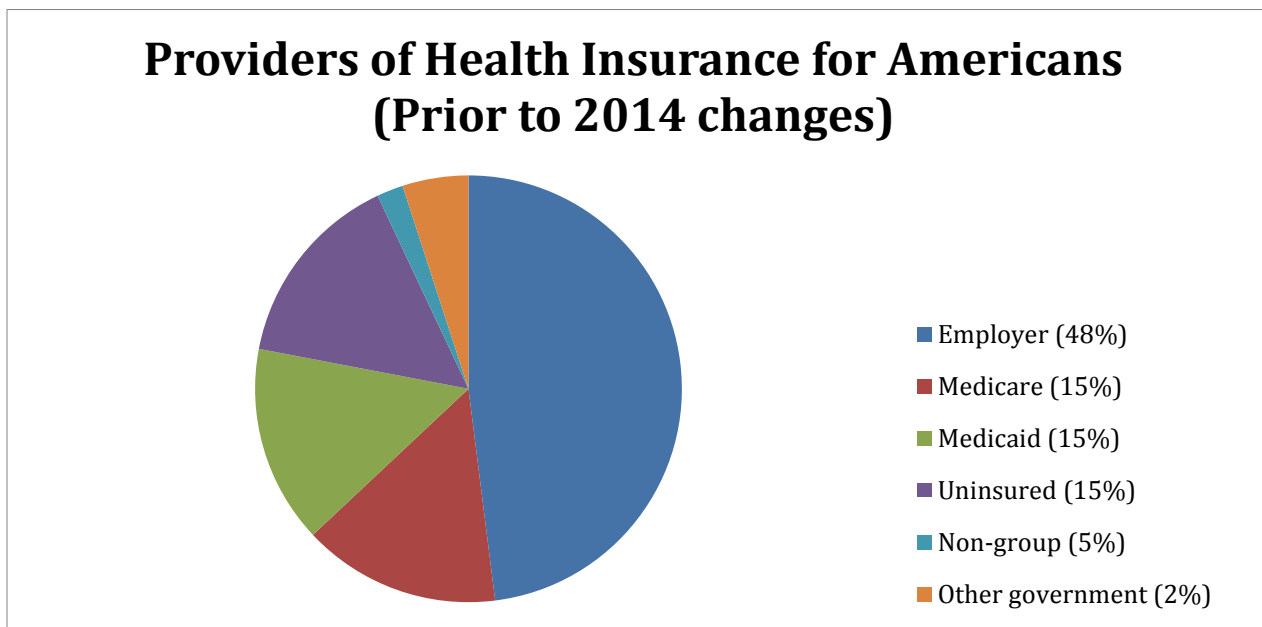
Prior to the passage of the PPACA, one of the most contentious issues in the United States' health care system was the denial of coverage for those who has pre-existing conditions. With insurance companies able to reject clients with a history of health problems, health care costs soared. The PPACA mandated to put a stop to these actions of insurance companies, along with commitment to providing affordability, extending coverage to children under 25, and fixing the system through expansion of insurance – in short, setting up “marketplace exchanges” for Americans to pick health care plans for themselves and their families.

In the centre of the health care debate in the United States is the question of how to reform the private insurance industry. A central defining feature of the American system, which is not typically specifically referred to as “market-based”, is the private insurance industry. Individual health care plans are expensive and before the passage of the PPACA, were not available for people with pre-existing conditions.

The PPACA reformed the private insurance industry by banning practices such as refusing patients with pre-existing conditions and making health care more affordable and accessible

through a variety of steps. However, fundamentally, there was no major change: “The PPACA did not fix the fundamental economic structure on which the private industry is built” (Feldman, 2012, p.8). The PPACA did not automatically cause millions of uninsured to become insured overnight. Rather, this act represents a gradual change to the health care system within its existing parameters. As President Obama stated himself, the goal of health care reform under his mandate was not to create a new system, but rather to build on the current existing system.

Figure 1.



Data retrieved from: <http://obamacarefacts.com/howdoes-obamacare-work.php>

Source: Obamacarefacts.com

2.2.1. Before the PPACA

This section examines the type of healthcare system, state of health care coverage and also the distinction between framing and the actual systems. Despite Medicare and Medicaid, the two largest government-funded health care provision programs, the United States system is primarily a privately-delivered, privately financed system (Deber, 2002).

The right to health is enshrined in various legal documents worldwide, at both the international and national levels. The Universal Declaration of Human rights, drafted under American leadership, is one such document that proclaims the right to adequate health ensured by governments. The Clinton Plan in the 1990s originally sought to follow this theme of universality.

By several accounts, some more sensationalized than others, the system in the United States was not ensuring adequate health care to its citizens throughout the 1980s and 1990s, continuing on the recent years. As mentioned in the rights portion of this chapter, the 1983 President's Commission on the Right to Health Care rejected the usage of rights framing during health care reform policy development, opting instead to use language of "social obligation" which entailed limited entitlements to health care. Furthermore, President Bill Clinton's Task Force on Health Reform did not use rights framing either – while the values and principles of universal coverage are extolled, the right to health care is not entrenched legally, in order to prevent a legal entitlement.

The Clinton health reform plan had at its core a protection of the coverage that the insured already enjoyed, rather than an extension of coverage to the uninsured. As Schneider & Ingram (1993) would highlight, the "dependent" groups in society were powerless and thus not considered to be of political importance, and so, resource allocation was channelled not to reform

the system to have universal coverage for all Americans, but rather to lower costs for those already insured. Thus, the failed Clinton health reform plans has as their main goal to reduce costs for already-insured Americans. Iton in Boychuk (2008) explains that universal coverage – what Chapman (1994) refers to as a rights approach that extends universality – was not proposed because of the divide between the insured and uninsured, an “us” vs. “them” mentality.

The Clinton plan comprises the most relevant health care reform plan prior to the PPACA. While actually proposing to lower costs for the already-insured, the plan was widely perceived as a program to expand services and increase taxes. As such, the perception of a rights framework in the context of racial tensions present in the 1990s in the United States contributed to the failure of the plan, although Clinton himself used market-based framing to highlight the plan, labelling it as “a private system,” “guaranteed private insurance,” and private care, private insurance, private management, but a national system to put a lid on costs” (Boychuk, 2008, p. 82).

One very important idea in the notion of contentious rights framing in the United States with regard to health care has to do with the various interpretations of “rights” and to who, or what they extend. Leary (1994) explains that the rights approach in the U.S. constitution is based on “individualistic, liberal tradition in which social rights such as the right to health care have no place” (Leary, 1994, p. 91). This indeed forms the basis of opponent’s arguments to the proposed PPACA.

Chapman (1994) clearly outlines the overlaps between obligations and rights in discourses of health care, while arguing that universality and no means of exclusion are central to the

rights approach. Employing rights language in health care provision would entail that health care is seen as a fundamental good in society that is different from other goods.

It is particularly important to note that the PPACA focused mainly on lowering insurance costs, preventing Americans from being rejected by insurance companies for having pre-existing conditions and generally ensured an individual mandate that would require Americans to purchase their own insurance. Thus, the PPACA's goal was to operate within the existing market (private) system, and not create a new system. The Republican discourse in response to the rights framing by Democratic representatives used rights framing in the context of having a consumers' right to choose. In the United States, health care has been a private good financed by the individual or provided by government or employers, and the PPACA did not fundamentally change the fact that private delivery of health care would be financed by private insurance. The framing used to pass the PPACA is separated into rights and market. The PPACA represents a market solution; that is, the premise of the act is to continue to expand coverage within an employer-based, market system. That said, both market and rights framing can be used to angle argument for the PPACA's passage.

When the Obama Administration made health care as a priority, the state of health care in the United States was both a rights issue and an economic problem. With 47 million uninsured Americans, increasingly high insurance rates, and a patchwork of public-private systems, health care reform was prioritized as a method to help combat macroeconomic issues in the United States (Lawrence, 2008). As insurance costs increased, fewer employers were willing to provide insurance, and fewer Americans were able to afford the insurance. The main arguments for passing the PPACA are laid out in tables in Chapter 3, where President Obama highlights economic

arguments, and transitions into anecdotes and some rights framing to argue for the PPACA's passage.

2.2.2. After the PPACA

The passage of the PPACA marked significant changes in the American healthcare system, as well as the political system. In 2012, opponents of the PPACA challenged the constitutionality of the act, claiming that the mandate for Americans to purchase their own insurance or else incur a tax penalty was unconstitutional. During this time period, online marketplace exchanges were set up for citizens of the 50 states and the District of Columbia to enrol online. Finally, other changes that were an integral part of the PPACA including affordability of insurance plans, changes to insurance companies to regulate their plans, expansion of Medicaid and other requirements – such as small businesses having to provide insurance – came into effect. Progress reports of the PPACA as well as political strategy for the future show that after the PPACA, positive trends towards the increased number of Americans covered under an insurance plan.

Overall, the number of Americans signed up through individual marketplaces has been tallied at approximately 8 million, which exceeds the predictions of the Congressional Budget Office. A progress report published in the *New England Journal of Medicine* gauges the success of the new law by examining the enrolment rate since the PPACA's passage (numbers of uninsured Americans) the adequacy of insurance (assessed by the number of citizens remaining uninsured, and the affordability of private coverage). The report highlights that one of the most visible changes is the increased number of young Americans able to stay on their parents' insurance up

until the age of 26. The number of young people without insurance has dropped by approximately 1 million (Blumenthal & Collins, 2014).

The law went forward in setting out new guidelines for insurance companies and regulating their standards for selling insurance plans. New private insurance marketplace exchanges were set up for the 50 states, and Medicaid was expanded to increase coverage. The progress report highlights the malfunctioning of the healthcare.gov website, and the focus of the media on the importance of citizens signing up.

As such, the passage of the PPACA has had a significant change in making healthcare accessible to Americans, through a market-based system that encourages citizens to purchase insurance. Follow-up reports on increasing quality of healthcare will be more comprehensive in the next few years. It is anticipated that states will expand their coverage in the future.

One further important change mandated by the PPACA is the requirement for small businesses with 50 or more full-time employees will be required to provide insurance. It is still too early to determine how many people will benefit from insurance through their employers, but the passage of the PPACA is meant to also make insurance cheaper for small businesses.

The passage of the PPACA in March of 2010 was the beginning of the implementation of important changes in the health care system, including but not limited to: protection of Americans against discriminatory practices by insurance companies, the setup of state marketplace exchanges” where Americans would be able to purchase insurance, expansion of Medicaid, and increasing the number of young people on their parent’s insurance. In sum, the law made multiple-pronged approaches to expanding availability and affordability of access, while being challenged

as unconstitutional. All Americans are required to have insurance by 2014, or else have to pay a monthly minimal penalty.

Following the passage of the PPACA, the Supreme Court upheld its constitutionality, after it was challenged by opponents for being unconstitutional in its requirement for Americans to purchase insurance. The mandate was not seen as a “command” to purchase insurance, but rather, the condition of having no insurance was made taxable. Thus, those Americans without insurance are penalized through a tax.

In 2012, 200 million Americans had private health insurance, the majority of which was paid for by employers (Feldman, 2012). Individual health care plans are expensive and before the passage of the PPACA, were not available for people with pre-existing conditions. As such, the New England Journal of Medicine’s progress report indicates that significant advances have been made in implementing at least the framework for the large scale changes that the PPACA brings. The state of health care in the United States is expected to continue to improve in the way that more and more Americans will have insurance coverage.

Congress’s potential option of creating a system to give Americans free health care would require more taxes and the displacement of the existing private sector. Feldman (2012) takes into account the “irony” of the PPACA’s passage, considering that both Democrats and Republicans largely favoured creating health care exchanges, and how this system is now widely criticized by voters. Despite the controversy about the PPACA and the arguments, challenges towards its constitutionality and website difficulties, the PPACA has made and continues to make changes to health care in the United States with the outcome of lowering health care costs

and expenditures, and increasing the number of Americans signed up in marketplace exchanges, among other gains.

2.3. RIGHTS AND MARKET BASED APPROACHES

The current literature on the topic of health care, human rights and political culture is heavily centred on the post-World War II era, the 1990s as well as growing literature on 2008-present day. The focus on these time lines is in line with major welfare reforms that occurred at the global level. Analysis of health care through both a rights perspective and the market perspective is very important to better understand framing techniques used by President Obama in developing the PPACA. Several scholars and accounts of health care and human rights ask the question: what is a rights or a market approach to health care? This section of the chapter will explain first what a rights based approach to health care is, the theoretical underpinnings of this model, and then explain the market based approach to health care. This chapter seeks also to explain the type of reform that the PPACA constitutes by using examples from different countries and from different time eras. At the end, the link between these types of approaches will allow a better understanding of the environment in which the PPACA was developed. This will allow us to code the content of President Obama's speeches into two main categories and understand the frames used in support of the PPACA.

The PPACA is as its core an individual mandate, meaning that it requires American citizens to purchase their own insurance. It was passed due to strong emphasis on a need for change and for the right of American citizens to affordable care, not the mention the power of lobbying

groups and pharmaceutical industries which worked together with the parties to create a health care bill. Essentially, this entails both a “market” and a “rights” approach to health care. The relationship between rights and market discourses throughout the development of the PPACA demonstrates the unique challenge that the Obama administration faced from 2008 onward in the realm of health care.

2.3.1. Rights approach to health care

“The market approach is the contrary of a rights-based approach” (Leary in Chapman, 1994, p. 97).

A rights approach to health care is commonly attributed to systems such as the Canadian system, which is decidedly different from the American model. According to Chapman (1994) there are five main features that constitute a rights approach to health care:

- 1) Mandatory universal coverage, regardless of age, income, race, class, disability or any other factors
- 2) Equitable financing (or a program of subsidizing those whose income is less, in the form of a payroll tax while eliminating employer-provided insurance)
- 3) Mandated comprehensive benefits (preventative care)
- 4) An efficient delivery system
- 5) Cost containment; keeping medical costs low.

A rights approach to health care, thus, mandates universality of coverage, while also having a provision of equitable financing. According to the list of five factors, the Canadian system meets the requirements for a “right-based” approach to health care, with the possible exception

of number 4 – an efficient delivery system – which is debateable based on the waiting times that certain Canadians must endure for ER, specific surgeries or procedures. Leary (1994) adds to this that a rights-based approach to health care requires health care to be considered a public good. Fundamental to the rights approach to health care are values that include non-discrimination, and viewing health care as more than simply a commodity.

The theoretical principles underpinning the preference for rights-based health care discourse stems from the school of thought that values universal welfare. A fundamental concept of welfare is the societal sense of an us vs. them mentality, or in other words, “we” vs. “others” (Daly, 2011). Proponents of rights approaches to health care understand welfare in terms of basic social obligations.

The existence of a “we” and an “our” is not in doubt; rather what is contested is who constitutes the “we” and what obligations or responsibilities members of the particular group have to fellow members and to “others” (Daly, 2011, p. 30).

One interpretation of welfare according to the “we” and “our” relationship correlates to those who have power and those who do not. Thus, privileged groups have a certain obligation to ensure that members of less privileged groups are able to enjoy accessible and affordable health care. This creation of a “we” vs. “them” mentality relates to Schneider & Ingram’s (1993) premise that politicians separate groups into different socially constructed target populations in order to frame their claims. In the case of health care, there is considerable contestation as to who constitutes the “we” vs. “them” as different groups have different beliefs and notions as to who is responsible for shouldering costs of health care – whether it be the government through taxpayers, or individuals themselves.

One way to interpret this statement regarding health care is to highlight which group has constituted the “other” in the case of American health care. In the case of the United States, the

group that has constituted the “other” has recently been the 50 million uninsured Americans up until the signing of the Patient Protection and Affordable Care Act. The argument is made for this significant portion of the population being an “other” group, because despite being spread across gender, racial and class categories, they constitute a group that is disadvantaged when it comes to unexpected health care costs, and this narrative is often reported through anecdotal evidence of uninsured Americans who encounter bankruptcy after health costs. The uninsured raise costs for everyone, and although the uninsured are often framed or portrayed as poor, it must be noted that this group is spread across class, race and gender boundaries. So to that effect, this group is not a conventionally “othered” group, but does constitute an “other” group in the “we” and “other” of welfare policy. Furthermore, Navarro (1994) explains that categorizing Americans by health care benefits serves to further drive apart social cohesion and decreases levels of empathy between groups that have health care benefits through employment, and those who do not enjoy such benefits.

2.3.2. Rights in the American context

There are two very important distinguishing factors to be made about the concept of rights in the United States. The first is the unique nature of rights in the American context that favours individual rights over collective rights, and how this translates into policies such as welfare. This links with theories of liberalism explored in the market section. The second important distinguishing factor about rights and the American concept is the way that rights framing can occur when discussing a market based policy – such as the PPACA, which did not reform health

care insofar as making the United States system into a single-payer, universal system, but rather worked to continue a similar market system as existed prior.

The concept of rights in the United States differs from the implied United Nations or other main international bodies' definition of human rights. "Modern conceptions of human rights formulated at the end of World War II assume a very different conception of the nature of rights and the role of governments than the eighteenth century liberal interpretation still current in the United States" (Chapman, 1994, p.4). Thus, the American concept of rights that is present in the political culture of the United States focuses on political rights, representing protection of individuals from authoritarian governments - which would in many interpretations be considered a threat to human welfare.

When discussing the "rights" framework in terms of the PPACA, it is imperative to keep in mind that the American context is quite different from the way the "right to health care" is framed at the international level, or in other countries. "Rights" frameworks were rarely used at the policy level in the early 1990s (Leary, 1994). Leary juxtaposes rights-based approaches to health care against market-based, cost-benefit or ethical obligations approaches. If the PPACA represents a market-based approach – as indeed, the reform bill champions affordability and purchasing health care – then it will not have been framed through "rights".

The rights framework in this thesis contextualizes discourses of rights not to the broad label of "human rights", but rather to "rights". This enables us to avoid the potential pitfall of discussing human rights and health care in a way that is not suited for the American context. "Rights" approaches to health care are generally linked with documents and bodies such as the Universal Declaration of Human Rights and the United Nations, with core values of universal

human rights. Rights language in the American context is very important in public policy, but also has a different interpretation that is linked strongly with the American concept of “rights”. Rights are so fundamental to the American political landscape that Primus (1999) argues that rights take the place over any moral argument. Rights in the American context have historical significance in relation with the American Bill of Rights and the Declaration of Independence, two important documents that have a particular emphasis on freedom, as well as the right to life, liberty and the pursuit of happiness.

Rights, conceived of in the international context in the development of the Universal Declaration of human rights, have a context of universality to begin with. On the other hand, the early American conception of rights was created and crafted as a response to infringement on rights by British rule, as the conception of the constitution, the declaration of independence and the Bill of Rights occurred as a result of political tension between Great Britain and the United States. In contrast to this, the Universal Declaration of Human Rights may seem like a more broad ideal. This is not to say that American political attitudes on rights are static; but rather to highlight how the American concept of rights differs from the international definition by virtue of the contexts in which they emerged. One was in the 18th Century, as a response to British rule, with heavy emphasis on liberty. The other was in response to the massive destruction of Europe and other parts of the world following the Second World War. While both the Universal Declaration of Rights and the American Bill of Rights share similar points, it is important to distinguish between rights that inherent to the American context and the concept of “human rights” which is more broad, and used more in an international context.

“The language of rights...is a powerful and coherent method [to reflect and privilege] substantive political commitments” (Primus, 1999, p.8). Rights discourse in the American con-

text may be problematic as it may complicate political debate – as political commitments, when paired with the concept of rights, carry a heavier meaning (Primus, 1999). This may be one of the reasons that rights discourse has such great appeal.

There is a societal obligation to ensure health care for Americans. In political discourse on health care, the rights perspective is not focused as much on a moral right to care, but rather as a synonym for societal obligation. The usage of the term “social obligation” is thus a linguistic preference. In general, “rights language has greater political force than the language of societal obligation” (Brock, 1994, p. 66). Thus, those advocating for revolutionary health care reform are more likely to use language of rights than social obligation, although rights language is seen as more powerful.

A 1983 document entitled “Securing Access to Health care,” created by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research, reveals the prevalence of rights discourse in drafting health care policy under the presidency of Ronald Reagan, whose tenure in office was marked by a cut in spending on social programs. One of the key foundations of the Commission’s work was the assumption that there exists a “moral obligation to ensure that everyone has access to an adequate level of health care” (Brock, 1994, p. 67). Interestingly, experts maintained that the federal government had a major role to play in ensuring availability of and accessibility to health care. However, they were careful about the language used, understanding that the focus on rights discourse could be at times too strong.

The staff philosopher of this Commission brought concepts of societal obligation rather than individual rights into questions on health care. In political debate, the language of rights has

a stronger clout than that of “social obligations.” In 1983, the President’s Commission on the Right to Health Care rejected the usage of rights framing. The President’s Commission on the Right to Health Care found that framing the position in terms of rights would be a mistake, as the Commission believed in limited entitlements to health care, rather than unlimited entitlements. Thus, the framing of the Commission’s position was done not through a rights framework but rather as a “societal obligation to ensure access to an adequate level of health care for all” (Brock, p. 73, 1994). This will be important to analyze in Chapter 3, the categorization of frames used in President Obama’s speeches. This also illustrates the importance of language and its impact on policy, as the development of health care policy moved away from a universalistic model, opting rather for a less powerful claim of social obligation over rights. The language of social obligations does not emphasize as strongly the necessity to extend coverage universally. A social obligation may consist of a policy that does not fundamentally change an existing system, but still represents an obligation – simply not as strongly as a “rights” argument.

Chapman (1994) suggests a rights based approach to health care is superior to a market-based approach, with the reasoning that entitlement to basic health care should not depend on financial nor employment status, based on the principle that each citizen would enjoy the same standard for care available to everyone. However, the fact remains that achieving a health care system that embodies the rights approach required a commitment of ongoing involvement of each citizen. Thus, a human rights *approach* to health care is inextricably linked to collectivism and engagement. The rights approach involves citizens working together to ensure a level of commitment to equal access to health care.

While Chapman’s (1994) account of rights would focus on the ideal of universalism and of individual citizen engagement, Beechey’s analysis of floor speeches in the November 7, 2009

debate prior to the passage of the PPPACA highlights the language used by Democrats and Republicans in the debate – relevant for the upcoming chapter. This language is categorized into rights, needs, entitlements and deservingness. Beechey’s speech analysis uncovers need as the angle most taken, making up 62% of the frames – and excerpts of speeches given prove the linguistic focus on appeals to Americans “requiring” or “needing” affordable care. This shows the linguistic link between rights and the concepts of requiring and needing care.

There is considerable relevance of market and rights approaches to the literature on *framing*. The framing of development of the PPACA by President Obama can be divided into two categories: rights framing and market framing. The frames used in President Obama’s speeches reflect to what degree the general population responds to strategies that invoke different symbols and notions. Rights framing, as has been discussed in this chapter, has a very unique position in the American context, given that policies such as the PPACA that do not call for universalized health care - but rather a market-based solution - can still be framed in terms of rights. The American concept of rights framing in health care is demonstrably unique, which is shown further in the market section.

2.3.3. Different types of market based systems

The 1990s marked an important juncture for literature on health care and human rights, as the Clinton health reform plan and its subsequent failure were at the forefront of American politics at the time. The PPACA was developed in a political environment that did not frame health as a human right, but rather, as an addition to the existing structure that does not adhere to an overall rights-based system (Carmalt, Zaidi & Yamin, 2011). The United States health care sys-

tem is market-based, not universalistic. Carmalt et al. (2011) explain the opposing systems of “consumer-driven” or market-based proposals for health care reform, which is in opposition to a “human rights” approach to health care. According to Carmalt et al. (2011), the foundation of a human rights approach to health care includes claims to entitlements.

The claim that the United States is a market based health care system is contested, however. Some scholars may make the claim that the American system is still rights-based, but that two different arguments can be made: 1) that all citizens ought to have a right to the same level of care 2) that all citizens ought to have a right to *some minimum* of care. The United States political system operates under the second argument, according to Mueller (1993), who focuses on the many government programs that do exist to cover marginalized Americans, including Medicare (for the elderly) Medicaid (for children in poor households) veterans. A major challenge in overhauling health care policy would be that when corporate interests control health care delivery, there is a risk of bankruptcy for the business.

Without specifically mentioning the market as a frame, Mueller (1993) explains that the plight of working class Americans who lose health benefits should motivate politicians to change the existing system, and claims that families are not always insured through the workplace. This hints at the anecdotes that President Obama employs in speeches delivered after the passage of the PPACA, where anecdotes and the concept of the right to afford insurance are raised.

Another way to look at the market-based policy reforms to health care in the USA is to read between the lines of the 1988 Democratic Party Primary Elections, where candidates such as Jesse Jackson focused on what he referred to as the medical-industrial complex of the United States. According to Jackson, the United States’ lack of national health insurance was not a ques-

tion of affordability but rather the specific system where funding and organization of health care services happens through private insurers. “Introducing a national health care plan similar to the Canadian one would save \$70 billion a year while providing comprehensive health care coverage to all” (Navarro, 1994, p. 83). Up until 1966, Canada and the United States had similar levels of health expenditures, but the national health care that was introduced in Canada has resulted in slower growth of health expenditures. However, the Democratic candidate Paul Dukakis widely referenced the notion of universal health care, while the campaign actually promoted expanding Medicare and Medicaid. Dukakis would have to address the “medical-industrial” complex of insurance companies in order to begin addressing universal health care coverage, as the US is the only industrialized country in the world to rely on private insurance companies for health care (Navarro, 1994). A federally funded, universal health care program would not be able to function by relying on private insurance companies. The unique position of health care in the United States, where private insurance remains a major aspect of the system, lends further credibility to reform policies that build upon the existing private-public blend, rather than overhauling the system.

The market based approach to health care is a unique position of the United States, and is based on historically significant factors including American liberalism, the growth of insurance companies and employer-based insurance programs, and President Obama’s reform policy that operates within the constraints of the existing market system. This is to say, the PPACA does not call for an overhaul of the existing market approach to health care.

In contrast to the key points to a rights approach to health care highlighted by Chapman (1994), the market approach to health care has certain key aspects. These four points are not ex-

plained explicitly by any one author, but have been compiled as defining features of the American system:

- 1) That each individual purchase their own insurance
- 2) That employers provide health care insurance benefit packages as an employment perk – although this poses a problem for those who do not have health care benefit perks associated with employment, and this is a major challenge to Americans and to President Obama.
- 3) That high quality health care delivery is given on the condition of payment
- 4) The market approach does not fall in line with the single-payer system of Canada where the government is central to the system; rather, the system in the United States is the individual mandate.

This market system or “approach” highlight characteristics of a system that currently exists in the United States, given that nearly half of Americans have their health care insurance financed and covered by employers, and that individuals may purchase insurance. Again, the market system and market “framing” are different, as the analysis chapter demonstrates that market frames can be used to forward a rights-based system, and vice versa: Rights framing may be used to forward a market-based system or policy. As such, rights and market “systems” and rights and market “frames” are different. In analysis speeches, it is important to separate the policy from the frame being used.

Two further categories of health systems are useful to understanding the market approach to health care – the “corporate health service model” and “welfare market capitalism”. The “corporate health service model” is a class-based system where capitalist classes had to ally

with aristocrats against the working class, and highlights examples from Germany, Austria, France and Italy in the 19th Century (Navarro, 1994). The capitalist and aristocratic classes were able to divide and control the working class through the Health Security Act of 1888, which attributed health benefits to the working class based on type of employment. The corporate health model is thus seen as a system to keep the aristocracy and capitalists in power to regulate benefits of the working class. This is the opposite of a rights-based model of health care that Chapman highlights as something based off of one's birthright. In the European countries mentioned above, the working class was able to re-gain its power as socialist political parties worked towards universalism. According to Navarro (1994), those nations where class division was higher and the working class was not able to penetrate to high levels of political institutions, social change and shifting health care to a government control was more difficult. In the case of the United States, segregation and racial politics played an important role in securing the status quo of the market approach, which went hand in hand with class division.

The Australian, American and Canadian models fall under the category of "welfare market capitalism", where there was never a capitalist class establishing power over the working class in alignment with aristocracy. Rather, "health policies have been characterized by a reliance on the market, with its attachment for private contractual health insurance and fringe benefits" (Navarro, 1994, p. 182). The welfare market capitalism model is attributed to countries where the working class has been divided through ethnicity and race. The nations falling under this category are described as "immigrant" nations. In the 1990s, 85% of health benefits in the US were work-related, a practice which can contribute to strengthening inequalities (Navarro, 1994). Furthermore, "those sectors of the working class that command a privileged position in the private market are less likely to support and identify with public programs" (Navarro, 1994,

p. 184). In other words, those citizens who are employed and enjoy the employment benefits of health care enjoy a position of privilege over those who have, for example, part-time jobs or are unemployed and have no access to a benefits package including health care. This further creates a societal schism where the privileged, defined as those who work and enjoy health care as a result of their employment, do not identify or support the idea of publically funded, universal health care.

Patel & Rushevsky (2005) explain how health care providers have monopolized health care policy development, and how associations and private health interest groups are the most powerful at legislative forums. This is also, then, a factor in the prevalence of the market system to health care - or perhaps rather than a factor, a result.

When discussing market systems and market policies, it is as always important to distinguish this from market and rights frames. While the US system has consistently, over the past few decades, demonstrated its propensity towards healthcare policies that involve further developing private market insurance providers, the ways in which arguments have been formulated comprise the frames. These frames may be both rights or market, regardless of whether the policy or system is more market-oriented.

2.4. DISCUSSION AND ANALYSIS ON FRAMING, RIGHTS AND MARKET

The authors on framing and target populations intertwine together to provide a backdrop to the importance of language and brings the discussion back to discursive frames. The authors and articles taken together demonstrate how framing is not simply an angle that is taken, but ra-

ther, a complex process that incorporates the power of public officials, the impact of their words on groups in society, and strategy. In the analysis section of President Obama's speeches, engagement in the debate (between political elites) as well as the appeal to socially constructed groups will be reviewed. The next part of this chapter detailed the two main frames that are used by analyzing what authors on human rights approaches to health care and welfare have researched. Coupled with speech analysis, the second part of this chapter will lay a basis for the way in which President Obama's speeches on the PPACA targeted specific groups, invoked certain discourses and affected public opinion.

Four main trends drive the force for changing the status quo of the American health care system – from the perspective of a viewpoint nearly 20 years ago. However, these have held true over the past decades, and have become increasingly central to the debate.

The first is rising health costs, with factors such as an aging population, equipment costs and a need for more care for the chronically ill. The second is the increasing gap in health care coverage, cited at 38.9 million uninsured Americans in 1992 – a number that has risen to nearly 48 million in 2013, at the time in between the passage of the PPACA and its implementation (Chapman, 1994, p. 2; U.S. Census Bureau, 2013).

The third point is that access to health care is a need with a cost that is too high, posing such a problem that it is not only lower-class citizens that are affected, but that this transcends class divisions and becomes an issue for middle class citizens as well, lending momentum to it being even more important. The final point is that preventative health care is lagging and that the structure of the health care system and its focus on specialists increases health care costs in the US.

“A rights approach would empower individuals and groups to assert their claims” (Chapman, 1994, p.153). A rights approach means that having a fundamental human right to health care overrules any claim to privilege, charity, or optional service. Further evidence of the importance of rights language can be found throughout the works of various authors. “The language of rights pushes us, more insistently than does the language of duties, responsibilities, obligations, legislation and respect for law...” (Baier, 1994, p.154). This assertion places rights as the ideal; that being human is enough to allow for rights.

A human right to health care is not just about the concept of each individual human having a claim to proper, affordable health care, but also engenders the necessity of having an education system in place where individuals are capable of knowing their rights. As such, the rights approach to health care empowers individuals to claim their right and receive entitlements.

The rights-based frame of health care is the normative and more theoretical of the two frames, whereas the market frame is the more empirical frame. In the United States constitution, the declaration of human rights as well as discourse in the previous Clinton health policy reform bill, rights discourse is prevalent. However, what do rights mean under the U.S. constitution, and how successful was rights framing in the Clinton health reform plan?

In order to answer these questions, it is imperative to first grasp that market framing underlies in the American model and that President Obama used both rights and market framing to frame the PPACA. Within the primarily market-based health care system of the United States, there is a usage of both market and rights frames. Health care is provided to Americans using both private (employer) and public (Medicare/Medicaid) systems. Figure 1 on page 50 outlined the breakdown of providers of health insurance for Americans, illustrating that the system is

mixed, and private insurance dominates. The chart also illustrates how health care reform would likely be done in line with the existing system, as nearly half of all insurance is provided by employers in a private system.

The private system of health care can be described as the “American” health care model, as well as the “private,” “employer-based” or “consumer” model. This approach is closely linked with the rights approach in the case of the United States. This is because while discourses of rights have certainly been invoked in calling for health care reforms, and while health care was a main priority in President Obama’s platform in 2008, the manner in which reform was achieved was done within an existing system that is not rights-based, but rather market-based. Because the health care industry in the United States is split into several groups of insured citizens through either employer insurance (private), Medicare (public), Medicaid (public) or the millions who are uninsured, there exist different systems, and not one universal system that each citizen can receive through the basis of possessing American citizenship.

Thus, the relationship between rights and market approaches supposes that one can discuss a market system using appeals to rights; that the existing system and policy is different from the frame used to discuss that policy. This suggests that the American health care system and the PPACA are neither rights-based system or a rights-based policy, but that rights framing can be used even to appeal to modifying a system that supports purchasing insurance. In short, a policy or system is different from a frame used to describe that policy or system.

The PPACA proposed an individual mandate; that is, that each individual is responsible for purchasing their insurance, whereas previously, Americans were not required to purchase insurance. Framing the debate on healthcare was done using both rights and market frames for a

primarily market-based policy change. The penalty for failing to purchase insurance after March 31st, 2014, is 95\$ per adult (Obamacare facts, 2014). This is different from Congress's other option when President Obama began the process of overhauling the health care system.

Congress's two options when reforming health care in the US consisted of either mandating each individual to purchase health insurance through state-monitored health exchanges, or providing free health insurance for all Americans through a universal health care plan, funded by the government. These two possible choices represent the market vs. the rights approach to health care on the surface. However, when it comes to speech analysis in Chapter 3, we will see the type of rights language used in framing the PPACA as well as market frames.

The United States health care system constitutes a primarily market approach to health care, based on the prevalence of health insurers that sell their policies. Up until the passage of the PPACA, health insurance groups were able to increase their profit by excluding patients with pre-existing conditions, being aware of the fact that less than 20% of the American population accounts for over 70% of health care costs – those Americans that require medical attention often suffer from serious and chronic illness (Feldman, 2012). Another statistic that highlights the market forces driving insurance companies in the United States is that 5% of the population accounts for over half of health care costs (Feldman, 2012). While similar statistics are present in other nations that have different systems, the American health care system was never set up to be universal, like the system in Canada. Although public programs are existent, the majority of Americans receive either private insurance or no insurance.

To conclude, this chapter draws links between framing literatures and rights/market approaches and discourses. It is important to note that the overlap of disciplines (political science

and public policy) further enriches the understanding of both academic definitions of “rights discourse” and more policy-oriented accounts of right approaches to health care versus market approaches to health care. This will be an important step to move towards the coding and speech analysis to accurately pinpoint where discourses of rights vs. discourses of market health care are present.

3. CHAPTER THREE – SPEECH ANALYSIS

Recalling that the main research question investigates what frames were used in the development and implementation of the PPACA, the central aim of this chapter is to determine whether health care reform in the United States was framed using a market or a rights approach. This is accomplished through an analysis of several speeches given by President Obama over the course of 2009-2013. This allows us to answer the sub-questions:

1. How are the “rights” and “market” arguments in health care policy development in the U.S. delivered?
2. What is the role of “rights” discourse in policy reform, and how does it interact with market discourse and framing?

The previous chapter lays out relevant scholarly discourse on approaches to rights vs. market framing in health policy, as well as the history of the development of health care reform bills in the United States. It also establishes the United States system as a privately financed, privately delivered system, which makes it markedly different from systems in countries where health care is publically delivered. This is key to understanding the mixed frame of market and rights seen in the analysis of President Obama’s speeches. The selected speeches span five years and each one provides important information, quotes, and themes that allows for categorization into rights or market frames. The purpose of the speech analysis is to uncover whether the frames were more oriented towards discussion of the market/economy, or whether it was motivated by convictions of rights (human rights, or rights in the American context). The emergence of a third, “mixed” frame is a result, given that the reform bill focuses on a market solution to a historically,

highly rights-framed issue. Health care and human rights share a strong connection in the literature review, while health care and the market is discussed in arguments for the importance to choose and purchase health care, and framed largely as a solution to the economic downturn.

3.1. CHALLENGES AND LIMITATIONS

The speeches have been narrowed down to their central themes of only a few sentences at most, and the main goals of each speech are also laid out. Following the succinct analysis, a more in-depth analysis and chart of rights and market discourses is done for each of the five speeches. The breakdown of each speech encompasses a qualitative analysis of sections, wording, framing and terminology that relate either rights or of market framing. The key words used for the selection of five long speeches spanning the years 2009-2013, are “health care” in the speech title on the presidency.ucsb.edu database and “Patient Protection” in later years. This allows the search to be narrowed down to speeches that focus on health care reform, including but not limited to the PPACA, as the name “Patient Protection and Affordable Care Act” would not have existed in the early development stages of health care reform.

As mentioned in the introduction, Critical Discourse Analysis (CDA) is used to narrow down the goals and themes of each speech and categorize the ideas based on the framing used. The 5 long speeches were selected through the American Presidency Project using keywords, and selected based on length and relevance.

Within the time frame of January 2009-December 2009, a search through the American Presidency Project identified 37 speeches and statements with the key words “health care” in the

speech title. Of these speeches, several were preceded by terms further narrowing the speech to a specific context, such as “Veterans health care” or “Senate meeting”. Between January 2010-December 2010 by comparison, there were only 12 speeches with the key words “health care” in the speech title. From December 2010-December 2013 the numbers dwindled drastically again, with only 11 speeches existing between this nearly four year time span with the key words “Patient Protection”. This was the speech selection process from which the final 5 speeches were chosen. The final decision on picking the speech, as mentioned, was to pick one speech generally one year apart from the last, and for the speeches to conform to a standard length, as well as for the content to be focused on health care reform as a whole, rather than a more specific part of it. For example, this facilitated the speech selection process especially in 2009, where amid the 37 speeches with the words “health care” in the title, only a select few would meet these criteria, as many of the speeches were either too short, or only focused on a specific aspect of problem with health care rather than a general problem.

There exist two main challenges in this qualitative speech analysis. One of the challenges lies in the qualitative methodology used to analyze the speeches. While qualitative analysis of language is used in framing literature and is appropriate for this project, there is a potential issue of qualitative analysis having various interpretations. As such, in certain cases, the market and rights framing can be difficult to discern - for instance, in cases where there exists a claim to the right to affordable health care. While the main idea may be framed in rights discourse or even using the term “rights”, the main focus of the arguments are still steeped in what can also be subjectively attributed to a right to affordability and a right to a consumer’s choice to purchase insurance. This right is different from the general understanding of universal rights and Chapman’s interpretation of “rights” in health care, but still constitutes rights discourse within a market

framework. This complication and the unique context of the United States in this case is important to clarify throughout the rights vs. market interpretation and speech analysis.

In a similar vein, the second challenge linked to this is the scale of the speeches being analyzed. Although the selection has been narrowed down to 5 long speeches selected over a time-span of 5 years, there is a challenge in adequately summarizing and categorizing the main parts of each speech. At the same time, categorizing is rendered easier when the speech is narrowed down to the two main themes of rights and market approaches, along with the anecdotes that in certain cases serve as a third theme (or a “mixed” theme). As such, these two challenges can be surmounted and the potential issues in using this methodology can be defended.

3.2. CATEGORIZATION INTO RIGHTS AND MARKET

The categorization of ideas in a speech into the two frames is separate from the actual primarily market-based policy being advanced. Rights framing occurs when appeals are made to concepts that include entitlement, deservingness and needs, and any mention of Chapman’s five main cornerstones of a rights approach to health care – universality, government subsidization for those who earn less, and ending unfair practices. In any instance where an anecdote or a story of human suffering and injustice is made in forwarding the reasons for which health reform must be made, this would be categorized under rights framing.

Market framing occurs when the reason for reform is attributed to macroeconomic reasons, or when a distinct appeal to the importance of Americans purchasing their insurance is made. As mentioned in the previous chapter, it will be important to discern market and rights framing in instances where a rights argument is made through a market frame; for instance,

claiming that it is a right of all Americans to purchase their own health insurance plan. This supports the action of purchasing insurance rather than operating in a single-payer universalistic system, yet, the framing is done through “rights”.

Analyzing President Obama’s speeches for type of discourse – market or rights – is a reflection of the history of the United States and also will give insight into what other factors motivated the passage of the PPACA.

The format of this chapter follows the five speeches in chronological order in order to track the development of the frames.

3.3. UNPACKING THE ADDRESSES AND THE REMARKS, 2009-2013

Below I have categorized each speech by theme and goal that illustrate the interaction of the competing ideas that President Obama has put forth. As per Fairclough & Fairclough’s (2012) classification technique, the categorization is kept very brief. Fairclough & Fairclough’s (2012) approach to argumentation requires that there be a context of action; a desirable goal influenced by certain values in each speech.

Giving the example of one of Tony Blair’s speeches, the general flow of long speeches takes on the following format beginning with a broad, open question, which is the reason, or what can be done in the speech. Following this, there is the context of the speech, which in Obama’s speeches takes between 1-4 paragraphs. The deliberation section takes place after this, where options are presented: in President Obama’s case, these are presented largely as the hypothetical single-payer system, or the more realistic employer-based system. The speech then closes

es with a critical discussion on possible options. The five speeches outlined below have been summarized according to the Fairclough & Fairclough's (2012) methodology of isolating three key aspects of the speech: the central theme, the goal, and the main points. Thus, for each of the five speeches, the goal and theme are given in a brief overview of the key points.

Results Table: Table 1

Speech title	Speech date	Main points	Frame
<u>Address Before a Joint Session of the Congress on Health Care Reform</u>	<u>9/09/2009</u>	-affordable healthcare is a major priority -health care problem is deficit problem -employer-based system preferable to the single-payer system	Market
<u>Remarks at the Opening Session of a Bipartisan Meeting on Health Care Reform</u>	<u>25/02/2010</u>	-deficit problem may be solved by health care reform -anecdotes are used to convey urgency -cost of premiums will continue to increase if health care is left unchecked	Market and introduction of mixed frame
<u>Remarks on Health Care Reform</u>	<u>3/03/2010</u>	-Americans have the right to choose their plans -usage of broad anecdotes to convey urgency and -health care is unaffordable and high prices are unsustainable (para. 5) and the proposal will reduce health care costs	Market and mixed
<u>Remarks on the United States Supreme Court Ruling on the Affordable Care Act</u>	<u>28/06/2012</u>	-ACA will make healthcare more affordable and prevent discriminatory actions by insurance companies -strong usage of anecdotal evidence showing medical history premiums increased -prevent financial ruin -personal responsibility to buy health insurance	Rights and mixed
<u>Remarks on the Patient Protection and Affordable Care Act</u>	<u>18/07/2013</u>	-choice and affordability -prevention of rising costs -ensuring higher quality health care -millions deserve health care -fighting to secure the right to care -extensive use of various anecdotes where central figures are named	Rights and mixed

September 9, 2009 - Address Before a Joint Session of the Congress on Health Care Reform

The central theme of the 2009 address is to introduce the concept of health care reform. The goal of the address, broadly speaking, is to convince representatives and the American people of three major points: The first, that the health care system in the United States is in dire need of reform. Second, the address seeks to convince that the market approach, or “employer based” system for health care reform is a better choice for Americans than a single-payer system. Finally, the address describes how the proposed market solution will provide Americans with more choice and they will thus be able to not only choose better plans, but insurance companies will also be restricted on discriminatory practice. As President Obama states in the speech, it will “save money, save lives”. Thus, the first address lays out specifically what the future of health care reform under the Obama administration will look like: it will not be an overhaul of the current system, but rather, it will continue looking for solutions in an employer-based context.

February 25, 2010 - Remarks at the Opening Session of a Bipartisan Meeting on Health Care Reform

The central theme of this speech is solving the deficit through health care reform. These remarks from 2010 have as the main goal to convince representatives that the health care problem can be framed as a market problem that entails a market solution.

March 3, 2010 - Remarks on Health Care Reform

The theme of these remarks center around one type of reform: reform of private insurance

practices and structure. Private insurance is highlighted as a priority, because insurance is currently not affordable. The main goal of this speech is to explain three major changes that the PPACA will put forth: The first major change is that the PPACA will prevent insurance companies from denying coverage based on pre-existing conditions. Secondly, the PPACA will give uninsured Americans ability to choose an affordable health care plan. The third major change will be the resulting savings at the macro level.

June 28, 2012 - Remarks on the United States Supreme Court Ruling on the Affordable Care Act

The central theme of this 2012 speech is the benefits of the PPACA. This is the speech where extensive usage of a realistic anecdote is employed: much of the substance of the speech centers around the case of Natoma Canfield within the framework of the justice system. The goal of this speech is to prove that upholding the PPACA ought to be upheld as constitutional by explaining in detail how the PPACA works to protect Americans and make them secure.

July 18, 2013 - Remarks on the Patient Protection and Affordable Care Act

The theme of this speech is two-fold: holding insurance companies accountable and ensuring that Americans get the “health care that they deserve”. The goal of the speech is to show that the PPACA is “doing what it's designed to do: deliver more choices, better benefits, a check on rising costs, and higher quality health care”.

These comprise the five speeches that will undergo a qualitative analysis and later be grouped into a chart illustrating the types of framing used to convey their main messages.

3.3.2. Address Before a Joint Session of the Congress on Health Care Reform: Speech 1

September 9, 2009

Since health care represents one-sixth of our economy, I believe it makes more sense to build on what works and fix what doesn't, rather than try to build an entirely new system from scratch. And that is precisely what those of you in Congress have tried to do over the several—past several months (para. 12).

In the September 9th 2009, Address Before a Joint Session of the Congress on Health Care Reform, the main topic of the speech is the necessity for the federal government to reform health care, as it relates to the economy and well-being of Americans. The bill did not have a name at this point, but this speech lays out that the reform is necessary, important for Americans, and will solve the deficit issue in the US.

The speech can be broken down into the following four central arguments:

- 1) The concept of health care reform in the United States can be conceived of as a history of collective failure
- 2) Current, poor, health care legislation affects everyone; not just lower-income Americans
- 3) Rising health care costs reduce American competitiveness in the global arena
- 4) There are two routes that American health care reform could have chosen; the new law will follow the American model which is focused on the existent employer-based system, rather than a single-payer system.

President Obama discusses that over the span of decades, the failure to adequately address health care reform represents a collective failure. People who suffer the repercussions of

poor health care legislation are not just on welfare but are middle class Americans. The people affected by health care include middle class Americans, not only the poor. Thirty million Americans cannot get coverage, and anyone may lose their coverage due to insurance companies.

After noting these facts, President Obama highlights one of the main problems over the course of this speech: that there exists is a major problem of rising health care costs in the United States, as Americans spend 1.5 times as much per person on health care in comparison with other countries. This is a reason that employers may drop insurance and another reason that reduces American competitiveness in the international arena.

It is important to note that while the concept of “not going broke” because of health expenditures is existent, it is not directly stated in this speech. Rights language and rights framing is thus not as strong as the market framing, which explains the new – and as of yet unnamed – law as one that accomplish two main goals: First, it will solve the deficit, and second, provide American consumers with choice. The following table lays out the main ideas that clearly delineate market and rights framing:

Table 2.

	Rights	Market
<u>September 9th, 2009</u>	<ul style="list-style-type: none"> -reform will end insurance company abuses such as dropping coverage or discriminating based on preexisting conditions (para. 34 & 37) -Americans will continue to lose coverage and get sicker if no legislative action is taken (para. 47) -The issue is one of fundamental social justice (para. 49) -The public option is one option, but representatives should remain open to anything that makes health care more affordable (para. 34) 	<ul style="list-style-type: none"> -“Our health care problem is our deficit problem. Nothing else even comes close. Nothing else” (para. 10) -Health care represents 1/6 of the American economy. The employer-based system is preferable to the single-payer system (para. 12) -In creating a new insurance exchange/marketplace, Americans will shop for health insurance at competitive prices (para. 20 & 22) -“Consumers do better when there is choice and competition” (para. 30) -New law will slow the growth of health care costs and ensure stability (para. 16 & 19) -The proposed law would make it so that anyone who can afford insurance must purchase insurance (para. 23) -Insurance executives are not bad people and there is no intent to put these companies out of business (para. 31).

In this speech, President Obama highlights how there are two ways to reform, both of which are described as “radical shifts”. One system highlighted is the single-payer system used in Canada which would require the government to provide coverage and restrict private insurance companies. The other system is employer-based and requires individuals to purchase insurance on their own.

Obama warns against playing partisan games, and argues for making inroads, using a decidedly market frame to forward the idea of using an employer-based health care system. In this first speech, Obama highlights three things that reform would highlight, without naming the bill in particular or referencing the PPACA.

...three basic goals: It will provide more security and stability to those who have health insurance; it will provide insurance for those who don't; and it will slow the growth of health care costs for our families, our businesses, and our Government (para. 16).

Obama details that nothing is required to change in any American citizen's plans, and lays out the bulk of what the PPACA does in what is categorized as "explanatory discourse" or "problematization" – an overview of the history of the health care system in the United States, and what the proposed legislation will do (Fairclough & Fairclough, 2012; Vallgarda, 2007):

What this plan will do is make the insurance you have work better for you. Under this plan, it will be against the law for insurance companies to deny you coverage because of a preexisting condition. As soon as I sign this bill, it will be against the law for insurance companies to drop your coverage when you get sick or water it down when you need it the most. They will no longer be able to place some arbitrary cap on the amount of coverage you can receive in a given year or in a lifetime. We will place a limit on how much you can be charged for out-of-pocket expenses, because in the United States of America, no one should go broke because they get sick. And insurance companies will be required to cover, with no extra charge, routine checkups and preventive care, like mammograms and colonoscopies, because there's no reason we shouldn't be catching diseases like breast cancer and colon cancer before they get worse. That makes sense, it saves money, and it saves lives (para. 18).

In the next paragraph explaining what the proposed policy is, Obama details that there will be the creation of "a new insurance exchange, a marketplace where individuals and small businesses will be able to shop for health insurance at competitive prices," and that these exchanges will take effect in 4 years, giving ample time for development. The American health care system poses a burden to taxpayers, as costs rise and more strain is placed on Medicare and Medicaid, and the health care problem is equated to the deficit problem. "Put simply, our health care problem is

our deficit problem. Nothing else even comes close. Nothing else” (para. 10). The amount of market framing throughout this explanation is significant.

President Obama also discusses how some Americans may still choose to go without health care coverage, despite affordable options. This costs the rest of Americans money, but no provision is given to combat this, as he mentions earlier in the speech the employer-based model that represents a dramatic shift, but is not as dramatic as the adoption of a new system of health care such a single-payer system.

In order to understand the interaction of rights and market framing, it is important to analyze the speech in a larger context. President Obama focuses much of his speech on explaining exactly what the health reform bill would entail. In doing so, market language is inevitably invoked, seeing as the reform bill would be modifying the existing system. It is quite possible to postulate that advocating for a single-payer system would result in more rights language. However, increased usage of rights discourse may be seen in the other speeches.

The second half of the speech addresses concern over uncertainties, doubts and confusion surrounding the health care reform. President Obama re-states that consensus exists for striving towards a model of consumer-based health care reform. The discourse surrounding the consumer-based system is, as mentioned above and in the first half of the speech, motivated using a market frame. The new law would have “a requirement that people who can afford insurance get insurance.” This would be highlighted as a market-based approach, as this clearly is not universalistic in its reasoning. If only those who can afford insurance get insurance, then by definition, there is no rights argument.

There is still a potential for rights argument. If, when using a market based model, every American were obligated to purchase insurance, one could still make an argument that this was done using rights approaches – the right for each individual to have insurance. However, President Obama clarifies that illegal immigrants will not benefit from this new policy, and goes on to state that competition in the market yields best results. He defends the health care proposal from critics who claim that it constitutes a government takeover, and mentions that “My guiding principle is, and always has been, that consumers do better when there is choice and competition” (para. 30). Competition, according to President Obama, keeps insurance costs competitively low. These two instances would be widely rejected as rights framing, given that a bill meant to make care affordable still rejects a certain portion of the population, and that consumerism and health care are coupled together.

President Obama uses another market frame in showing neutrality to insurance companies and supporting the system that favours private insurance and profitability:

Insurance executives don't do this because they're bad people; they do it because it's profitable. I have no interest in putting insurance companies out of business... They provide a legitimate service and employ a lot of our friends and neighbors. I just want to hold them accountable (para. 31-32).

The final part of the speech, Obama discusses an issue that concern him and the public greatly: “how we pay for this plan” (para. 36).

...if Americans can't find affordable coverage, we will provide you with a choice. And I will make sure that no Government bureaucrat or insurance company bureaucrat gets between you and the care that you need (para. 35).

No Medicare funds will be used to pay for the new plan, as it is important to uphold “the sacred trust” that care for seniors, who have contributed to a lifetime of hard work and thus should not have high medical bills (para. 38). Obama does not plan on going into deficit to pay for the plan,

but explains rather that savings can be found within the existing health care system. Several vows are made to protect Medicare, referring again to reducing the costs of Medicare and indeed reducing health care costs for everyone. The plan is estimated to cost around \$900 billion over a decade. This is problematized as “less than we have spent on the Iraq and Afghanistan wars” (para. 44).

His discourses on reducing health care costs for everyone represent a blend of rights and market discourses, as the aim of this is to lower costs for the collective, which in turn would result in a more just and ideal society. Referring back to the 5 principles of a rights approach to health care however, it is not changing the system. The rights language conveyed that “everyone” should have a right to purchase health care is not only incompatible with previous discourse on illegal immigrants, and thus is not strong enough to make this count as a rights approach. However, the “driving idea” behind the reform is stated to be two main concerns: Ending abuses by insurance companies, and making coverage available.

Everyone in this room knows what will happen if we do nothing. Our deficit will grow, more families will go bankrupt, more businesses will close, more Americans will lose their coverage when they are sick and need it the most, and more will die as a result. We know these things to be true (para. 47).

This concluding statement reframes the market discourse. The final concluding statement comprises of borrowed words from Ted Kennedy and his words on health care, mentioning the patient’s bill of rights that he worked on with John McCain. ““What we face,” he wrote, “is above all a moral issue; at stake are not just the details of policy, but fundamental principles of social justice and the character of our country” (para. 49). This frames health care as a moral issue.

Using Ted Kennedy’s words is a technique to insert rights discourse in the last part of the speech. These main themes covered in the 2009 speech lay out the groundwork for what will be-

come the PPACA. Interestingly, there are more instances of market language being invoked than rights language, and the majority of this speech focuses on the macroeconomic aspect and necessity of health care reform.

3.3.3. Remarks at the Opening Session of a Bipartisan Meeting on Health Care Reform – Speech 2

February 25, 2010

“I said at the State of the Union, and I’ll repeat: I didn’t take this on because I thought it was good politics. This is such a complicated issue that it’s inevitably going to be contentious” (para. 4)

Based on the title of this speech, there is an expectation for President Obama to highlight the importance of health care reform transcending partisan lines. Because the second speech is at an opening session of a bipartisan meeting on health care reform, it follows that much of the body of the speech highlights the importance of collaboration between parties.

In the introduction, President Obama makes a few brief remarks, the first one highlighting the financial difficulties of the previous year, where getting through the economic recession, restoring economic growth and ensuring Americans got back to work was the main priority. President Obama goes on to link this with the fundamental structural problems in the American economy that impact the deficits and debts. In doing so, President Obama links the market with health care reform at the beginning of this speech, acknowledging that it is of utmost importance to solve the economic deficit crisis through health care reform. He mentions hosting a health care summit, highlighting that health reform was “one of the biggest drags on our economy and represents one of the biggest hardships that families face”.

The next paragraph gives anecdotal evidence of financial hardship illustrating the difficulties that some families face, even going bankrupt as a result of rising health care costs. President Obama again highlights, “this is an issue affecting everyone”. The anecdote used is the worker in Nevada whose child, born with a hare lip, is billed 90,000\$ for treatment and reconstructive surgery. This anecdote employs both rights and market discourses, as the story is framed in terms of the injustice it is for a working father to be given such a hefty bill.

The anecdotes are significant in that these two reference are the first ones that occur throughout the speech analysis. This warrants the creation of a new column that encompasses the mixed framing. This anecdote serves two purposes. First, it illustrates that the market aspect of the health care reform bill is co-dependent on the market-based one. Without one type of framing, the other framing would not exist. If health care were more affordable and more accessible, the inability to pay the hospital bill would not exist, and nor would the rights claim. Second, it demonstrates that access to health care is a problem due to affordability restrictions, and this is an issue, as the right to access affordable health care is important. It is important to note that within these remarks, several paragraphs of a statement given by Democratic Senate Majority Leader Harry Mason Reid from Nevada are included. Senator Reid adds the narrative of Jesus Gutierrez, the worker in Nevada whose health care case was highlighted as a mixed rights and market anecdote; an example of insurance company abuses and the need for urgent health care reform.

Another major concern is that those people who have health insurance – President Obama is not speaking to those without, but those with – will see their premiums double in cost. Another stark piece of market framing occurs as the deficit and debt discourses surface (Obama, 2010):

Almost all of the long-term deficit and debt that we face relates to the exploding costs of Medicare and Medicaid--almost all of it. I mean, that is the single biggest driver of our Federal deficit. And if we don't get control over that, we can't get control over our Federal Budget (para. 9).

Table 3.

	Rights	Market	Mixed
February 25, 2010	-no specific mention of any isolated “right” aside from the Republican’s “right” to oppose health care legislation (para. 44, Senator Harry Reid)	-solve the economic deficit through health care reform (para. 42) -almost all long-term deficit and debt can be traced back to costs of Medicare and Medicaid (para. 9) -Health care costs are the biggest driver of the deficit (para.9) - a reform bill would see buyers (citizens) have pooling power (para. 18) -Currently and without any reform attempts, people will see their premiums doubling in cost (para. 7) -the reform will set up an exchange where consumers can choose (para. 18)	-Jesus Gutierrez, worker in Nevada whose child’s hare lip resulted in 90,000\$ hospital bill = injustice. This appeals to emotion (rights), and also to the rationale for making health care affordable (market) (para. 42, Senator Harry Reid) -in the last months of Obama’s mother’s life, she struggled for reimbursement from insurance companies. Justice, fairness – “rights” is only inferred (para. 11). -bankrupcy due to rising health care costs affects everyone. The issue is universal (para. 6 & 13)

The speech focuses heavily on exploding costs of government-run systems and health care being the biggest driver of deficit. Framing healthcare as a deficit and economic argument is a way to align market with people's rights and justice. But rights are not mentioned: They are inferred. The appeal to emotive reasoning through another personal anecdotes illustrates the intertwining of rights and market framing, as rights are constructed vis-à-vis affordability.

My mother, who was self-employed, didn't have reliable health care, and she died of ovarian cancer. And there's probably nothing that modern medicine could have done about that. It was caught late, and that's a hard cancer to diagnose. But I do remember the last 6 months of her life--insurance companies threatening that they would not reimburse her for her costs and her having to be on the phone in the hospital room arguing with insurance companies when what she should have been doing is spending time with her family. I do remember that (para. 11).

Obama highlights how there is the potential for this debate to become highly partisan, while his motivations are purely based on wanting to agree and see bipartisanship come about. However, there is absolutely no specific mention of rights in this speech. President Obama does outline once again in this speech – as done in the previous one – what exactly an exchange entails (Obama, 2010).

The basic concept is that we would set up an exchange, meaning a place where individuals and small businesses could go and get choice and competition for private health care plans the same way that Members of Congress get choice and competition for their health care plans. For people who couldn't afford it, we would provide them some subsidies. But because people would have some pooling power, the costs overall would be lower because they'd be in a stronger position to negotiate (para 18).

3.3.4. Remarks on Health Care Reform: Speech 3 March 3, 2010

The March 3rd, 2010 remarks given by President Obama illustrate that deliberation over the types of models of health care has been done, and now the time for a firm decision on the type is required. Obama makes appeals to bipartisanship by highlighting that there is consensus between

the two sides that the status quo is not working because of its lack of affordability. This, however, is framed as a rights argument in the introduction, as he reasons that “health insurance is becoming more expensive by the day. Families can’t afford it.” Again, the rights based argument of having a right to afford health care is laid out at the beginning.

This third speech aligns very well with the second one as the themes of choosing a health care model (employer-based), appealing to a bipartisan audience, and employing anecdotes in political discourse are all highlighted.

In the introduction, market framing is employed to emphasize the importance of health care reform, stating that neither families, business, nor the Federal Government can afford health insurance. In sum, the status quo is defined as unsustainable, as indicated in this passage (Obama, 2010).

My proposal would bring down the cost of health care for millions: families, businesses, and the Federal Government. We have now incorporated most of the serious ideas from across the political spectrum about how to contain the rising cost of health care, ideas that go after the waste and abuse in our system, especially in programs like Medicare. But we do this while protecting Medicare benefits and extending the financial stability of the program by nearly a decade (para. 15).

The terms President Obama uses in this speech relate to “control” over health care and bipartisan remarks. He claims that although several other countries have government-run (or single-payer health care systems, this would not be practical nor realistic in the United States. He also rejects to the plans of the Republicans who believe in loosening regulations on the insurance industry, in hopes of the market forces lowering costs. The new health care bill is frames in terms of giving Americans control over their own health care.

The control that American citizens should and will have under the new plan is indicative of rights framing, as President Obama claims that Americans will have more control over their

health because they will hold insurance companies more accountable. This control discourse ties in with the choice discourse, which is all under the rights framing. Americans have the right to control whichever plan they choose.

Obama discusses 3 changes:

1) Insurance companies will not be able to deny coverage based on pre-existing conditions or raise premiums. This first point is the change that will end bad practices. This is framed in terms of rights, as the narrative surrounding the worst practices of insurance companies is often framed as infringing on American's rights.

2) Uninsured individuals and small-business owners will be given the same choice of private insurance as do Congress members. "if it's good enough for Members of Congress, I's good enough for the people who pay their salaries (para. 12)". This is a clear rights framing technique, as it follows the principles laid out by Chapman (1994): it implies universality, although the overall plan is not based on universal coverage. This is used as an opportunity to mention the marketplace "exchange" central to the PPACA. Switching from the individual market to the new marketplace is mostly a way to help the middle class.

3) This will cost 100\$ billion per year, but comes out of the 2\$ trillion that is spent on health care. Obama says that this plan will ensure that the money spent on health care is not done wastefully - taxpayer subsidies will not go to insurance companies, this is one way in which Obama sees that the money will be spent wisely. This part is mostly market framed.

The most obvious rights framing takes place when the PPACA plan to cover 31 million Americans, is compared to the Republican's plan, which due to budget/market constraints, proposed to only have 3 million Americans covered. In response, Obama claims that health care re-

form only makes sense if everyone has access to health: Chapman's (1994) principles of rights in health care are applied in this case, and President Obama makes several appeals to the necessity of universality in his proposed plan.

The problem with that approach is that unless everyone has access to affordable coverage, you can't prevent insurance companies from denying coverage based on pre-existing conditions, you can't limit the amount families are forced to pay out of their own pockets. The insurance reforms rest on everybody having access to coverage. And you also don't do anything about the fact that taxpayers currently end up subsidizing the uninsured when they're forced to go to the emergency room for care, to the tune of about a thousand bucks per family. You can't get those savings if those people are still going to the emergency room. So the fact is, health reform only works if you take care of all of these problems at once (para. 20).

Both market and rights framing are employed in the closing remarks – again by highlighting the injustice of insurance companies raising premiums. Referring to both the American people and then to the US economy, Obama combines rights and market frames in a conclusion that highlights urgency: “Moreover, the insurance companies aren't starting over; they're continuing to raise premiums and deny coverage as we speak (para. 22).”

Why would rights and market framing be combined? And to what extent is it a right not to have to pay? Rights framing, in this instance, is disguised as market framing. Rights discourse can be invoked in what appears to be a market frame when the mention of terms or ideas pertaining to payment, high prices relates to injustice of a working American having to pay this much. Again, the speech does not focus as much on the policy following a market-based system, but rather, there is a high level of framing interaction over anecdotal topics, the concept of choice versus affordability – and the mention of affordability highlights the main goal of the PPACA. Affordability can be seen as both a “rights” and a “market” frame. As such, anecdotes bring the two together. While cost containment is a market argument, affordability is also a part of a rights approach to health care. These are combined through anecdotes.

Table 4.

	Rights	Market	Mixed
March 3 rd , 2010	<ul style="list-style-type: none"> -insurance companies deny coverage to those with pre-existing conditions (para. 5, 6 & 11) -Americans have the right to choose their plan (para. 10) -Americans should have the same “choice of private insurance as do congress members” (para. 12) -the republican plan would not make health care accessible to enough Americans (para 21). 	<ul style="list-style-type: none"> -health care is unaffordable and high prices are unsustainable (para. 5) -Medicare and Medicaid costs result in increased government debt (para. 6) -restated: single payer or government-run system is not realistic for the United States; in contrast, PPACA gives Americans control through choice and consumerism (para. 7) -the proposal will “bring down health care costs for families, business, and the Federal Government” (para. 17) 	<p>Broader anecdotes: small business owners, middle class families, mothers with breast cancer.</p> <p>Specific anecdotes: Talking to a young mother in Wisconsin with two young children. She had cancer and despite having a job, medical bills landed them in debt. “This should not happen in the United States of America. And it doesn't have to” (para. 29 & 30)</p>

Market framing occurs when the terms or ideas pertain to macroeconomics; the US economy or also the importance of creating an exchange that makes health care more affordable and accessible. The following passage consists of anecdotes and appeals to emotion, which would fit under rights framing.

And when we started our push for reform last year, I talked to a young mother in Wisconsin named Laura Klitzka. She has two young children. She thought she had beaten her breast cancer, but then later discovered it had spread to her bones. She and her husband were working and had insurance, but their medical bills still landed them in debt. And now she spends time worrying about that debt when all she wants

to do is spend time with her children and focus on getting well. This should not happen in the United States of America. And it doesn't have to (para. 29)

This is concluded with the statement that achieving a better society can be done by “making private health insurance more secure and more affordable (para. 31)”

3.3.5. Remarks on the U.S. Supreme Court Ruling on the Affordable Care Act – Speech 4 June 28, 2012

The fourth speech represents a drastic shift in framing from market to rights. Obama speaks about a fundamental principle that “in the wealthiest nation on Earth, no illness or accident should lead to any family’s financial ruin (para. 1).” This is an example of rights framing through market framing; the idea that no American should have to endure hardship of economic difficulties.

The decision of the Supreme Court to uphold the constitutionality of the PPACA is framed through a justice or rights framework, claiming that American lives will be more secure because of the reform. Obama again explains what the new law means, which is that all Americans with coverage keep their insurance; the PPACA only makes it more affordable. Insurance companies are no longer allowed to infringe upon the rights of Americans by denying them access to health care if they have a pre-existing condition or if the person in question gets sick.

In sum, the PPACA has achieved its goals of requiring insurers to provide preventative medical care, such as check-ups. Furthermore, adults under age 26 can stay on their parents insurance plans, and seniors receive more discounts on prescription drugs. Finally, the states have set up their own plan, designed as an insurance marketplace “exchange”.

Table 5.

	Rights	Market	Mixed: anecdotes
June 28, 2012	-the ACA makes health care more affordable, and prevents discrimination based on pre-existing conditions (para. 4 & 8)		-This law was passed to rectify the injustice of people like Natoma whose insurance premiums were unaffordably high because of their history of cancer. Obama states this law was passed so that people like her would not have to hang onto chance (para 15-17). -“in the wealthiest nation on Earth, no illness or accident should lead to any family’s financial ruin” (para. 1) -“the Supreme Court also upheld the principle that people who can afford health insurance should take the responsibility to buy health insurance” (para. 9 & 12)

Today, the Supreme Court also upheld the principle that people who can afford health insurance should take the responsibility to buy health insurance. This is important for two reasons: First, when uninsured people who can afford coverage get sick, and show up at the emergency room for care, the rest of us end up paying for their care in the form of higher premiums. And second, if you ask insurance companies to cover people with pre-existing conditions, but don't require people who can afford it to buy their own insurance, some folks might wait until they're sick to buy the care they need, which would also drive up everybody else's premiums (para. 9-11).

Throughout the remainder of the speech, rights framing is employed, without any further discussion about the economy or any macro market-based frames – rather, using an anecdote of Natoma Canfield, claiming that it is for Americans in the same situation as she that the law was passed. Interestingly, there are no claims to the PPACA in relation to solving the economic deficit, as the mention had been earlier. This is attributed to the fact that the speech was given upon

the ruling of the Supreme Court. While market framing is present when listing the accomplishments of the PPACA regarding the exchanges, this is not a focus; it is only mentioned in passing. “...we ultimately included a provision in the Affordable Care Act that people who can afford to buy health insurance should take the responsibility to do so (para. 12)”

3.3.6. Remarks on the Patient Protection and Affordable Care Act – Speech 5 July 18, 2013

The final speech is uses market framing at the beginning, highlighting the fact that consumers will see competition for better insurance packages and that several states have already designed new competitive packages that are pushing down costs.

Benefits of collectivity in health insurance by stating that “And what this means is that hundreds of thousands of New Yorkers who don't have insurance will finally be able to afford it because these exchanges, this big pool is going to reduce the cost.”

This speech functions as a recap of the deliberative process over the course of the previous speeches, where vacillation from rights to market has been quite stark in certain cases – this speech encompasses all types of framing, but mostly mixed framing. When Obama focuses on what the PPACA does for Americans, rights framing is employed. There is no more mention of market framing as a reason for the PPACA coming about, as evidenced through this except:

So this is just an example of how the Affordable Care Act is doing what it's designed to do: deliver more choices, better benefits, a check on rising costs, and higher quality health care. That's what it was designed to do, and we're already seeing those effects take place (para. 7).

Table 6.

	Rights	Market	Mixed
July 18, 2013	<p>-PPACA represents choice (para 4 & 7)</p> <p>-prevention of rising costs and affordable insurance (para. 7)</p> <p>-ensuring higher quality health care for all Americans (para. 3 & 7)</p> <p>-millions deserve health care</p> <p>“we're going to keep fighting to secure that right, to make sure that every American gets the care that they need” (para. 28)</p>	<p>-consumers will be competition for better insurance packages. The “big pool” reduces costs (para. 6)</p>	<p>Anecdote: Morgan: "It felt like someone was actually being held accountable for the dollars I was spending on health care" (para. 14)</p> <p>-“It's about the dad in Maryland who, for the first time ever, saw his family's premiums go down instead of up. It's about the grandma in Oregon whose free mammogram caught her breast cancer before it had a chance to spread. It's about the mom in Arizona who can afford heart surgery for her little girl now that the lifetime” (para. 22)</p> <p>-Examples of Dan Hart, Rick Shewell, Claudia Diamond receiving rebates after the ACA’s passage (para. 15-17)</p>

The reasons that the PPACA was designed the way it was, is that in order to secure more choice, benefits, prevent rising costs and ensure higher quality health care for all Americans. These are all reasons that fall into rights framing, because having more choice, being able to afford insurance and having a higher quality of health care are rights rather than market frames. By stating

that the main goal was to ensure higher quality health care, Obama is not even mentioning the affordability of it, removing any relevance to market framing.

Because there are still millions of people out there who not only want to get health insurance, but many who have health insurance who deserve a better deal and deserve the kinds of savings that the Affordable Care Act will offer (para. 9).

Deservingness is part of the discourse on rights (Beechey, 2013).

After she got a rebate for the first time—and I'm quoting Morgan now—she said, "It felt like someone was actually being held accountable for the dollars I was spending on health care." That's one of core principles of the Affordable Care Act: holding insurance companies and providers accountable so that we all get a better deal (para. 14).

Receiving a rebate resulted in a feeling: that health care dollars meant they were being accountable.

He reasserts again that the PPACA is helping the middle class of Americans, and the core of the PPACA is getting what you pay for. The string of anecdotes reinforce rights framing, and more discourses of deservingness: that Americans “deserve a fair shot.”

It's about the dad in Maryland who, for the first time ever, saw his family's premiums go down instead of up. It's about the grandma in Oregon whose free mammogram caught her breast cancer before it had a chance to spread. It's about the mom in Arizona who can afford heart surgery for her little girl now that the lifetime cap on her coverage has been lifted. It's about the folks here today who got a little bit of relief (para. 22).

Obama compares the PPACA's recent development to the American dream and also to the development of Medicare. “It's part of that basic bargain that if you work hard, if you're doing the right thing, that you can get ahead in this country and that you can provide some basic protections for your family.” So instead of health care being framed mainly as a market endeavour –

which it is to a certain extent when competitive prices are highlighted, and the importance of the insurance marketplace “exchange” – multiple reaffirmations of PPACA being a way to provide basic protection for the family weights this speech heavily towards rights framing.

The speech ends with significant rights framing, with that element of market framing underpinning it through the lens of affordability.

“So we're going to keep fighting to secure that right, to make sure that every American gets the care that they need, when they need it, at a price they can afford. That's the America we believe in. That's what families deserve. That's what we're going to keep on working to deliver. We're going to keep on working to make sure many people around this country who are already paying premiums are getting cheaper prices, that the money is being actually spent on their health care, that you're not having to worry about the fine print, and that if you don't have health insurance, you finally are in a position to get some at an affordable price, to give you and your family the kind of security you deserve (para. 28).

CONCLUSION

In conclusion, the critical discourse analysis of five speeches given over a span of five years provides interesting insight into the frames used by President Obama. Notably, the shift in the type of framing used shows that earlier speeches in the developmental stage of the PPACA were relayed to the public with a strong market frame based on the speeches analyzed, and that this shifted towards a mixed and a rights frame over time. Recalling that framing is a technique used by political elites to speak to the general public, it is worthy to take note of the shift in the narrative and the discourse from 2009, prior to the PPACA's passage, until 2013.

The five speeches provide a wealth of information concerning what the PPACA will change, and they also make up the main part of the frame analysis. President Obama consistently implied throughout the speeches and remarks that all Americans would benefit from the reform, not just a certain group of Americans. This is a rights frame, as the notion that all Americans will

benefit implies an element of universality. However, the speeches also make very clear through explanatory discourse and facts that the PPACA does not change the system into a universal system. Rather, Americans will be required to purchase insurance, and everyday working Americans especially will be able to keep their coverage for themselves and their families. As mentioned prior, there is a fundamental difference in the system or health care model that exists, and the framing that is used to convey the model. As such, for a market-solution such as the PPACA, it is possible to have both rights and market frames employed, despite the fact that the system is primarily employer-based.

The emergence of the mixed frame is made clear when the anecdotes begin to surface in the second speech (February 2010). The emotional appeals through anecdotes make reference to a core problem: healthcare being unaffordable. In a different context, the issue may have been the lack of quality healthcare, an insufficient number of doctors, or an insufficient amount of medication available to a population. In the case of the United States, the main problem arising from these anecdotes shared the common theme of lack of affordability. Medication and treatment is available, but citizens are having their rights revoked by being forced into bankruptcy, or being denied insurance coverage. An infringement on the right to healthcare is thus framed as the right to affordable healthcare. This becomes the narrative of the speeches supporting the PPACA, and the blend between market and rights discourses becomes blurred. The “right” to affordable health care then becomes the dominant narrative, transitioning from health care simply being the deficit problem. This transition is seen in the results table, where the frame used follows the pattern of beginning with market frame, transitioning to a mixed frame with more market frame, and ending with rights and mixed framing.

The speech analysis demonstrates three main findings: the first is that market and rights frames have a high level of interaction in the speeches, and that indeed, more market framing is used than rights framing in the first speech. This is because President Obama problematizes health care reform not as an issue of social justice and every citizen's birthright, but as a solution to the economic downturn. This suggests that market framing is a very effective method of passing legislation in a time of economic austerity. Secondly, the speech analysis demonstrates the emergence of the mixed frame which constitutes anecdotes, but is not limited to them. Finally, the third finding is the "right to affordable healthcare" illustrated by the mixed frame.

4. CHAPTER FOUR: FINDINGS

4.1. SUMMARY OF RESEARCH QUESTIONS AND ARGUMENTS

The main research question of this thesis focused on how the rights and market frames impacted the passage of health care reform in the PPACA. This thesis had as its primary goal to answer the question of what frames were used by President Obama in his speeches through the passage and implementation of the PPACA. This question had many other components to it, including a requirement for background study, international and temporal comparison, and a detailed overview of what rights and market frames and discourses are. Fundamentally, understanding that framing is a technique used by politicians to convey ideas to the public is central to this question. To restate the two further questions linked to the main research question, these included:

1. How are the “rights” and “market” arguments in health care policy development in the U.S. employed?
2. What is the role of “rights” discourse in policy reform, and how does it interact with market discourse and framing?

My research questions was underpinned by the question of whether discourses on rights are increasingly employed in presidential discourses, and whether it would be reflective of a wider change in both public opinion as well as the Administration's priorities. Conclusions that require more research may indicate certain patterns in the language of legislation, given the link between the increased market framing prior to the passage of the PPACA. Further research may be done to examine whether market framing has a relationship with the effectiveness of passing

legislation. Regardless, market framing constitutes a strong and heavily-used framing technique in the realm of health care.

My initial expectations were partially true; my initial researcher's bias expected to see more rights framing invoked at the beginning as the main motivator for passing a costly bill during a time of economic austerity, under the assumption that rights framing would trump market framing and that the clout carried by rights framing would transcend partisan lines. What surfaced instead was a technique that turned this assumption on its head: market framing was heavily employed before the passage of the reform bill, and only when the PPACA had been passed, that this was justified using rights framing. Health care reform was framed as the solution to the economic downturn and as an opportunity for major savings at a macro-economic level. After the act was passed, health care reform was framed as something that everyday, relatable Americans deserved to be able to access and afford.

My initial expectation was that rights and market frames played a significant role in the development of the PPACA. Future scholarship will benefit from an analysis of how market framing of social policy is used in the United States, and whether this is reflective of a changing political culture. Mixed framing, constituting a blend between market and rights discourses often through usage of anecdotes, is highly and effectively employed after the PPACA's passage. Discourses on rights and access to health care have been employed in both scholarly discourses as well as in the public sphere since the 1960s in particular, and have become more important and more used since then. However, the findings show that the amount of rights framing is not significantly dominant over market framing. The speeches show an increased amount of market framing where key words and phrases relate to the economic aspect of health care policy reform. This is due largely to the fact that the proposed reform bill would not be overhauling the system into a

single-payer system. However, there is also an expectation that rights framing will occur as a result of the challenge in forwarding health care reform. As stated in Chapter 2, scholars have highlighted that rights language is stronger than the language of obligations, and appealing to rights is an effective technique in policymaking. What is unknown then, is whether rights language is stronger than market language in pushing for a reform bill.

4.2. ANSWERING THE RESEARCH QUESTION AND PRESENTING THE EVIDENCE

My research question, “What were the frames used by President Obama in his speeches through the passage and implementation of the PPACA?” was answered in a two-fold process: first, through an literature review of framing, market, and rights literature framed through rights and market discourses, and second, through an analysis of speeches which demonstrate that rights and market frames have indeed had a significant impact on the passage of the PPACA. The literature in Chapter 2 lays the basis of the relationship between framing and rights/market discourses, while the analysis in Chapter 3 provides the actual response to the question of how these frames impacted the PPACA.

The evidence shows that market rights, and mixed framing were used over a time period between 2009-2013. Furthermore, the speech analysis shows the trend from market frames to mixed frames to rights frames from 2009-2013, based on the language, motifs and content of the speeches. Ideas and statements suggesting that health care was an economic deficit problem transition into anecdotes that Americans are able to relate to better, and finally, the focus of the act once it was specified as the PPACA concentrates heavily on the right to affordable health care.

The three main findings are presented below: The increased market framing, the usage of anecdotes, and the right to affordable healthcare.

4.3. INCREASED MARKET FRAMING IN EARLY SPEECHES

The findings from the speech analysis demonstrates that rights and market frames impacted the passage and development of the PPACA by showing three main trends: market language in the first speeches, the emergence of mixed framing through anecdotes, and the concept of the right to *affordable* health care. The first trend is the heavy market framing used in the speech prior to the PPACA's passage. In fact, most ideas and goals of the first two speeches focused on macroeconomics and health care, seen through the repeated emphasis of health care being an economic issue, not a rights issue. This is shown through instances where President Obama equates the health care problem to the deficit problem. One main reason to promote health care policy change is thus framed heavily in terms of costs, solving the deficit problem, and ensuring affordability.

In the 2009 speech, without invoking direct rights language, President Obama does devote several paragraphs to the importance of everyone "doing their part". Chapman (1994) would interpret this as ensuring ongoing citizen involvement in achieving a rights-based model to health care. While the health care model is not necessarily universal and would be characterized as a model that is closer to the market approach, President Obama still invokes language that speaks to the importance of "all" Americans contributing to the functioning of this system. Ideally, every American would purchase insurance, which would make this market system universal; however, President Obama takes into account the realities that not everyone is able nor willing to pay for insurance.

In the first speech given on health care in September 2009, President Obama highlights several instances of market framing. These are found through phrases that include emotional appeals as well as normative discourse. Market framing may have been highlighted so strongly at the beginning of the PPACA's inception due political actors and Obama's colleagues being more likely to respond to market framing rather than rights argumentation. Further research on what the impact of market framing had on the passage of the PPACA would be reserved for future projects.

4.4. ANECDOTES: THE MIX OF RIGHTS AND MARKET

The second interesting trend emerges through anecdotes, which constitute a third type of framing, which I call the mixed frame of market and rights. This second trend sees that mixed framing and rights framing increases dramatically after 2011, when the PPACA has been passed. This is significant in that it shows how market framing was used primarily in the discourses before the bill was the passed, while rights framing was employed more after the bill's passage. This signifies that rights and market framing are used for different purposes, and for constructing arguments to persuade the electorate and the public, market framing is more effective at passing legislation.

Anecdotes used by President Obama are present in 4 of the 5 speeches: in the 2010, 2011, 2013 speeches, President Obama refers to individuals as well as a broader notion of anecdotal reasoning.

Within these two categories, there exist appeals to justice and anecdotal evidence, which appeals to emotive reasoning. The anecdotes serve both to humanize the policy aspect of health care reform, as well as personal narratives serving a function of being primarily rights based, but have a market component to them. Several anecdotes illustrate injustice, based on health care being unaffordable, and also based on insurance companies denying coverage. Stories that are told can be framed both in terms of market or rights.

This is about what reform would mean for the mother with breast cancer whose insurance company will finally have to pay for her chemotherapy. This is about what reform would mean for the small-business owner who will no longer have to choose between hiring more workers or offering coverage to the employees she has. This is about what reform would mean for middle class families who will be able to afford health insurance for the very first time in their lives and get a regular checkup once in a while and have some security about their children if they get sick (Obama, 2010).

Another category that is not linked to market and rights is the large amount of what could be categorized as “explanatory discourse”, or passages and areas which explain exactly what the PPACA will do and also includes historical background. This may not just be explanatory but also a narrative of the problem of why health care reform in the United States has been so fraught with failures; a problematization of health care reform.

Anecdotes are used for various purposes; as an appeal to emotive reasoning, a personal narrative to which citizens can relate. Personal narratives serve a function of being either rights or market based. Through anecdotes of Americans who have specific needs that must be met through health care reform, Obama may tell a story of both human suffering and also the dollar value of insurance and payments. Again, this is possible because of the type of health care reform he agrees upon in the first speech, where market framing is widely used to highlight the consumer-friendly, employer-based system of insurance that does not guarantee universal coverage nor make the government responsible for administering all programs in a single-payer sys-

tem. Thus, another important usage of anecdotes is that they constitute a blend, or “mix” of frames. Mixed frames are reflected in anecdotes that talk about the strife and difficulties that citizens face due to economic issues that equally put forth a narrative of rights in a system that is market-based.

4.5. UNPACKING THE “RIGHT TO AFFORDABLE HEALTH CARE” THROUGH MIXED FRAMING

The third and final finding is the usage of the “right to health care” and the “right to affordable health care.” Several times, through mixed framing, Obama highlights the importance of the PPACA’s goal to ensure affordable access to health care, instead of the concept of ensuring a basic right to health care. This is largely due to the fact that in the beginning stages, a potential for creating a single-payer system had been discussed, although a private, employer-based bill that followed the same private, existing system ended up constituting the health care reform bill. Thus, the notion of a “right to affordable health care” demonstrates how this idea emerges from mixed framing that blends rights and market frames. While a right to health care is the underlying purpose of the PPACA, it is more accurate to say that ensuring a right to affordable health care forms the basis of this bill. After all, the name – the Patient Protection and Affordable Care Act – reflects the priorities of the act; that is, ensuring that patients are protected from possible bankruptcy and unfair practices from insurance companies, and also making health care more affordable.

The right to affordable health care is not only a slogan, but also an ideology which em-

bodies a mixed approach to market and rights framing. Rights language is invoked to achieve access to services; in this case, health care. This is one of the two trends that has emerged from the analysis: Market and rights framing interact by supporting one another. While the first speeches deal primarily with market framing, speeches delivered after the PPACA's passage reflect a merged narrative where the right to affordable health care is championed, rather than the simple "right to health care". This highlights the unique position of the United States and the relationship between rights and health care reform. The insertion of the term and notion of "affordable" keeps the reform framing within the parameters of a market, employer-based private system of the United States. Advancing the notion of rights is not achieved without a significant mention of market language.

The change in framing used based on the time/date of the speech reflects a change in the debate based on the languages used to communicate the PPACA. It also shows the evolution of the reform from a vague idea without a name, to the precise act that is defended and lauded using mixed rights-market language.

The PPACA was enacted to fix a system that currently existed. If health care reform in 2009 had been promoted as a universalized system, perhaps rights language would have been more heavily invoked. However, the conclusions of this project demonstrate how market framing was used heavily by President Obama. While it is possible that rights framing was indeed used more than in the past, it would be necessary to compare this with other statements and speeches from previous terms in detail. This would be useful for a future project beyond the scope of this thesis.

To conclude, the research question was answered through reviewing literature and conducting a qualitative analysis of Obama's speeches. Through this process, I found that there exists a gap in literature surrounding market framing in health care, although the existent system in the United States is inferred to be market-based. As it was not highlighted specifically, theories of liberalism and its impact on American political culture are used. Previous health care reform attempts in the United States were not framed using rights language (Boychuk, 2008). However, various factors could point to the PPACA having a strong rights narrative to drive the speeches, including its framing as a landmark health care reform, the increasing importance of rights language. Thus, the most accurate conclusion that can be offered is that a mixture of rights framing as well as clear market framing is used to convey the idea that the PPACA is a piece of legislation that follows the existent employer-based, private system to ensure the right to affordable health care. Market framing is used in connection with rights framing to persuade colleagues of the importance of the PPACA. It is expected that a mix of market and rights framing would be found, given that discourses of the right to afford health care and on the injustice of having to pay higher premiums. The "right to be a consumer" encompasses the mixed frame that is distinctive to the US.

4.6. THE PERSUASIVE PURPOSE OF MARKET FRAMING TO PASS A BILL

One more important trend reflected in the speech analysis is the market framing, apparently used for persuasive purposes to pass a bill. Based off of the significantly higher incidence rate of market framing in the first two speeches, it would appear that representatives would be more receptive to the idea of reform during a time of economic austerity when it is framed as a

solution to the deficit, rather than an appeal to rights. This reflects the importance of framing and language behind the PPACA's passage, and how this is relevant for future study of rights-based reform bill passages.

To summarize, President Obama uses market framing as a persuasive approach to get the PPACA bill passed. Market framing appears efficient in persuading representatives, and blending market and rights framing through the notion of the "right to affordable health care" – narrated through personal stories and anecdotes – is a framing technique used in the speeches following the bill's passage.

The tables in Chapter 3 illustrate the invocations of rights, market, and the number of anecdotes. They serve as a tool to illustrate the overlap of ideas as well as a visual aid to show the increase in anecdotes over time. Further research on the effectiveness of market framing to pass bills would be a complement to this research.

4.7. OUTLOOK AND FUTURE STUDY

The development of health care reform in the United States has been problematized by various administrations, and addressed through decades of reform policies. This analysis has shown that rights discourse is indeed important in president Obama's speeches on health care reform, but that a mixed frame that incorporates market framing is most employed. Potential reasons for this could have been due to the main motivator really being the economic downturn, or it might have been a desire to be bipartisan. The unique nature of the United States' approach to health care reform, and the right to affordable health care are also important reasons.

There are three points that I would like to highlight for the outlook for future study: what can be changed, what can be improved? How would different American presidents employ different discourses? And finally, in the next election, how will health care be problematized, in what political context?

The American culture of health care can be analyzed in a comparative context with other countries. While this project touched upon one American example – the Clinton health care reform – as well as a comparison of the Canadian system, a more in-depth and longer term project could continue the study of the culture behind health care reform in the American context along with several country comparisons.

This project highlights how language influences policy, and how the passage of bills is affected by framing – language, symbols and ideas. There are many follow-up questions and in-depth research which could be conducted on American health care reform. What remains to be seen is how the PPACA will influence future policy reform, and what this means in the broader global context for the United States. Given that the definition of rights is contextualized to Americans and that this narrative is present throughout the framing of the PPACA, what kind of policy change will be introduced to continue to improve health care policy? How will this be framed? Will rights framing become more prevalent should a single-payer system be introduced, or will market framing still be employed? Would market framing be more effective in passing legislation, or have other examples demonstrated how rights framing can be a successful tool in passing landmark health care legislation?

Health care will continue to be a contentious topic with room for improvement and room for policy change. The extent of the PPACA's impact on solving the debt and deficit crisis in the United States remains to be seen, but the amount of market framing and the development of the

mixed frame reflect the unique culture of health care of the American government, seen through the discourses given at the federal level by President Obama.

Future study would allow for more in-depth speech analysis between Republican and Democratic presidents in order to better understand the role that framing plays in persuading electorates, voters and populations into effecting policy change.

An interesting future project could include an analysis of the implications of mixed rights-market framing for future reforms, at a smaller as well as in a global context. In the upcoming elections, will health care be problematized in a similar fashion, through mixed frames? How can we continue the discussion on health care reform with further study of the American system in comparison with universal health care systems? Has rights framing been effectively used for other reforms in other countries or other contexts? There is a wide scope of possible research questions that may stem from this project.

In sum, health care reform policy in the United States is a historically constructed narrative of complex relations between insurance companies, political cultures, and political elites. Health care is problematized and subsequently conveyed through discourses framed in mainly rights and market contexts, but not exclusive to these, as the emergence of the mixed frame demonstrates. A unique interaction of rights and market is present throughout the development of the PPACA, and the dominant market discourse prior to its passage is reflective of the type of reform promoted – that is, one that focused not on universal access to health care or a single-payer system, but rather affordability and a “right to affordable health care”. If rights discourse is used more frequently in future reforms, then it will perhaps indeed be reflective of a change in political cultures. Until then, the PPACA was created to amend the current system, not to change the fundamental system into single-payer. To do this, rights and market framing were used and

had a high level of interaction with one another, resulting in a mixed-frame. Further research into the effectiveness of framing with regards to passing health care legislation will confirm and continue the scholarship and dialogue around rights and market frames.

5. REFERENCES

Address Before a Joint Session of the Congress on Health Care Reform (2009). The American Presidency Project. Retrieved Dec. 1, 2013 from <http://www.presidency.ucsb.edu/ws/index.php?pid=86592>

Barack Obama's Inaugural Address . Published January 20th, 2009. Retrieved Jan. 27 2013 from http://www.nytimes.com/2009/01/20/us/politics/20text-obama.html?pagewanted=all&_r=0

Beechey, S. (2013) "Discourses of Rights, Entitlement, Need, and Deservingness in the Affordable Care Act" Whitman College, Conference paper.

Berns-McGown, R. "Political culture, not values" International Journal; Spring 2005; 60, 2; Worldwide Political Science Abstracts. p. 341

Blumenthal, D. & Collins, S. (2014). Health Care Coverage under the Affordable Care Act — A Progress Report <http://www.nejm.org/doi/full/10.1056/NEJMhpr1405667>

Boychuk, G. (2008). National Health Insurance in the United States and Canada: Race, Territory and the Roots of difference. Georgetown University Press, USA.

Brewer, P. & Gross, K. (2005). Values, Framing, and Citizens' Thoughts about Policy Issues: Effects on Content and Quantity Political Psychology, Vol. 26, No. 6, 2005

Brock, D. The President's Commission on the Rights to Health Care: in Chapman, A. (1994).

Health Care Reform: A Human Rights Perspective. Georgetown University Press. USA.
Pp. 65-83.

Carmalt, J., Zaidi, S. & Yamin, A. Entrenched Inequity: Health Care in the United States: in

Hertel, S., & Libal, K. (2011). Human Rights in the United States: Beyond
Exceptionalism. Cambridge University Press. Cambridge, UK.

Chapman, A. (1994). Health Care Reform: A Human Rights Perspective. Georgetown University
Press. USA.

Daly, M. (2011). Welfare. Key Concepts Series. Polity Press, Cambridge, UK.

Deber, R. (2002). Delivering Health Care Services: Public, Not-For-Profit, or Private? Discus-
sion paper No.17. Commission on the Future of Health Care in Canada. University of
Toronto.

Erickson, D. (1997). "Presidential inaugural addresses and American political culture".
Presidential Studies Quarterly, Vol. 27, No. 4

Fairclough, N. (2003). Analysing Discourse: Textual Analysis for Social Research. Routledge.
Ebook publication date: April 2003.

Fairclough, Isabela & Fairclough, N. (2012). Political Discourse Analysis. A Method for
Advanced Students. (London : Routledge)

Fast Stats. <http://www.cdc.gov/nchs/fastats/hinsure.htm>. Accessed March 11 2014.

Feldman, A. (2012). *Understanding Health Care Reform: Bridging the Gap between Myth and Reality*. CRC Press, Florida, USA.

Hacker, J. (2010). *The road to somewhere: why health reform happened*. Perspectives on Politics. Cambridge University Press.

Health Insurance Marketplace (2014). Retrieved on August 3rd 2013 from www.health care.gov

Jacoby, W. (2000). Issue Framing and Public Opinion on Government Spending. *American Journal of Political Science*, Vol. 44, No. 4 (Oct., 2000), pp. 750-767

Jerit, J. (2007). Issue Framing and Engagement: Rhetorical Strategy in Public Policy Debates. Published online: 12 September 2007. *Polit Behav* (2008) 30:1–24

Kaiser Family Foundation. (2014). Key Facts About the Uninsured Population. retrieved on October 27th from <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

Koch, J. (1998). Political Rhetoric and Political Persuasion: The Changing Structure of Citizens' Preferences on Health Insurance During Policy Debate. *The Public Opinion Quarterly*, Vol. 62, No. 2 (Summer, 1998), pp. 209-229

Leary, V. Defining the Right to Health Care: in Chapman, A. (1994). *Health Care Reform: A Human Rights Perspective*. Georgetown University Press. USA. Pp. 87-105.

Mueller, K. (1993). *Health Care Policy in the United States*. University of Nebraska Press. USA.

Navarro, V. (1994). *The Politics of Health Policy: The US Refors, 1980-1994*. Blackwell Publishers, UK.

Neagu, M. (2013). Decoding Political Discourse: Conceptual Metaphors and Argumentation. Palgrave Pivot. Ebook publication date: February 2013.

Number Of Uninsured Americans Drops By 1.3 Million. (2012). Retrieved August 4th 2014 from <http://www.kaiserhealthnews.org/daily-reports/2012/september/13/census-numbers.aspx>

ObamaCare Facts: Facts on the Obama Health Care Plan. (2013). Retrieved February 27 2013 from <http://obamacarefacts.com/obamacare-facts.php>

Obamacare Facts: Retrieved February 27 2013 from <http://obamacarefacts.com/obamacare-individual-mandate.php>

Patel, K. & Rushevsky, M. (2005). The Politics of Public Health in the United States. M.E. Sharpe, New York.

Primus, R. (1999). The American Language of Rights. Cambridge University Press. Cambridge, UK.

Quadagno, J. (2005). One Nation, Uninsured: Why the US has no national health insurance. New York: Oxford University Press.

Remarks at the Opening Session of a Bipartisan Meeting on Health Care Reform. (2010). The American Presidency Project. Retrieved Dec. 1, 2013 from <http://www.presidency.ucsb.edu/ws/?pid=87574>

Remarks on Health Care Reform. (2010). The American Presidency Project. Retrieved Dec. 1 2013 from <http://www.presidency.ucsb.edu/ws/?pid=87593>

Remarks on the Patient Protection and Affordable Care Act. (2013) The American Presidency

Project. Retrieved Dec. 1 2013 from <http://www.presidency.ucsb.edu/ws/?pid=103914>

Remarks on the United States Supreme Court Ruling on the Affordable Care Act (2012). The American Presidency Project. Retrieved Dec. 1 2013 from <http://www.presidency.ucsb.edu/index.php>

Revisions to CBO's Projections of Federal Health Care Spending. July 28, 2014. <http://www.cbo.gov/publication/45581>

Riker, W. (1996). *The Strategy of Rhetoric: Campaigning for the American Constitution*. Yale University Press.

Shaw, G. (2010). *Historical Guides to Controversial Issues in America: The Health care Debate*. Greenwood. Santa Barbara, California, USA.

Schmidt, P. (2011). *Medicare and the Patient Protection and Affordable Care Act*. Nova Scotia Publishers, Inc. New York.

Schneider, A. & Ingram, H. (2013). Social Construction of Target Populations: Implications for Politics and Policy. *American Political Science Review*. Vol. 87, no. 2 (June 2013). Pp. 334-347

Skocpol, T. (1994). *From Social Security to Health Security? Opinion and Rhetoric in U.S. Social Policy Making*

The White House: President Barack Obama. (2013). Retrieved January 26, 2013 from [http://www.whitehouse.gov/healthreform/myths-and-facts#health care-menu](http://www.whitehouse.gov/healthreform/myths-and-facts#health%20care-menu)

U.S. Census: Retrieved October 17, 2013, from:

<http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2012/tables.html>

Vallgarda, S. (2007). Health inequalities: Political problematizations in Denmark and Sweden. Institute of Public Health, University of Copenhagen, Denmark.

Yanow & Schwartz-Shea. (2006). Interpretation and Method: Empirical Research Methods and the Interpretive Turn. M.E. Sharpe.